Running Head Right-hand: Learning to collaborate

Running Head Left-hand: Ann Griffin and Catherine O'Keeffe

Chapter 4

Learning to collaborate

Boundary work and contemporary approaches in interprofessional education

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Learning objectives:

- Revisit key concepts associated with education for collaboration including multi-professional and IPE.
- Be introduced to the emerging concepts of trans-professional education, hybridicity, border discourse, related educational theories and their value for understanding professional identities as context change.
- Consider the importance of educational relationships for promoting collaborative learning across primary, community and integrated care settings.
- Identify essential components when designing educational programmes for collaboration.

Background

There is increasing focus on the need for professionals to be able to work effectively in multi-professional teams (Imison and Bohmer 2013). Collaborating is considered crucial to respond to the complex needs of patients with LTCs; the emergence of new, diverse roles with varying degrees of professional status; and systems and structural re-organisation within the NHS.

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Failures in education to respond to the changing needs of the population, to persist with hospitals as the preferred educational setting and a lack of focus on teamwork and leadership are now the focus of global educational reform (Frenk et al. 2010). However, a significant barrier to progress is *the so-called tribalism of the professions – that is, the tendency of the various professions to act in isolation from or even in competition with each other* (ibid). There has been much discussion on the value of interprofessional learning, an educational model which supports improved collaboration and its contribution to better healthcare (see, e.g., Clifton, Dale and Bradshaw 2006; Faresjo 2006 and Barr and Low 2013). IPE, learning 'with, from and about each other' (Barr and Low 2013), is widely regarded as an essential educational strategy to break down siloed thinking and working to develop professionals who have the skills to be effective collaborators and team members. Effective teamwork requires each professional to have some understanding of the nature of the roles and professional identities of other team members. However, the impact of context also has an important influence on professional identities and how they are expressed within teams. Of increasing importance is the need for educators to work and support learners collaboratively across settings as integrated care pathways are promoted in response to community and primary focussed service development (NHS England 2014).

Multi-professional education was described by Barr and Low (2013, and expanded in the CAIPE statement of 2017) as

> occasions when professions learn side by side'. Interprofessional education is defined as occasions when professions learn with, from, and about each other, to improve collaboration and the quality of care.

Rather than a mixed professional group learning to perform the same skill or acquire specific knowledge, IPE focusses on sharing professional perspectives and expertise to understand the roles and working practices of the other – to understand *how* to work collaboratively. Trans-professional education takes our understanding of collaboration one step further. It has a more holistic view of healthcare collaboration and includes '"non-professional" health workers e.g.

ancillary staff, administrators, managers, policy makers, community leaders' (Frenk et al. 2010). Trans-professional education thereby permits a 'systems approach' examining the practices and processes of healthcare systems but equally mindful of individuals' professional boundaries and roles – both traditional and emerging (Thistlethwaite 2012).

In this chapter we will illustrate the pressing need to educate for collaboration in primary and community settings. We will begin by considering the professional roles now emerging within this setting and discuss opportunities as well as the tensions involved in learning to collaborate. We will focus on IPE and supervision as this is an area of critical importance. We will then briefly examine a range of literatures, including theoretical, that help educators develop a more nuanced understanding of education for collaboration. We will then present a case study from London which exemplifies some important features of educating for collaboration within this context.

The changing nature of the multi-disciplinary team

Frenk et al. (2010) in the Lancet Commission, *Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World*, advises educators to

> promote interprofessional and transprofessional education that breaks down professional silos while enhancing collaborative and non-hierarchical relationships in effective teams . . . develop[s] a common set of values around social accountability.
>
> (p. 1924)

The need for educators in primary care to work collaboratively and interprofessionally is becoming more pressing given the emergence of expanded and new roles across a range of HCPs. Five Year Forward View (FYFV) and subsequent reports, including the Roland

Commission on Primary Care (Roland 2015), have identified trends including a growing ageing population with complex comorbidity and LTCs and the move to 'personalised medicine' informed by developments in genomics as well as technological innovation which require a move away from approaches to treatment and care based on 'one size fits all'. Current and future health professionals will need to retain and develop generalist as well as specialist skills and the ability to adapt throughout their careers to accommodate new and expanded roles. Such capabilities are essential to ensure that flexible services are provided that can respond to emergent patient and population needs. The King's Fund (2015) summarises these challenges noting:

