Inter-professional Collaboration: Passing Fad or Way of the Future?

Patty Solomon

CPA President and Board of Directors, colleagues, friends and family—what an honour you have bestowed upon me today. And if you believe in coming full circle, it is most appropriate that I deliver this lecture in Calgary. I gave my very first presentation at a CPA congress in Calgary in 1986. I was so nervous—I don't think I slept the night before, and I didn't eat for about 24 hours ahead of time either. And now, 23 years later, I stand here with a different type of nervousness. I reflect on the many wonderful Enid Graham lecturers I have heard, mentors, friends, and leaders in the profession, and hope that I can share some of my ideas and passion for our profession in our short time together.

It wasn't difficult for me to decide what my topic would be for today. I have had the opportunity for the past few years to lead the initiative on inter-professional education and collaborative practice at McMaster University. This has shifted my career and challenged some of my thinking. So today I would like to share some of what I have learned, talk to you about some of the challenges to collaborative practice that our profession faces, and present some new ways of thinking about what collaboration entails.

Before I start I will try to clarify all the confusion around the different terms that people often use interchangeably. The current focus is on the term “inter-professional collaboration,” which implies interaction between two or more professions, organized into a common effort to address common issues, with the participation of the patient.¹

Inter-professional education, on the other hand, “occurs when two or more professions learn with, from, and about each other to improve collaboration and the quality of care.”² This definition emphasizes an inclusive view of the term “professional” and includes all learning in academic and clinical settings, before and after qualification.

You will often see the term “inter-professional education” used to describe learner outcomes and “inter-

professional collaboration” used to describe patient outcomes, and there is continuing debate about this. In reality there is overlap between the two, and I will be using both terms today. However, my intent is to focus on our collaborative relationships in the clinical setting.

It is also important to state what inter-professional collaboration is not. It does not mean that we are being cross-trained to perform others' roles. Nor is it necessarily about developing a team consensus or about thinking alike. It is about taking responsibility for your own area of practice and coordinating it effectively, and with others, as you make decisions about patient management.³

I am often asked what motivated me to work in inter-professional education. At one Health Canada meeting a group of like-minded health professionals started sharing stories about how and why they became involved in promoting collaborative practice. From this meeting a qualitative research project evolved in which eight of us from medicine, nursing, occupational therapy, physiotherapy, and massage therapy participated in interviews to generate hypotheses regarding factors that influence engagement in collaborative practice.⁴ We used a methodology called *narrative research*, in which participants share their experiences through telling and retelling stories. One of the findings, not surprisingly, was that positive exposure to collaborative environments was an important influence on the choice to practice collaboratively. I ask you now to think of a time when you enjoyed working with those from other professions—this could be a team situation or it could be one-on-one, it could be a phone call, a corridor consultation, or a team conference. This was easy for me to do, as in the mid-1980s I worked on a chronic pain team with a fabulous psychiatrist who role-modelled and fostered collaborative practice like no one I had ever encountered before. The mutual respect, sharing of roles and responsibilities, and learning that occurred between the professions, and the sense of support in dealing with what was a very difficult patient population, made for one of the most rewarding clinical experiences of my career. Now, in the interests of being appreciative and positive, I will not ask you to think of a time when you had a particularly non-collaborative experience; however, I will share the experience that I spoke of during my interview for the narrative research project. And I quote directly from the

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interview as it was published in an article in *Canadian Family Physician*:

If I look at my whole spectrum of team experiences and what's influenced some of my decisions and passion for interprofessional practice, it's some of the negative ones that have influenced me as much as the positive ones. One that stands out in my mind was being in a team conference, with the physician, the OT and the nurse and a patient had come in and had been complaining, complaining bitterly of pain and accusing me of not acknowledging her pain ... the patient left and the physician turned to me and said "Well what were you thinking? How come you didn't treat her pain, what's going on here?" I opened my mouth to say what I thought and he yelled at me and said "I don't give a **** what you thought!" ... It's funny how you remember these things ... I can remember it to this day because it was so totally inappropriate and that would be the very low end of my horrible, horrible team experiences ... But it really influenced me to think people shouldn't have to work in those types of environments and people shouldn't have that kind of communication with each other and it's really important to have respectful communication.^{4(p.1323)}

And although I was horrified at the time, to this day I am very grateful to that physician, as he allowed me to contrast my experiences and to realize how much our negative experiences can influence and motivate us to change.

