Rural and Remote Health
FRAME ARHEN
ISSN 1445-6354
The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy

EDITORIAL

# Interprofessional education - to break boundaries and build bridges

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***Submitted:*** *8 June 2006;* ***Published:*** *7 July 2006*

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***Rural and Remote Health*** **6: 602. (Online), 2006**

**Available from: http://rrh.deakin.edu.au**

Today we are educating health sciences students for the coming 40 years, and we expect them to be skilful and professional in their own disciplines. However, modern healthcare organisations also recognise the importance of interprofessional competence, which could be seen as an additional aspect to the professional compass. Being professional today and tomorrow includes having interprofessional competence, which could be defined as the ability to cooperate with other professions, and to know and understand the importance, functions and roles of other healthcare professional groups. The working together of healthcare professionals to meet the increasingly complex patients' and clients' needs most effectively is more important today than ever before. This is especially so in rural and remote areas around the world, where available healthcare resources are often quite sparse. In such cases, it is essential that health and social professionals work together in order to supply efficient care within available resources.

Interprofessional education (IPE) in the field of the health sciences is now widely perceived as a potentially effective method for enhancing collaborative practice. IPE occurs when professions learn with, from and about one other to facilitate collaboration in practice. However, the skills required to work together interprofessionally are gained in a process over time. IPE has it's origin in a WHO report 'Learning together to work together for better health', from 1988, which encouraged the development of IPE activities around the world to promote effective teamwork in health care[1]. The basic idea was that it is favourable for undergraduate students to experience other professions in the health and social sectors. Inherent in this scheme is that the various professions will work together in practice.

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IPE has been a rising policy objective of many governments and universities worldwide. Different initiatives have commenced, for example in UK by the National Health Services (NHS) and the Department of Health[2]. In recent years several universities in the UK have changed their curricula to include IPE. An early European example of IPE is the Faculty of Health Sciences at Linkoping University in Sweden which, for 20 years, has allocated up to 12 weeks of the curricula of all health science programs to IPE[3]. In addition, the Karolinska Institute in Stockholm, Sweden, has recently decided that all their health science programs should devote parts of the curriculum to IPE. The interest in IPE has risen greatly in North America, especially in Canada where the government and National Health Council (IECPCP) has allocated considerable resources to IPE initiatives. However, although the evidence of IPE's effect on professional practice and also on healthcare outcomes is sparse so far, such evidence is constantly increasing[4].

An international conference promoting IPE and practice entitled 'All Together Better Health' was held in April 2006 in London. This event was the third international conference of its kind; the next will be held in 2008 in Sweden. At the 2006 conference the International Association for Interprofessional Education and Collaborative Practice entitled InterEd was launched, and this will be hosted at the College of Health Disciplines, University of British Columbia in Vancouver, Canada. Another initiative of this kind in the Scandinavian countries is a Nordic network entitled Nipnet[5]. There are links between the newly formed InterEd network and the long-established international network 'The Network – Towards unity for health'(TUFH)[6].

## Why interprofessional education and practice?

There are several important trends and social changes in communities worldwide that influence health policy and call for increasing IPE and practice. Many societies tend to be more multicultural, with a high degree of mobility. The differing cultural and social traditions are mixed, which means that health problems faced in health and social care tend to be complex. In many countries the population is ageing. Europe has, for example, the highest proportion of old people worldwide[7]. Both these trends carry implications for the organisation, delivery and cost of health and social care, increasing the pressure on practising professionals in both urban and rural areas. In order to respond effectively and to realise the ideals of holistic care, interprofessional competence is called for.

Other general trends in health care include greater emphasis on preventive measures, the transition of patients from hospital care to primary care due to rising healthcare costs, advances in medical technology, and demographic changes. For an increasing number of patients, the foundation of care is now the local community in semi-rural and rural areas. Integrating health and social care, and also community and hospital care, is critical, but depends on practising professionals in all settings having the motivation and competence to establish collaborative practice. This is especially so in rural areas.

The cost of healthcare is rising worldwide due to the complexity of diseases and the consequent high involvement of new medical technology. Both new medical technology and new pharmaceuticals place high demands health care professionals, and coordinated teams and interprofessional competence meet such demands most efficiently.

Individuals today are exposed to a never-ending explosion of information, not the least of which is advice about health, health risks and healthy behaviour. The individual as a consumer of knowledge is better informed today but is also more demanding and sometimes more critical. This is a healthy trend but it demands close collaboration among the health professions. Such pressures contribute to stress and burnout which are common today among healthcare staff. Rising expectations with limited resources and sometimes shrinking staffing in healthcare organisations worsen such stress, calling for new ways of working together to set limits on the demands made on any one profession, to spread the load and to build in mutual support.

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Certainly there are obstacles to overcome and boundaries to break in order to gain health care characterized by collaboration and cooperation among professions. Working together in teams is not always the most natural way to organize health care. We must also keep in mind that the extent of interprofessional practice is related to socio-cultural beliefs and attitudes in different healthcare organisations and countries. In this respect, willingness to cooperate could be related the relative power of different professions. The medical profession is strong with a long tradition and is a profoundly defined profession. However, in defining and assessing medical professional competence, interprofessional skills and life-long learning have been found to be important domains[8]. Other health professional such as nursing, physiotherapy and occupational therapy also strive to establish themselves not only as professions, but also as scientific disciplines. In this process, the principle of effective teamwork can be encouraged and nurtured. Indeed, this is occurring in many countries for our health science students in their training wards and primary health care placements.

Primary health care in the local community is the most natural and cost-effective base for healthcare organisations. Today, at community level, there is a climate of increasing incentives to work effectively in interprofessional teams. This is of especially high relevance and concern in rural settings. Promising rural initiatives of IPE have, for example, been made in Australia[9]. Student placements in rural Australian primary care have been shown to improve interprofessional abilities. This has the potential to influence change towards collaborative practices in students' future workplaces, and to strengthen health students' intention to work in rural health settings after graduation[10]. The challenges of IPE and interprofessional practice has also been made in Canadian rural communities, related to interdisciplinary collaboration in health systems and also health care actions in northern Canadian Aboriginal communities[11,12].

Breaking the boundaries among health professions to work interprofessionally in the best interests of the patient is definitely challenging. However starting to build bridges among the healthcare professions must be concurrent with a basic belief that the winner of such cooperation and collaboration is, in the end, the patient and client. The patient should always be viewed as 'the main character' in all health care interactions. Primary health care in rural areas, characterized by interprofessional health care practice of high quality, is a challenge for all healthcare systems in order to meet the patient's needs effectively.

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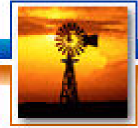

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