INTERPROFESSIONAL EDUCATION

Attributes of a collaborative practitioner in the Australian healthcare system

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Abstract

Introduction: Interprofessional collaborative practice is required to organise healthcare around the individual needs and preferences of patients, carers and their families. In order to prepare graduates for interprofessional collaborative practice, the attributes required of health professionals must be made explicit, however at present, there is no consensus regarding the interprofessional competencies required of Australian health professional graduates. This study sought to articulate the current and future (or desired) attributes of a collaborative practitioner within the contemporary healthcare system.

Methods: Taking a constructivist approach, focus groups were conducted with 84 participants, including consumers, education providers and healthcare practitioners, to understand the attributes of a collaborative practitioner. Framework analysis was undertaken to summarise the conceptual, procedural and dispositional knowledge attributes that underpin collaborative practice now and into the future.

Results: Knowledge about patient centredness, healthcare roles and the healthcare system, skills in communication, the efficient use of digital technology, cultural awareness, teamwork, leadership and conflict management and the attributes of respect, trust, empathy and humility featured.

Conclusion: The results of this research establish the groundwork for the development of a collaborative practice competency framework for Australian healthcare practice.

Keywords: health professional education; interprofessional learning; curriculum

Introduction

The Australian healthcare system is made up of a complex combination of public and private organisations through which patients and their families must navigate to seek the care they need. Community expectations are for health professionals to work collaboratively to help patients navigate this complexity in order to deliver comprehensive and patient centred care. Unfortunately, this is not always achieved, and Australian health

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system inquiries into issues and inadequacies in mental health care, aged care and care for people with disability have emphasised the urgent need to reorganise healthcare around patients and their families rather than historical ways of working in silos (Commonwealth of Australia, 2021; State of Victoria, 2021).

Interprofessional collaborative practice (IPCP) describes the type of practice required "when multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care" (WHO, 2010, p. 7). However, operationalisation of IPCP has proven difficult in clinical practice, with a challenge translating competencies to tangible ways of working (Hepp et al., 2015). The independently chaired accreditation committee of the Australian Health Practitioner Regulation Agency (Ahpra), as part of the National Registration and Accreditation Scheme, has committed to work towards this aim with the recent publication of the Interprofessional Collaborative Practice Statement of Intent, aspiring to embed IPCP across the Australian healthcare system in education, training, clinical governance, research and practice (Ahpra, 2024).

To embed IPCP in education, the attributes required of health professionals to work collaboratively must be made explicit. Interprofessional competency frameworks have increasingly been used to make explicit the knowledge, skills and behaviours required for collaborative practice (Reeves, 2012; Thistlethwaite et al., 2014). A competency framework also serves the additional goals of clarifying the priority areas of focus for education providers and accreditation authorities (Reeves et al., 2009). Progress has been made towards this goal. Thistlethwaite and Moran (2010) conducted a literature review to determine the learning domains underpinning interprofessional practice, and a list of graduate outcomes have been proposed (O'Keefe et al., 2017). However, there is great variation in interprofessional education priorities in Australia, and no single agreed interprofessional competency framework (Bogossian & Craven, 2021). In the absence of an agreed framework, education institutions have each selected their own approach. International interprofessional competency frameworks (e.g., Canadian Interprofessional Health Collaboration, 2010) have been adopted by some Australian institutions despite their scope extending beyond pre-registration learners; university-based competency frameworks have been developed by others to align with the health professions represented within their institutional contexts (Brewer & Jones, 2013; Maddock et al., 2019). However, the absence of a single framework complicates the work of education providers who are required to choose or develop a framework and of accreditation authorities in understanding the target competencies required for IPCP.

