“IPE/IPC Missing – the worst is feared… Health Professional Educators and Practitioners React…”

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Faculty/Presenter Disclosure

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Relationships with commercial interests:

"I have no conflict of interest to declare regarding relationship with commercial interests"

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Objectives

- Seek evidence about whether and why IPE/IPC is missing and explore reactions to their possible death
- Explore the implications of the theory/practice divide
- Propose transformative resuscitation of the IPE/IPC agenda

While I have no conflict of interest, I am not free of bias!
My intentions today are to argue that …

- The processes of healthcare education and clinical practices are poorly understood
- Focus of IPL must be in the clinical setting
- Transformative resuscitation of the health professional education and practice interprofessional agenda is needed, and NICHE can be front and centre!

Evidence that IPE is missing...

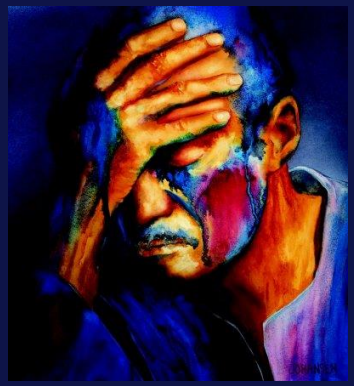
- Interprofessional groups of students rarely learn “from or with” each other – they do learn “about” each other...
- In many programs, students learn about IP from members of their own discipline...or by guest faculty who come in for a “show and tell” (for which there is no assessment)
- Generally inconsistent and superficial assessment of IP knowledge and the associated skills
- Formal classroom-based and clinical IPE sessions tend to be voluntary – not everyone can, and no one must, participate
- Classroom pedagogy is (a) discipline-focused and (b) single system focused – we talk about wholistic care but teach in disciplinary and disease or system silos and in the context of “one thing wrong” – this misses the complexities that constitute the need for IPC and makes collaboration seem like an inefficient luxury we don’t need and can’t afford...

What explains this?

- Multiple institutions train healthcare professionals; scheduling nightmare in both classroom and clinical learning environments
- We assess best and most frequently what we value most...the lack of robust assessment of IPE/IPC becomes part of the hidden (null) curriculum
- Curricular crunch associated with the demand for discipline-specific content – IPE is a luxury, except that...
- Accreditation requirements keep us trying to figure this out!
- Pedagogical differences between programs – lectures vs small group self-directed learning – challenges IP learning
- Teaching "about" – leads to "reification" of an abstract concept or model; interprofessionalism , collaboration, are fundamentally practice issues... teaching a theory of practice in the abstract does not sufficiently influence or transfer to the "lived" experience of practice

Imagine for a moment that IPE is dead...

- What is there to mourn about this?



- What is there to celebrate?

Evidence that IPC is missing...

- Students tell us it is...
  - ”all well and good in theory, but in practice, we don’t see it”
  - “we really don’t interact with students from other health disciplines in the academic or clinical settings...interprofessionalism in silos...hmmm”
- Staff tell us it is...
  - “not all voices are equal...as long as there are different rules based on who you are, it won’t work”
  - “it takes too long...no one has time...”
  - “we don’t have the same staff from day to day…how realistic is teamwork…”
  - “teamwork is all well and good, but at the end of the day, who’s really responsible?”
- Patient tell us it is...
  - “Don’t you people talk to each other?”
  - “I don’t really know what’s going on...different people tell me different things...”

We had a peek inside the coffin...