HISTORICAL PERSPECTIVE

Winston Churchill is widely supposed to have said that "the farther backward you can look, the farther forward you can see,"⁵ and I believe he had it right, so I am going to provide you with a very brief historical perspective on inter-professional education. I am drawing on some of the work of Dr. De Witt Baldwin, an American psychiatrist who was ahead of his time in promoting teamwork. Prior to meeting Dr. Baldwin, or "Bud," at a meeting, I used to trace the origins of inter-professional education back to the mid-1980s, when the World Health Organization became involved. Bud sent me a few of his early articles, one of which traced the history of inter-professional education. Early reports identify that prior to 1900 there were mission hospitals in India that sent out teams of physicians, nurses, and auxiliaries to remote communities.⁶ An article published in 1915 advocated a team of doctor, educator, and social worker.⁶ In 1920, the Dawson Report touted the team approach and the establishment of health centres.⁶ So you can see that this idea of working together is hardly new. World War II demonstrated the effectiveness of multidisciplinary teams, and teams in areas such as burns, long-term care, and mental health were an outgrowth of this success.⁶ In Canada, the University of British Columbia

(UBC) was an early innovator, offering inter-professional elective courses in the health sciences beginning in 1969. In 1986, the Ottawa Charter called for inter-professional education to meet changing societal needs; UBC led the way in 2001 by establishing the inter-professional College of Health Disciplines, which became the first university-based centre in Canada to move collaborative education, practice, and research forward. Others have since followed suit, and universities across the country have established various programmes and offices of inter-professional education and collaboration.

But in the early 1970s Bud Baldwin was involved with an innovative programme in which there was an entire inter-professional curriculum for students in 11 health-related disciplines. Students had inter-professional courses in the sciences and also in content areas that were common across professions, such as health systems, nutrition, and communication skills.⁶ This was more than 30 years ago, remember.

Perhaps it is not surprising that Dr Baldwin's innovations were not widely adopted. Where did physiotherapy fit within this context? Like many female-dominated professions at that time, we were striving for increased recognition, increased education, a theoretical and research basis for what we do—and, though this was not overtly spoken of, along with these would come increased power and status. Why would physiotherapy, and not only physiotherapy but others, want to diminish our professional voice when we were only just starting to be heard?

Clearly what seemed like a good idea has taken some time to take hold in the health care system. Calls for greater collaboration and improved teamwork are not new. What is new is an emphasis on policy change and the call for a fundamental change in the way we do business—a change in culture. And what makes me hopeful that this is not "just a passing fad" is that we have key reports, such as the Romanow Report⁷ and a report from the Canadian Health Services Research Foundation,⁸ pushing for more collaborative practice. There are myriad benefits ascribed to working together collaboratively. But perhaps the biggest shift from the early years is the emphasis on patient safety as a prime motivator. Death, disability, and associated costs related to health care error make governments pay attention, particularly when much of the error can be attributed to misunderstandings about the scope of practice of others, delegation of inappropriate tasks, or communication issues. Patient safety may just be the "tipping point" to ensure that the move toward collaborative practice is here to stay.

In summary, initial attempts at inter-professional education and collaboration were not widely adopted. Perhaps we just weren't ready then; but think of the widespread changes in the health care system since the 1970s and 1980s. Think of our own profession—we have gone from diploma to baccalaureate to master's entry

level. We have gone from having little knowledge of research to having our own body of knowledge and our own cadre of respected researchers. Our practice has shifted from one that was predominantly institutionally based to one that is community based. We have embraced entrepreneurialism, new models of practice, and evidence-based practice. But are we ready to really collaborate, or will we again experience inter-professionalism as a passing fad?

