Policy Document

Interprofessional Education (2022)

Position Statement

The Australian Medical Students' Association (AMSA) believes that:

1. Multidisciplinary practice is the cornerstone of modern, effective, safe and compassionate healthcare;
2. Interprofessional education (IPE) plays a key role in fostering a positive interdisciplinary culture and establishing essential graduate competencies for healthcare students;
3. The current level of IPE provided by Australian medical schools is insufficient in preparing graduates to work collaboratively within a multidisciplinary team;
4. Aboriginal and/ or Torres Strait Islander Healthcare Workers are essential in all aspects of healthcare and their role must be better understood by all medical, nursing and allied health students and practitioners;
5. The onus for IPE for all healthcare students must not be on interdisciplinary peers, and instead should be a key part of formal curricula and ongoing professional development in the workplace;
6. There is insufficient research exploring IPE methods, particularly in an Australian healthcare context.

Policy Points

AMSA calls upon:

1. The Australian Federal and State and Territory Governments to:
    a. Provide funding for research exploring the methods and outcomes of interprofessional practice;
    b. Provide funding for hospitals to facilitate interprofessional teaching of students and early career healthcare workers;
    c. Provide funding for rural teaching experiences which enhance student understanding of multidisciplinary care in resource-poor settings.
2. Medical schools, universities, educational institutions and other health professional training bodies to:
    a. Provide institutional support by means of funding, staffing, central timetabling and resource allocation to facilitate the introduction or expansion of IPE in health curricula;
    b. Optimise clinical placement schedules and locations to maximise student exposure to multidisciplinary models of care and opportunity for learning alongside interdisciplinary peers;
    c. Coordinate medical and allied health curricula in clinical placement in a manner which enables students studying their degree to learn from exposure care planning;

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d. Include explicit teaching on the roles and scopes of practice of different health professions led by professionals of those disciplines;
e. Emphasise early interprofessional education to develop a collaborative interdisciplinary culture for students and graduates;
f. Require demonstration of interprofessional communication skills and multidisciplinary care planning in objective and subjective assessments;
g. Facilitate inclusion of Aboriginal and Torres Strait Islander led teaching on the role of Aboriginal and/ or Torres Strait Islander Health Workers into the curriculum;
h. Provide opportunities for rural experiences which enhance student understanding of multidisciplinary care in resource-poor settings;
i. Evaluate and report on the outcomes of interprofessional education initiatives;
j. Regularly review the IPE curriculum (including optional placements and electives) to ensure it is kept up to date with best practice and is conscious of modern issues and sensitivities and changing competencies required of future healthcare practitioners;
k. Evaluate IPE implementation within rural settings and formulate consistent standards and expectations between clinical site teaching of IPE.

3. The Australian Medical Council to:
   a. Include well-defined accountable statements and practice-focused outcome measures in program accreditation standards requiring teaching on the roles of different health professions and approaches to multidisciplinary care;
   b. Encourage collaborative models of medical, nursing, and allied health teaching;
   c. Liaise with other program accreditation bodies and cooperatively develop more universal IPE curriculum standards across all health professions;
   d. Incorporate communication standard between students based between rural and metro placements.

4. Healthcare professionals and healthcare providers, including hospitals, to:
   a. Teach students under their supervision about the roles, skills, and scopes of interdisciplinary colleagues;
   b. Provide guidance to students under their supervision as to the interdisciplinary communication, resource sharing, and collaboration norms of their workplace;
   c. Support graduate and early career health professionals practising within a multidisciplinary framework to protect patient safety;

d. Provide training sessions to clinicians and students on the role of Aboriginal and/ or Torres Strait Islander Health Workers;
e. Facilitate interprofessional and inter-institutional teaching in the clinical setting.

5. Medical, Nursing, and Allied Health Students to:
    a. Foster a sense of mutual respect between the disciplines within healthcare;
    b. Expand student understanding and appreciation of the intersecting roles of healthcare professions involved within patient care;
    c. Take an inclusive approach to clubs, societies, and special interest groups by hosting collaborative social and academic events;
6. Australian Health Practitioner Regulation Agency (AHPRA) and non-ABPRA regulatory boards and representative bodies to:
    a. Require interprofessional communication skills as graduate competencies for registration for practice;
    b. Provide interprofessional educational experiences as continuing professional development and co-curricular learning for student and professional members.
7. Research institutes to:
    a. Investigate optimal interprofessional education approaches to maximise graduate competency working within the multidisciplinary team;
    b. Investigate implementation of interprofessional education in rural and remote settings;
    c. Investigate synergistic interdisciplinary practice between medical, nursing, midwifery, and allied health professionals, and Aboriginal and/ or Torres Strait Islander Health Workers.

