Inter-professional Education in the Acute-Care Setting: The Clinical Instructor's Point of View

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ABSTRACT

Purpose: The purpose of this study was to gain an understanding of the opportunities and challenges involved in providing clinical inter-professional education (IPE) to physical therapy (PT) students in the acute-care setting from the perspective of PT clinical instructors (CIs).

Methods: Focus groups were conducted in four acute-care hospitals in Toronto. Participants were recruited using a purposive and convenience sampling approach in order to enhance our understanding of the perceptions of acute-care PT CIs. Eighteen full-time PT CIs with an average of 11 years in practice participated. A constant comparative process was employed to identify recurrent issues and themes within and between groups.

Results: Three main themes emerged from the focus groups: (1) Clinical IPE happens when inter-professional collaboration (IPC) occurs; however, IPC differs according to setting, access to other professions, time, support, and structure. (2) IPE is a lifelong learning process that applies to both CIs and students. (3) Student preparedness is a prerequisite for clinical IPE.

Conclusions: IPC is an integral part of clinical IPE that requires ongoing commitment and reflection by CIs to ensure that they are ready to instruct students who have some preparation in formal IPE. More knowledge about providing clinical IPE in a structured manner, through academic and health institutions, will allow CIs to become role models for future generations of PT students.

Key Words: acute care, clinical instructors, clinical internship, inter-professional education, lifelong learning, physical therapy

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RÉSUMÉ

Objectif : L'objectif de cette étude était d'acquies une meilleure compréhension des possibilités et des défis posés par la formation clinique interdisciplinaire (FCI) pour les étudiants en physiothérapie (PT) dans le cadre de soins de courte durée, du point de vue des instructeurs cliniques en physiothérapie (ICP).

Méthodes : Des groupes de discussion ont été mis sur pied dans quatre hôpitaux de soins de courte durée de Toronto. Les participants ont été recrutés selon une approche d'échantillonnage au jugé et de commodité, afin que les chercheurs puissent mieux comprendre la perception des soins de courte durée chez les ICP. Au total, 18 ICP comptant en moyenne 11 années de pratique ont participé à l'étude. Un processus comparatif constant a été utilisé pour identifier les questions et les thèmes qui revenaient parmi les divers groupes.

Résultats : Trois grands thèmes se sont dégagés de ces groupes de discussion : (1) La FCI a lieu lorsqu'il y a collaboration interdisciplinaire. Toutefois, cette collaboration varie selon le cadre de pratique, l'accès aux autres professions, le temps, le soutien apporté et la structure du cadre de pratique. (2) La FCI est un processus d'apprentissage permanent, qui s'applique aussi bien aux instructeurs qu'aux étudiants. (3) Pour bénéficier de la FCI, les étudiants doivent être préparés.

Conclusions : La FCI constitue une partie intégrante de l'éducation clinique interdisciplinaire. Elle exige des instructeurs un engagement continu et un travail de réflexion afin qu'ils s'assurent d'être bien prêts à former les étudiants qui possèdent déjà une certaine forme de préparation à la FCI. Une plus grande connaissance de la formation clinique interdisciplinaire, plus structurée, dans le cadre des universités ou des institutions du secteur de la santé, permettra aux instructeurs de devenir des modèles pour les générations futures d'étudiants en physiothérapie.

Mots clés : formation continue, formation interdisciplinaire, instructeurs cliniques, internat clinique, physiothérapie, soins de courte durée

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INTRODUCTION

Inter-professional education (IPE) for collaborative patient-centred care has been identified as a potential method of addressing current and emerging health care issues such as efficiency and patient safety.¹ To achieve this goal, health care professionals need to be educated to function in inter-professional teams to enhance quality, safety, efficiency, and timeliness in our health care system.² Research has also demonstrated that health care professionals who practise teamwork in the workplace have improved job satisfaction and that patient-care outcomes are enhanced.³

IPE initiatives have been supported by Health Canada since 2002, when the Romanow Report stated that “if health care providers are expected to work together and share expertise in a team environment, it makes sense that their education and training should prepare them for this type of working arrangement.”^{4(p.109)} The 2003 federal budget committed funding over 5 years to promoting “interprofessional education for collaborative patient-centred practice.”^{5(p.2)} Similarly, in 2007, the Ontario government allocated funds to the Health Professions Mentorship, Preceptorship and Leadership Initiative.⁶ This bi-level government support has provided an opportunity to implement IPE initiatives, some of which are currently underway.