WHAT ARE THE BARRIERS TO COLLABORATION AND CHANGING THE CULTURE?

Much has been written about barriers to inter-professional collaboration, and I do not want to dwell on these, but I do want to highlight a few that I think are relevant to us as physiotherapists. I am also aware that you are a sophisticated audience, and if I were to ask you to generate a list of barriers to inter-professional collaboration I am positive that your list would reflect what is in the literature and go beyond this to identify challenges unique to your practice. I would like to focus on a few of these.

Rivalry and Turf Wars

We live in a competitive society. To enter our profession, students have to compete with many other applicants for coveted positions. When we think of the historical roots of the professions, and the structural components of the health care system, I believe we can never eliminate the differences in education, gender, and hierarchy that lead to differences in power and status. Competition is part of our professional and social culture, and to my mind it is naïve to think that we will ever be without it. But this means that we need to learn the skills to allow us to work in situations where power and status prevail. We must learn how to listen, yet advocate for our role. We must promote what is best for the patient and for quality of care, not necessarily what is best for ourselves or for the profession at that point in time. Collaboration isn't about "winning," and we may have to choose our battles from time to time. Collaboration is about coordinating our unique skill set with others as we work together to find the best solutions.

The Need to Broaden Our View of Collaboration

In my discussions with health professionals about collaborative practice, I am surprised at how many feel that collaboration is not relevant to them because they work in solo practice and not in a well-defined team. The words "teamwork" and "collaboration" are often used interchangeably, but they are not same. We know from our experiences that we can collaborate with the family physician of one of our patients, for example,

and yet we would not consider ourselves to be a team. Increasingly, as our practice becomes more and more community based, we work in very "loose" teams or with teams in which membership shifts and changes. So collaboration is not just about formal teams.

We also need to think of collaboration outside of our traditional health care boundaries. Our clients and patients are increasingly more complex. The health care systems that we are involved with are far from simple. As a profession, we have developed a better understanding of the broader determinants of health. So we need to think of collaboration with others beyond the health system and incorporate the broader social systems and other sectors. I have learned much from my work with people living with HIV in this regard. One of my areas of research involves examining disability in people living with HIV and developing the rehabilitation role. An occupational therapy colleague and I conducted a study several years ago in which we used the International Classification of Function, Disability and Health as a framework to examine barriers to and facilitators of participation for women living with HIV.⁹ We conducted in-depth interviews with 23 women, who shared their stories, challenges, and successes. We used a rehabilitation framework, anticipating that we would identify many instances and situations that would be amenable to rehabilitation; after all, one of our agendas was to indicate the need for rehabilitation interventions. Our qualitative analyses revealed the following themes associated with decreased participation: living in poverty, enduring depression and isolation, fearing disclosure and the resulting stigma, tolerating the signs and symptoms, experiencing barriers to work, and lacking supportive networks. These women understood that such things as eating properly, taking vitamins, and exercising would contribute to their overall health, but they struggled to obtain the basic necessities of life. Many of them lived with pain, fatigue, and decreases in strength, endurance, and mobility that would be responsive to physiotherapy. If you are poor or depressed or afraid to disclose your status, however, first of all, you may not seek the rehabilitation supports that you would benefit from, and, second of all, personal health factors become secondary in importance to environmental factors. What was most important to these women? Certainly not physiotherapy. They wanted to be able to work, have an adequate income, and provide for their families. Then perhaps they could look at some of their personal needs that would be amenable to physiotherapy interventions.

I have also had the privilege of representing CPA on the Canadian Working Group on HIV and Rehabilitation for a number of years. It is very exciting to sit around the table with employers, representatives from insurance agencies and the Canada Pension Plan, people from sectors that I hadn't collaborated with in the past, to look at

models of employment for people with episodic disabilities.