Background

The Multidisciplinary Team

Modern healthcare involves a multifactorial approach to promoting patient health, recovery, and wellbeing. This complex care is best delivered by multidisciplinary teams (MDT), making optimal use of specialist knowledge and skills, through the sharing of interprofessional expertise [1, 2]. The disciplines which contribute to the MDT are difficult to enumerate, but can broadly be categorised into medical practitioners, nurses and midwives, and allied health professionals - collectively, 'the health professions' [3]. Bogossian and Craven developed an operational definition of the health professions as "discipline groups who adhere to ethical standards, possess special knowledge and skills derived from research, education, and training at a high level, and who apply this knowledge and exercise skills in the interest of the health of others", through which they identified 29 discrete health professions [3]. For a list of health professions identified through the background research for this policy, see Appendix.

While team members bring role-specific and task-specific competencies to patient care, the skills required to be an effective member of the MDT are not discipline specific [2, 4]. Skills such as effective interprofessional communication, adaptability, resource-sharing, coordination of care, and an understanding of the roles and discipline-specific skills of colleagues streamline workflow and minimise miscommunications, a key preventable cause of sentinel events [5]. MDTs often incorporate professionals across the disciplines based on opportunity and availability, resulting in a constantly changing team composition [2]. It is therefore essential for all team members to have a solid understanding of the avenues of care open to the team as a whole by understanding the roles of each colleague as an individual. The aim of interprofessional education is to grant healthcare students an understanding of the different disciplines, and to teach the skills necessary for working within the MDT upon completion of their studies [2].

A multidisciplinary practice (MDP) model is crucial in medical practice, as there are myriad of demonstrated benefits for both patients as well as the healthcare system. MDP results in improved patient experience, a greater sense of support during medical treatment, and can improve quality of life [6]. Furthermore, the involvement of an MDT increases patients' adherence to treatment, increased patient safety, improved outcomes, and can facilitate greater access to services and clinical trials [7, 8, 9].

The Role of Aboriginal and/ or Torres Strait Islander Health Workers

An Aboriginal and/ or Torres Strait Islander Health Worker is an Aboriginal and/ or Torres Strait Islander person who has completed a Certificate III within the fields of primary healthcare work clinical practice [10]. They have a unique scope of practice, performing comprehensive primary healthcare, health promotion, chronic disease management and intervention, as well as community advocacy and education [11]. Given the role of the western medical system in the ongoing colonisation and dispossession of Aboriginal and Torres Strait Islander peoples and the subsequent adverse health consequences for Indigenous communities, Aboriginal and/ or Torres Strait Islander Health Workers are integral to increasing access to culturally safe care [12, 13, 14]. Aboriginal and/ or Torres Strait Islander Health Workers are often called upon to provide leadership and act as cultural mentors for the community whilst also aiding non-Indigenous practitioners in decolonising their practice and communicating more effectively with Aboriginal and Torres Strait Islander patients [15, 16].

The positive effects of Aboriginal and/ or Torres Strait Islander Health Workers have been measured by improved neonatal clinical outcomes, increased uptake of preventative health screenings and improved chronic disease management in primary healthcare contexts [17, 18, 19, 20]. Given their integral role in enhancing patient safety for Aboriginal and Torres Strait Islander communities, there should also be a permanent place for Aboriginal and/ or Torres Strait

Islander Health Workers in acute care settings, whose work should be prioritised and supported even in times of resource shortage [12]. The present lack of representation has been attributed to insufficient research into the role of Aboriginal and/ or Torres Strait Islander Health Workers in acute care, which exacerbates the lack of understanding by employers and healthcare workers about the work that Aboriginal and/ or Torres Strait Islander Health Workers do [12, 15]. In the context of more rural and remote areas where the team may consist of a nurse and an Aboriginal and/ or Torres Strait Islander Health Worker, it has been found that a sound understanding of the role of Aboriginal and/ or Torres Strait Islander Health Workers by the nursing staff was a necessity for good practice and further the collaboration between the two professions was essential for practising with cultural integrity [21].

