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Interprofessional education evaluation and next steps

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Short Paper

Interprofessional education (IPE) has been highly promoted as a means of enhancing interprofessional practice and thereby having a positive impact on healthcare systems and patient outcomes. IPE is envisaged as a promising contributor to ensuring the appropriate supply and distribution of the health workforce. The WHO Framework for Action on Interprofessional Education and Collaborative Practice (WHO, 2010), affirms that there is sufficient evidence to demonstrate that IPE enables effective collaborative practice. In 2014, The Institute of Medicine convened experts who examined the evidence that links IPE to patient outcomes and concluded that “IPE can improve learners’ knowledge, skills and understanding of interprofessional practice”. However, this institution also acknowledged that “establishing a firm empirical relationship between IPE and patient, population and health system outcomes has proven more difficult” (Cox et al. 2016).

While it is the belief of many leading individuals and organisations that IPE will automatically result in improved outcomes, this is not entirely supported by solid evidence. The literature is replete with studies which were conducted to assess effects of IPE programmes, within different institutions and within different clinical environments e.g. mental health setting, emergency departments and surgical settings (Bowman et al. 2023). The results of these studies are based on claims of effectiveness rather than hard endpoints, such any improved healthcare outcomes. There are insufficient studies which assess the effectiveness of IPE interventions compared to separate, profession-specific interventions. Studies with robust methodologies such as randomized controlled trials, controlled before and after studies or interrupted time series type of designs with qualitative strands examining processes relating to the IPE and practice changes are lacking. Longitudinally designed studies to explore patient outcomes (Furness et al. 2011) and well- planned cost benefit analysis are also required (Reeves et al. 2013).

In view of the above, it is evident that the desired hard evidence is still missing. It is well acknowledged that there is much resistance to change due to sufficient lack of evidence as well as lack of leadership and possibly resources. Curricula also tend to add on IPE rather than modify the curriculum to embrace an IPE philosophy.

In the USA, the Health Professionals Accreditation Collaborative together with the National Centre for Interprofessional Practice and Education issued a Guidance on Developing Quality Interprofessional Education for Health Professions (2019) providing a framework which organisational leaders can use to design curricula through longitudinal planning. The latter may be used as a basis to set up IPE in different settings, which can then be evaluated with the robust methods detailed above, providing the firm evidence which is required. The approaches discussed could provide a more convincing platform for the uptake of IPE. Studies should generate evidence with regards to which stages and/or settings IPE would to be the most useful. In addition, IPE needs to be backed not only by solid evidence but also by political will if it is to effectively enhance health care institutions.

References

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