> The workforce of the future needs to be able to take on a greater breadth of tasks to meet increasingly complex patient needs, while working across different care settings and multidisciplinary providers. The challenge for the health service is to ensure that there is sufficient staff for current models of care, while also moving towards this very different future.
>
> (p. 4)

Recent education reviews, including the 'Shape of Training' (Greenway 2018) and 'Shape of Care' (Willis 2015), have highlighted approaches to health education that need to be adopted to prepare both the current and future workforce to respond to these challenges. In primary care, responses are being developed based on the recommendations of these reviews. Health Education England (HEE) is supporting training for advanced clinical practitioners (ACPs) in primary care including supporting GPNs to access advanced training to develop their capacity to assess patients and prescribe. NHS England (NHSE, 2015) have introduced a national programme to implement expanded pharmacy roles within GP practice as a key approach to improving the quality and safety of service delivery across the primary care system. Both the advanced training of GPNs and the introduction of clinical pharmacists in primary care represent expanded roles for existing HCPs. Physicians associates (PAs) are also being deployed in

primary care. The PA is an example of a new role – the practitioners perform specific medical functions under the supervision of a doctor. PAs are usually science graduates who have completed a two-year postgraduate programme. Currently they are unregulated, although they can join a voluntary register hosted by the Royal College of Physicians. The emergence of changing and new roles raises the question of how education needs to develop to prepare all practitioners to understand and work effectively across a wider range of professionals with varied responsibilities and scope of practice. Collaborative approaches to education are emerging to respond to these challenges.

Exercise

Consider the clinical or educational teams you work with.

- In what ways are the roles of team members changing?
- Are there any new roles within these teams?
- How are changes in roles or the emergence of new roles impacting on professional identities and educational needs?

Education as the predominant determinant for collaborative learning

Education has been positioned centre stage as the mechanism that supports collaborative learning: 'It represents the principal lever for promoting collaborative values amongst future healthcare professionals' (Martín-Rodrígues et al. 2005). In this next section we discuss commonalities in IPE including the development of supervisors and curricula before moving on to highlight the barriers which undermine into professional education interventions.

All of the roles mentioned in the previous section of this chapter require supervision and support from educators working in primary care which can present significant challenges, not

least supporting the development new emergent professional identities. The significance of the effective supervision for workplace learning has been re-emphasised in the Francis report (Francis 2013), the NHS Education Outcomes Framework (DoH 2013b) and the DoH Mandate to Health Education England (DoH 2013a). Consequently, educators are increasingly required to consider flexible, collaborative, interprofessional approaches to supervising learners in clinical practice. Arguably this should be a relatively straightforward process, as research (Austerberry and Newman 2013; Bentall 2014) has shown that the domains that underpin the frameworks and guidelines for clinical teachers are very similar. All refer in different ways to, for example, the need to focus on facilitating learning using appropriate learning theories, creating a safe and supporting learning environment and assessing and evaluating learning. Common themes regarding requirements include education as a requirement of all practitioners, reference to protecting patients and balancing local flexibility with the benefits of national standards of quality. Such commonality suggests that there are opportunities for collaboration across professions even if entry requirements for clinical teachers from specific disciplines are more restrictive.

Being equally prepared for multi-disciplinary or multi-professional work is featured across health professionals' curricula and occurs in one form or another across most of the professions. Interestingly although preparing learners for multi-professional work is mentioned in most of the documents reviewed, only a few areas actually stress the idea of interprofessional or shared learning. These include nursing, healthcare science and some of the allied healthcare professions, such as podiatry. Such programmes may have modules that are taught interprofessionally or learning activities such as interprofessional group activities.

Despite our unified goal to enhance patient care, our shared educational mission and common vision as espoused in curricula, collaborative work can be hard to achieve. There are a range of reasons for this relating to organisational and structural issues as well as individual factors. Bringing together learners is often a logistical challenge; working professionals as well as healthcare students are often geographically separate. Putting on a programme of education

that is meaningful for all professionals, permitting equal contribution and benefit, also tests the skills of interprofessional educators. A common concern that can inhibit interprofessional approaches to supporting workplace learning in healthcare is the position that individual health professions are distinctive and learners need to learn in different ways, which would make teaching them together difficult. An alternative, more expansive view is that reflection on clinical context can be harnessed to recognise that roles and boundaries may become blurred, creating new legitimate opportunities for collaborative learning. However, there has been no systematic investigation into how learning is perceived within each professional area and whether in fact there are great differences.