The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national leadership body for Aboriginal and Torres Strait Islander health in Australia [22]. NACCHO provides advice and guidance to the Australian Government and advocates for community-based initiatives to improve health outcomes [22]. NACCHO oversees 144 Aboriginal Community Controlled Health Organisations (ACCHOs) which all prioritise self-determination within healthcare and centre the role of Aboriginal and/ or Torres Strait Islander Health Workers [22]. The integration of Aboriginal and/ or Torres Strait Islander Health Workers alongside other healthcare practitioners is one of the ways ACCHOs prioritise cultural safety [23]. As this model is already comprehensively established, it would be highly opportune for other primary and acute care settings to adopt this model, to ensure safer care for patients and continual learning for providers [23]. This thus necessitates increasing awareness of and collaboration with Aboriginal and/ or Torres Strait Islander Health Workers.

The Benefits of Multidisciplinary Practice

An overarching feature of MDP is interprofessional communication that enables coordinated decision making to ultimately enhance the quality of patient care. The concurrent patient management by MDTs facilitates efficiency and continuity of care [24]. It is also suggested that MDP improves patient access to health services and clinical trials [9]. Moreover, there is evidence supporting increased patient satisfaction and treatment acceptance following the integration of MDT in community, palliative and mental health care [25]. There is also evidence that patients now hold their healthcare professionals more accountable and expect them to work collaboratively [26].

The MDP has been extensively implemented in oncology care with a substantial body of evidence indicating that MDP improves clinical outcomes [24]. MDP has been requested in the ongoing care and management of cancer patients in response to the shortcomings of conventional care [27]. These are largely attributed to miscommunication between care providers, engendering inconsistency in patient management resulting in unnecessary testing, treatment delays and lack of follow-up - all exacerbating patient anxiety [27]. Multidisciplinary approaches are associated with an increased number of

patients receiving prompt staging and treatment, and improved survival in various cancers [24].

The necessity and benefits of MDP are further highlighted from the perspective of the healthcare system. There is general consensus in current literature recommending MDP as a means of addressing the increasing complexity of health needs of the ageing population [28]. Several studies suggest that MDP streamlines the healthcare delivery process from patient referrals to discharge, which facilitates efficient use of limited healthcare resources [27, 28]. This has been exemplified by palliative care MDTs where efficient organisation of nursing home or individual home care leads to decreased length of hospitalisation time with earlier discharge, thereby reducing hospital costs [25]. MDP has also shown efficacy in preventing unexpected admissions to intensive care following the introduction of medical emergency MDTs [25]. In addition, it is demonstrated that MDP alleviates the unnecessary burden on hospital outpatient services by increasing access to primary health care [25].

Interprofessional Education

Interprofessional education (IPE) occurs when students of two or more disciplines learn from, with, and about one another, to improve interprofessional communication and collaboration skills, enabling graduate multidisciplinary practice [3]. This enhanced mutual understanding has downstream effects in optimising health services, strengthening the healthcare system, and improving outcomes for patient safety and care [3]. IPE is a key approach for enabling students to understand different professional roles and their associated scopes of practice, the values and perspectives of different disciplines, and methods of collaboration, teamwork, and leadership [31]. There is longstanding international consensus that IPE is essential to prepare healthcare students for an increasingly team based, patient-centred healthcare environment [32, 33].

The Australian Context

The requirements for medical school accreditation set out by the Australian Medical Council (AMC) include interprofessional skills. The AMC Standards for Assessment and Accreditation of Primary Medical Programs state that “students should have opportunities to appreciate the roles and function of all health care providers and to learn how to work effectively in a healthcare team”. In order to teach collaborative practice, interdisciplinary knowledge, skills and attitudes must be included in the curriculum [34]. However, the Australian approach to IPE in accreditation standards is fragmented and inconsistent between health disciplines, with many publicly available curriculum standards using poorly-defined terminology and lacking in accountability [3].

According to a review of requirements for IPE in accreditation and practice standards for health professionals in Australia, in which 29 health professions or social care professions with a health role in Australia are examined, 17 include statements about IPE in relation to program accreditation, and only 15 (including medicine) make accountable statements about including - with the

remainder of accreditation standards making no mention of IPE [3]. Only one profession (optometry) provides a specific set of IPE competency standards in their accreditation standards with the expectation that education providers demonstrate how competencies are embedded in the curriculum [3]. The majority of professions examined do not have a definition of IPE included in their accreditation standards [3]. This demonstrates a lack of consistency and standardisation in the approach to IPE requirements for accreditation and practice in health professions in Australia. While the feedback sought by the authors in development of this policy generally reflected a lack of quality IPE teaching across Australian medical schools, there is very little literature to draw on to conduct a comparative analysis of methods and outcomes.

