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Developing and Maintaining Interprofessional Teams in Rural and Remote Settings

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Introduction

The authors of this chapter all live in rural Australia and work in what are known as University Departments of Rural Health (UDRHs), which are part of the multimillion dollar, Australian Government funded Rural Health Multidisciplinary Training (RHMT) Programme (Australian Government Department of Health, 2018a). The purpose of the RHMT programme is to '*improve the recruitment and retention of medical, nursing, dental and allied health professionals in rural and remote*

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Australia', thus, in the longer term, improving the health status of the population living in those locations. As such, the objectives of the programme are to provide high quality rural health education experiences for health professional students, as well as to support existing rural and remote health professionals, engaging with the local community, including the local Indigenous population, and performing relevant research.

There are 16 UDRHs dotted across regional, rural and remote Australia and each is linked to one or more Australian universities that offer various health professional degrees. Supported by locally based interprofessional teams of educators and researchers, students undertake practice-based education with a real world, rural focus. As part of this approach and under their contractual obligations to the Australian Government Department of Health, all UDRHs are required provide opportunities for students to have interprofessional education experiences. Consequently, with co-located students and academic staff members from multiple health care disciplines, UDRHs have developed substantial expertise in interprofessional education and collaborative practice. This strategy promises to contribute to graduates' appreciation of sustaining existing models, as well as developing new models of interprofessional team-based care.

This chapter describes the features of rural and remote health service delivery and the numerous intersections with interprofessional education and collaborative team-based care. Rural and remote Australia encompasses multiple differing contexts including geographical, political, economic, cultural and spiritual variations. While the authors' personal experiences are grounded in the physical places and social spaces where we live, it is anticipated that there will be similarities with health care services and jurisdictions in other parts of the world, as well as contrasts that we hope will be informative.

Australia is a big country (some 7672,024 square kilometres) with a comparatively small population of 25 million people (Australian Bureau of Statistics, 2016a). Australia's total land area is larger than mainland Europe but with much lower population density. There are fewer than three persons per square kilometre in Australia compared to France with 117 people per square kilometre, Japan with 337 per square kilometre and even NZ with 15 people per square kilometre (http://alldownunder.

com/australian-facts/compare-size.htm). However, Australia's population is not spread across the entire land area. Figure 12.1 shows the Australian land mass shaded by degrees of remoteness, according to the Australian Standard Geographical Classification—Remoteness Area (ASGC-RA) (Australian Government Department of Health, 2018b). The vast, arid interior is sparsely populated, with most population concentrated along the Eastern and Southeast coast. The majority of Australians live less than 50 kilometres from coastal areas, which is where most large towns and major cities are located. There are, however, more than 1500 communities across Australia that are classified as rural or remote and

