Interprofessional Practice and Education in Clinical Learning Environments: Frontlines Perspective

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Abstract

This Invited Commentary is written by coauthors working to implement and study new models of interprofessional practice and education in clinical learning environments. There are many definitions and models of collaborative care, but the essential element is a spirit of collaboration and shared learning among health professionals, patients, and family members. This work is challenging, yet the benefits are striking. Patients and family members feel seen, heard, and understood. Health care professionals are able to contribute and feel appreciated in satisfying ways. Learners feel included. Care interactions are richer and less hierarchical, and human dimensions are more central. A crucial insight is that collaborative care requires psychological safety, so that people feel safe to speak up, ask questions, and make suggestions. The most important transformation is actively engaging patients and families as true partners in care creation. A leveling occurs between patients, family members, and health professionals, resulting from closer connections, deeper understandings, and greater mutual appreciation. Leadership happens at all levels in collaborative care, requiring team-level capabilities that can be learned and modeled, including patience, curiosity, and sharing power. These abilities grow as teams work and learn together, and can be intentionally advanced by reconfiguring organizational structures and care routines to support collective team reflection. Collaborative care requires awareness and deliberate practice both individually and as a team together. Respectful work is required, and setbacks should be considered normal at first. Once people have experienced the benefits of collaborative care, most "never want to go back."

Editor's Note: An Invited Commentary by T. Bodenheimer, M. Knox, and S. Syer appears on pages 1445–1447.

In another Invited Commentary in this issue of *Academic Medicine*, Brandt and colleagues[1] make a compelling case for interprofessional practice and education as emerging new standards in clinical learning environments. Yet, the distance between this vision and the realities of practice and education as experienced by patients, families, health professionals, educators, and learners in many traditional health care settings can be profound. This Invited Commentary is written by coauthors actively engaged in implementing and studying collaborative models of interprofessional practice and education in their clinical learning environments. It is a firsthand account of the rewards, challenges, and lessons learned about intentionally reshaping clinical learning environments so they can become places where interprofessional team-based care with active engagement of patients and families is an expected and usual way of working.

Most of the authors did not know one another before working on this paper together. Our clinical learning environments include an interprofessional outpatient clinic in an academic health center established using a patient-centered medical home model,[2] an outpatient clinic developed as a Veterans Administration National Centers of Excellence in Primary Care Education demonstration site using an interprofessional academic patient aligned care team model,[3] an inpatient unit in an academic health center organized as an accountable care unit,[4] and two collaborative care inpatient teaching services in academic health centers that use principles from the social field model of collaborative care.[5] Our writing collaboration was guided and enriched by the same principles we have identified as important for interprofessional collaborative care with patients and families. These principles are woven throughout the findings of our commentary.

"I Want the Kind of Care They Have Over There!"

First and foremost, we share a joy that collaboration across professions with active engagement of patients and families brings to everyone involved. When collaborative care works well, its value is apparent. Patients and family members feel seen, heard, and understood. Health care professionals are able to contribute and feel appreciated in satisfying ways. Learners feel included. Teaching and learning fill every interaction. When patients, families, and health professionals are able to see and participate in these changes, it is transformative for everyone.

Patients and families are often the first to notice the differences and appreciate the benefits of collaborative care. One of the authors (J.M.-R.) described an epiphany

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experience with which we all identified: "Once we had a patient in a semiprivate room. She noticed the entire collaborative care team around her roommate, listening attentively, smiling and laughing with her roommate and family. She said, '*I want the kind of care they have over there!*"

The Definition of Collaborative Care

Many definitions are used in the literature of interprofessional practice and education. We appreciate the World Health Organization definition of interprofessional collaborative practice because it embeds interprofessionalism in an aspirational context, emphasizing collaboration with patients, family members, other care givers, and communities in addition to collaboration across professions: "Collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care."[6]

To simplify, we use the term *collaborative care*, by which we mean health care practice and education involving interprofessional care teams with active engagement of patients and families. There are many frameworks[7] and models, but for us, the essential element is a spirit of collaboration and shared learning among health professionals, patients, and family members.

Important distinctions between traditional care and collaborative care concern the nature of care interactions and the quality of relationships among professional care team members, patients, and family members. Figure 1 summarizes these distinctions. Many of the distinctions involve power shifts. In collaborative care, interactions among all involved are richer and less hierarchical, and human dimensions of care are more central, with a trajectory that unfolds as collaborative care deepens.