Student Experiences of Interprofessional Education

Several articles exploring IPE compared and contrasted student experiences, ultimately highlighting a greater need for comprehensive IPE within medical education [4]. There was varied exposure to IPE within curricula, and, despite recognising the importance of IPE, many were uncertain of its definition [4]. Students reported that placements lacked structured opportunities with adequate time to interact with other professions [4].

Rural and remote interprofessional placements were commended in building positive IPE experiences where students were able to gain a deeper understanding of other professionals, collaboration and mutual respect. Students expressed that IPE in a community with previous gaps in services provided personal fulfilment [35]. Giving and receiving peer feedback between students of different disciplines increased self-reflection, and was therefore recognised as meaningful [32, 36]. Cooperative learning also allowed for students to consider a team-based approach to patient care. For example, medical students found nursing students had a larger skill-set than expected [37]. The importance of early intervention was highlighted by another study which found that fourth-year medical students do not change their bias towards other health professions following IPE [38].

Overall, both students and clinical facilitators spoke about the value of IPE in helping students to understand their own professional identity, while gaining an improved perception of the other professional roles within the healthcare team [4, 35, 39]. Medical and nursing students further emphasised that IPE could aid in removing hierarchical structures within clinical settings, ultimately improving interprofessional interactions [37].

IPE in Rural and Remote Healthcare

The rural and remote healthcare context provides a unique landscape for IPE. These healthcare environments are often smaller, with fewer staff and an increasing overlap in the scope of different providers. Healthcare providers are often isolated from their peers, and as a result, have to rely on their colleagues in other healthcare fields for professional support [40]. This increased communication is one of the major factors underpinning successful rural

interprofessional education (RIPE). It has been shown that rural areas tended to have a less overt hierarchical structure, promoting collaboration and teaching [41].

The lack of consistent resident practitioners in rural and remote practice was identified as a significant barrier for RIPE. The continual reliance on locum practitioners made it difficult to develop a sense of community, as visiting specialists often perceived themselves as being part of an external team and it is familiarity which greatly increased RIPE in the hospital environment [42]. Further, RIPE between different healthcare contexts, such as community-based practice and hospital practice due to perceived restrictions by individual organisational structures [42].

Rural and remote healthcare settings hold great potential for constructive and transformative experiences of IPE for students [43]. It has been shown that students on rural placements learn from professionals from other health disciplines, promoting interprofessional understanding, professional respect for other roles, collaboration and teamwork, however, further research is required to translate these findings into curricula [41, 43]. In the meantime, multiprofessional rural students' clubs and societies can serve as arenas for socialisation between different degrees, increasing awareness of RIPE, and promoting pursuit of rural clinical experiences [40].

Barriers to Interprofessional Education

There is concern that implementation of IPE may infringe on teaching time dedicated to clinical science curricula [39]. Moreover, current course requirements imposed by accrediting and licensing authorities make any change in curriculum challenging [3]. Course design and curriculum redevelopment is a time consuming and costly process. Due to the lack of research quantitatively validating IPE, lack of a standardised method of IPE course evaluation, and lack of established IPE frameworks, many post-secondary teaching institutions are reluctant to make the required overhaul [3]. The introduction of novel IPE approaches would also require significant upskilling of educators, many of whom lack familiarity with the current literature [39].

Furthermore, barriers such as curriculum variation and expected level of knowledge between different disciplines, the lack of infrastructure to accommodate all students, and challenges in coordinating cohorts, make it difficult to accommodate the content, format and frequency of IPE courses [44]. Health disciplines generally constitute a large student cohort in post-secondary institutions, rendering central timetabling a mammoth task with a large administrative burden [3].

Bias, stereotyping, and physician dominance all pose cultural barriers to the implementation of IPE in health curricula [3, 36]. The hierarchical team structure, supremacy of biomedical models in healthcare and gaps in salary and

compensation across different health professions gives rise to animosity between health professions, making interaction between students and educators of different disciplines challenging [45]. Differences in language and communication styles between professions can further entrench a cultural distance. These cultural barriers to IPE uptake are themselves reinforced by processes of uniprofessional identity formation which takes place in the absence of interdisciplinary experiences [36].

Outcomes of Interprofessional Education for Students and Clinicians

IPE enables development of common understanding regarding treatment plans and roles within the team [1]. This allows for effective communication during the often unprecedented situations which arise in healthcare [2]. Non-medical health professionals feel more empowered to voice their opinions, breaking down hierarchical barriers, staff distress and inefficiency [46]. A Cochrane review identified several potential benefits to patient care facilitated by IPE and MDP with low certainty evidence, including enhanced adherence to practice and prescription guidelines, and more effective resource use [47].