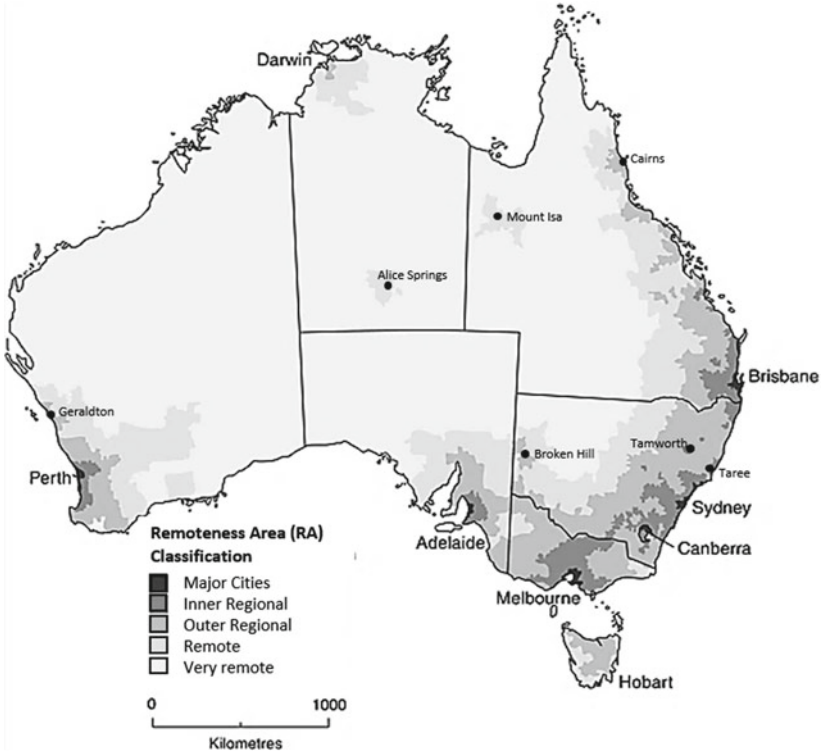

Fig. 12.1 Australian Standard Geographical Classification—Remoteness Area (ASGC-RA) (*Source* Australian Bureau of Statistics [ABS], 2016b)

over seven million people (almost one third of the population) live in those communities.

What Makes Rural and Remote Different?

While there are various ways of defining rural and remote and differentiating it from urban or metropolitan, there is a school of thought that it is not so much a matter of where people live, as the way they live that defines the difference. Geographical location and distance from the nearest large population centre are not the only defining characteristics. Rather, based on our observations, when people choose to live in smaller rural or remote communities they develop resilience and a sense independence, balanced by awareness of their dependence on each other, especially in the face of hardship and adversity. Although people who live outside the city may be relatively less affluent and have poorer access to services, it can also be argued that they tend to be more resilient and innovative in the way they approach such challenges than those who live in large cities. Rural communities are often described as rich in social capital (Alston, 2002), referring to the norms, values, beliefs and networks that bind communities together, as opposed to material symbols of wealth.

In an article titled 'Defining remote health', John Wakerman (2004) drew distinctions between 'rural', on the one hand, and 'remote' on the other. He wrote that in Australia 'remote health' is characterised by factors such as '*social isolation of practitioners*'; '*a strong multidisciplinary approach*'; '*overlapping and changing roles of team members*'; and, '*a relatively high degree of GP* [general practitioner] *substitution*' (p. 210). Consequently, he argued, in order to meet the needs of relatively less healthy, isolated and dispersed populations, a greater proportion of who are Indigenous, practitioners need particular capabilities, including being able to work across cultural, as well as professional boundaries.

The health needs and health disparities of Aboriginal and Torres Strait Islander people have been well documented. While they are intrinsically linked to intergenerational oppression since Australia was colonised, they also bear similarities to the needs of other First Nations

populations around the world who have experienced dispossession of land, diminishment of cultural identity and loss of sovereign autonomy (Saggers, Walter, & Gray, 2011). Historical outcomes of colonisation in Australia continue to play out in the health and wellbeing of Aboriginal and Torres Strait Islander peoples and 'closing the gap' on the health disparity between Indigenous and non-Indigenous Australians is an ongoing national priority (Australian Government Department of the Prime Minister and Cabinet, 2019).

The need for health care and health professional education teams in rural and remote settings to include Aboriginal and Torres Strait Islander team members, as well as for all Australian health care workers to be able to practice in a culturally responsive framework, is well recognised (Indigenous Allied Health Australia [IAHA], 2015). The challenges of introducing interprofessional competencies in training programmes have also been well reported; however, much less has been written about the challenges of implementing culturally responsive interprofessional teaching and learning in health professional training programmes. Most health professional education and training focusses on attainment of technical skills, often at the expense of the inclusion of developing collaborative skills that are applicable to person, family and community-centred care, communication and shared decision-making, and cultural respect (Frenk et al., 2010; WHO, 2010).

In the next section, Simon Munro, one of this chapter's co-authors, himself a health professional educator and an Aboriginal man, explores the challenges health professionals may experience in developing collegial and culturally responsive relationships with Aboriginal colleagues. Informed by Aboriginal sources of knowledge, and particularly relevant to health care teams in rural and remote settings, these concepts also have broader relevance to the functioning of health care teams in general.

