

## Feature



# Improving physician participation in interprofessional collaboration

There is emerging evidence supporting<sup>1-4</sup> and increasing attention being paid to the importance of interprofessional collaboration (IPC) as a necessary component to achieving high quality and safe healthcare. High performing interprofessional teams have better outcomes. This is seen in the care of obstetrical patients in which interprofessional team training and practice teams have produced better patient outcomes<sup>3</sup>. More recently, improving interprofessional communication and practice in the operating room was associated with a 30 percent reduction in death and complications of surgical patients<sup>4</sup>. However, incorporating

IPC and teamwork into routine practice is easier said than done with success being dependent on the commitment and involvement of all team members. Having physi-

examine some underlying reasons why physician engagement in IPC is challenging and provides some suggestions for increasing participation of physicians in IPC activities.

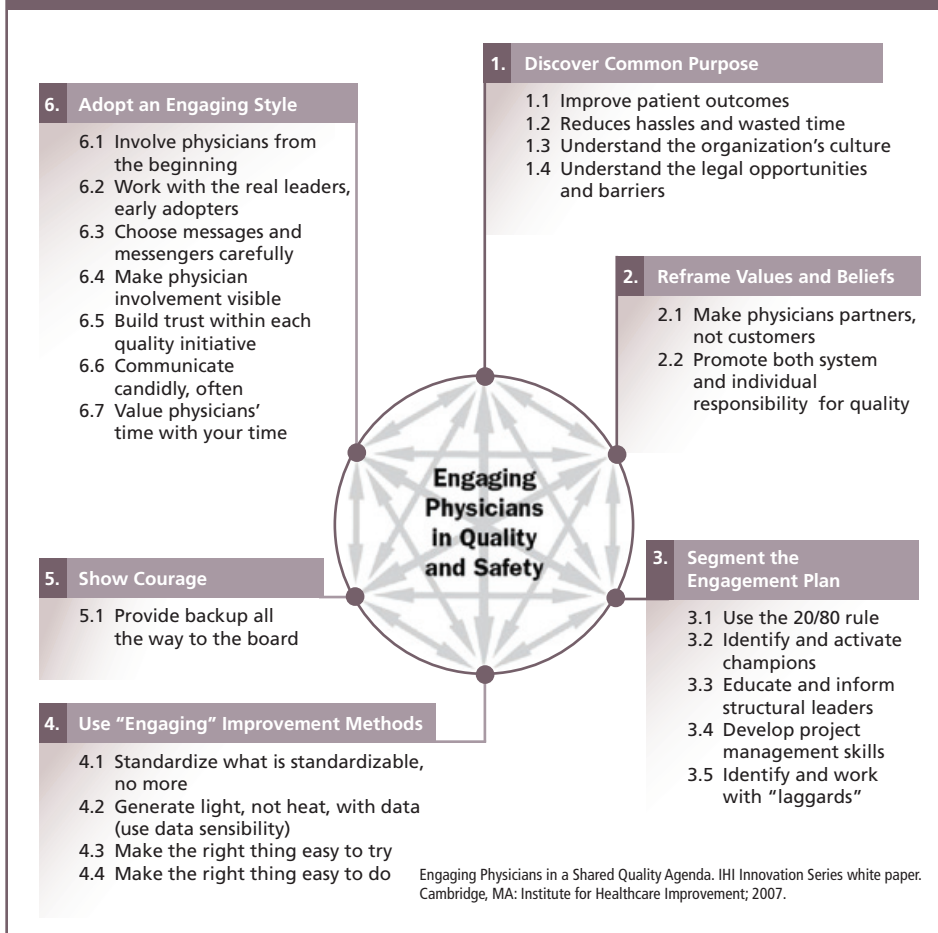
Developing IPC strategies that take into account the hospital-physician relationship and physician professional culture are important to increase physician participation.

cians interested and active in the creation or practice of interprofessional collaborative care is often seen as a complex issue that organizations and teams face. This article will

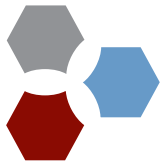
In order to understand the perceived lack of involvement of physicians in IPC, one has to consider two key elements: the historical relationship physicians have with the healthcare system in North America; and, physician professional culture. Nearly a century ago, hospitals began to transform from charitable and philanthropic organizations to a business or bureaucratic model<sup>5</sup>. In doing so there was concern that patient care could be jeopardized with this new orientation as physicians felt that their traditional and primary obligation to advocate for their patients, despite resources, financial pressures and politics, was at risk and could create a conflict of interest<sup>5</sup>. Thus an agreement was struck in which hospitals took responsibility of plant services, equipment, staffing, and financing and physicians took responsibility for medical care, under the governance of the medical staff organization (medical advisory committee, medical executive)<sup>4</sup>. Physicians were to provide medical services to patients, as consultants to the hospital with primary responsibility to the patient, not to the hospital. This historical model endures despite healthcare being much more complex and advanced than it was 100 years ago, and can create significant challenges if the hospital (and its clinical staff) wants to introduce change.