Conditions for Success

In our experience, establishing and sustaining collaborative care with active engagement of patients and families in clinical learning environments is not easy or straightforward. There are not yet proven road maps or best practices that can be applied with complete assurance of success.

We have identified certain supportive factors that seem to hold true across our different environments. However, we have learned, often to our surprise, that approaches and processes that have worked well in one care environment may not work in another. A host of deeply held patterns, routines, norms, and expectations—and, with them, professional identities and role cultures—must be carefully and respectfully examined, unwound, reconsidered, and reintegrated for new collaborative care processes to be successfully implemented and sustained.

The essential condition of psychological safety

A crucial insight is that collaborative care requires trust and psychological safety.

Figure 1 Observable distinctions between traditional care and collaborative care.

Psychological safety means that people feel safe to be vulnerable and contribute their perspectives without perceived risk.[8] In a psychologically safe environment, everyone feels free to speak up, ask questions, and make suggestions in the moment, no matter their role or position on the team.

Psychological safety grows and develops through positive shared experiences, in ongoing cycles of action-and-reflection learning in local care environments. As people see that contributions are honored, they feel increasingly safe to contribute, too. Welcoming and introductions, role modeling, respectful listening, and invitations to participate are intentional actions that weave people together. As trust and mutual respect grow, collaboration thrives.

Two of us (K.K., T.A.R.) work in a collaborative care environment where, for example, a physical therapist caught a recurrent stroke because of her awareness of a patient's condition from daily rounds and the psychological safety that developed there. Concerns were receptively voiced and heard and new findings immediately addressed because of the mutual knowledge, trust, and respect the care team had established together.

Preparing for collaborative care

Collaborative care requires new knowledge, skills, and attitudes from everyone. Acquiring these new abilities at both the individual and team levels requires intentional awareness and deliberate practice through ongoing care together, simulations, observations, and shared team reflection. Patient and family advisors can offer important insights. One of us (M.A.B.) said, "Teachers and learners in these new environments have to learn to recognize when collaboration is happening in the same way they learn to hear a heart murmur, or feel an enlarged spleen." Another (T.A.R.) said: "We are conditioned to emphasize individual competencies, but collaborative care is a team-level competency. We are just beginning to understand what that requires."

The collective awareness and abilities that underpin collaborative care grow as care teams work and learn together. This process of development can be

advanced by activities outside of care, including interprofessional journal clubs; writing groups; collaborative research projects; team presentations; and other interprofessional experiences across clinical, academic, research, and administrative roles that create new understandings across all roles and knowledge levels. When students, residents, and fellows across professions work and learn in collaborative environments side by side with interprofessional faculty, patients, and family members, everyone gains insights and capabilities that will be useful now and in future roles and other learning environments.

Supportive organizing structures and workflows

Collaboration across professions is enhanced by individual competencies that can be applied in any health care environment. And, an important insight is that collaborative care requires more than that. Success depends on supportive organizing structures and collaborative workflows.

For example, if a resident teaching service cares for patients across many floors of a hospital, we have found it unlikely that collaborative care will flourish among all the residents, nurses, and health professionals across all of the units where patients may be located. Such an environment is simply too big and too inconsistent for shared, team-level learning to happen, on which collaborative care depends. In contrast, if patients can be geographically colocated in one area, or if an interprofessional clinic can be established where people across professions can work consistently together on a routine basis, collaborative care is more likely to be successful.

In addition to geographic colocation and cohorting, collaborative workflows can be developed that bring people together across usual professional role boundaries. These include activities like collaborative rounds and, importantly, go beyond this. A crucial shift in team workflows is establishing opportunities for collective team reflection. In regular reflective team meetings, progress and concerns can be discussed together, resources can be coordinated, and changes can be made in the care environment. Regular reflective meetings establish an infrastructure for team-based learning and improvement, providing opportunities for people in the clinical learning environment to reflect and learn together and make changes in their care environment together.[9]

The importance of collaborative leadership

A frequently heard question is, "Who should lead the interprofessional collaborative team?" Our answer is that no single person or profession should lead. Across our care environments, formal and informal leaders have included physicians, nurses, physical therapists, occupational therapists, chaplains, nurse practitioners, pharmacists, social workers, patient–family advisors, and patients and families during their care. Nurse–physician dyads are one method of connecting professions in leadership functions.[10] Interprofessional steering committees and patient–family advisory councils are other useful collaborative leadership methods. Collaborative leadership begins with individuals but over time becomes a collective attribute of the entire care team.