There is a need to determine the current and future (desired) attributes of a collaborative practitioner in Australia. Multiple approaches have been used to categorise IPCP competencies in health professional education. For this study, we focused on the interprofessional competencies required of health professional learners by graduation, as one driver for this work was the need to inform accreditation authorities who set the

standards for the education of the health professions (Health Professions Accreditation Collaborative Forum, 2024). Billett (2015) posits that there are three broad dimensions of readiness for practice, where readiness comprises what an individual knows, can do and values. These dimensions have been described as conceptual, procedural and dispositional. Conceptual knowledge includes the cognitive facts and information about collaborative practice that a practitioner should be able to articulate. Procedural knowledge includes the observable skills, tasks and communication required of a collaborative practitioner, and dispositional knowledge includes the practitioner's attitude, values and interests. This practice-based framework was deemed a useful method to organise the attributes required of a collaborative practitioner without ascertaining predetermined domains of practice, where much variation exists across interprofessional competency frameworks.

Aim

The aim of this study was to describe the current and future (or desired) attributes of a collaborative practitioner within the contemporary Australian healthcare system. This research is part of a larger study that explored the development of collaborative practice in Australia, and in particular, the role that accreditation authorities and education providers could take in progressing this agenda (Health Professions Accreditation Collaborative Forum, 2024).

Methods

Design

A constructivist qualitative research design was selected to gather a comprehensive description of the attributes of a collaborative practitioner. Online focus groups were conducted with each stakeholder group separately (consumers, educators, health practitioners and members of the Health Professions Education Steering Group [HPESG]) and the questions modified slightly in wording to each group. HPESG comprises senior leaders across university health professions and jurisdictions in Australia. Focus groups were selected as the preferred method to facilitate dialogue within each stakeholder group, where responses of participants could build from the perspectives of others. A semi-structured interview schedule was drafted by the entire research team as part of the larger research project, with a justification provided for each question (Health Professions Accreditation Collaborative Forum, 2024). The perspectives of all stakeholders were then sought in response to the main focus group topics of enquiry:

- What does the term "collaborative practitioner" mean to you?
- Can you describe what you would hope to see if you were observing a collaborative practitioner?
- Looking to the future, what skills are emerging as necessary for a collaborative practitioner?

Recruitment and participants

Recruitment methods differed by stakeholder and involved email via formal organisations, social media and a snowballing technique via professional organisations and stakeholder networks. Health consumers who were formally aligned to a health consumer organisation were recruited via the Consumers Health Forum and Health Care Consumers Australia. Education providers, at any level of seniority, with knowledge of interprofessional education were recruited via the relevant accreditation authority. Healthcare practitioners with experience working in a healthcare team were recruited via state government health service leaders, professional organisations and stakeholder networks. We intentionally sought to recruit diverse perspectives by seeking representation from each health profession represented in the Australian National Registration and Accreditation Scheme, which includes an Aboriginal and Torres Strait Islander Health Practice perspective. Eligibility criteria were developed for each stakeholder group and a research study webpage was also published on the Australian Pharmacy Council website to provide information about the research study to any potential participants. Potential participants submitted an online expression of interest, after which the explanatory statement and consent form were distributed. Participants meeting the inclusion criteria were then allocated to their stakeholder focus group.

Data collection

Focus groups were conducted over Zoom between October and November 2022 and were audio recorded and transcribed verbatim using a third-party transcription service. Three members of the research team alternated in the facilitation of the focus groups. Focus groups lasted from 45 to 105 minutes, with between one and eight participants. Last minute cancellations resulted in two focus groups having a single attendee, and a semi-structured interview was conducted on these occasions.

Data analysis

Framework analysis was undertaken in the stages described by Ritchie and Spencer (1994). *Familiarisation* was undertaken in the first instance, whereby the entire research team read and inductively coded three diverse transcripts in response to the research questions and then met to discuss an agreed coding approach. Billet's (2015) three domains of readiness for practice were identified as a useful *coding framework* to organise the coding of this research question into the three domains of work readiness. *Indexing* was then undertaken by one researcher, who coded all transcripts using NVivoR software under the three domains, with frequent meetings with the larger research team for further amendments to language and synthesis of attributes of a collaborative practitioner. *Charting and mapping* were undertaken to determine the range of responses by different stakeholders around each attribute before *interpretation* was undertaken by the research team. Team reflexivity was undertaken through in-depth research team discussions throughout the analysis and writing stages.