In addition to the hospital-physician relationship, physician professional culture presents a challenge to the practice of IPC. Underpinning this culture is the belief that safe and high quality patient care is a must. Physicians believe that they have a personal accountability for quality and for the life and death of each patient they see and as such, perfection is the necessary goal – a message deeply rooted in

Figure 1: IHI Framework for Engaging Physicians in Quality and Safety



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medical education. This perceived accountability leads to a powerful sense of individual autonomy and decision making<sup>5</sup>. Physicians hold a specific view of safety and quality. They favour individual patient over population outcomes; clinical outcomes over administrative/financial, and find tension between providing patient-focused care and whole system improvement. Physicians also have a different view of teams and team roles. They are more likely to view their team as being comprised of physician peers and medical trainees. This may be due to a paucity of interprofessional team training during medical school and residency. Furthermore, changing physician practice often requires quantitative data from rigorously conducted research and/or influential physician peers to model practice. This creates a challenge to implement IPC in which much evidence is qualitative and non-physician spearheaded. Finally, a significant challenge is time. Physicians believe that time devoted to patient care is time better spent with administrative or planning activities perceived as of lesser value. With a high demand for clinical time, there is no time for less valued activities. However, physicians are very quick to vocalize frustrations with system inefficiencies – a potential source for a collaborative interprofessional project.

Understanding this unique relationship physicians have with the healthcare system and physicians' cultural perspective are important to enable effective partnering with physicians towards practicing IPC. Through this understanding, strategies can be created that further engage and attract physicians to participate. Although a few reported engagement strategies are reported, the most widely available is the program created by James Reinertsen et al.<sup>6</sup> in collaboration with the Institute for Healthcare Improvement (IHI). This framework, developed through examination of top performing hospitals and health systems, describes six primary elements shown to be successful in engaging with physicians. Although this framework (see Figure 1.) was designed primarily for a quality agenda, the tactics described are easily transferable to increasing physician participation in IPC activities. Below are listed some key tactics:

- **Discover a common purpose** – physicians are more likely to be interested and involved if the presumed benefits are

improved outcomes for their patients and/or reduced hassle and wasted time.

- **Create partnerships** – it is important to view physicians as partners in change, not consultants. Involve them in strategic planning and allow them to take ownership and responsibility for key initiatives
- **Involve physicians early** – physicians are more likely to be receptive to change if involved from its inception
- **Identify champions and make physician involvement visible** – physicians are more likely to respond to and identify with their peers. Work with a vocal champion, an early adopter, and consider making them the project lead
- **Work with medical leadership** – department chairs and medical executive are usually more aware of hospital initiatives and goals and are influential amongst their peer physicians
- **Use local data** – physicians are data driven and local (preferably uninterpreted) data is more likely to result in practice change
- **Make the right thing easy to try and do** – don't create plans that require large changes at once. Physicians (and most clinicians) are more willing to try using small tests of change rather than fully commit to a practice change. Work with a small group first, gain feedback then attempt spread. Plans that involve physicians to do more, or take more time, are less likely to succeed. Create change interventions that reduce hassle and improve efficiency.

The above tactics, and others described within the IHI white paper<sup>6</sup> will assist organizations and teams in creating IPC implementation strategies. Although, increased physician participation is not guaranteed, use of these tactics will increase the likelihood of success.

With publications highlighting the gaps in quality of care and issues in patient safety<sup>7-9</sup>, the traditional model of healthcare delivery has been called to question and hospitals and government have been charged with higher accountability over the delivery of healthcare. Interprofessional collaboration, high functioning teams, and partnership between clinicians and administration are necessary components to realize true improvement. Although there is increasing physician involvement in IPC and healthcare system redesign, more is needed. Developing IPC strategies that take into account the hospital-physician relationship and physician professional culture are important to increase physician participation. In addition,

the medical profession needs to reflect on how physician autonomy functions as a barrier to practice change. Further integration of interprofessional education and team training into undergraduate and continuing medical education (and all health professions training) is necessary if physicians are to play a larger role in the healthcare system redesign and improved healthcare quality and safety for patients. ❖

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