What We Can Learn from Indigenous Culture

Working with Aboriginal people as colleagues in a collaborative and understanding way seems to present as a mountain too high for many. It need not be so if we work collaboratively. For a non-Aboriginal health

professional, engaging with the many unknowns associated with Aboriginal knowledge and ways of knowing and learning can be a daunting prospect. That is why there are Aboriginal identified positions in health care and health education teams. The Indigenous team members in those positions are often appointed for a dual purpose; primarily, to meet the standard requirements and duties of their position but also, importantly, to be available for everything else to do with Aboriginal culture, as required.

On the second point, speaking from personal experience, Aboriginal workers may be guarded about the role they play in the work environment when it comes to acting as a representative of their culture. Sometimes, for Aboriginal workers, local politics and cultural beliefs may preclude them from getting too involved in capacities outside their general professional roles and responsibilities. They must know and respect cultural, as well as professional boundaries and thus, practice in culturally safe, as well as physically, mentally and emotionally safe ways.

Cultural links in a collaborative sense are about being prepared to engage with knowledge systems to achieve understanding and then maintaining ongoing and meaningful systems of 'cultural praxis'. Cultural Praxis stems from general notions of praxis (distinct practices or customs) but with themes that relate specifically to Indigenous ways of knowing and learning. At the heart of cultural praxis is equity and parity of participation in decision making. Thus, 'cultural praxis' reflects the notions of Fraser (2008) that working towards greater equity involves holding together three interconnected social justice dimensions. Those dimensions are redistribution, recognition and representation, with close attention paid to the personal influences or embodied subjectivities (McNay, 2008) experienced by Aboriginal and Torres Strait Islander people, as well as the politics of emotion (Ahmed, 2004).

There is a vast interconnectedness of influences and established hegemonic biases affecting Aboriginal and Torres Strait Islander workers from the perspective of their non-Aboriginal colleagues. In the context of cultural praxis, these need to be identified, acknowledged, talked about, dismantled, reimagined, actioned and revisited. Martin Nakata (in McGloin, 2009) proposed locating oneself in both Indigenous (Aboriginal) and Western knowledge systems. In simple terms, it is about

knowing where you are and where you stand; about a big 'knowledge map', the distinct features, the quicksand that might swallow you, the difficult areas that slow you down, the elements that obscure what is beyond, the blurred boundaries and the paths to negotiate. These concepts will be familiar to those who have attempted to find their way as part of an interprofessional health care team, especially in a rural and remote work environment with the added complexity of a cultural divide between team members, as well as with those needing care. When collaborating with Aboriginal co-workers and Aboriginal communities more broadly it is worthwhile to reflect on the numerous long-standing historical inequalities (Burke, Crozier, & Misiaszek, 2017) experienced directly and indirectly by Aboriginal and Torres Strait Islander people in an array of social, as well as professional domains.

It is important, therefore, to explore culturally sensitive strategies to support cross-cultural workplace collaboration. Indigenous Allied Health Australia (IAHA), an organisation that represents twenty-two different health professions, developed a culturally responsive framework based on six core capabilities embedded in a 'knowing, being, doing' context. The capabilities are: Respect for the centrality of cultures; Self-awareness; Proactivity; Inclusive engagement; Leadership; and, Responsibility and accountability (IAHA, 2015). These capabilities provide a structure and action plan for rural health care teams to work in a deeply collaborative and respectful way with Aboriginal health professionals for the benefit of all Australians. The IAHA framework has wider applicability, both within health care teams and for their engagement with communities more generally. Creating an environment that values diversity and welcomes Aboriginal and Torres Strait Islander health professionals has potential to increase the resilience of health care teams, with transformation of service delivery to meet the needs of individuals, families and communities.

Rural Practice Can Help Build Resilient Teams

There is a common perception that, because urban communities are more affluent and have greater access to resources and services, they are

better than rural communities and, therefore, set the standard in health care. That perception can be challenged in terms of the inherent capacity of rural and remote people and communities to innovate in ways of delivering care, largely driven by necessity. Faced with a greater burden of disease and more limited health care resources, including workforce shortages, many rural practitioners and health care organisations explore creative solutions to ensure that their communities receive the care they need (Panagariya, 2014). This is in spite of, if not due to the unpredictable nature of rural life, including flood, fire, drought and, in the future, the ravages of climate change.