Research team and reflexivity

The research team hold health professional backgrounds in nutrition and dietetics, pharmacy, physiotherapy and social work. Educational research PhDs are held by several team members (LC, FK, SM); others hold professional leadership and accreditation roles (BC, JM, GW). This diversity in perspectives, with expertise in education, research and accreditation, was coordinated through online meetings through the duration of the project, with all perspectives contributing to the research design, analysis and writing for publication.

Ethical considerations

All participants provided written informed consent prior to attending a focus group. Ethics approval was obtained from Monash University Human Research Ethics Committee (ID 34594)

Results

Nineteen focus groups were conducted between October and November 2022, with 84 participants consisting of education providers (n = 62), consumers (n = 10), a health professions steering group (n = 8) and healthcare practitioners (n = 4). Education providers self-identified their health professional perspective, with some representing a health program other than their own professional background or holding roles representing multiple professions. Considered collectively, the health professions interviewed included: Aboriginal and Torres Strait Islander Health Practice, chiropractic, dental, dietetics, medicine, medicine radiation practice, nursing and midwifery, occupational therapy, optometry, osteopathy, paramedicine, pharmacy, physiotherapy, podiatry, psychology and speech pathology.

When asked to define their vision for collaborative practitioners now and in the future, consumers, education providers and healthcare practitioners identified multiple knowledge, skills and attributes that should be prioritised. Key attributes related to these three dimensions are summarised below.

Conceptual knowledge included key areas of knowledge about the patient, the roles of others and the healthcare system.

A comprehensive understanding of the features of holistic healthcare and the processes required to facilitate continuity of care, including transitions between healthcare services, were viewed as important. The collaborative practitioner would work towards the organisation of health around a person in the community rather than around a hospital admission:

> *I think collaborative care would see them take a step back to remember that we are a whole person.* (Consumer, Participant 59)

> *Take a holistic approach to working with somebody's healthcare … which recognises their social, their physical, their spiritual, aspects of the self.* (Education provider, Participant 14)

> *That continuity of care … hospitals are just a small slither of people's lives. … Most people don't live in hospitals; they live in the community.* (Education provider, Participant 68)

There was the need to differentiate between the roles played by different health professionals and how each role worked together within the broader, and evolving, healthcare system:

> *Clear idea about what their role is and what their expertise is and where others fit in that, so that there isn't too much overlap of governance and decision making.* (Education provider, Participant 61)

> *So that would be looking at the healthcare systems particularly … who we are, what we do, where we do it, and why do we do it that way.* (Education provider, Participant 48)

Procedural knowledge included communication, cultural awareness and teamwork. Graduates were expected to prioritise and facilitate the centrality of the the patient, family and carers. There was the expectation for culturally safe practice and respectful listening to the needs and opinions of all involved and to facilitate the creation and implementation of shared goals. Communication was to be in a language shared with patients, families, carers and communities and other healthcare practitioners:

> *How to include the client or the patient as part of the collaboration.* (Education provider, Participant 74)

> *Being able to listen deeply and take the other professionals or the patients or the client's perspective and incorporate it into your view and your plans.* (Education provider, Participant 67)

> *Making sure that everybody is creating shared goals … no one's kind of going off and just doing what they think, but everybody is moving together along the … patient's journey.* (Education provider, Participant 23)

> *Somebody who's very willing to listen to the others in the group that's practising in a culturally responsive manner … focusing in on not just that other person, but also their own person and their own potential biases.* (Education provider, Participant 73)

Efficient use of digital technology, processes and systems were described to facilitate collaboration into the future:

> *Being good with technology … practitioners are going to have to collaborate … in all sorts of different ways.* (Education provider, Participant 76)

Teamwork, where professionals were able to work with other professions in the healthcare team was desired. Leadership skills and the ability to navigate areas of disagreement or conflict were also important attributes:

> *Understanding how a team works and why a team might not be working so that you're able to put strategies or approaches in place that actually reset the team.* (Education provider, Participant 78)

> *They need to deal with conflict as it arises. They need to make sure that that team, however massive it might be, can function effectively to provide that patient with the best care that they need.* (Education provider, Participant 64)

