Preparing the Ground for Interprofessional Education: Getting to Know Each Other

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The sentinel report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, prompted scrutiny of healthcare practices and a call to action to improve quality and safety of health care.[1] In addition, the Interprofessional Education (IPE) Collaborative Expert Panel of the World Health Organization identified the importance of IP collaboration as a foundation for improved team performance and reduction of medical errors. In response, nursing and medical school programs have been charged with embedding IP competencies into curricula to prepare a "collaborative practice-ready health workforce that is better prepared to respond to local health needs."[2]

We know from the literature, and our own experiences, that effective communication and team collaboration is inconsistently exhibited in clinical practice settings. Loversidge and Demb found that the most meaningful student experiences in IPE were "authentic, and faculty facilitated" and that "leadership commitment to full-time and adjunct faculty engagement and development were imperative".[3] Faculty development, an essential component for successful IPE, often focuses on curriculum design and teaching strategies for "uniprofessional" education,[4] rather than strategies to enhance collaboration, support, and networking among interprofessional faculty.

The desire to promote patient-centered quality care through interprofessional practice and education provided the impetus for forming our faculty development collaborative. Our program brought together faculty from across the health sciences center

to establish relationships, to enhance respect for each other, and to identify strategies for role modeling IP collaboration for students and colleagues. We believe that successful IPE requires building a strong foundation among faculty and clinical partners.

Our program aimed at laying the groundwork for IPE by building trust and getting to know each other as people and professionals. We believe that only after first laying this groundwork will fruitful collaborations result. We designed our longitudinal IPE group with that goal in mind but left the agenda open-ended. We did not envisage a specific project or set of projects as an outcome; rather we anticipated that IPE would develop in creative and innovative ways after fostering collaborative relationships and shared understanding among different professionals.

Our group consisted of teaching faculty members from different health science professions including five physicians, one nurse, one nurse midwife, two physician assistants, and two physical therapists. Each of us volunteered to participate in this group. We adapted a previously designed curriculum for humanism in medical faculty for use by our interprofessional group.[5] We sought to identify professional values we had in common and opportunities to prepare our students for interprofessional practice.

The Curriculum We Followed

Our curriculum topics are shown in Table 1. We made changes from the physicians' humanism curriculum by including the different professions in the role play exercises and including data from professions outside of medicine in sessions addressing specific topics like burnout, mindfulness and IPE itself.[6-8] We met for ten 90 minute sessions occurring at two to four week intervals between December, 2014 and August, 2015. Co-facilitators for this group included a physician and a nurse.

Table 1: Interprofessional Educational Faculty Development: Curricular Topics

1) Appreciative Inquiry Narrative Reflective Exercise
2) Through the Patient's Eyes: An exercise in empathy
3) Giving Bad News, A Teaching Exercise
4) Highly Functioning Teams
5) Session on Error Disclosure and Team Formation
6) After the Error: Learning, Growth and Disclosure
7) Well-Being and Renewal
8) Mindfulness
9) Inter-professional Education

Our curriculum began and ended with personal narrative-writing sessions. Group members selected their narratives based on important professional experiences in which they generally succeeded in accomplishing something they considered worthwhile. These are called appreciative inquiry narratives. Appreciative inquiry describes successful events or events that demonstrate strengths of the writer or her organization.[9] The purpose of including the appreciative inquiry narrative sessions was to help us get to know each other, and learn of the goals and values we might share. Narratives were read aloud to the group. Thoughtful self-reflection and supportive comments from the group provided the foundation for contemplation, appreciation, and development of trusting relationships.

Narrative writing was interspersed with sessions designed to role play the different professions working together on a shared issue, such as disclosing an error. Other sessions addressed mutually important topics like burnout, mindfulness and well-being. Teamwork was an important topic. Sessions on teamwork employed group-exercises and role plays. This curriculum was designed to take advantage of synergies between reflective learning and the mastery of the skills and topics.[10] Reflective learning establishes an atmosphere, which is meant to be reflective, as well as self-disclosing, intimate, and thoughtful. The following examples convey individuals' experiences in the curriculum.

Examples from the Curriculum

Physician example: A physician described his experience as follows: "I was moved early on in our group when Jenny, a nurse-mid-wife, expressed these feelings about her work: 'One of the most effective activities of our IPE group has been the use of appreciative inquiry as a strategy to come to know one another as representatives of different professions. Not just a social connection - but to know each other by discovering the heart we have for the work we do – a way to recognize our common humanity. I remember the first time we met, we wrote narratives on stories that would illustrate when we felt we were really doing something good and valuable for our patients. I wrote about my calling to strengthen global midwifery...'