Of particular relevance to this study at the outset was a joint project by the University of Toronto Council of Health Sciences Deans and the Toronto Academic Health Sciences Network that aimed to establish mandatory IPE programmes for all health sciences students by 2009.⁷ This proposed curriculum included a 4-week clinical placement where students would learn how to apply the theoretical concepts of collaboration in the health care setting. The objectives of this collaboration between educational and health care institutions was to develop an infrastructure to sustain IPE and provide consistency in health care education.⁸

There is an acknowledged need for IPE; most research to date, however, has focused on formal IPE within university settings, and there is limited research examining the perspectives of the clinical instructors (CIs) who provide clinical IPE to physical therapy (PT) students during clinical internships in the acute-care setting. The purpose of this study was to further explore the perceptions of physical therapists—as key players in providing valuable learning opportunities and instilling the requisite competencies for collaborative practice in authentic situations—related to their experiences of providing IPE to students during clinical internships.

LITERATURE REVIEW

The Centre for Advancement of Interprofessional Education (CAIPE) defines inter-professional education

as “occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care.”⁹ For the purposes of this study, the term “clinical IPE” will refer to the collaborative education that happens during PT clinical internships.

Much of the research on IPE to date has focused on formal, structured IPE in academic settings and has demonstrated that the attitude of university administrators is a major determinant of IPE efforts in the post-secondary setting.¹⁰ A high level of support for the concept and principles of IPE and collaborative patient care is required if academic IPE programmes are to be successful. Identified barriers to implementing academic IPE include rigid curricula, “turf battles” between various health care disciplines, lack of perceived value,¹⁰ “academic elitism,” and a “siloe” approach to education.¹

Research has also demonstrated that students embrace opportunities for IPE and reap benefits in the realms of knowledge, skills, and attitudes.^{7,11–16} Knowledge of a student’s chosen profession has been shown to be strengthened by working with students of other professions as they explain, compare, and contrast their clinical skills.^{12,17} Students have also been shown to benefit from collaborative patient care, which fosters the development of their professional roles^{12,13} and bridges the gap between student and practising health care professional.¹⁸

Development of communication skills through IPE has been noted in several studies.¹⁶ Close proximity and daily access to multiple professionals offer students many opportunities to ask questions about patient care, to seek clarification of professional and patient issues, and to provide more efficient interventions.¹⁵ Students perceived greater value in communication following IPE and considered it the foundation of teamwork.¹¹ Through working collaboratively, students are able to understand the limits of what they can do for patients and the role that other professionals can then play.

IPE and teamwork have been studied in several health care settings, including geriatrics, chronic disease management, mental health, palliative care, and surgical units.¹⁹ However, there is limited research on the experience of CIs in providing IPE. One study identified several key challenges for clinicians acting as facilitators.¹⁵ For example, the CIs enjoyed collaborating with other clinical instructors from different backgrounds, but they found it difficult to manage their usual roles and provide the students with sufficient support. The investigators found that although students were encouraged to work in teams, the CIs tended to work in parallel, with little inter-professional collaboration, and thereby missed valuable opportunities to be role models for their students.¹⁵ The authors stressed that “good facilitator preparation is central to the success of an interprofessional initiative but it is not known yet what type of preparation is needed.”^{20(p.33)} To address this gap in

knowledge, we considered it important to gain an understanding, from the perspective of the PT CI, of the opportunities and challenges involved in providing clinical IPE to PT students in the acute-care setting. The preparation that CIs need in order to engage their students effectively in IPE was also explored. We hope that the results of this study will not only support the literature on IPE but help to ensure an optimal IPE experience in acute-care PT clinical placements.

METHODS

Study Design

The study used a descriptive qualitative approach with focus groups. Qualitative research methods are used when the investigator seeks to gain an understanding of phenomena about which little is known and are considered ideal for exploring issues from an insider perspective.^{21,22} The focus-group format was chosen to collect data and probe the CIs' perceptions because we anticipated that the discussions would build on the shared experiences of the group and allow concurrent identification of similarities and differences in their views.²³

Sampling

Data were collected from physical therapists registered with the College of Physiotherapists of Ontario who had supervised students in at least one clinical internship and who carried a patient caseload in the acute-care setting. This setting was chosen because we anticipated that the challenges of providing clinical IPE would be greater here than in inpatient rehabilitation settings, where inter-professional teamwork is more established. Physical therapists in managerial positions were excluded.