To relate this back to barriers to collaborative practice: we need to see our roles much more broadly, as part of multiple systems and sectors. I am aware that many physiotherapists who work in the community with those living with chronic and complex conditions already have these connections and do work across sectors. But we need to be mindful of the need to educate others beyond those in the health care arena about our potential role and scope of practice—there are many living with chronic illness and disability who would benefit from physiotherapy but are not getting referred, or do not know how to access us, or simply are unaware that there could be benefits to physiotherapy care. If we are to embrace the broader determinants of health, we need to have strategies to advocate for our patients much more broadly and to collaborate with those whom we may not traditionally have worked with.

Concerns about Liability Risk

One barrier we read about in the literature is the concern that inter-professional collaboration will lead to increased liability risk. Clinicians working in teams worry that the team may be held accountable for the negligence of individual team members. Health professionals also worry that they will be held accountable for the standard of care provided by others. For example, there is a concern that a physiotherapist working in an extended scope, and found negligent of performing an act previously performed solely by a physician, would be held to the standard of care applicable to the physician.

I do not want to focus too intently on this area, but I did want to raise it as one in which many myths exist, and to refer you to an excellent report from the Conference Board of Canada, published in 2007,¹⁰ that should reassure those who have concerns related to liability. According to this report, liability has always been assessed against individuals, not teams. As we expand our scope of practice, I believe dialogue in this area will continue. I am surprised at how even those physicians whom I believe to be totally supportive of inter-professional collaboration insist on screening or assessing the patient before referring to another health professional because they believe that they will be open to litigation if something goes wrong while the patient is being treated by the physiotherapist, the dietician, or the midwife. I am again reminded of the need for us to more clearly articulate our high level of knowledge and skill, so that others are more knowledgeable about our capabilities. The Conference Board of Canada report provides some clear strategies to mitigate the possibility of error and subsequent litigation and stresses the importance

of being clear about the roles and responsibilities of others so that acts are not delegated inappropriately.

Lack of Evidence to Support Collaborative Practice

Now I have a confession: in preparation for my talk, I wanted to ensure that the Winston Churchill quote that I used a few minutes ago was accurate—and in searching for the quote came across a website of quotes attributed to him and became hooked on them. So I have sprinkled some of my favourites throughout my talk today, I hope not gratuitously, but as they relate to the subject at hand.

“However beautiful the strategy, you should occasionally look at the results.”¹⁵ Who knew Winston Churchill was also into-evidence based practice?

The lack of evidence to support collaborative practice provides an opportunity for some *not* to move forward in changing their practice. So I would be remiss if I did not spend a few moments talking about the evidence. There have been a number of systematic reviews on inter-professional collaboration. In 2007, a Best Evidence in Medical Education review looked at 10,495 abstracts examining whether learning together contributed to collaborative practice and better patient care;¹¹ 21 studies met their criteria. In a Cochrane Review examining the effects of inter-professional education on professional practice and outcomes,¹² six studies met the rigorous criteria for review, and four of these showed an effect; these were in the areas of working with victims of domestic violence in primary care, working in the emergency room, and working with community mental health providers.

In 2007 the Canadian Health Systems Research Foundation published a synthesis of literature specifically as it relates to inter-professional collaboration and primary health care.⁸ There is much to be heartened by in this report; of 206 studies, 17 were graded at a high level and 20 at the medium level of evidence. Let me give some highlights.

There is convincing evidence to support the idea that patient outcomes improve when care is delivered by collaborative teams. Many of the studies included measures of patient satisfaction but also outcome measures related to patient-centred practice, such as patients' reporting a greater sense of involvement in their care. Palliative-care patients reported improvements on quality-of-life measures. There was also a demonstration of improvement in clinical outcomes; for example, paediatric patients treated by collaborative teams had fewer asthma symptoms, patients in inter-professional weight-loss programmes were more likely to achieve weight-loss goals, and patients living with Alzheimer's received fewer antidepressants and had significantly fewer behavioural and psychological symptoms.⁸

The evidence to support the effectiveness of collaborative practice in improving patient outcomes is just starting to emerge. For those clinicians who need to be convinced that there is high level of evidence before changing their practice, this gap may be a barrier to changing their practice.

