

## *Some Thoughts on Creating Collaborative Care*



Mr. President, faculty, students and staff.

May I begin by thanking you for your most kind invitation to be at this important Faculty Convocation.

And may I also thank you for both the honour and privilege of being invited to give this address? It is a great pleasure to be at the institution that inspired my own university's analog of your remarkable Presidential Scholars Program.

The comedian George Burns is reputed to have said: "The secret of a good sermon is to have a good beginning and a good ending – and to have the two as close together as possible." I'll try to heed this excellent advice.

Almost a century ago, a research scholar at the Carnegie Foundation for the Advancement of Teaching, undertook an assessment of medical education in North America. He visited all 155 medical schools then in operation in the United States and Canada. His report in 1910, addressed primarily to the public, helped change the face of American – and probably global – medical education. His name was Abraham Flexner.

For two years Flexner had visited, unannounced, all schools of medicine in the United States and Canada. At the end of that journey he wrote a scathing report of medical education. In his report he made three *major* recommendations. Ultimately, those recommendations were to profoundly affect the education of *ALL* health professionals. Flexner recommended:

- ❧ *First*, that most of the proprietary schools of medicine in operation at that time should cease teaching forthwith.
- ❧ *Second*, that all remaining and future schools of medicine should be associated with universities and teaching hospitals.
- ❧ *Third*, that there should be a nucleus of physicians in each department of a medical school who would receive remuneration for teaching and research.

In the years since Flexner's report, wherever one looks in the developed world, medical education specifically – and the education of health professionals in general, has essentially followed the spirit of those recommendations.

Unfortunately, the consequences of those recommendations have *NOT* been as Flexner might have wished. For as medicine developed a research based, academically rigorous, teaching hospital approach to illness, professions came into collision.

The rigorous education envisioned by Flexner had an unintended consequence. That consequence was the emergence of a guild structure:

- ☞ each guild living within its own compound,
- ☞ each guild subscribing to its own belief system, and
- ☞ each guild erecting intellectual fences around its practice.

Now, almost 100 years after Flexner, we are all aware of what this guild structure means for health care systems in the developed world. For in spite of a high level of professional-*ism*, the patient has *NOT* emerged as the *subject* of professional attention – which was of course Flexner's intent. *Indeed, the impression is that quite the contrary has occurred.*

For the professional-*isation* of professions has in many respects turned the patient into an *object* of attention.

As a result of this profession-centric focus, the level of understanding of practice between and amongst our professions is now woefully inadequate.

This inadequacy has led to another unintended consequence – the consequence so clearly chronicled in the Institute of Medicine's report: *To Err is Human.*

That consequence – the unnecessary deaths of large numbers of patients we now recognize to be largely attributable to a lack of communication in the team collaboration between health professionals.

I do *NOT* think that a family – which has lost a member because of such lack of communication – would be much inclined to divine forgiveness, which is of course, then end of that quotation from (to forgive is divine. Alexander Pope. *An Essay on Criticism.* 1688-1744)

Interestingly – lip service has long been paid to team 0 or collaborative – approaches to the education of health care professionals. Yet the historical record shows few, if any, sustained successes.

Health education programs that educate and train professionals in environments that *promote* – or even *allow* students:

- ☞ to learn *with, from and about* each other,
- ☞ for the purposes of collaboration,
- ☞ to improve quality of care –

such programs are *ALMOST* as rare as hen’s teeth. Indeed, I am personally appalled that large numbers of programs do not even allow their students time for electives.

Wherever you go in the world, in most universities and colleges, health and human service professionals still tend to be educated:

- ☞ in isolated parts of their campuses,
- ☞ by different teachers,
- ☞ using different vocabularies,
- ☞ and infuriatingly disparate acronyms

All confounded by having few (or NO) strategies to lower the artificial barriers that have been built around, and between, the various disciplines.

When I was a young academic – my Dean, the great paediatrician Dr. John F. McCreary, wrote in a seminal article about teamwork published in 1964:

*“All of these diverse members of the health team should be brought together during their undergraduate years, taught by the same teachers, in the same classrooms and on the same patients” (op cit. p.6)*

Unfortunately, Jack McCreary didn’t live to work through the practical implications the work of his remarkable protégé, Dr. George Szasz.

Since 1964 we have ruefully learned that *articulating* a grand idea is very different from *putting a grand idea into practice*.

- ☞ *WHEN* to bring students together for collaborative learning?,
- ☞ *WHO* should teach them collaboratively?, and
- ☞ with *WHICH* patients to teach collaborative practice?

These fundamental questions have presented those trying to implement interprofessional education with many, many – mind bending, strategic problems.

*WHERE* to most effectively and efficiently teach and learn *inter*professionally, has been one of the largest and thorniest questions.

Timetabling and schedules have been and continue to be, the very best excuse for doing nothing.

In Canada we have slowly come to realize that the practice environment – not the campus, is probably the best milieu for students to learn with from and about their fellow health professionals.

An acute care setting, a community clinic, a drop in centre – these are all natural classrooms. It is in these settings that the shortcomings of *UNI*-professional education become glaringly apparent.