Recruitment

A purposive and convenience sampling approach was used to recruit participants with similar experiences, so as to "facilitate the initial bonding and make participants feel free to offer their input" during a focus group.^{24(p.416)} Physical therapists were recruited from four acute-care settings in the Greater Toronto Area (GTA) to participate in focus groups at their respective hospitals. Three large academic teaching hospitals and one large community hospital were chosen for the convenience offered by existing investigator and faculty advisor affiliations. Ethics approval was obtained from each participating hospital's Research Ethics Board and from the University of Toronto Ethics Review Board.

PT practice leaders at each study site were contacted by e-mail and asked to disseminate the study information and recruitment posters to PT staff. Interested

physical therapists replied directly to the investigators to express their intent to participate. A confirmation e-mail, including the date, time, and location of the focus group, was then sent, as well as an electronic copy of the study information and consent form. A reminder e-mail was sent 1 week before and then again 1 day before the focus group.

Data Collection

Focus groups were conducted in private meeting rooms at the participants' respective hospitals. Two of the authors (JD, JM) who were not affiliated with the study site facilitated the discussions, which allowed the CIs to express their views openly and to reveal their own perceptions and understanding of the questions. Prior to beginning each session, the group reviewed the purpose of the study, and participants were offered an opportunity to request clarification and to ask questions. One author functioned as moderator and the other as recorder. Participants already acquainted with the moderator or the recorder were allowed to leave if they so desired. All participants then signed the approved consent form.

The group moderator used a semi-structured set of questions developed by the authors to guide the discussion (see Table 1). Verbal probes to reframe or expand questions were used to clarify and explore issues in greater depth and to verify a clear understanding of the information collected. In accordance with the methodology, questions were sometimes adapted during or between focus groups to facilitate a richer discussion. All focus-group sessions were digitally recorded; in addition, the recorder collected field notes during each session to document the dynamics of the interactions and any problems encountered and kept a speaker log to track who spoke, and when, in order to assist with transcription and data analysis. At the conclusion of each session, each participant was asked to complete a brief questionnaire collecting demographic information, to help describe the sample population (see Table 2).

Data Analysis

The digital recordings of the focus-group session were transcribed verbatim by a professional transcriptionist.

Table 1 Focus-Group Questions

Tell me about your experience with inter-professional education.
Can you give me an example of a time when inter-professional education has worked really well during PT student clinical internships?
Can you give an example of a time when inter-professional education didn't work so well during clinical internships?
If you were to give someone advice on how to organize a clinical placement that includes inter-professional education, what would you suggest?

Table 2 Demographic Questionnaire

Please complete the following questionnaire to provide study investigators with your demographic information. Your participation will remain anonymous.

Year of Birth: _____

Gender: Male ☐ Female ☐

Number of years of practice: _____

Current employment status: _____

Length of time working in acute-care setting: _____

On average, how often do you provide student internships per year?

1 ☐ 2 ☐ 3 ☐ 4 ☐

Do you have any previous inter-professional education training?

Yes ☐ No ☐

If yes, please specify (e.g., seminars, workshops, readings):

The transcripts were verified for accuracy by the two authors who conducted the focus groups, then edited to remove identifying information. Data analysis and data collection took place concurrently; the authors discussed preliminary findings and refined focus-group questions immediately after completing the initial focus-group session, and the constant comparative method²⁵ was used throughout the data-analysis phase. In this approach, information gathered is coded into emergent themes and constantly revised after initial coding until no new themes emerge. This technique helps to identify the “meanings and values attributed by individuals in real life situations.”^{25(p.41)} In our study, issues and ideas were explored within and between groups using the following steps:

1. The transcripts were entered into QSR N6 (QSR International Pty Ltd., Doncaster, VIC, Australia) to manage and organize the text.
2. Each author independently coded the transcripts of the first focus group.
3. Consensus on coding was reached through discussion with the first three authors (JC, JD, JM).
4. The first set of codes was used for the remaining transcripts, and new codes were added as needed.
5. Final consensus on all coding was again reached through discussion with the first three authors.
6. The first three authors met with a faculty advisor (CAC) to assist with categorizing codes and identifying themes and trends within the findings.

RESULTS

Four focus-group sessions were completed between April and June 2008 (one at each of the four GTA acute-

care hospitals). The groups ranged in size from two to seven participants and ran from 37 to 53 minutes in length. A total of 18 full-time physical therapists in the acute-care setting were involved in the groups. All participants who enrolled completed the focus-group sessions. Participants were 13 female and 5 male physical therapists ranging in age from 27 to 53 years. On average, participants had practised for 11 years; however, years of practice ranged from 1.5 to 30. The average number of years worked in the acute-care setting was 8.5 (range: 1–20 years). Of the 18 participants, 11 had provided clinical internships in the acute-care setting with an average of two students per year; the rest had provided one or three internships per year on average. Thirteen of 18 participants reported having no formal inter-professional education or training; of those with some preparation in IPE, four had taken hospital-based seminars or workshops, and one had attended a university lecture on inter-professional collaboration as a student.

