Interprofessional practice research:

Working together to research together

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University of Queensland
Outline

• Definitions and context
• Research and evaluation
• Relationships
• Interprofessional and interdisciplinary identity
The Salisbury statement

There needs to be a shift in the way practice is researched so that it provides relevant knowledge for better practice in complex and uncertain situations.

How is professional practice to be researched better, to provide a basis for improved practice?

Practice research, involving equal dialogue between the worlds of practice and research is important as a concept, since it seeks to develop our understanding of the best ways to research this complexity.
“Practice research involves curiosity about practice. It is about identifying good and promising ways in which to help people; and it is about challenging troubling practice through the critical examination of practice and the development of new ideas in the light of experience.

It recognises that this is best done by practitioners in partnership with researchers, where the latter have as much, if not more, to learn from practitioners as practitioners have to learn from researchers. It is an inclusive approach to professional knowledge that is concerned with understanding the complexity of practice alongside the commitment to empower, and to realise social justice, through practice.”

Interprofessional AND interdisciplinary relationships: not easy
“There are many different interest groups involved (practitioners, service users, academics, researchers, policy makers, managers, the general public) who may represent contradictory interests”

ALMOST PRESUPPOSES THAT ALL PRACTITIONERS ARE HETEROGENEOUS WHILE RECOGNISING THE DIFFERENT TRIBES AND CULTURES INVOLVED ACROSS ‘DIFFERENT’ STAKEHOLDERS
The SO WHAT? question....

Need to ensure that research based in and on practice is relevant to practising health and social care professionals

Do we need to change our practice?

Practice ......practitioner ......practical
Plus ça change – plus c’est la même chose

Too much change

Change without evaluation may be harmful, leads to burnout and demotivation especially if there is little consultation and communication and rationale

Often political and idealistic rather than practical and user-centred
Examples of change - 2011

NHS 'to undergo radical overhaul’

BBC News

Health Secretary Andrew Lansley: "GPs will lead a bottom up design of services”

The NHS in England is to undergo a major restructuring in one of the biggest shake-ups in its history, the government has announced.

Hospitals are to be moved out of the NHS to create a "vibrant" industry of social enterprises under the proposals.

And, as expected, GPs are to take charge of much of the budget.

The move will lead to the abolition of all 10 strategic health authorities and the 152 management bodies known as primary care trusts.
Anything been done like this before?

Yes. Lansley says his switch to GP-led commissioning is a logical extension of two projects: **GP fundholding**, a Tory government initiative in the early 1990s, and practice-based commissioning, introduced by Tony Blair in 2005.

Under the latter, GP surgeries were able to hold budgets, and in co-operation with trusts decided on appropriate care. But the new plan is more radical, and some doctors fear the changes will mean the end of the NHS as we know it, since the service will cease to be a cohesive single entity.
Smith & Wilton, 1998

‘In the absence of any formal evaluation of fundholding, it is difficult to assess the overall success of this reform.’

‘Evidence concerning the success or otherwise of general practice fundholding over the past six years is incomplete and mixed. The major deficiency concerns any effect on health outcomes that may be the result of fundholding. Until such research is conducted, the jury will have to remain out on whether fundholding has secured improved efficiency in the delivery of health care.’
Health and social care professionals: change required…

- Evidence suggests that there is poor communication
- Issues of patient safety
- Lack of teamwork
- Bristol
- Child protection
- NSW hospitals
The story of the paediatric cardiac surgical service in Bristol is not an account of bad people. Nor is it an account of people who did not care, nor of people who wilfully harmed patients. It is an account of people who cared greatly about human suffering, and were dedicated and well-motivated. Sadly, some lacked insight and their behaviour was flawed. Many failed to communicate with each other, and to work together effectively for the interests of their patients. There was a lack of leadership, and of teamwork.'

‘Clinical education and training should be undertaken in a multidisciplinary environment which emphasises interdisciplinary team based patient centred care.’

The scope of the problem


Between 8 and 15 staff were involved in a patient’s care.

One patient, whose face-to-face interactions with staff lasted 47 minutes in total, had 62 separate encounters in that time.

While a number of different professionals were involved in care delivery (mainly doctors and nurses of various grades), there was very little interaction between them at the bedside and few interprofessional handovers.