There is nothing quite like confronting a co-morbidity for putting the limitations of uni-professional education into perspective. One is reminded of the words of the great *Dr Samuel Johnson*:

*“Depend upon it, sir, when a man knows he is to be hanged in a fortnight, it concentrates his mind wonderfully.” (Boswell: Life)*

Can you think of any other industry that would survive if it took 50 years to effect change?

The gradual academic development of health professions – by increasing educational credentials – from certificate to diploma to degree to post-graduate degree – *SHOULD* be a good thing.

Because this professional growth means that the average education level in the modern health industry *FAR* exceeds that of organizations in other service sectors.

This high level of education *SHOULD* provide an organizational climate that is welcoming to critical thought and well-designed and executed research.

This highly – educated – workforce *SHOULD* provide fertile ground in which to nourish interprofessional collaborative education, and its outcome, the highest quality of care.

Let me follow this thought about health professional education with one concerning health professional regulation.

For this highly educated workforce, and its work imperatives, it is not surprising that “*Getting it right the first time*” is at a premium. This is not an imperative we see in most other service organizations, excepting perhaps for airlines.

This imperative means that the *regulation of health care provision* is incredibly tight, over all its dimensions

☞ from people, – to buildings – to equipment.

It’s this ubiquity of regulatory oversight that is in part responsible for the extraordinary complexity of professional credentialing within health care.

Why note these facts?

Because since Flexner’s report, these developments have brought the highest standards to uni-professional health education and practice. But these same developments have, at the same time, made it immensely difficult to provide environments for interprofessional education.

The professional imperatives imposed by professional associations and societies have largely obstructed any capacity to learn with, from and about each other as prerequisites for collaboration in the cause of the highest quality of care.

The initiative started at *this* university is therefore immensely innovative and at the same time immensely brave.

In his most famous work, *The Prince*, Machiavelli wrote in 1513:

*“It must be remembered that there is nothing more difficult to plan, more doubtful of success, or more dangerous to manage than the creation of a new system. For the initiator has the enmity of all who would profit by the preservation of the old institution and merely luke-warm defenders in those who would gain by the new one”.*

When the notion of interprofessionalism was first discussed 43 or so years ago, it was thought that the best time for students to learn together would be in their first or second year. It was reasoned that if students learned Anatomy and Physiology together they would (perhaps by osmosis) learn to understand each other.

It is clear, however, that not every health and human service professional needs to take Anatomy and Physiology, certainly Social Workers and Counseling Psychologists don't – so this did not prove to be an effective mechanism.

The data show that students who enter professional programs are very concerned in their early years of preparation to develop a clear sense of themselves *in* their profession. Having them work collaboratively with other students in other professional programs *before* they have gained that identity is an interesting experimental question in which you are engaged.

Ultimately of course, every health and human service programs *should* recognize that IPE forms a small, vital and *permanent* part of their curricula. That IPE is *NOT* an add-on. It is *NOT* dumbing down. It is *NOT* multi-skilling. That IPE is now a *necessary* part of educating health and human service professionals.

We are surely past the point of baffling with acronyms in order to protect professional power. And we are surely at the place when every student about to graduate can justifiably claim that she or he has actually met and worked with other aspiring health professionals – *BEFORE* entering the workforce.

Over the 62 years since the end of the Second War, many health professions have developed and matured. It is unfortunate, however, that their efforts to ensure the stature envisioned by Flexner have had another unintended consequence. That consequence? Each profession has tended to forget that it is only one of *many* that serve the needs of the population.

Your university's commitment to IPE is therefore immensely heartening. Your commitment is the first of many steps to ensure that patients are *NOT* compromised by professional lack of understanding and communication about shared roles and responsibilities.

It is imperative that knowledge of interprofessional care you develop becomes enshrined in accreditation, licensing and other programs. And that by such recognition we ensure, and assure, that health professionals graduating to enter

practice are indeed qualified to collaborate for the better health of each of our communities.

Health care – as we all know, is subject to *life cycle effects* (please forgive the pun) – it is far too easy to give up when the cycle to implement is long, challenging and at times frustrating.

So – let’s not be *too* concerned that IPE will take some years to go through sufficient of these iterations before is viewed as a normal part of health professional education.

Your illustrious *old* university is engaged in a bold *new* venture, for which all of you engaged in change deserve the highest commendation.

The journey ahead will not be easy. As Calvin Coolidge, or was it Teddy Roosevelt?, said:

*“Changing a college curriculum is like moving a graveyard. It’s not the stones that are a problem, it’s the friends of the dead.”*

So – as you move ahead with this *bold new venture*, let me leave you with the *bold* words from that greatest of playwrights, William Shakespeare:

*“There is a tide in the affairs of men,  
Which, taken at the flood, leads on to fortune;  
Omitted, all the voyage of their life  
Is bound in shallows and in miseries.  
On such a full sea are we now afloat;  
And we must take the current when it serves,  
Or lose our ventures.  
(Brutus Julius Ceasar Act IV. Scene III.)*

Thank you for your attention.

All my relations

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