Three themes were identified from the focus-group data: (1) clinical IPE happens when inter-professional collaboration (IPC) occurs; (2) learning IPE is a lifelong process; and (3) student preparedness is a prerequisite for clinical IPE. These findings represent the key issues that the CIs perceived as important in providing optimal clinical IPE experiences to students in the acute-care setting.

Clinical IPE Happens When IPC Occurs

The first theme that emerged was the idea that for clinical IPE to happen successfully in the hospital setting, IPC needs to be in place. Similarly, when IPC was seen to occur, clinical IPE easily fell into place. In fact, the terms “IPE” and “IPC” were often used interchangeably, and the two were seen as interrelated in focus-group discussions. In the context of this study, however, IPC differed within the acute-care setting depending on access to other professions, support, and structure—all of which, consequently, had an impact on the clinical IPE experience.

Setting

Participants in this study reported a fair degree of variability within acute-care settings as to the amount and type of IPC that occurred. For example, one participant argued that IPC is not necessary to achieve good patient outcomes when working with uncomplicated patients on surgical floors, where clinical pathways direct professional interventions; in this setting, it was more challenging to offer a clinical IPE experience. According to many CIs, the more collaboration was in place on their unit, the easier it was to offer clinical IPE for their students:

Like we have been saying, we don't really practise in an IPC model, so to say to a student, "Here we go, here's your IPE, but just do as I say not as I do," it's not going to be as effective as if we had a group of students who are actually working on IPC goals together, letting them live the experience. (Group 4, participant A)

CIs talked of the benefits of having students follow their lead in "co-treating and co-assessing" with the occupational therapist, especially with frail patients who are unable to tolerate extensive therapy sessions.

In the intensive-care unit (ICU), a few participants reported, working together as a team is difficult because rounds and other interactions are primarily led by physicians. In this setting, there seem to be few structures in place to embrace opinions from a variety of professions. One participant commented that since allied health professionals on this type of unit have to be very confident and proactive in speaking up to have their views heard, it is very difficult for students to find their voice:

The biggest barrier for me in the ICU is that in rounds, when they are discussing patients, it's very medically based, and it's hard for allied health in general, not just physio but all allied health, to get their two cents in because there are 10 medical residents and [they] all get their two cents and then they start walking away to the next patient as you're like trailing behind them to get their attention. (Group 4, participant D)

Access to Other Professions

Access to other allied health professionals is crucial to IPC and, thus, to clinical IPE. The participants felt that clinical IPE should be easy to facilitate in many acute-care settings, since many professions are available throughout the day to provide the multiple services required by patients in acute care. This close proximity increases opportunities to learn about the other professional roles.

All participants considered access to occupational therapy (OT) basic and essential. In fact, PT/OT collaboration was felt to "come naturally" and is the most common form of clinical IPE that PT students are exposed to in clinical internships. As one participant noted,

We often partner with the OTs. So I would say the inter-collaboration is probably the strongest between physio and OT ... because they often work towards common goals. (Group 4, participant F)

Participants from most groups commented that access to physicians and surgeons varies from setting to setting. On many hospital units there is a high turnover of medical residents, which makes team-building interactions difficult:

From where I've worked previously, too, the doctors were accessible and on the floor all day long, and then I went to a different setting in an ICU where the residents change hands quickly ... so you don't get to build the relationship that you would ... with somebody that's there on a more consistent basis. (Group 1, participant D)

Further, one participant expressed concern that there is some sense that doctors are less available for collaborative interactions because medical interventions such as surgery are prioritized:

You need the buy-in from the physicians as well, and you need that consistently built into their time here, so that they are aware of the collaboration across all professions. (Group 4, participant A)

Time

Most group participants agreed that time and timing are key factors in their ability to offer successful clinical IPE in student placements. Occasionally, they reported, everything falls into place well, but a variety of issues contribute to the timing challenges faced by CIs in acute care. Time off from work; workload; availability of patients, students, and staff; and the unpredictability of the setting were cited as reasons that clinical IPE may be inconsistent. Flexibility is essential on the part of both the CI and the student in most internships. One CI summed up her frustration this way:

I'm finding it's a challenge partly due to time constraints. In the clinical setting, the staffing has decreased to the point where you only have one person per unit or whatever and you have all the responsibility of the patient care, then the student and arranging the inter-professional education as well as that. It gets to be very challenging, because you're seeking cooperation from almost every level. (Group 2, participant A)

There was agreement among many participants that longer clinical placements would be helpful; one participant recalled a placement in which "one extra week really made a difference." However, they also realized that increasing the length of placements may be detrimental, in light of the resistance on the part of some physical therapists to taking students in the first place. Additionally, regardless of placement length, PT student placements often do not coincide with other disciplines' placements or with any formalized IPE opportunities; as a result, many students miss out on a truly collaborative experience. The CIs agreed that lack of preparation and of protected time for clinical IPE works against their efforts to provide a clinical IPE placement. This discussion led one participant to compare the acute-care setting to outpatient rehabilitation and to offer the following insight:

I think because it's not as hectic, you know, in an outpatient setting, it was easier to schedule team meetings, and that's sort of where the collaboration and the cooperation between different disciplines took place ... PT, OT, speech, social worker, intake coordinator ... so it was sort of very easy in that way, because there was structure in there ... compared with the acute care, where things are less structured. (Group 4, participant F)

Support

According to the participants, one reason that clinical IPE does not happen in a more standardized and cohesive way is that CIs have lacked support and direction in several areas. Universities were seen as the source of the current thrust toward IPE, but many CIs felt unclear about the university's expectations in terms of clinical IPE for their students. Several participants reiterated that in order to implement IPE successfully in clinical internships, they need clear communication and direction from the academic setting to understand what is being taught academically about IPE, what the learning objectives are, and how these objectives will be evaluated. For example, participants felt that IPE is not clearly delineated in the clinical performance tool they have used to evaluate students. As well, most participants felt that the university should be aware of what opportunities for clinical IPE/IPC are available in various hospital and clinical settings:

It [IPE] is a priority for this organization, and I can't speak for all the other institutions, but maybe there are some out there that are not as developed, or they are not supportive of it. So sending a student there may not be fair. Maybe the university should make sure that the institution has IPC implemented there. (Group 4, participant E)

Furthermore, recent changes in curriculum have been unsettling for some CIs:

I think it is getting more and more challenging, frankly. The expectations are not going down, they are going up, and now that it's a degree, a master's level, expectations all round are going up. I think that community hospitals are hard pressed to meet that. (Group 2, participant A)

In the hospital setting, the participants concurred, support must not only come from "higher up" but also be reinforced at the unit level. It was emphasized that most clinical IPE happens at the discretion of the CI. For this reason, some participants wondered whether hospital administrators are unaware of clinical IPE initiatives or whether clinical IPE is seen as an "extra" and not valued as much as patient treatment. Certainly most CIs felt they would need hospital support in order to give clinical IPE the time and energy that it deserves. As one participant commented,

So then, we could get this hospital executive committee to also support the front-line staff, taking time to teach more students or to make something formal. (Group 3, participant C)

Operationally, the CIs said, they need the support of their multidisciplinary peers in order to offer successful clinical IPE. This support varies from simply providing back-up to cover students in a CI's absence to ensuring multidisciplinary clinical IPE exposure.

Structure

The majority of participants said that clinical IPE in the acute-care setting is, for the most part, unstructured, informal, and organized by the CI. Despite believing strongly in the inter-professional experience for their students, some PTs felt that leaving this responsibility up to CIs is not ideal. There seemed to be a growing sense that although IPE is the "new buzzword," they are not seeing a standardized, more formal approach to offering clinical IPE to all students. A few CIs reported that more formal IPE opportunities are becoming available for their students but that these are quite variable and occur sporadically. Talking about her setting, one participant said,

to date it has been the preceptor, but now with the inter-professional education being such a push there are programmes in the hospital where there are opportunities for professions to go and learn together ... there's been a couple of those here at this hospital ... students will go for an hour during lunch ... (Group 3, participant A)

Many participants felt that rounds are an important form of clinical IPE, whether Grand Medical Rounds or daily unit rounds during which the different professions meet to discuss patients and model IPC:

But we make sure that, you know, the students are introduced to the whole team and that they come to everyday morning rounds, so that they are able to see how the other team also contributes to the patients' care, so they're not just limited to their PT goals. (Group 1, participant C)

Clearly, although the CIs in this study have easily linked IPC and IPE and have tried to offer both in PT clinical placements, there are organizational and practical barriers that have thwarted their efforts.

