

# The Paradox of Interprofessional Education: IPE as a Mechanism of Maintaining Physician Power?

Ayelet Kuper & Cynthia Whitehead

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## **Affiliations:**

Ayelet Kuper, Wilson Centre for Research in Education, Sunnybrook Health Sciences Centre & Department of Medicine, all at the University of Toronto

Cynthia Whitehead, Wilson Centre for Research in Education, Women's College Hospital & Department of Family and Community Medicine, all at the University of Toronto

Collaborative practice has become the standard of care in many types of inpatient and outpatient settings (Health Professions Network Nursing and Midwifery Office of the Department of Human Resources for Health, 2010). As physicians who work in these team settings, we strongly value collaborative practice and the benefits it provides to our patients and their families. As clinical educators, we emphasize to our medical students and residents the importance of interprofessional teamwork through our words and our actions. As education researchers, therefore, we are obliged to critically examine the broader educational processes that are supposed to be preparing our trainees for collaborative teamwork. Through this examination we have come to question both the efficacy and the purpose of a major component of current preparation for collaborative practice – interprofessional education (IPE).

We are, of course, not the first to question the benefits of IPE. Reeves et al (2008), in their Cochrane Review, concluded that there was a lack of high quality quantitative evidence regarding the efficacy of IPE. Other authors have expressed more specific criticisms. It has been suggested (Carpenter & Dickinson, 2011) that professional stereotypes may in fact be reinforced through IPE activities. There have also been concerns that poorly designed IPE activities may actually limit students' interest in collaborative practice (Rosenfield, Oandasan, & Reeves, 2011).

That the efficacy of IPE remains unproven is not, in and of itself, reason to doubt its educational value. It is difficult (if not impossible) to conduct rigorous outcomes studies in health professions education; too often educators make outcomes claims that are inappropriate for their curricular products (Whitehead, Kuper, & Webster, 2012). However, in the absence of clear evidence of efficacy, we became curious about the degree to which IPE is being hailed as a solution for a multitude of health systems woes (Frenk et al., 2010; Health Professions Network Nursing and Midwifery Office of the Department of Human Resources for Health, 2010). This led us to wonder what other purposes IPE might be serving. IPE is a social construct like any other, and the social sciences teach us that such social constructs are created and perpetuated because of

social, cultural and economic forces (Berger & Luckmann, 1966). How, then, can we understand the play of these forces in the words and world of IPE?

A useful lens with which to examine social constructs like IPE is through language. There are many different research frameworks that take language to be as socially constructed (Bakhtin, 1986; Mills, 2004); within a variety of these frameworks, the intersection between language and practice is seen as an enactment of power relations and carries implications for what is valued and privileged (Foucault, 1980; Mills, 2004; Smith, 1999). While the research literature does not yet provide a thorough analysis of the language of IPE, interprofessionalism is now clearly regarded as “a powerful global discourse” (Kitto, Reeves, Chesters, & Thistlethwaite, 2011, p. 209) – a way of seeing and describing the world through language that creates and gives power to particular practices.

### **IPE as Ideology**

The language in two recent prominent international reports, the World Health Organization’s 2010 *Framework for action on interprofessional education and collaborative practice* (Health Professions Network Nursing and Midwifery Office of the Department of Human Resources for Health, 2010) and the Global Health Commission’s *Health Professionals for a New Century* (Frenk et al., 2010), demonstrates the growing acceptance of IPE truth claims. In the World Health Organization document, for example, IPE is positioned as the vehicle for making trainees “collaborative practice ready” (Health Professions Network Nursing and Midwifery Office of the Department of Human Resources for Health, 2010, p. 12). Moreover, throughout this document, the terms ‘IPE’ and ‘collaborative practice’ are regularly placed together in the same sentence. Using the terms in this way links them without actually demonstrating, neither theoretically nor empirically, how IPE creates collaborative-practice-ready practitioners. This conflating of terms is used to enable the one (IPE) to be accepted as integrally relevant to the other (collaborative practice). Since collaborative practice is unquestioningly accepted as good, IPE therefore must be unquestionably good as well.

Indeed, as Chesters et al note, IPE is frequently “uncritically positioned as ‘common sense’ and at times comes close to being an ideology” (Chesters, Thistlethwaite, Reeves, & Kitto, 2011, p. 1). If IPE is discursively established as the ‘right’ way to enable collaborative practice, then it follows that IPE just needs to be tinkered with until it works well. However, there are increasing suggestions in the literature that more critical appraisals of IPE are necessary. For example, Carpenter and Dickinson (2011) question one of the key underlying assumptions (and design principles) of IPE: that contact with other health professions learners will reduce stereotypes and change understanding and

behaviour. Drawing on the social psychology literature they suggest that this ‘contact hypothesis’, although largely unquestioned within IPE, is seriously flawed.