Funding Models to Promote Physiotherapy Collaboration

I would like to tell you about two scenarios that I was involved in over the past few months. I received a phone call from a physiotherapist in the community who had heard that I was involved in looking at collaborative practice issues and wondered about sources of funding. She was very excited to tell me about the relationship she had developed with an orthopaedic surgeon. They had worked together for many years, and, to hear her description, had developed a mutual respect and admiration for each other's skills and expertise. He had the never-ending dilemma of a long wait list, populated with patients with chronic low back pain who were hopeful for a cure. A typical story would see that patient wait for a year, then finally see the surgeon, only to be told that he or she was not a surgical candidate. In an attempt to decrease the wait list and facilitate access to conservative treatment, the physiotherapist performed assessments and determined who would need to be referred for surgery. They had done some statistical analyses and determined that there was a high rate of interrater agreement between the physiotherapist and the surgeon with respect to determining who was a surgical candidate. She was excited to share her story and wondered how this model could be expanded.

The second scenario: I was at a meeting, sitting beside a rather forthright nurse practitioner who worked in a large primary-care clinic. She recognized the value of and the need for rehabilitation and had been working with the physician director over a number of years to try to get services for their patients. While the director was supportive, the clinic's finances were a significant barrier to moving forward. At the end of the meeting, she turned to me and said, "I don't care what he says, I am telling him we are getting in rehabilitation services and we will figure out a way."

What are the similarities between these two scenarios? In both situations, the skills, knowledge, and expertise of the physiotherapist were acknowledged and seen as essential. But the funding of physiotherapy services was a significant barrier. The other similarity was the enthusiasm of a champion for the cause. And how exciting that there are those outside of our profession, such as the nurse practitioner and the surgeon, who are advocating for our role!

Very shortly after that, I had the opportunity to listen to Stephen Lewis, the health care policy guru, talk about inter-professional collaboration. And, as often happens

when I listen to a talk, one gem sticks out for me. It is easy to get mired down and negative about the current economic context—especially when one hears the same news day after day. But Mr. Lewis said that tighter money will either paralyse us or spur creativity and innovation.¹³ In both of the scenarios I have described, there were advocates who understood the critical role that physiotherapy plays in the health care system and, in spite of barriers, were determined to move forward.

I don't pretend to have the answer to the funding issue. However, it is important that we continue to develop our entrepreneurial skills, as individuals and as a profession. We need to support and become involved with our provincial and national associations as they lobby for different funding models for physiotherapy. And we need to continue to educate others about the value added of physiotherapy services.

"A pessimist sees the difficulty in every opportunity; an optimist sees the opportunity in every difficulty."¹⁵

RELATIONSHIP-CENTRED CARE

I would like to shift away from looking at barriers and systemic issues to looking more specifically at the relationships we develop in our interactions with patients and colleagues. After all, inter-professional collaboration is predicated on the relationships we have with others.

The patient is an important part of the collaborative-practice equation, and patient-centred care is now part of the lexicon of physiotherapy practice. I do believe that our occupational therapy colleagues have shown leadership in this area; however, our profession has increasingly become more aware of the need to incorporate patient goals, desires, and perspectives in our treatment plans. Susan Harris spoke very eloquently about this during her Enid Graham Lecture 3 years ago,¹⁴ and I do not wish to repeat her words or her sentiments. However, I would like to introduce you to another term: *relationship-centred care*.¹⁵

The term "relationship-centred care" was coined by physicians at the University of Indiana. Relationship-centred care promotes inter-professional collaboration in a somewhat different way: in relationship-centred care, relationships are seen as critical to the care provided by any practitioner and as a source of job satisfaction.¹⁵ Relationship-centred care is the foundation of any therapeutic activity. The reason I am so fond of this term is that it by definition includes not only the relationships we have with patients and clients but also our relationships with our team members and colleagues, with our communities, and, finally, with ourselves. It is a more all-encompassing term.