Individual factors include the power and hierarchy differences that can work to reinforce stereotypes and marginalise other professionals (Martín-Rodríguez et al. 2005; Floyd and Morrison 2014). In Baker et al.'s (2010) research professionals were seen to preserve their own sense of identity when involved in IPE, which acted as a barrier to shared decision making.

Others go further and urge us to take a more critical lens to the concept of IPE (Floyd and Morrison 2014). They wish to counter the assumption that 'being professional today means being interprofessional' (Hammick et al. 2009, p. 37) and the unquestioned supposition that this form of education leads to better patient care.

Exercise

Reflect on your experiences of teaching and learning with other professionals.

- What similarities have you noticed in curricula and in approaches to teaching and learning?
- What are the main differences?
- In what ways have professional identities and power relations helped or inhibited sharing and learning?

Theoretical perspectives: contact hypothesis, 'professional projects' and 'hybridicity'

In this section theoretical approaches are described that can help in understanding common barriers to IPE and collaborative learning. IPE is often criticised for being under-theorised, without sufficient explanatory frameworks for the clinical educator to understand why certain approaches to IPE succeed or fail (Floyd and Morrison 2014; Paradis and Whitehead 2018; Reeves 2017). These theories focus on the influences of stereotyping and power in creating boundaries and in helping understand ways in which the educator can influence these social barriers and support the renegotiation of professional identities and values.

Contact theory is the most frequently used theoretical framework for IPE (Paradis and Whitehead 2018). It is based on the work of Allport (1975), who explored the negative effects of stereotyping on intergroup race relationships. He found that interpersonal contact and learning about the other group decreased prejudice by promoting understanding of the different cultural norms and values. However, in order for contact theory to work effectively, the groups must be of equal status, they should have a common goal and prestige and rank should be minimised. These later reasons explain why poorly constructed IPE often only reinforces negative stereotypes and leads to educational initiatives failing (Paradis and Whitehead 2018).

Traditional professional education reflects what Larson (1977) describes as 'professional projects', whereby occupational groups are seen to work towards utilising social stratification for their own advancement. Macdonald (1995) examines how this concept has been used to study the rise of professionalism in an extensive review of research on the sociology of the professions. Macdonald (1995) argues that traditional professions, such as law and medicine, are awarded higher social status and rewards by virtue of their specialist knowledge and control and highly competitive entry to the profession. In this model the professions are seen to be autonomous in terms of determining who enters the profession, how they are educated and trained and ultimately how they gain power for autonomous practice. Aligned occupational groups in

healthcare, such as nursing or the allied healthcare professions in this model are deemed to have 'semi-professional' status as their ability to practice autonomously is constrained by the more dominate professional group, in this case, medicine. Occupations with semi-professional status may aim to emulate established professions by introducing higher entry requirements and more academically demanding training programmes as well as attempting to produce a distinct body of knowledge to support their practice (Macdonald 1995). However professional projects are active phenomena (Larson 1977). Professions constantly react and adapt to changing circumstances to maintain, and improve, their own social and economic capital. Their strategic (re-)positioning reveals either professional advancement or regression. Changing professional roles such as the increased autonomy of ACPs and the emergence of new roles such as PAs embody the re-positioning of professional projects in practice. Underpinning this re-positioning is the struggle over the control of 'boundaried' specialist knowledge and consequently areas of professional practice. This struggle can also be the source of interprofessional tension and conflict, creating a challenging and contentious space for educators to work in.

In recent years emerging models of professionalism have been identified that may help educators approach their work in contentious, boundaried areas. Whitty (2008) values more collaborative and democratic models of professionalism that recognise the socially constructed nature of disciplinarity[1] and the need to challenge established boundaries between professionals in practice and the education of those beginning their professional careers. A key driver for challenging the established models of traditional professionalism is their reliance on what are seen to be unique bodies of knowledge that inform specialist professional practice, practice that aims to address specific issues or problems. Such specialist approaches are however unable to address the issues and challenges that arise as a result of the 'complexity' and 'super complexity' associated with current professional life (Barnett 2008). The so-called wicked problems that professions are required to attempt to solve cannot by their very nature be addressed by one discipline. Rather strategies are required that enable professionals to recognise the many different factors that influence the problems professional practice aims to address. In healthcare

such complexity is evident on many levels, from the range of drugs and treatments that individual patients may require to the social factors that influence the support available to aid recovery.