Moreover, writing in this journal, Baker et al (Baker, Egan-Lee, Martimianakis, & Reeves, 2011) recently used Witz’s neo-Weberian model of professional closure to study six IPE programs at a single university and found that IPE actually reinforced conventional relational hierarchies between health professions. As they pointed out, Witz’s model is useful for examining power relations within IPE because it focuses on strategies used by dominant and subordinate groups in order to maintain or increase their power. They concluded that IPE was seen by some physicians as a threat to their power as the dominant profession, whereas other health professionals tried to use IPE to increase the power of their own professions. They also noted that physicians were largely unengaged in IPE activities, a phenomenon which has frequently been reported elsewhere in the IPE literature. Unfortunately, most of the rest of the IPE literature pays very little overt attention to power, focussing instead on atheoretical descriptions of single IPE initiatives (Reeves, 2011) Indeed, the common goal of inspiring behaviour change in individual learners precludes an explicit focus on systemic and institutional hierarchies and power structures.

### **Physicians’ Self-Centred Focus**

While the IPE literature has focussed on interactions between multiple professions, physicians appear instead to have focussed inward. They have been struggling in the medical education literature with their own professional identities, with the professionalism movement portraying the ideal physician as the prototype of the perfect professional (Wear & Kuczewski, 2004). Physicians have also been focussed on definitions of their own professional competence, as seen in the large literature on outcomes-based education and competency frameworks (Carraccio, Wolfsthal, Englander, Ferentz, & Martin, 2002; Ho, Yu, Hirsh, Huang, & Yang, 2011). Both of these movements have centred physician attention on themselves, and some have suggested that these movements are part of medicine’s attempted reconstruction of itself as the dominant profession (Hodges et al., 2011; Martimianakis, Maniate, & Hodges, 2009; Whitehead, Austin, & Hodges, 2011).

### **Analysis**

There is not yet enough research evidence to provide a complete analysis, but the current research literature and our lived experiences as collaborative practitioners together provide enough clues for us to propose several intertwined intended and unintended effects of the current discourse of IPE.

The IPE discourse may indeed be a form of ‘boundary-work’, Gieryn’s concept which foregrounds the discursive mechanisms by which different social groups struggle to define themselves as the legitimate holders of knowledge and power and to exclude others from having that same legitimacy (Gieryn, 1983). Although Gieryn initially developed this concept with respect to rhetorical struggles for distinguishing “science” and “non-science”, boundary-work has been extended to encompass struggles between different professional groups, particularly in the health field (Mizrachi & Shuval, 2005). Within this model, the IPE discourse could be seen as boundary-work: as a way for less powerful health professions to attempt the shift in power relations required by the collaborative practice discourse with which it is conflated, to expand the range of professions that can legitimately hold significant power in the health professions hierarchy.

Indeed, the IPE discourse seems to be acting like a boundary object between the professions, having a different meaning for each group that it connects (Star & Griesemer, 1989). Paradoxically, despite its stated purpose of creating greater collaborative practice, it allows physicians to maintain the status quo in the face of increasing pressure to share their professional power. Physicians can officially, but ambivalently, support a supposed mechanism to promote collaborative practice (i.e. IPE), while simultaneously devoting a considerable amount of the rhetorical resources of their profession to shoring up its own power through its internal professionalism discourse. Furthermore, apparent physician support for IPE also helps perpetuate the existence of a curricular model that, as currently conceived and designed, remains focussed upon changing attitudes and behaviours in individual learners. Since the discursive logic of IPE positions it as ‘naturally’ and ‘inevitably’ leading to collaborative practice, the IPE discourse sets up an expectation that the structural changes required for effective collaborative practice will someday occur when we finally find the way to ‘do IPE right’. While the lack of focus on social processes in the IPE literature has previously been noted (Reeves, 2011), this possible ironic effect on maintaining physician privilege has not yet been highlighted.

As researchers we find this fascinating. But where does that leave us as physicians and educators who are deeply committed to collaborative practice and who have chosen to work in settings in which such collaboration is firmly embedded? IPE as currently constructed is unlikely to bring about the sorts of systemic change that are promised by the discursive strategy of conflating it with collaborative practice. We suggest that in its current form, it is having quite the contrary effect: that of engaging health practitioners in the design of complicated curricular sessions while leaving embedded hierarchies untouched, which seems to be an effective strategy for maintaining physician privilege. We suggest that health care practitioners, educators and researchers who care about effective collaboration should make use of critical theoretical frameworks such as those

drawn upon in this editorial both to examine the current premises and practices of IPE and to consider what changes are needed in order to advance the important goal of effective collaborative practice within our health care systems.

### **Declaration of interest:**

The authors report no declarations of interest.

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