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COMMENTARY

Rural multidisciplinary training: opportunity to focus on interprofessional rapport-building

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ABSTRACT

In 2016, the Australian Government committed further funds in support of quality rural health education to improve the health and wellbeing of rural and remote communities. The stated funding requirement for longer rural placements in all disciplines is an exciting opportunity for greater investment in interprofessional education to foster collaborative practice, a global system imperative for health care. This commentary explores how findings from earlier research, which investigated *how students in a co-located area learn to work with other health professions*, can be translated into practice. While recognising the importance of an individual's interpersonal capabilities, this commentary focuses on how the *core contextual conditions for interprofessional-rapport-building opportunities* (shared space, adequate time and balance of disciplines) were considered in one rural centre.

Educational leaders and academics globally should recognise that offering health professional students opportunity to live and work together in extended placements in rural settings has potential benefits for interprofessional education. Understanding the contextual conditions for building rapport between health professional learners, and reflecting on these, potentially will lay the foundation for collaborative practice when these learners become health professionals. Through the reflective questions we pose, policy-makers, health managers and clinical leaders from all health disciplines can build on this foundation by considering the *interpersonal capability* and *contextual conditions* for *rapport-building* in the health workforce to foster a collaborative practice environment for graduates to embrace when they enter the health workplace.

The Commonwealth-supported consolidated Rural Health Multidisciplinary Training (RHMT) program heralds a new era in rural health professional education in Australia[1]. It is founded on the mounting evidence base that indicates that medical students who undertake extended training in a rural area, and those from a rural background, are more likely to take up rural practice on

graduation, and that these factors are likely to be influential in the rural retention of other health graduates[1-5].

To deliver the rural health training, university academic and administrative staff are required to live and work locally in a range of rural 'campuses' across Australia. Students learn from and work with local health professionals and the broader community in these rural settings[1]. In 2016, the federal government committed further funds in support of quality rural health education to improve the health and wellbeing of rural and remote communities in Australia[6]. The resulting RHMT program aims to make a measurable impact on addressing the maldistribution of the rural health workforce. Depending on the education programs they offer, Australian universities accepting RHMT funds are required to place greater emphasis on improving recruitment and retention of professionals from nursing, dentistry, allied health and/or medicine in rural and remote Australia. The stated funding requirement for longer rural placements in all disciplines is an exciting opportunity for greater investment in interprofessional education to foster collaborative practice, a global health system imperative for care that is centred around the patient[7].

A decade or so of higher funding support and targets (25% of Australian Commonwealth-supported students) for year-long rural medical placements has resulted in more longitudinal placements in medicine than for other disciplines. Now, with rural health professional education evolving to reflect the greater requirement for recruitment of rural origin students and long-term rural placements for all health disciplines, new educational possibilities unfold. Increased numbers of students from a range of disciplines, living, socialising and learning together over longer time periods, creates the ideal conditions to prepare students for future collaborative practice. We share insights into how to maximise this opportunity at rural education centres and suggest questions for ongoing reflection on how best to capitalise on these conditions.

Like others in Australia, our rural educational centre, with its extended placements for many health disciplines and its multiprofessional learning environment, has great potential for interprofessional education. Each student is supported by one or more academics from their own profession, and these academics support each other and all students during interprofessional learning activities. Administrative staff provide support for the program, including managing accommodation, coordinating social activities and assisting with preparation of educational activities. Commitment from managerial staff over many years has been crucial to the interprofessional nature of the centre.

At the centre of the insights shared in this perspective is our centre's relationship-focused research finding that *rapport* is core to 'how students in a co-located area learn to work with other health professions'[8]. The components of rapport that enabled students to learn to work together were identified in relation to *interpersonal capabilities* (being interested, being inclusive, developing interpersonal bonds, bringing a sense of own discipline, giving and receiving respect, and being patient-centred) and *core contextual conditions for interprofessional-rapport-building opportunities* (shared space, adequate time and balance of disciplines). While recognising the importance of an individual's interpersonal capabilities, this perspective focuses on the core contextual conditions.

