The Need for Interprofessional Team Training

A key component of health professionals' education for a new century

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An overview

• Some assumptions

• Why team working of contemporary relevance

• Systems approach

• Different approaches to team training

• Stereotype change and social innovation

• Team training initiatives across the world
Unpicking some assumptions

- Collaborative practice rather than team working.
- Interprofessional versus uniprofessional.
- Professions are not necessarily health care professionals.
POPULATION/PRACTICE DRIVERS

- Ageing population/long term conditions.
- Complexity of care and specialisation.
- Rapidly changing health care environment.

SOCIAL DRIVERS

- More than one set of skills.
- More than one person (Sharpe and Curran, 2011).

POLICY DRIVERS

- Health Professions Education: A Bridge to Quality (NRC, 2003).
- Lancet Commission (Frenk et al., 2010).
Perspective 1: systems approach

Educators need to provide interprofessional training that responds to this demand in both quality and quantity.

Practice, social & policy drivers demand a workforce able to work collaboratively.

Interdependence

Frenk et al. 2010
Perspective 2: A systems approach

Von Bertalanffy.

Cannot separate organism from surroundings.
• Doctors cannot work separately from their environment.

• Cannot train people as isolated skill holders but as embedded within complex systems.

• Technology, other professions, organisational structures.
Swiss cheese as a systems approach

Team
Technology
Organisation
Individual

Patient safety error:

Reason, 2000
What does collaborative practice training look like for the individual?

- to know about the roles of others.
- to work with other professionals.
- to substitute for roles traditionally played by other professionals.
- for flexibility in career routes: “moving across” (Finch, 2000).
Role substitution in more detail: a glaucoma case study

Population need:

Globally, +60 million with glaucoma, 8.4 million blind 80 million and 11.2 million by 2020 (Foster and Cook, 2012).

Sufficient workforce-quantity? Workforce adequately trained-quality?

Limited financial resource.
Moorfields Eye Hospital Glaucoma Service Intervention:

Extend role of optometrist.

Training in routine assessment/clinical decision making (Banes, 2000).

Advantage:

• frees ophthalmologist.
• money savings.
• implications for shortages of ophthalmologists.
Never simple:

- Role clarity? Who does what, when?
- Equity?
- Loss of power?
- Contact is not enough (Allport 1954).
- Specific contact conditions are required (e.g. equity).
- Negative stereotypes may develop.
Professional stereotypes

- Stereotypes start early (Hean et al. 2006).
- Counteracted by collaborative practice training.
Social innovation & collaboration

- Create new knowledge, combine existing knowledge in new ways.

- Apply to new contexts, to address social challenges.

- Be reflective, willing to cross organisational or disciplinary borders.

- Training in collaborative practice addresses this.
Under representation of interprofessional team training in developing countries (Abu-Rish et al., 2012)

Loss of insight into: global vs country specific.

e.g. RSA, crossing professional, language, ethnic, class, nutritional boundaries.
Key messages

- Training in **collaborative practice** is of contemporary relevance in health profession education:
  - population needs
  - social innovation.

- A **systems approach** is required but consider alternative perspectives.

- Think of **role substitution** but issues of learning **with, from and about** other professions also.

- A greater emphasis on **international perspectives**.
Thank you