Paraprofessionals such as Aboriginal and/ or Torres Strait Islander Health Workers and healthcare interpreters may function as a bridge between healthcare providers from the dominant culture to facilitate safe care for patients from minoritised backgrounds [48]. In the particular context of safety in Aboriginal and Torres Strait Islander health, it is considered essential to safe cultural practice for all providers to have a strong interprofessional relationship with Aboriginal and/ or Torres Strait Islander Health Workers [21]. This not only decreases cultural barriers for patients but further helps to inform clinicians of their blind spots, increasing their capacity to effectively work with patients from different backgrounds [49].

IPE within the MDT environment can aid in deconstructing professional stereotypes that exist within healthcare, by addressing these notions prior to entering the workforce, thereby mitigating misconceptions about role and stigma [50, 51]. This considered, it is critical to include all relevant professions when conducting IPE, as the absence of certain disciplines can leave stereotypes unchallenged [51]. IPE can instil a greater sense of mutual respect between professions within the MDT, while employing clear boundaries regarding professional responsibilities for each discipline, thus improving cohesion, efficiency, and the development of mutual goals for patient care [51, 52, 53]. This in turn improves patient safety, adherence to interventions, and overall quality of care [54].

The goal for IPE at the university level is to train students to learn with, from and about several professions from the beginning of their studies [55]. This aims to foster understanding about the contributions of the health professionals they will work alongside and enable collaborative learning to establish effective working relationships in healthcare [55]. A meta-analysis has shown a consistently positive response to IPE by students as measured by better attitudes, understanding, collaborative knowledge and skills [56]. The effectiveness of IPE appears to have an even greater impact when incorporated into clinical-based teaching and assessments [57].

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Appendix

Registered Health Professional Disciplines, adapted from Bogossian and Craven with additional health professions identified through literature search conducted in the development of this policy:

Aboriginal and Torres Strait Islander Health Practice, regulated by the Aboriginal and Torres Strait Islander Health Practice Board of Australia
Chinese Medicine, regulated by the Chinese Medicine Board of Australia
Chiropractic, regulated by the Chiropractic Board of Australia
Dentistry, regulated by the Dental Board of Australia
Medicine, regulated by the Medical Board of Australia
Medical Radiation Practice, including **Radiography, Nuclear Medicine Technology,** and **Radiation Therapy**, regulated by the Medical Radiation Practice Board of Australia
Nursing and Midwifery, including **Enrolled Nursing, Registered Nursing,** and **Midwifery**, regulated by the Nursing and Midwifery Board of Australia
Occupational Therapy, regulated by the Occupational Therapy Board of Australia
Optometry, regulated by the Optometry Board of Australia
Osteopathy, regulated by the Osteopathy Board of Australia
Paramedicine, regulated by the Paramedicine Board of Australia
Pharmacy, regulated by the Pharmacy Board of Australia
Physiotherapy, regulated by the Physiotherapy Board of Australia
Podiatry, regulated by the Podiatry Board of Australia
Psychology, regulated by the Psychology Board of Australia

Audiology, represented by Audiology Australia
Dietetics, represented by the Dietitians Association of Australia
Exercise and Sports Science, represented by Exercise and Sports Science Australia
Speech Pathology, represented by Speech Pathology Australia
Genetic Counselling, represented by the Australasian Society of Genetic Counsellors
Perfusion, represented by the Australian and New Zealand College of Perfusionists
Social Work, represented by the Australian Association of Social Workers
Music Therapy, represented by the Australian Music Therapy Association
Orthotics and **Prosthetics**, represented by the Australian Orthotic Prosthetic Association
Arts Therapy, represented by the Australian, New Zealand and Asian Creative Arts Therapy Association
Orthoptics, represented by Orthoptics Australia
Rehabilitation Counselling, represented by Rehabilitation Counselling Association of Australasia
Sonography and **Echocardiography**, represented by the Australasian Sonographers Association

AMSA recognises that this list is not exhaustive.

Policy Details:

Name: Interprofessional Education (2022)

Category: B – Medical Education

History: **Reviewed Council 3, 2022**
Ebony Layton, Dineli Kalansuriya, Ching Ting Sonia Tsui, Anagha Kanive-Hariharan, Jiwon Lee, Sophie Conroy, Maryanne Li (Policy Mentor), Ashraf Docrat (National Policy Officer)

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Reviewed Council 2, 2014
Adopted Council 2, 2009