Dispositional knowledge included how practitioners approached and worked with the patient and their families, and their colleagues. Respect for the patient and others in the healthcare team was expected. The contributions of all healthcare members were to be valued and incorporated in collaborative decision making, which involved a willingness to seek out and work collaboratively with others. There were expectations that everyone was approached with dignity, compassion and empathy and that open-mindedness and trust with the patient and other healthcare practitioners was demonstrated. Humility with patients and other healthcare practitioners was expected in order to learn and develop, with health professionals engaged in reflexivity on collaborative patient-centred practice:

> *I think when I see them working together and working with me and recognising that I have my own views and my own life and my own experiences outside my healthcare … that sort of mutual respect … for everybody who's there.* (Consumer, Participant 51)

> *Have compassion and empathy for not only our patients, but also the people that we're … working with.* (Education provider, Participant 45)

> *Trust … where another health professional may have done an assessment, how you trust that information and don't duplicate that effort.* (HPESG, Participant 68)

> *They are aware of themselves and others … that takes a degree of reflexivity … I think that internal mirror has to be very strong, and I think they have to be open and reflexive in the way they go about their business.* (Education provider, Participant 81)

Discussion

The research identified the current and aspirational attributes required of health professionals in the delivery of IPCP in Australia. Conceptually, health professions need knowledge of patient centredness, the roles of others and the healthcare system to underpin IPCP. Within the procedural domain, traditional and digital communication skills, cultural awareness, teamwork and conflict management are required and, finally, respect, trust, empathy and humility should be demonstrated.

These attributes replicate many of those previously identified in the literature (Hepp et al., 2015) and international interprofessional frameworks (Thistlethwaite & Moran,

2010). The need to primarily focus on holistic and comprehensive consideration of the patient's perspective was raised across all three dimensions of knowledge, skill and values. This finding aligns with the Canadian interprofessional framework domain of "Relationship focussed care/services" (Canadian Interprofessional Health Collaboration, 2024) and the American interprofessional framework domains of "Persons and Populations" (Interprofessional Education Collaborative, 2023). The domains of interprofessional communication, role clarification, teamwork, leadership and conflict resolution also align with previous research (Hepp et al., 2015) and are common to interprofessional frameworks. The multiple dispositional attributes of respect, trust and humility, which featured in our findings, align most closely with the American interprofessional framework key domain of "Values and ethics" (Interprofessional Education Collaborative, 2023).

Our findings emphasised the need for practitioners to work collaboratively beyond localised or co-located hospital teams. The ability to navigate and support patient transitions across acute, subacute and community healthcare sectors was viewed as an important attribute of a collaborative practitioner. This finding deviates from earlier conceptualisations of teamwork as predominately co-located, stable teams (Reeves et al., 2018). The need for collaborative working beyond local teams aligns with the different types of interprofessional activity and the associated skills described by Xyrichis et al. (2018). The InterPACT classification makes explicit the difference in skills required within different clinical settings, e.g., care coordination provided by co-located teams compared to dispersed teams (Xyrichis et al., 2018). We intentionally sought to understand a broad view of IPCP rather than the simpler construct of co-located teamwork. Indeed, developing the skills required to assist the patient navigate the complexity of multiple health-related systems, whereby professional roles differ by context, poses a challenge to educators. Digital technology was identified as an important mechanism to facilitate IPCP. Furthermore, the systems within which healthcare is delivered have the potential to both enable and inhibit collaborative practice (Kent et al., 2024), thus emphasising the need for careful consideration of interprofessional workplace learning opportunities.

Patients and their families need to be invited and empowered to take a central role in the healthcare team. Health professionals, therefore, require the skill to facilitate this inclusion, which encompasses the ability to acknowledge the expertise of the patient and/or family member and to encourage and enable their contribution (van Oort et al., 2019). Viewing the patient holistically, with multiple facets and roles beyond their health condition, was described as a key attribute of a collaborative practitioner and was described as essential to effective collaborative practice (Meiklejohn et al., 2024). Moreover, interprofessional education can make explicit how the patient perspective can contribute to skill development, particularly where patients contribute to the curriculum (Romme et al., 2020).