IPE Is a Lifelong Learning Process

The second theme that emerged from the data was the concept that learning IPC through IPE is a lifelong process. The key components of this theme are that CIs also need to have structured IPE, that they need to learn how to work in teams, and that they need to be self-aware with respect to their own knowledge and comfort level with IPC.

Structured Learning Is Required

In order to teach and model well, CIs want to learn IPC in a structured manner. Focus-group participants often used themselves as examples of how one learns IPC. They felt there is a perception among physical therapists who supervise students that they lack knowledge of IPE and IPC, which makes teaching these concepts more challenging:

I think you have to ensure that the clinical instructors are quite knowledgeable about IPC and IPE before bringing students in front of them and saying, "Ah, that's an IPE placement." I don't know how you would test that, but you would have to ensure that a clinical instructor is well aware and has attended the courses or has participated in some sort of an IPC/IPE session. (Group 4, participant E)

At one particular site, some structured IPE sessions were already in place for students at the time of our study. This programme, however, excluded the professionals who were supervising the students. One PT from this focus group felt that they should have been included:

It actually would have been beneficial if they included us a little bit more, because maybe we would have started to model what our students were doing with each other. (Group 4, participant A)

Learning Teamwork

As part of the process of lifelong learning, the CIs reported, they generally learned how to practise inter-professionally by working in teams. How well these teams interact determines the quality of the clinical IPE experience for students. Some participants said that for them this process started with observation of other roles as students, or early in their careers, and progressed to "on-the-job training." Others commented that they learned collaboration and teamwork by attending rounds. Realizing that they did not have all the answers to their patients' problems, participants increasingly appreciated the notion of "sharing patient care" and IPC:

I got more of my inter-professional perspective from being in the practice, like in the clinical setting, and working through things with my colleagues. (Group 1, participant C)

Further, there was agreement among clinicians that learning IPC takes time and that comfort in working collaboratively comes with experience:

I think you need to develop your own sort of rapport with your team and be able to be comfortable with that before you can take on a student. (Group 1, participant C)

Development of one's own professional role and the ability to understand other team members' roles was considered essential to practising in an inter-professional manner. The CIs understood how their role as PTs contributes to patient-centred, holistic care; however, they also saw the limits of their skills and the importance of multiple disciplines to achieving good patient outcomes. It was important to these CIs that this message be communicated to their students in their clinical placements, as one participant noted:

Yes, it's not all about the range of motion and the walking. It's about the whole patient and why they can't go home ... [you] shouldn't get so caught up in your discipline ... you need to see that patient is also being treated by other disciplines ... 'cause you can't know all this as one clinician. (Group 3, participant C)

A few participants shared concerns about perceptions of other team members' roles as well as about how they thought their PT role was perceived and respected. Misunderstandings in this area have the potential to cause gaps in patient care. Sometimes this is evident in one professional's lack of trust in the written chart entries of another. The CIs told us they worry that when students witness this territoriality, inappropriate modelling occurs that confuses students in training and perpetuates negative stereotypes:

If it says in the patient's chart that they're walking, they should not not walk over the weekend; you know, they shouldn't be bedbound on the weekend just because the physio isn't there to go into the closet and take the walker out. And so the student got it, you know, the student totally was aware that it wasn't, you know, best practice. (Group 2, participant B)

Self-Awareness Is Required

Developing IPE and IPC skills requires self-awareness and self-reflection. The PT CIs in the focus groups seemed to be well aware that IPE is not limited to students but, rather, is a lifelong process of learning and experience. It seemed natural to the participants that they should reflect on their journey toward IPC in order to best transfer these important skills to future generations of physical therapists. Responding to the CAIPE definition of IPE, one participant remarked,

Sorry, the definition is when two or more professions learn from each other. [That] doesn't necessarily mean that it's when you are a student. This could be when you are already working in your respective profession[s]. (Group 3, participant A)

Further, some reiterated that it is difficult to emulate IPC when they do not currently practise collaboratively with others:

And so it's hard for us to model the behaviours we would like in certain settings when the bigger environment itself isn't like that. (Group 4, participant G)

The CIs in this study believed that experiencing collaborative teamwork has greatly enhanced their ability to provide IPE to PT students.

Student Preparedness Is a Prerequisite for Clinical IPE

The final theme emerging from the data is the idea that students need to be prepared for IPE in the clinical setting. The factors affecting this preparedness are the

student's skill level, the degree of academic preparation for clinical placements, and the student's attitude toward and respect for other disciplines.