A contemporary theory of IPE therefore needs to facilitate flexible interpretations of roles and professional identity. Greenwood and Maanaki Wilson's (2006) developed a theory of 'hybridicity'. Hybridicity refers to the work practitioners do when they broker different sorts of disciplinary knowledges. Hybrid practitioners act as in-betweeners, actively engaging with these different knowledges, re-contextualising and co-constructing knowledge which can be integrated and applied to practice. This co-construction of knowledge permits new opportunities for identity and role but also exposes new conflicts and threats. However, a key feature of the hybridisation of knowledge is to blur traditional professional boundaries. Making the demarcation of professional knowledge less certain and more changeable allows for emergent, expansive professional projects. Professional narratives under these circumstances can become less bounded and encourage a 'border discourse' (Perloff 1998), promoting a reflective and expansive notion of professionalism.

Exercise

Consider one or two complex issues in your professional practice that may not have clear solutions and which by their nature require collaboration across disciplines to care for patients.

- Can you identify examples of underpinning knowledge regarding patient care that is blurred, less certain and not confined to one professional group?
- If so, what educational challenges and opportunities can arise when you are supporting teaching and learning on these issues?

Current research exploring the impact of changes in traditional roles, the emergence of new roles on professional identity, and collaborative practice that would help our understanding

of border discourse and implications for educational support and supervision is limited. The evaluation of the Programme for Integrated Child Health (PICH) is an example of an educational intervention aimed to nurture the development of collaboration. What follows is a summary of a formal evaluation which illustrates the affordances of this educational space.

Case study: learning to collaborate – the Programme for Integrated Child Health

PICH was established by paediatricians at Imperial College and St. Mary's hospitals, London, in 2014. PICH is an intraprofessional education programme for trainee paediatricians and GPs supporting them to set up, deliver and evaluate integrated care across primary and secondary care. Over a year-long course, trainees work together on integrated care projects for children, with the skills that they learn by doing so augmented by monthly training seminars and mentoring from senior clinicians with experience in developing integrated care systems.

The evaluation involved interviews with programme mentors and previous trainees and observations of teaching sessions aimed to explore the effectiveness of the programme. The participants highlighted the persistence and prevalence of rigid roles and boundaries in operation in healthcare environments. Silos were reported as commonplace. Notably, education and training were reported as contributing to this situation, as a PICH mentor reports, 'The vast majority of the people they'll train in a medical school or a nursing school – stay in one place and never get out of the four walls'. So traditional educational systems, which promote immersive socialisation, contribute to establishing barriers to collaboration (Martín-Rodríguez et al. 2005).

However, by coming together in the PICH, participants, whilst retaining a clear sense of professional identity, were able to change their attitudes and behaviours. By understanding their own roles and those of others more clearly, they were able to develop enhanced collaborative

practice. Building effective relationships and communication was key to traversing chasms that prevented professional collaboration. As one trainee reports,

> The primary care . . . aspect . . . that's been really really important. And I'd argue it matters less about what the actual content is than getting those multiple lenses. Because what you start to experience then is how multiple views on a particular situation can completely unlock things. And what my hope is that people start taking that into other aspects of their working lives.

This was not just between doctors but within healthcare teams, including patients. Relationships and communication were strengthened by mutual dialogue and sharing stories; for this space they were needed. The educational space provided by the PICH was fundamental to this learning as another trainee illustrates:

> Hearing the discussions between GPs and paediatricians has been really interesting. You know there's often a grey area between what's in the realm of GP and what's in the realm of the paediatrician but is actually lots of shared work and this actually lots of unknown areas that we just sort of fudge through.

This finding mirrors the work of other research highlighting the central importance of communication and relationships (Martín-Rodríguez et al. 2005; Sutter 2009).