Participants identified humility and reflexivity as important attributes of a collaborative practitioner. This was further described as openness and a willingness to be challenged by others in the delivery of patient-centred care. The recent refresh of the Canadian framework similarly addresses the process of navigating disagreements (Canadian Interprofessional Health Collaboration, 2024). Our findings suggest an important characteristic of a collaborative practitioner is the deliberate choice to focus on the patient rather than professional boundaries, to intentionally collaborate when professional differences arise. This "collaborative intent" was viewed as an important contributor to collaborative practice for optimal patient outcomes.

Our findings offer support for the development of a national competency framework, which would assist all Australian stakeholders focus on the learning required for the development of a collaborative practitioner (Bogossian & Craven, 2021). To achieve this goal, next steps would involve seeking support for the establishment of a national interprofessional research team. A draft framework informed by the published literature and the findings of this study, refined through a process of Delphi review, would allow a clear articulation of the competencies of a collaborative practitioner in the Australian healthcare system to assist all stakeholders work towards achieving this goal.

Limitations

A strength of the study is the breadth of stakeholders consulted, although a challenge of consulting this broad group was to delineate between what might be perceived as expert collaborative practice compared to that expected of a new graduate. The learning and enactment of collaborative practice occurs across a continuum, from an early undergraduate learner to an expert clinician in practice. We sought to understand the expectation of a collaborative practitioner at a minimum, at the point of health professional graduation, where education institutions and accreditation authorities can have impact. However, we recognise that the expectations of IPCP at different stages of practice may not have been the focus of some stakeholders. We also acknowledge that a larger representation from health practitioners would have further informed the research question. Our recruitment of working practitioners was difficult during the period of workforce stress and staff shortages resulting from the Covid-19 pandemic.

Conclusion

This study highlights the characteristics of the collaborative practitioner from the perspective of patients, educators and healthcare practitioners. Many of the suggested characteristics align with published frameworks for interprofessional collaboration. Skills deemed important in the Australian context include assisting patients navigate the complexity of the healthcare system, facilitation of culturally safe practice, the efficient use of technology and the demonstration of respect, humility and reflective practice.

Conflicts of interest and funding

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References

Australian Health Professional Regulation Authority (Ahpra). (2024). *Interprofessional collaborative practice statement of intent*. https://www.ahpra.gov.au/About-Ahpra/Who-We-Are/Ahpra-Board/Accreditation-Committee/Publications.aspx

Billett, S. (2015). Readiness and learning in health care education. *The Clinical Teacher*, *12*(6), 367–372. https://doi.org/10.1111/tct.12477

Bogossian, F., & Craven, D. (2021). A review of the requirements for interprofessional education and interprofessional collaboration in accreditation and practice standards for health professionals in Australia. *Journal of Interprofessional Care*, *35*(5), 691–700. https://doi.org/10.1080/13561820.2020.1808601

Brewer, M. L., & Jones, S. (2013). An interprofessional practice capability framework focusing on safe, high-quality, client-centred health service. *Journal of Allied Health*, *42*(2), 45E–49E.

Canadian Interprofessional Health Collaboration. (2024). *CIHC competency framework for advancing collaboration*. https://cihc-cpis.com/wp-content/uploads/2024/06/CIHC-Competency-Framework.pdf

Commmonwealth of Australia. (2021). *Aged care royal commission final report: Summary*. https://www.royalcommission.gov.au/aged-care/final-report

Health Professions Accreditation Collaborative Forum. (2024). *Developing a collaborative health practitioner through strengthened accreditation processes*. http://hpacf.org.au/wp-content/uploads/2024/09/Developing-a-collaborative-health-practitioner-August-2024.pdf

Hepp, S. L., Suter, E., Jackson, K., Deutschlander, S., Makwarimba, E., Jennings, J., & Birmingham, L. (2015). Using an interprofessional competency framework to examine collaborative practice. *Journal of Interprofessional Care*, *29*(2), 131–137. https://doi.org/10.3109/13561820.2014.955910