The Pew Report on Relationship Centred Care was the seminal work in this area.¹⁵ This report stated that a therapeutic relationship requires that the practitioner and the patient share an understanding of the meaning

of the illness. Through our professional socialization, we view the understanding and meaning of illness through a rehabilitation lens that is unique to us, although parts of this view are certainly shared by other health professionals. This unique perspective reinforces the importance of working collaboratively in relationships so that others understand our perspective.

And what of our relationships with our communities? Relationship-centred care promotes the development of relationships with communities so that clinicians understand local community dynamics, participate in the development of health-promoting community policy, and work for the health of the public to gain a better understanding of the community's health care resources—and, ultimately, to enhance community health.¹⁵ Although we, as a profession, have been slow to embrace population health and community-based health strategies, these too have shown an increase in the past few years. Liz Harrison, in another Enid Graham Memorial Lecture delivered 2 years ago at WCPT,¹⁶ spoke about primary care and balancing the needs of the population with the needs of the individual client, as well as about the strides we have made in this area of practice.

As I mentioned, the concept of relationship-centred care also includes the relationship we have with ourselves. By this I mean self-awareness of our own emotional responses to patient needs. We need to be aware of our own reactions and stressors; as health care providers, we often deal with difficult and emotion-laden situations. In our fast-paced society, balancing multiple demands of career, family, ageing parents, and a demanding job in a fiscally tough environment, we often do not take the time for self-reflection and well-being. BlackBerryes, expectations for immediate response, and fear-mongering by the media all contribute to our ongoing need for success and accomplishment, often at the expense of our own personal health. As health professionals, we need to recognize the importance of our own well-being and serve as role models to colleagues, patients, and learners.

COMPLEXITY SCIENCE AND INTER-PROFESSIONAL COLLABORATION

I have discussed the importance of being collaborative, engaging in positive relationships, and potential barriers to doing so. Some clinicians with whom I have spoken express a sense of futility about their personal ability to change the culture or to promote a more collaborative environment. I want to spend a few moments reflecting on how you, as an individual, can influence your environment to be more collaborative. In doing so, I will introduce you to complexity science.

I have worked closely over the past few years with a physician colleague who introduced me to complexity science. This is not a new area, but it is relatively new

for the health sciences. I could take our entire time today to explain the concepts, and I confess that at times I struggle to apply them. I also recognize that I am taking a risk in introducing this topic at the end of a long day.

The complexity sciences arose from the failure of traditional science to explain some types of complex phenomena. For many years the scientific way was based on a reductionist cause-and-effect model. In the late twentieth century, scientists recognized that this linear way of viewing the world had limitations in trying to explain complex living systems such as the brain, or complex phenomena such as the interactions of people and groups in a community or in a health care setting.^{17,18} These things are complex, in that they are made up of multiple interconnected elements. They are systems that have the ability to internalize information, to learn, and to modify behaviour or evolve as they adapt to changes in the environment. In complexity science, the concept of linear cause and effect goes out the window. The notion that we can understand what happened by reducing things to their components and examining their parts is considered to be old science and an old view of reality.¹⁸ Exact outcomes are uncertain, because the interactions among multiple components in a system can produce unpredictable behaviour.

When we apply complexity science to trying to institute change in an organization in today's fast-evolving and rapidly changing environment—in this instance, trying to change how we relate to one another in a collaborative way—different strategies are required. Another rule of complexity science is that small changes can lead to large effects, because of the interdependency and unpredictability of organizations.¹⁸ When we consider this, suddenly we realize that the day-to-day and moment-to-moment interactions and conversations that we have with others are meaningful and can lead to change. Communication patterns and interactions among team members can change only if the persisting patterns of communication and interaction among members of the team also change. So your individual decision to reflect on your actions and communicate with colleagues in a different way can lead to change. This means that change can occur through many small interactions or strategies. To me this is very empowering, and it is a rule we can apply to patient care, health organizations, or changing collaborative practice.