However, workplace spaces were more problematic and acted as barriers to collaborative practice through varied and changing structures and systems. This coupled with the individual factors – rigid professional identity, boundaried specialised roles and stereotyping – highlights the struggles *in action* that occur in workplace settings. Further research is needed into how the principles revealed in the PICH evaluation could be applied more broadly and result in growing impact on clinical settings. However, the evaluation gave tentative cause for optimism and demonstrated how educational environments could encourage collaboration.

Exercise

Reflecting on the experience of the PICH programme, consider whether you may be able to apply some of the approaches they developed to training initiatives you are involved in or whether you could consider different approaches that would enable learners to gain greater insight into the roles of other professionals to promote collaboration in practice.

Conclusion

Traditional approaches to professional education in healthcare are being challenged to prepare practitioners to work collaboratively and flexibly across professional boundaries as health systems adapt to emergent population healthcare needs. IPE has, with varying degrees of success, attempted to promote collaborative working across the healthcare professions. In this chapter we have argued that IPE needs to be re-positioned as collaborative education that promotes new, hybrid professional identities through border discourse and boundary working if it is to enable educators to create innovative strategies ensuring learners become capable and confident practitioners in this changing context. Educational theories discussed in this chapter provide intellectual tools educators can use to engage their professional imagination (Powers 2008) to think and act differently as they design and implement new, innovative educational programmes as exemplified by PICH. The example shared demonstrates how a carefully crafted educational programme can enable learners to develop new insights into their own professional identities and that of others. Such insights challenge traditional siloed perspectives on practice as learners engage in border discourse on the grey areas of practice that may be seen as complex, difficult and challenging. Reflection on learning through border discourse can enable learners to understand the value of and develop the skills needed to practice collaboration for the benefit of patient care. A key attribute of such programmes is collaborative education, which provides

opportunities to develop interprofessional relationships and to renegotiate how professional identities are enacted mindful of contemporary healthcare practice.

The complexity of contemporary clinical practice situated within systems that are changing rapidly – socially, culturally and structurally – affects professional education (Martín-Rodríguez et al. 2005). For collaborative education to be effective Paradis and Whitehead (2018) note that attention needs to be paid to structural and external factors:

> In overemphasizing education, we ignore the systemic issues that underpin problems of collaboration. Future education for collaboration should stress the limited impact of educational interventions when trying to solve major structural problems and ensure that organizational and legal factors are included as essential areas for improving collaborative care delivery.
>
> (p. 1461)

Although little empirical research has been undertaken in this area, Martín-Rodríguez et al. suggest that consideration needs to be given to the organisational structure and philosophy in which educational programmes are developed. Time and space for collaborative learning in situ needs to be planned for and supported by the organisation providing learning opportunities – all of which have implications for the commissioning and financing of education. Due consideration will be required of these broader organisational and contextual factors if education for collaboration is to succeed.

Education for collaboration is a complex and challenging field. The educational theory and practice we have reviewed suggest that essential components need to be considered as educational programmes are designed most notably:

- They should ensure there are opportunities for learners to work and engage in meaningful discussion with professionals and learners from a variety of disciplines to provide opportunities for border discourse – such opportunities need to be accompanied by

reflective discussion with educators to promote insight into collaborative professional practice.

- Educators need to develop their leadership skills to create safe spaces where learners and clinicians working with them in practice can feel comfortable discussing professional identities and boundaries, both traditional and emergent. Such spaces can help reduce a sense of professional protectionism that may inhibit open discussion of ways practitioners can work across established boundaries.
- Educators need to recognise the opportunities and constraints associated with specific organisational contexts. Working with educational commissioners, due consideration needs to be given to social, cultural and structural factors that could impede learning so that educational programmes can be crafted to provide time and space to ensure collaboration and aid learning.

As educators develop expertise in designing collaborative education in response to shifting contextual affordances, it is possible that fluid hybrid professionals become the ‘valued’ professional currency. That being interprofessional becomes synonymous with collaboration, understanding interprofessionality and advocating interprofessional supervision and education as a means of promoting interprofessional learning may represent an emergent hybrid collaborative professional practice. Professionals who work and learn in collaborative, interprofessional ways could help practitioners formulate appropriate values in difficult situations as they can be more flexible about how they see their professional selves and understand their roles and partnerships.

Note

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1 Disciplinarity in this context refers to regulated professions within healthcare, for example, medicine or nursing.