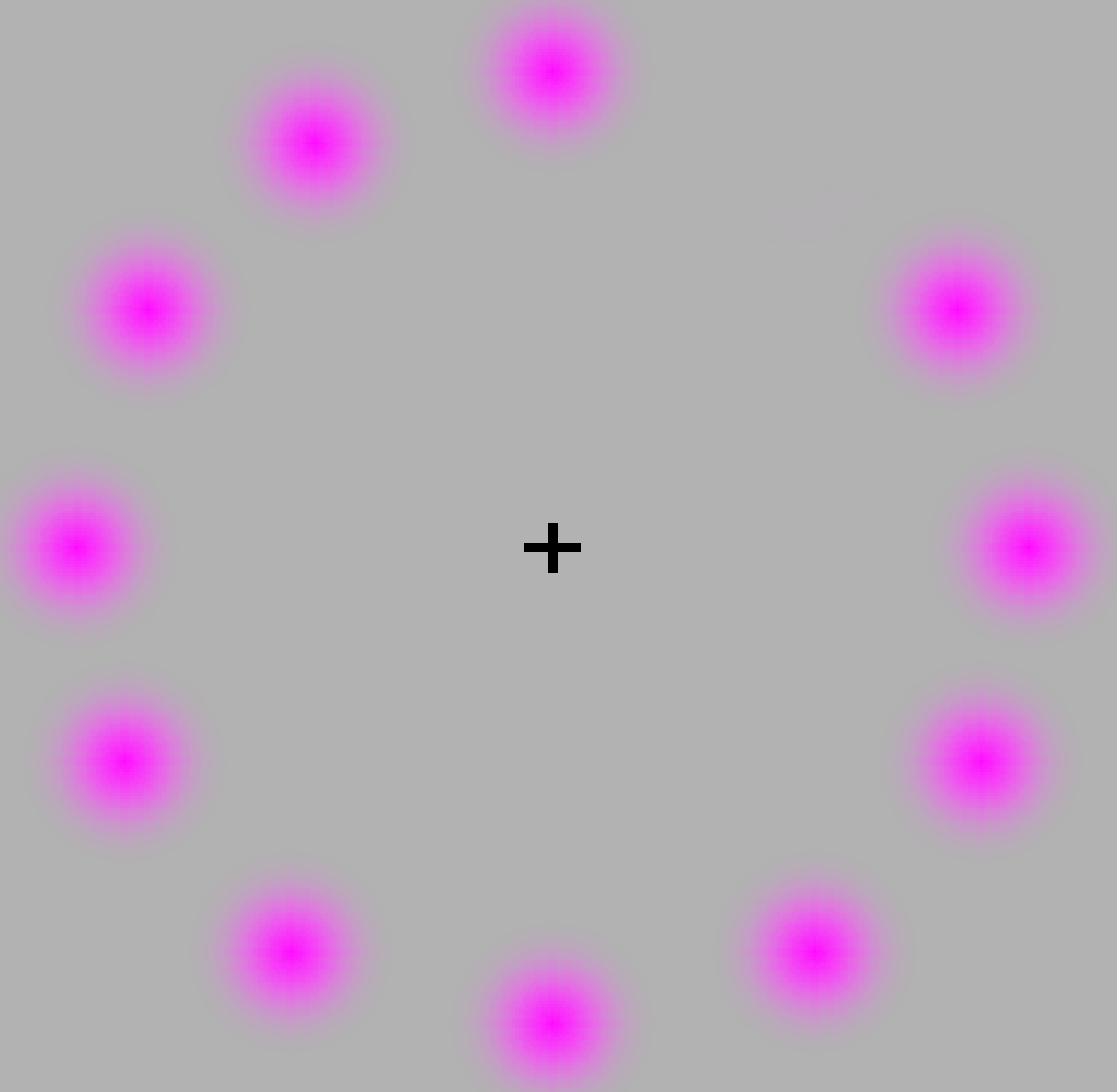
When “science” or “evidence-based practice” is the predominant driver of our thinking…

There is a tacit assumption of – or perhaps a fond hope – that there is “**a right way**”…

“…the evidence “speaks for itself”…

That leads to an “audit and compliance” culture…and the predominance of the “translation” metaphor in practice…

Bruner, 1990; Sandberg and Tsoukas, 2011: 340-341; Rorty, 1979; Stacey, 2007, 2010



My premise about compassionate, collaborative person-centred care is that...

It is generated moment by moment in the complex and interdependent intersections between what we "ought" to do; what it is "fitting" to do; and what we "can" do

Practices are negotiated processes deeply influenced by individual values and group norms; they are cooperative and competitive, accepted and contested, predictable and unpredictable...all at the same time!

"...Professional practices are **interpretive practices**, centrally concerned with **how practitioners…make judgments**…"

Clinicians believe evidence ONLY to the extent that the evidence matches their experience and (to a lesser degree) on whether they know and respect the person providing the evidence.

In EVERY clinical encounter, we are called to know more than we were taught.

Kinsella, EA. (2012). Practitioner reflection and judgement as phronesis.
In Kinsella, EA & Pitman, A (Eds). Phronesis as professional knowledge: Practical wisdom in the professions. Rotterdam. Sense Publishers;

Gabbay, J., & le May, A. (2011) Practice-based evidence for healthcare: Clinical mindlines, New York: Routledge.