As I look at these words on the page, I realize they fall short of Jenny's presence in the room, how she conveyed in facial expressions and tone of voice, what it meant to her to have this calling. I had not previously heard a nurse speak so passionately of her work. It rubbed off. I realized we are in this together, and how much is left undone in the world. Jenny is taking it on. This gave me a warm feeling, and made me feel good also about my work. It reminded me that I ought to embrace my own callings with renewed fervor."

Physical Therapist Example: A physical therapist remembers this session: "I remember our first meeting. We sat around a long table; probably there were 10 of us. I recall trying to guess the professions of each while realizing I was doing the opposite of what the workshop intended –stereotyping individuals, and emphasizing categorical differences. 'Well,' I thought, 'at least I am in the right place for change.' At that point, we went around the room introducing ourselves – it was a funny process, I listened but really did not hear what others were saying – I was too much focused on my internal dialogue of what I would say when my turn came, while smiling and trying to make eye contact with the speaker.

I imagine that many of us were similarly self-centered and self-conscious as I was at the beginning of the IPE workshop. I suspect that it takes a while to move toward a more group-centered attitude. Sharing narratives with each other certainly helped, as did the role playing. At first, I was an erratic listener, focusing more on what I was preparing to say in my own narrative. Yet, over time, I began to listen more closely to the stories of others. Stories have a way of doing that – they bring the 'inside out' and help connect us to each other as human beings who happen to be professional healthcare workers."

Physician Assistant Example: A physician assistant described this experience: "During the first meeting I

felt self-conscious and distracted. I wondered why I had agreed to joining the group when I had so many demands on my time. I knew that while I was in the group session I would receive many more emails that I would have to address after hours. Being new to Emory and in my position I wondered what the culture was at Emory, and what expectations others had of me. However, with time I started to look forward to our group meetings. The turning point for me was half way through the sessions when we had to describe another group member based on observed actions, comments, and contributions of that person in the group. With time, these sessions became a time of calm and reflection, of support, trust and understanding. Now I am very comfortable with the group members and know I can reach out to them when I have questions or an idea for a collaborative project."

Nurse Example: A nurse-mid-wife's experience: "One of the most important sessions for me happened quite late in our series of meetings. We discussed mistakes we had made in our professional careers. I talked about two incidents in my professional life as a nurse-midwife which have haunted me with shame, ever since they happened. Both incidents were related to omissions in communication, rather than poor health outcomes. The point was not really the content of these stories; the point was that I felt safe enough within the group to discuss them. I never really knew a lot of social facts about others in the group (What made them decide to get into healthcare? What did they teach? Who had children?). Nonetheless, we had built up enough trust that I was able to be vulnerable with them. This is the basis for successful interprofessional work. This is the experience we need for our students to understand."

What We Learned from Each Other

These examples show some of the things we learned from being in the group, and learned about each other. We gained a deeper understanding of the perspectives of those from other professions. One physician member of the group further reflected:

"The nature of the group made for fairly intimate disclosure about inner thoughts and significant experiences because of the understanding that the group was going to be confidential. Some of these things are possibly things that haven't been shared with anyone else. Being able to understand other departments and their unique skills and perspectives is important in order to create a coherent IPE program. I feel that bringing this group together has already brought about interesting synergies that I am using in other interprofessional groups that I am involved in. I am bringing up programs and concepts that people have mentioned in their reflections and sharing."

"It was not that I didn't have any idea that people in the nursing community, physical therapy community, and medical community had different experiences in healthcare, but being involved in a group comprised of different specialties and fields gave a sense of concrete context. In other words, it put faces to different departments rather than an abstract group of people. Hearing other people's personal narratives and their discussion about them afterwards was interesting in that it gave me a different perspective about how other people within my own field and in other fields approach and conceptualize their jobs and one another."

Where We Go from Here

Working at an academic health sciences center affords ample opportunities for interprofessional education and collaboration that are often underutilized. Logistical barriers easily become the scapegoat as professionals more accustomed to parallel education and practice settle for the path of least resistance. Having faculty personally see and experience the kinds of insights and richness that were experienced in this current project can serve as a model for other programs to facilitate transformational change in developing shared curriculum across the health professions.

The contacts and relationships that can be developed through these types of faculty meetings can act as a starting block for collaboration. Having an advocate for IPE in multiple departments can serve as a strong communication link to coordinate with one another. Examples of shared collaborations from our group included invitations to provide lectures on our professions or personal topics of expertise to other health science programs and developing shared scholarship projects related to IPE. We recognize that we can lead IPE efforts on campus by leveraging lessons learned and reflecting on our own learning as an interprofessional group. We have personally experienced working collaboratively. We understand our shared values in improving patient care, and we understand the importance of working together. We have proposed the forming of additional groups like ours to build a critical mass of faculty in each of the professions who know each other and wish to work together. As educators experience similar IPE faculty growth opportunities, health science programs can build and enrich their development and implementation of IPE for their students.

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