One of the greatest innovations in the delivery of health care to rural and remote Australians was the Royal Flying Doctor Service (RFDS). Pioneered by Reverend John Flynn in 1928 and first flying out of Cloncurry in Queensland, the service now covers virtually the entire continent. Interestingly, the RFDS was also the precursor to other fly-in fly-out (FIFO) models of care. The RFDS is highly regarded and provides an excellent service but FIFO has been referred to as a '*necessary evil*' (Hanley, 2012) and the question asked as to whether it is '*the panacea or the problem*' (Wakerman, Curry, & McEldowney, 2012). Flying specialised services into more remote population centres has obvious benefits in terms of access; however, the principal problem with FIFO, as well as with drive-in drive-out (DIDO) services, is that communities are reliant on a non-resident health workforce, so immediacy and continuity of care are still lacking. The further problem is that, although the FIFO and DIDO teams of health professionals may be effective, it is questionable whether they contribute to team-building and interprofessional leadership in the locations they visit. The valuable contributions of the FIFO and DIDO teams need to be backed-up with models of care that also support interprofessional team building and leadership development on the ground in relatively isolated, less well-served communities.

Rural practice is characterised by individuals with a common goal of ensuring sustainable local health service delivery, the withdrawal or absence of which can threaten the well-being of the entire community. In urban communities, if the hospital is closed or downgraded, or if the local general medical practice closes down, perhaps the worst outcome would be a longer journey by public transport to another hospital or

general practice. In contrast, in rural and remote areas, the next nearest hospital may be hundreds of kilometres away, with no public transport available. Such challenges and potential threats build strong communities of resolute individuals, including committed health professionals who value each other's roles. Typically, rural health professionals practice in teams in which working and learning, as well as socialising together, often across professional boundaries, build a stronger sense of collegiality. When health professionals may be relatively isolated from their professional peers, the tendency is to rely on support or advice from those from another health profession. In the urban context, where there are more health professionals, each occupational group has great capacity and opportunity to form intra-professional rather than interprofessional relationships and teams.

Let us consider the style of leadership that might be appropriate to a situation where the workforce is transient and less permanent than in urban settings. While the team may share the common goal of providing health care to the community, as is the case in other contexts, individuals within the team may not share common professional attitudes, values and beliefs about how that goal might be best achieved. The leadership challenge, therefore, is how to bring disparate health professionals together so that common goals are represented in the way that the team works together. In real terms, consider how a rural or remote health service manager, who has their own particular professional affiliation and identity, might influence the performance of a team of rural health professionals, many of who are from a discipline other than their own.

In the late 1960s and early 1970s, Paul Hersey and Ken Blanchard developed a theory referred to as *situational leadership* (Hersey & Blanchard, 1969), the fundamental principle of which is that no single leadership style can be successfully applied in all circumstances. Leaders and managers need to be responsive to situations and being effective requires flexibility and a willingness to change style as needed. Hersey and Blanchard categorised leadership styles or behaviours as:

- *Telling*, where the leader or manager instructs the team with a unidirectional flow of information, the aim being to complete the task at hand safely and in a timely manner;

- *Selling*, where the idea is to open a two way communication aimed at convincing the team of the need to achieve the goal or complete the task;
- *Participation*, where decision-making is shared, with a more democratic approach and greater emphasis on relationship-building; and lastly,
- *Delegating*, where the manager or leader allocates tasks or duties, overseeing or monitoring activities, making sure the targeted outcomes are achieved.