In essence, I have provided a very cursory introduction to complexity science to reinforce the importance of the day-to-day interactions that we have with colleagues. Because of the complex and interrelated systems that we are involved in, which are often unpredictable in nature, a small change can lead to larger system change. I believe we will hear more and more about complexity sciences in health care in the years to come. For those of you interested in learning more about complexity theory, a series of four articles published in the

British Medical Journal in 2001 will be useful in trying to understand this way of thinking.^{18–21}

CONCLUDING REMARKS

Before I finish today, I feel it is important to provide a caveat. Occasionally, the idea of inter-professional collaboration can begin to take on mystical qualities. One has to guard against the zealotry or fanaticism that can occur with innovation—there is indeed the risk of collaboration becoming a “passing fad” if this occurs. As one of my colleagues wrote in a commentary on inter-professional education initiatives, “the whole is not always greater than the sum of its parts.”^{22(p.314)} In some instances, working as a team may be less efficient. Of course we know this intuitively; we have all had the experience of enduring a 3-hour meeting to make a decision that one could have made independently in 5 minutes.

I would like to summarize and leave you with some suggestions to consider.

I gave some historical perspective on inter-professional collaboration, and it is clear that this is not a new phenomenon. One of the pioneers in this area noted in 1996 that each new generation seems to repeat the experiences and frustrations of the past.⁶ It is clear that there are barriers to change, ranging from the lack of priority given to providing learners with collaborative practice skills through professional territoriality to a lack of evidence that inter-professional collaboration makes a difference to patient outcomes. What can we do to sustain the momentum and move forward?

As educators—and I am talking about both academic and clinical education here, so that includes all of us—we need to view the knowledge, skills, and attitudes for collaborative practice as foundational or “need to know.” There is no doubt that these are skills that need practice and honing—for example, knowing how and when to refer to others, understanding group and team dynamics, giving feedback to others, and developing strategies for conflict resolution. These skills do not come naturally, and they need to be developed in our learners. No one would argue that these skills are not important. But as long as we see them as *important* yet not *essential*, they will not find their way into the mainstream of our education, and learners will see them as an “add-on.” I am well aware of the rapidly changing knowledge base of our profession and the tendency to keep adding more and more content into our curricula. So this means we need to be creative and look at how what we are currently doing in our programmes can be enhanced and the inter-professional component made explicit, so that we are not simply adding to our students’ burden. Similarly, clinicians need to allow for opportunities in the clinical setting and give the message that these skills are essential. Never forget the impact

you have as a role model—when you “doctor bash” or “nurse bash” or “OT bash,” you are sending a powerful message to students. And, yes, students will see examples of non-collaborative and disrespectful behaviours, so it is important for us to use these as an opportunity to reflect and learn. We need to ask our learners, “What was it about what you saw or heard today that was disturbing?” “What would you have done differently?” “What did you learn from today that will inform how you collaborate with other health professionals in the future?”

I want to say a few words about turf protection and territorialism. In the current health care environment, we will not win the battle to have exclusive rights for certain areas of practice. We have had many battles over the years with chiropractors, kinesiologists, exercise therapists, and acupuncturists, to name a few. I see my nurse practitioner colleagues ready to do battle with physician assistants as this new profession emerges in this country. These battles are time consuming, exhausting, and, in my view, a questionable use of time, as we are not likely to win. There is more than enough work to go around. What we need to be clear about are the unique contributions that physiotherapists make to the team, our high levels of knowledge and problem-solving ability, and the ever-emerging research that informs our practice. As I prepared my talk, I was struck by how many times I came back to the same issue: that other health professionals and the public do not have a clear sense of what we do. Many have dated views of what we are able to provide, and we need to be mindful of the ongoing need to educate others about our roles, skills, and contributions as a profession. If we revert to territorialism, we will be destined to relive history. We are mature enough as a profession to be able to share our scope of practice and to be confident that we make a contribution to health care that is unique to us. We are in a time of great opportunity, with advanced practice, extended scope, and specialization. Let’s move ahead collaboratively, with confidence, educating others about our role and working with others to develop new models of practice and funding.