This resulted in the information gathered about and given to the patient becoming fragmented.
a social network approach to studying interprofessional communication

ISSAC LIM
MS, MA, MSc, BBA(H)
(NATIONAL HEALTHCARE GROUP)

with Chung King Chia, Mui Peng Wong, Puay Yee Kwek & Philip Choo
(TAN TOCK SENG HOSPITAL)
0700 – 1000 hours

out-degrees (the intensity of interaction initiated)

in-degrees (the intensity of interaction received)

[social network analysis]

[GM]
### [social network analysis]
### [descriptive statistics]

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<th></th>
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<td><strong>Between 0700 to 1000</strong></td>
<td></td>
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<td>On patients</td>
<td>864 (26.9%)</td>
<td>1049 (27.4%)</td>
<td>719 (21.1%)</td>
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<td>On PC/Admin</td>
<td>970 (30.2%)</td>
<td>759 (19.8%)</td>
<td>1006 (29.5%)</td>
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<td>442 (13.7%)</td>
<td>1360 (35.5%)</td>
<td>840 (24.6%)</td>
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<tr>
<td>Nurses ↔ Nurses</td>
<td>831 (25.8%)</td>
<td>624 (16.3%)</td>
<td>542 (15.9%)</td>
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<tr>
<td>Doctors ↔ Nurses</td>
<td>46 (1.4%)</td>
<td>28 (0.7%)</td>
<td>260 (7.6%)</td>
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<td><strong>Total recorded activity (minutes)</strong></td>
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Framework for Action on Interprofessional Education & Collaborative Practice
What does being interprofessional mean to you?
IPE and IPECP: are they effective?

IPE: occasions when two or more professions learn from, with and about each other to improve collaboration and the quality of care (CAIPE)

Interprofessional collaboration is the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/ families and communities to enable optimal health outcomes (CIHC)
Together Everyone Achieves More
CLAIMS

Actively/potentially contributes to teamwork and collaboration between health and social care professionals from different disciplines

Harnesses the skill mix of the professions

Breaks down s***s between the professions

Enhances relations and understanding of common values
Research v evaluation

Evaluation of programmes is important
Can add new knowledge if innovative design
OR – higher level of evaluation
However, tend to be descriptive and not generalisable (?)
Classic experimental design: assumes causality

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Does X (IPE/IPECP) work? (outcome)
Realistic evaluation (Pawson & Tilley – various years)

Rather than asking ‘what works’ or ‘does it work’?

- we should be asking : which methods work best for which types of learners/professionals and/or in what types of settings/environments?

(outcome and process)
Generative causation (P&T, 1997)

Causal outcomes follow from mechanisms acting in context
The realist experiment (P&T, 1997)

Educational/practice intervention

Manipulate context

Mechanism

Outcome

Explanatory mechanism – how it works (test theory)
Realist evaluation cycle

- What works for whom in what circumstances
- Data collection
- Program specification
- Theory
- Observations
- Hypotheses
- Mechanisms
- Context
- Outcomes

What might work for whom under what circumstances
Theorising interprofessional interaction

• Communities of practice and situated learning (Lave & Wenger, 1991)

• Students undertaking interprofessional activities move first from the periphery of their own profession into a greater understanding of their role within it, and then interact with other professions first as observers and later members of the team (Thistlethwaite & Nisbet, 2011)

• Knowledge exchange and knowledge transfer are key components of such activities and fit within the learning ‘with, from and about’ paradigm (Kaufman & Mann, 2007)
4 theories to underpin IPP (Reeves et al, 2010)

• Relational theories (eg Tajfel and Turner, Goffman)
• Processual (Engeström’s activity theory)
• Organisational (DiMaggio & Powell)
• Contextual (Freidson’s work on professionalism, Foucault’s discourse analysis)
He/she was so professional...
What is a profession?
What is professionalism?

Interprofessionalism
Interprofessionality
Different values? Different views of professionalism?
Different language? Different epistemologies?

In medicine: the gold standard is the double blind randomised cross over trial

Try to extrapolate methods into health professional education and practice research

Qualitative, constructivist and interpretive methodologies often viewed with suspicion – it’s a numbers game

Even different journals!
Hard versus soft disciplines...

Becher has noted that practitioners from the pure sciences and technologies ‘reported putting greater stock in the validity of empirical observations and the ability to draw valid conclusions of general applicability from those observations’. Those from the humanities and social sciences were seen as privileging ‘perceptions of knowledge as subject to the vagaries of structural, historical and cultural contexts’ (Becher 1987, cited in Frost and Jean, 2003, p. 142).
Clans, tribes….disciplines

Perhaps the most classic view of the disciplines is as clans or tribes, which are characterised by particular epistemological and social features (Becher, 1994; 2001).

Cultural practices of a discipline can include values, beliefs, attitudes, traditions and social practices, behaviours, norms, language and shared meanings (Becher & Trowler, 2001).
A commonly applied metaphor in health & social care is ‘turf war’ (or ‘turf battle’ or ‘tribal war’). Such wars have been described not only inter-professionally (e.g. Axelsson & Axelsson, 2009) but also intra-professionally (Jones et al, 2005).
Values-based practice

‘...a blending of the values of both the service user and the health and social care professional, thus creating a true, as opposed to a tokenistic partnership’ (Thomas, Burt & Parkes, 2010, p15).
Identity: professional or interprofessional?