Using a framework of core contextual interprofessional-rapport-building opportunities[8], a cross-section of multidisciplinary academic and professional staff at the centre asked and/or were asked a series of questions to informally explore how the research findings had impacted on the centre's practice. They were encouraged to make explicit their current operational process behind ensuring that students were offered sufficient shared space, adequate time and balance of disciplines to ensure rapport-building between members of different professions. Key aspects of these core contextual conditions were iteratively discussed. The questions that arose from, and were part of, these discussions are shared in Table 1 as an illustration of how the model can be operationalised in a rural education context. By highlighting opportunities and challenges integral to facilitating students' development of interprofessional rapport on long-term rural placements, we invite international readers to reflect on the issues these questions raise, to encourage rapport-building between students in their educational contexts. Through such reflection, additional questions may be raised that are specific to readers' particular situations and experiences.

Table 1: Operationalisation of the rapport-building model – questions to consider[†]

Context for rapport-building	Shared space	Adequate time	Balance of disciplines
Social	To what extent should students get a preference for which professions they live with, in shared accommodation? Does it matter if particular professions claim particular spaces for socialising or studying?	Should students on short-term placements be allocated to accommodation units with students of longer placements? How can we encourage students who live off campus to spend time with students from other professions? To what extent should social events be controlled by the educational institution or left to evolve between students?	Are there issues associated with allocating too many students of one profession in each accommodation unit? To what extent should students be encouraged to understand the educational requirements of different professions, and how these may impact on participation in social events?
Academic	In relation to regular interprofessional learning activities, how can we ensure that students don't miss interprofessional rapport building opportunities by congregating in professional groups?	How can we gain commitment from clinical supervisors of all professions to embed regular interprofessional learning modules into academic and clinical timetables?	While encouraging all students to participate in intraprofessional learning activities, how can we ensure professions with larger numbers of students do not dominate?
Clinical	How can common areas on clinical placements be welcoming for professions with smaller numbers of students?	How can we quarantine time during clinical placements for students to develop interprofessional rapport with people from other professions?	How can patient care benefit from the interprofessional rapport students have with each other?

[†] A cross-section of multidisciplinary academic and professional staff at the centre asked and/or were asked a series of questions to informally explore how the research findings had impacted on practice.

To build rapport between rural co-located students from many disciplines, the following issues are important: (i) congruence between core contextual conditions across a range of rapport-building opportunities and (ii) sensitivity for which aspects of rapport-building need to be explicitly controlled and which need to evolve organically. Key to the successful operationalisation of the interprofessional-rapport-building model is continuing to seek and maintain this congruence and sensitivity in relation to decisions made about shared space, adequate time, and balance of disciplines, for students to get to know each other and learn to work together for collaborative patient-centred practice. Readers can consider the relevance of these, and the balance and clarity between them, in their own educational settings.

Importantly the same issues need to be considered for educators and clinicians[9]; for example, what spaces do educators and clinicians of different professions share, and is there adequate time for them to 'get to know each other'? Academic program directors need to enable and support interprofessional-rapport-building opportunities for their staff as well as their students, and healthcare managers/leaders should reflect on the same contextual conditions to enable rapport-building between their health professionals.

Although the contextual issues have been foregrounded, clearly it is important to note that the behaviours of people within the spaces, time and professions are important for rapport[10]. Facilitating the development of these behaviours by exploring interprofessional "rapport-building moments" in clinical situations

is currently being further researched by Croker and colleagues[8-10] with findings potentially having utility for interprofessional education and collaborative practice. Translating interprofessional education in to collaborative practice is one of the challenges for health professional education[11]. Australian health policy-makers, by increasing the RHMT funding for longer term rural placements for all health professional students, have enhanced opportunity to co-locate rural learners and build interprofessional rapport. These early steps towards collaborative practice are usually more difficult to achieve in urban settings due to the logistics of staging interprofessional educationactivities for larger student numbers, and the reduced occurrence of interprofessional groups of students living together over time.

Educational leaders and academics globally should recognise that offering health professional students opportunity to live and work together in extended placements in rural settings has potential benefits for interprofessional education. Governance structures then need to facilitate time and space for interprofessional learning. Understanding the contextual conditions for building rapport between health professional learners, and reflecting on these, potentially will lay the foundation for collaborative practice when these learners become health professionals. Policy-makers, health managers and clinical leaders from medicine and all health disciplines must build on this foundation by considering the interpersonal capabilities and contextual conditions for rapport-building in the health workforce. This should foster a collaborative practice environment for graduates to embrace when they enter the health workplace.

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