I talked about the evidence and about how the absence of high levels of evidence allows the sceptics to question the value of inter-professional collaboration. Studies in this area are hard to conduct, but they are emerging. I am convinced that with government support of research and evaluation of inter-professional initiatives, we will continue to gather evidence and learn about the most effective ways to deliver inter-professional care.

Relationship-centred care reinforces the need for positive relationships with our colleagues from other professions and highlights the importance of patient-centred care. The focus on relationships with our communities, our organizations, and ourselves provides a broader framework in which to think about the nature of inter-professional collaboration.

Finally, I bravely introduced the field of complexity science, which offers a new way of viewing our collaborative interactions and new ways of responding to the challenges in health care today. In complex systems such as health care and teams, unpredictability is ever present. We can learn from complexity theory that tension and uncertainty are normal in complex systems; we should anticipate them. Complexity science offers a framework for understanding that a degree of uncertainty and unpredictability is a necessary part of any system.¹⁷

From complexity science we also learn that small changes can have a big impact over time. As we as physiotherapists aim to find our role on the team, to educate others, to provide the best patient care, we should never forget the power of the moment, or that small things can lead to big changes. This requires us to be mindful and reflective and to act with intention. So when you next feel yourself dreading an encounter with a colleague whom you have found particularly uncollaborative in the past, or wondering how you can change the tenor of your team meetings, remember that changing the way you personally communicate or interact can lead to change.

As I come to the end of our time this afternoon, I would like to do what others have done before me; I would like to acknowledge Enid Graham, the physiotherapist whom we honour with this lectureship. Those of you who are regular congress attendees will know the story, but I think it bears repeating, and it is important for newcomers and students in the audience today. It is thanks to Joan Cleather, last year's Enid Graham Lecturer, that we have a historical record of our profession and of Enid Graham's contributions. Enid was a founding member of CPA and a leader throughout the early years of the association. Having served as a volunteer in World War I, Enid went on to study physical therapy in the United States.²³ She helped establish physiotherapy schools at McGill University and the University of Toronto,²³ and it was her leadership that led to the establishment of the Canadian Physiotherapy Association in 1935. She was a true leader and pioneer in our profession.

I would like to thank those who nominated me for this honour and wrote letters of support. I am truly humbled by your acknowledgement of my professional contributions. To my colleagues across the country who e-mailed me their best wishes, and my colleagues and friends at McMaster, I thank you for your enthusiasm and congratulations—they were overwhelming at times. I have learned much from my collaborations with colleagues from other professions, and I want to acknowledge that what I have shared today is a result of much discussion, interaction, debate, sharing, and learning that has enriched my world and challenged me to widen my professional lens. And, finally, thanks to my family here

today and to my husband, Hart, who has always supported my professional journey.

Is inter-professional collaboration a passing fad? Are we destined to relive the past and retreat again into our professional silos after a flurry of collaborative enthusiasm over the past few years? In my view, no: We have momentum; we have government support; we have increased awareness from patients, their families, and other professionals; and we have emerging evidence. The culture is changing—and physiotherapists are leaders in this cultural shift. Across this country, in both academic and clinical settings, physiotherapists have assumed leadership roles in promoting inter-professional collaboration in much greater proportion than the comparatively small numbers of our profession. We as physiotherapists have the knowledge, skills, sensitivity, awareness, and tenacity to promote collaboration, though it is not always easy. It is important that others understand our unique contributions, skills, and potential. It is our way of the future.

As you ponder ways to make your practice and interactions more collaborative, I will end with another wise quote attributed to Winston Churchill: "I never worry about action, but only inaction."⁵

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