To make sense of our practices, we need to develop an understanding of them that accounts for their complexity …there is no single right answer, no single right act, no single right way to be…

Three interdependent processes each of which is very complex, partial, critical …

What we “ought” to do…
What it is “fitting” to do…
What we “can” do…

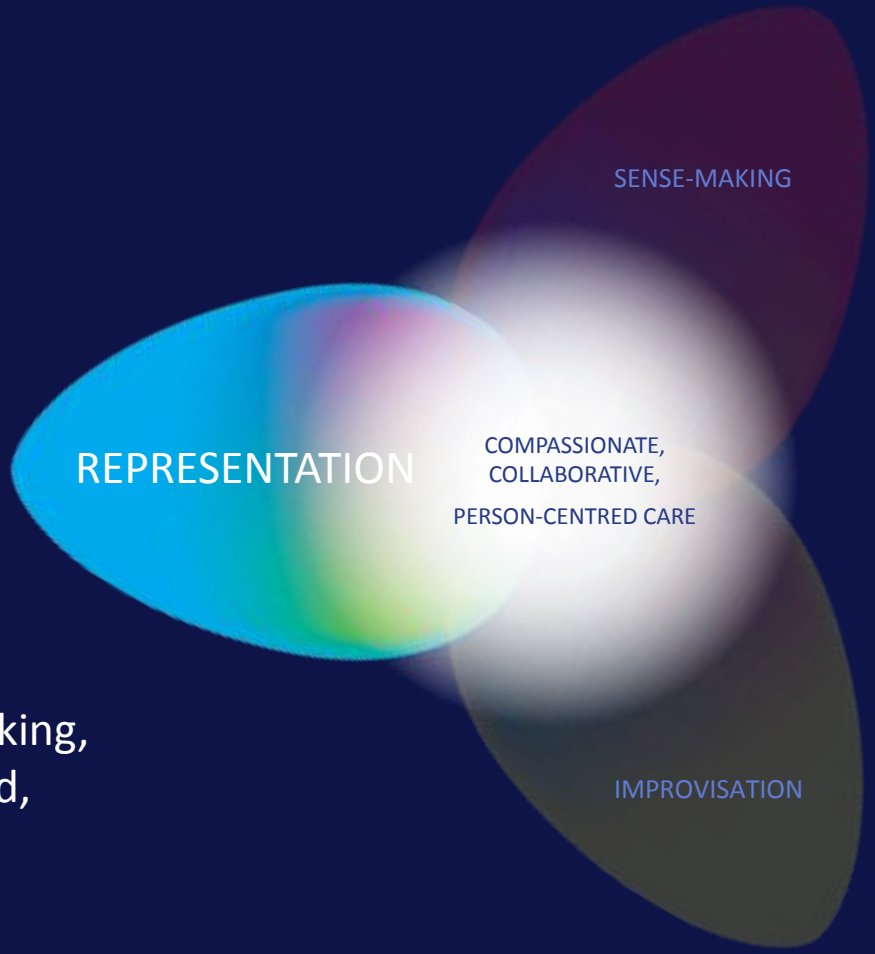
Representation

What we "ought" to do

Intellectual tradition: Episteme
Science lives comfortably here ...

- Best practice guidelines
- Algorithms and practice guidelines
- Policies
- Professional regulation
- Translation metaphors
- Strategic Planning
- Assessments, lab values, imaging
- Principle-based ethical paradigms
- Knowledge as abstract, a-contextual

These helpfully influence activity and thinking, but are insufficient alone to support sound, relevant clinical decision-making