Skill Level

Most of the CIs agreed that students need time to focus on learning their PT role by developing basic treatment and handling skills. In particular, one CI noted that the students “need that confidence and to trust their skills; once they get that comfort level, the other things fall into place ... they are going to be able to approach an OT and interact and do those things” (Group 1, participant C). Given the time constraints facing clinicians, participants said, there is only so much that can be covered in each internship. Some reported that given the steep learning curve that occurs during earlier clinical internships, clinical IPE placements would be best introduced later in training, when students are able to handle the increased complexity of an IPE component:

I wouldn't necessarily choose an IPE placement for their first ones just because they tend to be heavily focused on learning physio ... interviewing, interacting, communication, your general handling skills. Once they are more comfortable with those skills, then adding IPE will be more suited. (Group 4, participant G)

Student Attitude

To ensure optimal preparedness for clinical IPE, students, just like practising therapists, need to learn their own identity within the PT scope of practice while maintaining a respectful attitude toward other professions. One participant expressed concern that in early training, PT students can easily develop a tendency to highlight their own professional strengths to the exclusion of the strengths of other professionals. The CIs in our focus groups emphasized the importance of focusing not only on the role of PT but on the various disciplines and their meaningful contributions to overall patient care. Introducing IPE and IPC concepts early is essential, as this participant emphasized:

I think if we start students off with the mentality of IPC, whether it's just a lecture or an afternoon with an interdisciplinary team so they know there's more than one discipline treating the patient, I think it would be beneficial before they come to an environment like acute care. (Group 3, participant C)

There was general agreement that introducing the concept of IPC would be beneficial during students' academic training, when combined with appropriate timing of clinical placements.

DISCUSSION

The purpose of this study was to explore the opportunities and challenges PT CIs face in offering IPE in

Figure 1 Factors affecting inter-professional education and inter-professional collaboration in the acute-care setting

clinical internships, in order to improve the collaborative experience for future generations of PT students. IPE was not a new concept to the PTs participating in the focus groups. There was much agreement in the group discussions, and the results indicate that these CIs felt they were offering IPE to their students. However, they faced limitations in their knowledge of how to teach IPC and reported significant obstacles to delivering IPE in the clinical setting. Many of these obstacles are similar to those identified in the recent IPE literature,^{26–28} but there remains an inconsistent approach to IPE in the acute-care settings represented in this study.

A key finding from this study is that clinical IPE happens when IPC occurs. However, IPC differs from hospital to hospital, unit to unit, profession to profession, and individual to individual. Each hospital setting, and each unit within that setting, varies in terms of factors such as accessibility, time, support, and structure, as outlined in Figure 1. The CIs came to each setting with individual differences and diverse experiences with multidisciplinary teams. Teamwork itself involves a complex matrix of behaviours, skills, and processes²⁹ and is also influenced by the aforementioned factors. This “complex and messy reality of clinical practice”^{30(p.126)} creates a need for CIs to become flexible and adaptable in how they learn IPC and how they teach it to students.

Clinical IPE should become mandatory and an extension of clinical education, since it is vital for optimal client care.^{10,20,31} Too often, however, the CIs interviewed did not perceive IPE as an integral part of direct patient care. When IPE is seen to be truly valued, CIs will successfully offer this experience to their students. As stated by Reeves, Goldman, and Oandasan, “elective

Figure 2 The building blocks of learning IPE and IPC (IPL = inter-professional learning)

or voluntary IPE can give the message that this type of learning occupies a ‘low status.’^{28(p.232)} Providing protected time for academic learning about IPE, time to prepare for clinical internships, and an overall vision to promote IPC and IPE will reflect an organization’s level of support for the philosophy and principles of IPE.²⁶ This, in turn, will foster a sustainable culture of collaborative teamwork.

The second key finding identified in this study is that IPC is a process of incremental learning that comes with time, commitment, and self-reflection, as shown in Figure 2. As Clark^{32(p.581)} succinctly put it, “learning is a continuous process, grounded in experience, not an outcome.” Becoming a collaborative, experienced professional role model for IPC starts by recognizing the value of working well in teams. As identified in the focus-group discussions, learning to collaborate well in daily practice creates better role models for clinical IPE. Research has found that students are more accepting of IPE when “they see a direct relevance between their educational experiences and current or future practices.”^{28(p.232)} The gap between theory and practice needs to be bridged with a true commitment by physical therapists to become experts in IPC in order to teach students well.