According to Hersey and Blanchard, one behaviour is no better than the others; it is entirely situationally dependent. However, in a diverse interprofessional team in a small rural or remote health service, where team members may have considerable clinical experience, as well as competence and strong commitment, the more collegial and consultative leadership styles (*Participation* and *Delegation*) are perhaps likely to be more effective than the more authoritarian approaches (*Telling* or *Selling*). The particular situation is one where the capabilities of individual team members must be acknowledged and guided accordingly. The manager or leader is like the conductor of an orchestra, trusting in the ability of each member to deliver when called upon, even if their services are not always required. Thus, the situationally dependent challenge is to ensure that when those more transient practitioners are present, such as FIFO or DIDO service providers, they are integrated into the team effectively and are thus 'playing the same tune' as more permanent, locally-based team members.

Sustaining a Culture of Rural Collaborative Practice

The culture of an organisation, such as a health service, speaks to the way that things are done within that organisation. The development of a culture that values diversity and change is an essential element of leadership

of interprofessional rural health care teams. Champions of interprofessional practice may come and go within a rural health organisation; however, individuals do not sustain teams that genuinely embody a culture of interprofessionalism. The culture needs to be embedded and enshrined in the vision and mission statement within the strategic plan of the organisation, so that even if the champion or champions move on, the culture of interprofessional collaboration is supported and sustained within a reconstituted team. Careful consideration should be given to how the vision and mission of the organisation are framed in order to represent the key elements of interprofessional collaborative practice. Although it is possible to tease-out generic aspects, it is also important to appreciate that each organisation is different and these differences also need to be acknowledged and represented among the team if the vision is to be sustained.

The World Health Organization (WHO) published a *Framework for Action on Interprofessional Education and Collaborative Practice* in 2010. In that document, collaborative practice is defined as '*when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality care across settings*' (WHO, 2010, p. 7). Part of the argument in the framework is that collaborative practice is most effective where care addresses and is organised around the target population's needs. Effective leadership of interprofessional rural health teams needs to value the uniqueness of the community it serves and respond according to defined community need.

It is sometimes said that, 'if you have seen *one* rural community, you have seen *one* rural community', meaning that they are all different in various ways. The generic aim is to create a 'collaborative practice-ready' health care team, while at the same time recognising that all rural communities are not the same and so the population needs may differ substantially from one community to another. For example, a coastal rural community with a high retiree population will have greatly different health care needs compared with an inland mining community. In a similar sense, no two teams are the same, whether because of the different disciplines represented within the team or because of the different individuals involved at different times. While diversity and change may be

assured elements of rural practice, it is nevertheless possible to distil certain core components that contribute to the development of a sustainable culture of collaborative practice. These are summarised in Table 12.1, as informed by and formulated from multiple sources. Though perhaps not uniquely rural, they are certainly fundamental considerations in the rural

Table 12.1 Key elements, features and characteristics that support development and maintenance of interprofessional collaborative rural practice (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2009; Lindeke & Block, 1998; Morris & Matthews, 2014; Norsen, Opladen, & Quinn, 1995; San Martín-Rodríguez, Beaulieu, D'Amour, & Ferrada-Videla, 2009; WHO, 2010)

Key elements	Features and characteristics
Defined community needs	• Familiarity with patient, family and carer populations and locally-relevant health care needs • Deep appreciation of local Indigenous health • Evidence-based indicators and predictors of need • Evaluation of health care outcomes
Staff education and training	• Sound foundational profession-specific knowledge and skills • Continuing development of interprofessional and cross-cultural competencies • Awareness and appreciation of practice roles and boundaries
Shared goals, attitudes, values and beliefs	• Valuing diversity and potential for change • Respect and trust between team members • Interpersonal communication and relationships • Welcoming environment for new, part-time and casual staff
Responsive situational leadership	• Participatory governance, with shared decision-making • Delineation of authority and accountability • Champions of, and advocacy for interprofessional collaborative practice • Awareness of organisational policies and politics
Targeted resourcing and built environment	• Adequate available resources and information technology • Alignment of resources with organisational and human needs • Physical representation of local Indigenous art and culture • Efficient use and equitable allocation of resources and funding • Shared, negotiated space and time

and remote context and are a useful guide to leaders of rural interprofessional health care teams.

Case Study—What to Do About Macaloo?