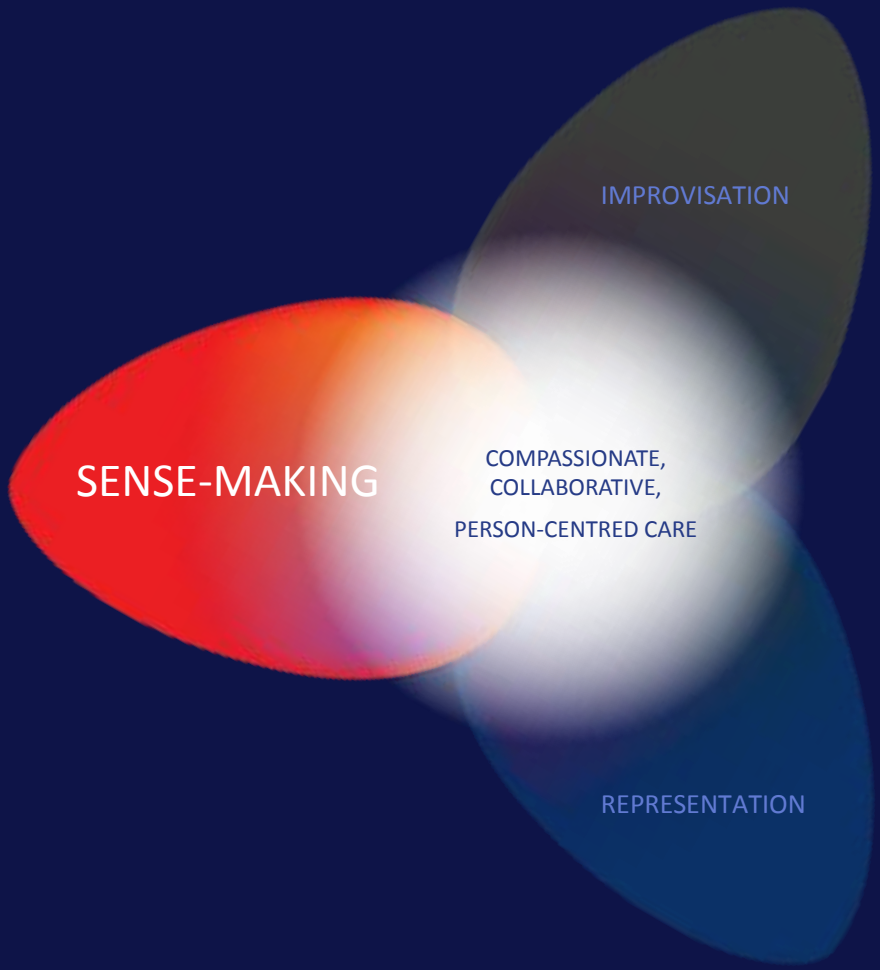


Sense-making

What it is “fitting” to do

Intellectual tradition: Phronesis (**practical wisdom**)
Unique patients and contexts live here

- Reflection-on-action
- Negotiated goals and values
- Power dynamics; identity formation
- Knowledge generating dialogues
- Social capital – norms of reciprocity…
- Collaborative decision-making
- Discerning what is salient
- Use multiple ways of thinking
  (e.g. epistemic, technical, practical wisdom (phronesis), critical deconstruction, imaginative, speculative, innovative, “thick” contextual, cultural …
- Develop and use clinical and moral imagination
- Relational ethics paradigms
- Situational knowledge; context relevance