Leadership happens at all levels in collaborative care and requires abilities that can be learned and modeled. These include curiosity, openness, patience, comfort with ambiguity, sharing power with others, holding high standards, and seeking innovation past barriers. Collaborative leadership flows from person to person across roles and hierarchies, creating shared trust and knowledge while connecting the needs of everyone with the most helpful expertise available.[11]

The reality of power

Part of what makes implementing and sustaining collaborative care difficult is deeply held power structures that underpin traditional care. Navigating and redefining power boundaries is inherent in collaborative care. This requires reimagining methods of leadership and decision making, often in small steps. For example, simply inviting one or two other professions to meetings that are traditionally just for one profession can go a long way in developing the connections and trust necessary for collaborative care. New relationships bring new possibilities.

Active engagement of patients and families

The most important transformation of collaborative care is actively engaging patients and families. Collaborative care starts with patients and families not "at the center" but as true equal partners in care. Collaborative care is cocreated among everyone involved: Assessments happen together in real time, care plans are jointly developed, and patients and families are there every step of the way. How profoundly different this is from traditional care cannot be overstated.

In our experience, this shift from traditional care takes time and can be surprisingly hard to appreciate from the perspective of traditional care routines, where talking *about* and making decisions *on behalf of* patients is usual. Intentionally talking *with*, and making decisions *with*, patients and families requires a level of inclusion and openness, and carries vulnerabilities, that may be unsettling at first for many health professionals. As comfort is gained, and engagement of patients and families grows, these dynamics change. A leveling occurs in collaborative care among patients, family members, and health professionals. This leveling arises from closer connections, deeper understandings, and greater appreciation. A richer care experience ensues, creating bonds among health professionals, patients, and family members that last lifetimes.

Approaching barriers with understanding and respect

Distress about collaborative care may occur in any role, and in any environment. We believe that it is not helpful to view potential barriers as resistance. Rather, we view perceived resistance as a reflection of how deeply existing models of education and practice are incorporated in traditional health care culture. Respectful work is required, and patience and persistence are essential. One author (J.B.) said, "So what our research is showing is that the 'wheel needs to be reinvented, over and over again, in every care environment.'" Another (P.N.U.) said: "We have learned not to try to convert every skeptic. It is easier and much more effective to 'work with the willing.'"

A "spirit of trying"

In the words of one of us (W.E.R.), success often begins with "a spirit of trying." That spirit starts with early innovators who identify with an imperative to promote teamwork and strengthen engagement with patients and families. These innovators see

opportunities and are willing to take risks and take on roles as champions to promote change. In our experience there will be champions in every institution, at every level, and from every profession, willing to take on this creative challenge if given opportunities.

A Better Way

At some point each of us experienced a shift in our understanding about collaborative care and its value. Most of us excelled in the older care models we were taught, and for various reasons began to move past these models to explore more inclusive ways of practicing and teaching. We now stand with feet in both worlds. It is like being bilingual. We have to be fluent in the old models because they are still an expectation, and we have to be fluent in the new ways of working, too, because we want health care to be this way. It is just so much better.

At first, emerging collaborative care routines are likely to take longer and seem inefficient and impractical. With time and experience, most people in collaborative care environments recognize that something better is happening. New connections are forming. Deeper appreciation grows for others' strengths and capabilities. Stronger bonds are forged among colleagues, and with patients and families. Work has greater meaning. Synergies arise that make care better and easier, and learning richer. Care and learning happen from multiple sources, by and from everyone present.

One author (M.H.) said, "When physicians are learning from students and residents, and pharmacists are becoming more understanding of challenges the bedside nurse faces every day, and patients and families are participating in everything we do—when we go through these new experiences side by side together—doors open in wonderful ways." Another (T.A.R.) said, "We are all really learners in this process." We see and do things differently now.

Once this shift occurs, you never want to go back.

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