Across education and health professions, there have been concerns that interprofessionality dilutes specialisms, threatening to transmute professionals into all-purpose generalists.

For individuals, the perceived threats may run deep, striking to the core of their professional identity.
At the heart of this issue lies uncertainty about the nature and status of ‘expertise’ in interprofessional settings. Writing from an educational perspective, Edwards et al. (2010, p.31) emphasise that notwithstanding certain generic skills ‘that enable people to collaborate across professional boundaries … for us the specialist professional expertise that practitioners bring to complex problems is paramount’.

Interprofessionality, it is stressed, requires an ‘additional layer of expertise’ (ibid, p.31) – it is not an alternative.
Accounts of interprofessionalism are, often, characterised by a dark lexicon:

risk(y), danger(ous), threat(ening), rule-bend(ing), role-break(ing), custom-defy(ing), side-step(ping), rule-break(ing), struggle(s), vulnerable and difficult(ies).
I’m not interested in creating grey, generic children’s service professionals. You can’t make social workers into nurses and you can’t make nurses into social workers but it is possible to develop a better understanding of other agencies. Joint training would help create mutual understanding - but we could still retain our specialisms”. (Leadbetter, 2006, p. 54)
Separate or shared identities?

The intent of interprofessional education is not to produce khaki-brown generic workers. Its goal is better described by the metaphor of a richly coloured tapestry within which many colours are interwoven to create a picture that no one colour can produce on its own. (Headrick et al., 1998, p.772)
Deconstructing ‘collaborative practice’
(Thistlethwaite et al in press)

Words and phrases soon become professional jargon, and their frequent usage leads to assumptions that we all agree on what they mean. But deconstruction challenges the notion that words have fixed meanings and ‘are instead always hinting at other contexts than the one they are appearing in’ (Sim, 1999, p.71).

Oxford English dictionary: ‘a method of critical analysis of philosophical and literary language which emphasizes the internal workings of language and conceptual systems, the relational quality of meaning and the assumptions implicit in forms of expression’
Deconstructing practice
Repetitive action to improve performance

To paraphrase Humpty Dumpty, when we use words, they mean whatever we choose them to mean, neither more nor less (Lewis Carroll, 1871).

Practice(s) are moments of human significance beyond self, by which people participate in and thus experience something greater than their own perceptions and perspectives of the world (Kemmis & Trede, 2010).

The enactment of the role of a profession or occupational group in serving or contributing to society (Higgs, McAllister & Whiteford, 2009).

A socially institutionalised and socially acceptable form of interaction requiring cognitive understanding and reflection (Barnett, 2010).
Collaboration: ‘Widespread and varied usage of the term collaboration renders it nearly meaningless’ (Thomson et al, 2007; p24).

Collaboration – working with the enemy; working with each other; working together, from laboro (Latin) work

Origin France about 1855

Vulnerability is a feature of the person who trusts and trust is necessary for functional teamwork – the absence of trust being one of the five features of dysfunctional teams (Lencioni, 2002). Thus we place our trust in those with whom we collaborate, and imply both we, as well as our patients/clients, are vulnerable.
Differences in ways of thinking and doing have been proposed to ‘generate considerable bewilderment, if not suspicion in interdisciplinary discourse and reduce its potential benefits’ (Frost & Jean, 2003, p. 142) and hamper integrative and cohesive forms of practice (Smith, Mitton, Peacock, Cornelissen, & MacLeod, 2009). It has been suggested that successful interdisciplinarity can only occur if individuals are helped to understand the basic knowledge and values of other disciplines (Clark, 2006; McCallin, 2006; Petrie, 1976).
Identity

How one defines oneself to oneself and to others (Lasky, 2005).

Not a static or fixed entity but flexible, multifaceted, and in a continuous process of formation and transformation (Giddens, 1991; Sveningsson & Alvesson, 2003).

Open to change and relatively sensitive to situational influences (Swann Jr, Johnson, & Bosson, 2009). A state of ‘becoming, rather than being’ (Alvesson, Ashcraft, & Thomas, 2008, p. 15)
Identity Personal v professional

Identity dissonance
  +ve dissonance
  -ve dissonance

Identity consonance
  +ve experience

Kumar 2012 based on Costello 2005
Conclusion: Practice research (for me) is

- Interprofessional
- Interdisciplinary

We need to discuss our (our includes users):
- Values
- Theories/beliefs
- Approaches

In order to collaborate