The following case study of the fictional town of Macaloo reflects our shared experiences of health service delivery in remote communities. While Macaloo does not really exist, the challenges and the joys of working in rural and remote locations such as Macaloo are very real. We invite you to make use of the comments at the end of the case study to help you contemplate how we as educators, managers, clinicians, planners and health policy makers can support the sustainability and resilience of rural health services and the communities they serve.

Macaloo is a small remote town 800 kilometres inland from the nearest metropolitan city on the Australian East coast. It has a population of 1300 people, approximately 60% of whom are of Aboriginal heritage and are a collective of several different Aboriginal nations in that area. The town was once prosperous in wool, cattle and cotton production. The effects of drought and advent of mechanised mega-farming has resulted in business closures, unemployment and families relocating to find work. The main land use is now large-scale cattle farming and open-cut coal mining. The mines have a mostly FIFO workforce accommodated on the mine site, so the town sees little of the financial benefit from the Macaloo mine.

The town still has one medical centre, with a sole doctor who trained in India and moved to Australia eight years ago. There is also an Aboriginal practice nurse and an Aboriginal Health Worker, both of whom grew up locally, a part-time physiotherapist who is married to a local farmer, and an Egyptian-born pharmacist who runs the chemist shop and works closely with the local doctor.

The Macaloo health services are supplemented by a DIDO chronic disease management team, which visits once per month to support people living with a range of metabolic and cardio-vascular conditions. This team includes a dietitian, exercise physiologist, diabetic educator and nurse coordinator. Because of the way their funding works, they are not

able to see people with anything other than chronic diseases. There is also a FIFO paediatric team, which provides occupational therapy, speech pathology, psychology and audiology services for one week every three months. Children who are referred to this service must first been seen by the regional consultant paediatrician who flies in once every six months.

The medical centre is the hub for all health service delivery in the district and operates five and half days each week. Otherwise, afterhours, there is a telehealth service but, unfortunately, the technology is unreliable. There are no hospital beds in the town and no residential aged care or mental health services. For all in-patient care, local people must travel to the nearest rural hospital, which has 40 acute care and 24 aged care beds. It is over 200 kilometres away by road. For more complex inpatient care, patients must be evacuated to one of several metropolitan hospitals, the nearest of which is 850 kilometres away. The Royal Flying Doctors service operates an air transport service for urgent transfers.

For most of the Aboriginal population in the Macaloo district, barriers restricting timely engagement with health services in the larger centres are financial, suitable transport, concerns about being away from home and family, accommodation and the cultural insensitivity and judgemental attitudes of unfamiliar health service providers and other staff. For those health professionals who do work in the region, living in a rural or remote community and providing wrap around primary health services also comes with a range of challenges and barriers, so few stay for very long and recruitment is always ongoing. Their challenges include differing funding streams that make service integration difficult, a transient health workforce, with the exception of a few locals who experience 'change fatigue' due to the frequent personnel changes on the visiting teams, and difficulty accessing continuing professional development.

Therefore, it is important to remember that:

- Teams must actively intersect and engage to provide support to one another.
- The local population can be engaged in and become part of the team-based care in remote communities to minimise fragmentation of service delivery.

- Personnel changes provide challenges for collaboration. Visiting and resident teams must actively connect in order to provide high quality care in a high-need community like Macaloo.

Summary and Conclusion

Living and working in a rural and remote location presents health care challenges that have potential to strengthen the resilience of both individuals and teams. The construct of resilience, or the ability to successfully adapt to life's demands has moved beyond being considered a fixed personality trait to be re-conceptualised as a developmental pathway that can be enhanced via experience and over time (Luthar, Cicchetti, & Becker, 2000). Resilience is an important capability for the successful transition into practice for new graduates and, therefore, for sustaining the rural and remote health professional workforce. Indeed, this is why strategies such as the Australian Government's funding of the RHMT programme are important for future workforce development. However challenging, rural and remote health care provides a broad variety of professional development opportunities, including interprofessional collaborative practice and the development of cross-cultural competencies, which helps create highly capable and resilient practitioners.

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