In its position statement on IPE, the Canadian Physiotherapy Association has identified IPC as an essential prerequisite for optimal patient-focused care³³ and that physical therapists should continue to develop competencies for effective IPC throughout their careers. Atwal et al.³⁴ have suggested that health care professionals need to participate in postgraduate training in order to further develop inter-professional leadership skills. Ongoing self-reflection and identification of learning goals and objectives in the area of IPC and IPE could become part of the College of Physiotherapists of Ontario’s annual Professional Issues Self Assessment

(PISA) in order to ensure that PT CIs meet the obligations and accountabilities of their current practice.³⁵

The literature to date suggests that a high level of support for the principles of IPE and teamwork exists among Canadian academic administrators.¹¹ In the acute-care settings represented in this study, by contrast, CIs reported scheduling difficulties, territoriality, and failure to perceive the value of IPE as ongoing barriers that need to be addressed in order to create successful clinical IPE opportunities for students. Enhanced collaboration between academic and hospital administrators will help to overcome these barriers and to translate “top-down drive into action.”^{36(p.742)}

The CIs in this study felt that they are offering clinical IPE to their students. Without formal guidance from the university, however, they are uncertain and cannot validate that what they teach from their own experience is adequate. Communication from the university needs to highlight learning objectives for clinical IPE. Incorporating IPC as a component of the student performance evaluation will further enhance consistency across student internships. According to Verma et al.,³⁷ one barrier to successful IPE has been the lack of shared competencies in health care teams. Consensus on core competencies for clinical IPC will help to establish a framework that defines expected skills for teaching and thus “fosters empowerment, accountability, and performance evaluation which is consistent and equitable.”^{37(p.110)}

There was agreement among participants that preparation is needed for CIs to deliver IPE. Educational opportunities may be provided through academic or health institutions. Reeves et al.²⁸ surmised that structured academic IPE sessions on topics such as understanding the roles and responsibilities of the different professions and planning strategies for inter-professional groups can effectively prepare and provide ongoing support to CIs. For IPE initiatives to be successful, facilitator education is seen to be important in encouraging participation and “buy-in” and in developing role models for collaborative practice.¹⁹

The third key finding is that the CIs in this study believed that students need to be prepared and to have confidence in their own clinical skills prior to engaging in clinical IPE. This belief is consistent with the views of those who advocate introducing IPE later in students’ training to ensure that they are secure in their professional role and in their ability to function as effective team members.²⁰ On the other hand, participants also felt that students need to be aware of the roles of other disciplines early on in their training. Researchers agree that when introduced early in the curriculum, IPE can reduce negative stereotyping and generate positive attitudes and respect.^{20,26} The CIs interviewed suggested that early introduction of the various disciplines’ roles through lectures or problem-based learning would

indeed allow for a basic understanding of the potential for teamwork.

In the past, teaching students inter-professional awareness and collaboration through appropriate communication was mostly left to the discretion of CIs during clinical internships. According to Smith and Green,³⁸ not all students are equipped with the social skills that allow for personal interaction, discussion, and negotiation in a team setting. Training teamwork through modules in a classroom is seen as a useful preparation prior to real-life clinical interactions, where students are under pressure and are expected to solve problems efficiently. Timing of IPE, according to participating CIs, should follow a continuum of development from early education through preparation for collaborative practice and into clinical practice to reinforcing learning (see circled area in Figure 2).

LIMITATIONS

We acknowledge that there are limitations to our study. Recruitment proved challenging at all four sites because of the volume of commitments for CIs that conflicted with the times available for focus groups. This resulted in two small groups with two and three participants. As well, all the focus groups took place in urban hospitals; other settings such as community care, rehabilitation, and outpatient clinics, as well as more rural locations, would be areas to consider for future research.

CONCLUSION

The CIs who participated in this study were in favour of clinical IPE but felt that it is subject to individual, professional, and organizational constraints. Our findings emphasize that clinical IPE is best fostered in an environment where IPC is valued. Lifelong learning of IPC principles and constructs, as well as enhanced preparation of both PT students and CIs for IPE, are essential to achieve the ideals of safe, quality patient care.

KEY MESSAGES

What Is Already Known on This Topic

The concept of IPE as a learning opportunity to improve collaborative patient-centred care is embraced by students and university administrators, and current IPE programmes are offered in a structured academic environment. However, close daily access to multiple professionals in a clinical setting is seen to have many benefits in building the foundation of teamwork.

What This Study Adds

The success of IPE in a clinical setting depends on clinical instructors' (CIs') commitment to fostering this

type of learning. This study explored the perceptions of the PT CIs and their views on the opportunities and challenges of this role. Extrinsic factors such as time, support, and student preparedness and intrinsic factors such as self-reflection and lifelong learning are believed to influence the IPE experience. University educators and hospital administrators can aim to support CIs by addressing some of these elements.

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