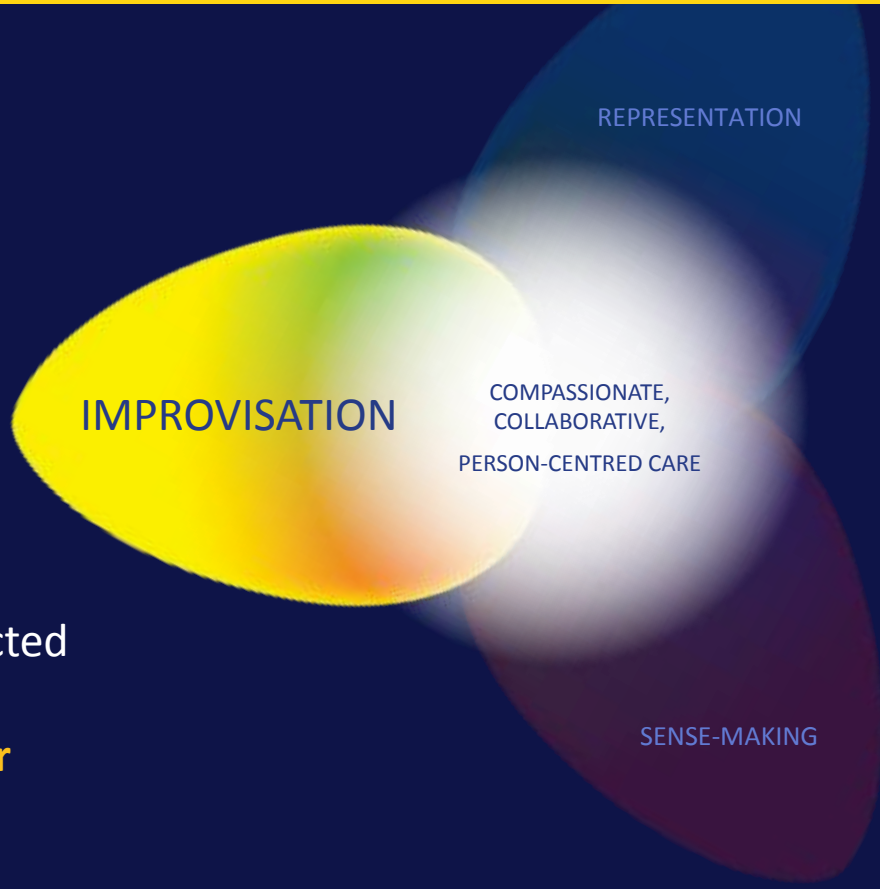
Improvisation

What we "can" do

(In every clinical encounter, we are called to know more than we were taught.)

Intellectual tradition: Techne/Metis; **Praxis lives here** – action, informed by theory and experience, aimed toward achieving a particular goal .

- Reflection-in-action
- Technical skill; technique
- Interdependent interaction
- Use of equipment
- Bodily movement
- Negotiating position and priorities
- Building and using social capital
- Relational ethics
- Negotiating hierarchy and power
- Contextual, emergence of the unexpected
- Knowledge as emergent
- **The continuous evolution of particular practices in particular communities**

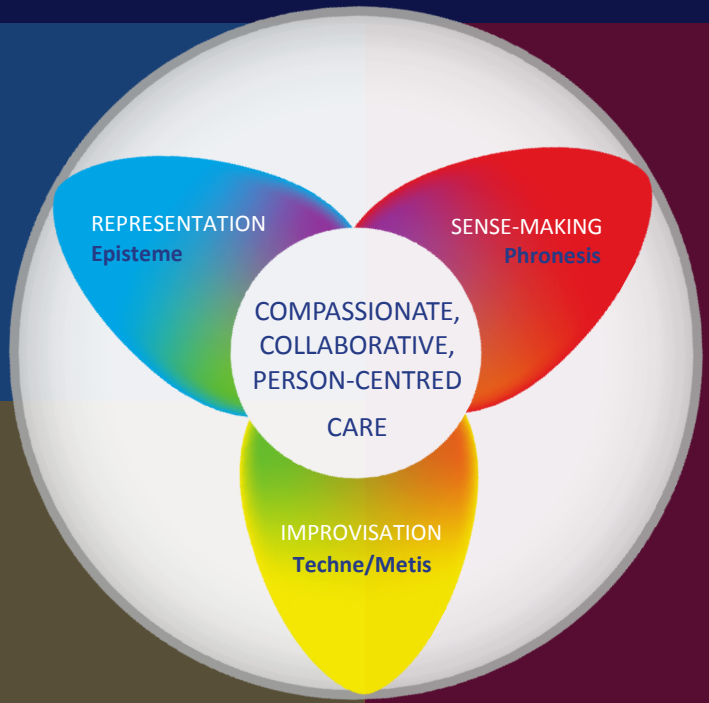


The practice/theory paradox

Questions of theory arise in practice, are applied and further elaborated in practice and generate new questions in practice…practice and theory are two aspects of the same phenomenon…

REPRESENTATION

- **Algorithms and practice guidelines**
- **Policies**
- **Professional regulation**
- **Translation metaphors**
- **Strategic Planning**
- **Assessments, lab values, imaging**



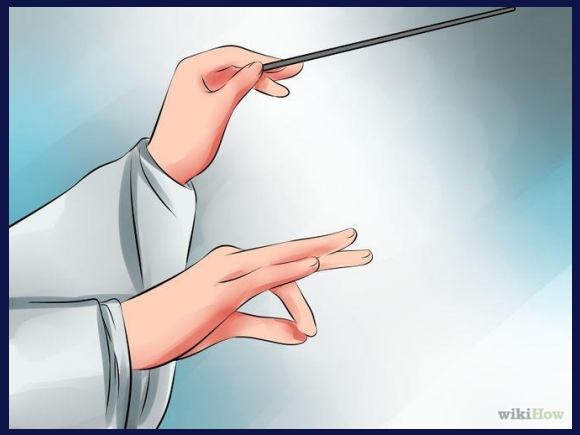
SENSE-MAKING

- **Reflective/reflexive sense-making**
- **Shared goals and values**
- **Collaborative decision-making**
- **Social capital**
- **Discerning what is salient**
- **Use multiple ways of thinking (**e.g. epistemic, technical, practical wisdom (phronesis), critical deconstruction, imaginative, speculative, innovative, "thick" contextual, cultural …
- **Develop clinical and moral imagination**