Interprofessional Education Collaborative. (2023). *IPEC core competencies for interprofessional collaborative practice*. https://www.ipecollaborative.org/assets/core-competencies/IPEC_Core_Competencies_Version_3_2023.pdf

Kent, F., Cardiff, L., Clark, B., Gustavs, J., Jolly, B., Maundu, J., Wilkinson, G., & Meiklejohn, S. (2024). Accreditation as a lever for change in the development of the collaborative practitioner in the Australian health system. *Australian Health Review*. https://doi.org/10.1071/AH24165

Maddock, B., Kumar, A., & Kent, F. (2019). Creating a collaborative care curriculum framework. *The Clinical Teacher*, *16*(2), 120–124. https://doi.org/10.1111/tct.12796

Meiklejohn, S., Cardiff, L., Clark, B., Jolly, B., Maundu, J., Walters, T., Wilkinson, G., & Kent, F. (2024). "The patients first and foremost" Collaborative practice in the Australian health care system. *MedEd Publish*, *14*(131).

O'Keefe, M., Henderson, A., & Chick, R. (2017). Defining a set of common interprofessional learning competencies for health profession students. *Medical Teacher*, *39*(5), 463–468. https://doi.org/10.1080/0142159X.2017.1300246

Reeves, S. (2012). The rise and rise of interprofessional competence. *Journal of Interprofessional Care*, *26*(4), 253–255. https://doi.org/10.3109/13561820.2012.695542

Reeves, S., Alexanian, J., Kendall-Gallagher, D., Dorman, T., & Kitto, S. (2018). Collaborative practice in critical care settings: A workbook (1st ed.). Routledge. https://doi.org/10.4324/9781315207308

Reeves, S., Fox, A., & Hodges, B. D. (2009). The competency movement in the health professions: Ensuring consistent standards or reproducing conventional domains of practice? *Advances in Health Sciences Education*, *14*, 451–453. https://doi.org/10.1007/s10459-009-9166-2

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. Burgess (Eds.), *Analyzing qualitative data* (pp. 173–194). Routledge. https://doi.org/10.4324/9780203413081

Romme, S., Bosveld, M. H., Van Bokhoven, M. A., De Nooijer, J., Van den Besselaar, H., & Van Dongen, J. J. (2020). Patient involvement in interprofessional education: A qualitative study yielding recommendations on incorporating the patient's perspective. *Health Expectations*, *23*(4), 943–957. https://doi.org/10.1111/hex.13073

State of Victoria. (2021). *Royal commission into Victoria's mental health system: Final report.* https://www.vic.gov.au/royal-commission-victorias-mental-health-system-final-report.

Thistlethwaite, J. E., Forman, D., Matthews, L. R., Rogers, G. D., Steketee, C., & Yassine, T. (2014). Competencies and frameworks in interprofessional education: A comparative analysis. *Academic Medicine*, *89*(6), 869–875. https://doi.org/10.1097/acm.0000000000000249

Thistlethwaite, J. E., & Moran, M. (2010). Learning outcomes for interprofessional education (IPE): Literature review and synthesis. *Journal of Interprofessional Care*, *24*(5), 503–513. https://doi.org/10.3109/13561820.2010.483366

van Oort, P. J., Maaskant, J. M., Smeulers, M., van Oostrum, N., Vermeulen, E., & van Goudoever, J. B. (2019). Participation of parents of hospitalized children in medical rounds: A qualitative study on contributory factors. *Journal of Pediatric Nursing*, *46*, e44–e51. https://doi.org/10.1016/j.pedn.2019.02.033

World Health Organisation (WHO). (2010). *Framework for action on interprofessional education & collaborative practice*. https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice

Xyrichis, A., Reeves, S., & Zwarenstein, M. (2018). Examining the nature of interprofessional practice: An initial framework validation and creation of the InterProfessional Activity Classification Tool (InterPACT). *Journal of Interprofessional Care*, *32*(4), 416–425. https://doi.org/10.1080/13561820.2017.1408576