IMPROVISATION

- **Negotiating position**
- **Temporal sequencing**
- **Bodily movement**
- **Use of equipment, guidelines, policies**
- **Hierarchy and power**
- **Social capital**
- **Tyranny of the urgent over the important**
- **Contextual, emergent enactment**

Ode to Mattie Banzhaf



Transformative Pedagogy (1 of 3)
Engage the NICHE Network to develop a pan-Northern Core Curriculum:

- Enunciate common theoretical constructs for:
  - Practice
  - Interprofessionalism
  - Reflection (personal and group)
- Distinguish the purpose and actions of collaboration, communication, coordination, and cooperation
- Articulate person-centred care through four key relationships:
    - Practitioner/Patient
    - Practitioner relationships with each other
    - Inter-organizational/inter-sectorial relationships
    - Practitioner relationship with self

Purpose:

- Establish common language around key principles of compassionate, collaborative, person-centred care among all health professionals trained in the North

Assessment/Evaluation:

- Common student assessment across all HP programs to evaluate the extent to which the core curriculum is creating consistency in knowledge of the principles, practices and discourses of compassionate, collaborative person-centred care

Transformative Pedagogy (2 of 3)

Through the NICHE Network, develop a deep partnership between the academic programs and clinical teaching sites to:

- Establish powerful relationships (communities of learning) between academic leaders, clinical education leaders and preceptors, and clinical administrative leaders to:
  - Support *reciprocal learning* and *realize mutual benefit;* context matters; the relationships and partnerships matter…
  - Support the articulation *in each clinical placement site, key collaborative competencies and related learning activities* that are mandatory for any student on clinical placement and all staff
  - Help clinical sites to *see* the benefit of students and both to *feel* the mutual benefit of clinical/academic collaboration…

Transformative Pedagogy (3 of 3)

As strong NICHE/Clinical Teaching Site (Regional?) Networks emerge…

Promote and nurture social accountability in education, research, and practice…

Through *integrated, compassionate and collaborative clinical education*…

Where future practitioners learn from and with each other, patients, and the communities they serve, and become the practitioners that will *achieve a healthier North* together

So, is IPE/IPC Missing, Dying, or Dead?

- NO! But it is time to critical engage with the usual IP discourse and practices (e.g. there actually IS an "I" in team; discussions about role and scope of practice can strengthen boundaries and create barriers to collaboration!)
- The impact and power of IP is in the clinical setting and each clinical setting is unique – one size does not fit all
- Except for some basics, which can and should be introduced through a common core curriculum, interprofessionalism is best learned through intentional pedagogical practices in the clinical setting, but with strong academic partnerships
- "Transformative" pedagogies critically engage with power and privilege and align with the imperatives of social accountability – embrace and welcome that! Social accountability in both micro and macro contexts is the raison d'être for IP

A strong and vital NICHE is needed

- None of us can do this alone – it will take the whole village, and generations of new practitioners to reshape healthcare practices
- Our collective academic programs must work together – a structure is needed to facilitate that – NICHE is it!
- The purpose of NICHE must shift from teaching about interprofessionalism in the abstract, to supporting practitioners and learners to make sense of the evidence in each context and each clinical encounter and to successfully improvise-in-action in practice

Calling on NICHE…

- The imperatives to learn together in the academic settings are not strong – legitimate competing priorities are limiting
- The imperatives to work together clinically are very strong – clinically, we must and do work together – but we can do it badly and without clear intention
- Changing that – making our practices explicit and clear – expanding what it is that we talk about together beyond the boundary of science/evidence – is crucial

Calling on NICHE to lead a transformation…

- Develop common core curriculum…
- Build strong partnerships between HE and clinical teaching sites…
- Embrace social accountability through transformative pedagogy and practice…

Thank you!

Let’s meet at the intersections…

Hvae you eevr ralezeid tihs?

Acocdrnig to a cmabdigre unviesitry sutdy, the oredr of letetrs in a wrod deson't mttaer - the olny thnig thta's iopmrantt is that the frsit and lsat ltteer of eevry word is in the crorcet ptoision. The rset can be jmbueld itno a tatol mses and one is stlil albe to raed the txet wiohtut dclftfuiiy – rlelay wouthit any porbelm at all. Tihs is bcuseae the huamn mnid deos not raed ervey lteter by istlef, but the wrod as a wlohe.

Prtety amzanig dnot you tihnk?