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Leadership Challenges When Creating and Sustaining Cultural Change for Interprofessional Collaboration

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Introduction

Leadership for What? Leadership by Whom?

Leadership in health care—'the action of leading a group of people or an organisation; different styles of leadership' (Oxford English Dictionary)—has been much debated, investigated and written about in thousands of publications. Apart from the most well-known texts e.g. Barr and Dowding (2019) and Lee and Cosgrove (2018) and the journal *Leadership in Health Services* (Emerald Publishing), there are literally hundreds of books which explore leadership in a broad range of industries. In this essay I shall not attempt to cover the myriad topics such publications examine but will focus particular attention on aspects

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of interest seen in successful attempts to create and sustain cultural change across the continuum of interprofessional education.

For the purposes of this essay I shall use the acronym IPE (interprofessional education) i.e. 'Occasions when members or students of two or more professions learn with, from and about each other, to improve collaboration and the quality of care and services' (CAIPE, 2018) to describe interprofessional education (IPE) as a continuum of collaboration that spans interprofessional learning (IPL), which is continuously and continually interwoven into interprofessional practice (IPP), and interprofessional care (IPC), beginning in the years prior to licensure/registration then further developed in post-licensure continuing professional development (CPD) and life-long learning (LLL).[1] The role of leaders in post-secondary education, and in systems of health and social care, is to create and sustain the cultural change needed to effect system change across the continuum of IPE. Leaders must be both lantern and lighthouse.

Leadership Challenges—Many Identities, Many Cultures

A major challenge confronting any leader of IPE is to understand and assess the multiplicity of identities and cultures[2] (Harper & Leicht, 2006) that are interwoven in the workforce of post-secondary education and health and social care. Each person in the workforce comes from a culture that defines her/his individual identity. Each comes gendered. Each comes as part of a community that is unrelated to her/his work site. At this time, each identifies as a member of a siloed profession, but also carries an identity as a member of a siloed professional community. Each comes with an identity as a care provider (in the sense of providing a professional service). Each carries an identity as a sometime(s) patient/client/customer/service user. Every day, the interplay of these

[1] In this essay I use the word 'professional' in its broadest sense i.e. 'a person competent or skilled in a particular activity' (Oxford English Dictionary) and not exclusively of regulated professions, in order to recognise the plethora of health and social care occupations that play important roles across the continuum of IPE.

[2] Culture encompasses shared forms of 'living and thinking' comprising 'symbols and language … knowledge … values … norms … and techniques.'

various identities contributes to the larger complex culture of her/his workplace which is, itself, most frequently siloed, and deeply rooted in personal values.

Values-based leadership (Barrett, 2006) is a construct which proposes that leaders should draw on their own and followers' values for direction and motivation; it asserts that people are mostly motivated by values and live according to these beliefs. A leader of IPE must constantly assess and evaluate how the complex of identities can be promoted to work together and understand how to manage the values of individual cultures when they come into conflict. Thus, for example, good leaders of IPE foster environments in which learners and practitioners actively engage themselves and others, including the client/patient/family, in positively and constructively addressing disagreements as they arise. But good leaders of IPE need to ensure that in a culture of collaboration there is value in learning the potential positive nature of disagreement and to ensure that all engaged in collaborative practice and care feel that in spite of disagreement, their viewpoints have been heard, and their values noted, no matter what the outcome. Culture change comes about when leaders of IPE understand these challenges, and values-based leadership assumes that an organisation based around shared values is likely to be more flexible and productive.

Creating Cultural Change for IPE—Some Challenges

Creating cultural change is defined as 'causing something to happen as a result of one's actions' (Oxford English Dictionary). In the Framework for Action on Interprofessional Education and Collaborative Practice, (WHO, 2010) three major categories of activity were identified as shaping the culture of interprofessional collaboration. These categories, which also illustrate the challenges faced by all leaders of IPE, were articulated as: (1) interprofessional education, (2) collaborative practice and (3) the systems of health and education. Since publication of the Framework, extensive research has in many senses supported these artificial categories, strengthened the concept of IPE as a continuum and heightened the need to understand, develop and integrate the three categories across

the IPE continuum that might then motivate systemic cultural change. Leaders of IPE wishing to understand, develop and integrate those categories are attempting to provide cogent and coherent answers to the following questions:

First: How can universities, colleges, institutes, health and social care organisations and governments together build an interprofessional collaborative, civic community by developing a values-based organisation? A community that takes civic and social responsibility for health and social care in the broadest sense envisioned by the World Health Organization: '… there is a health baseline below which no individuals in any country should find themselves: all people in all countries should have a level of health that will permit them to work productively and to participate actively in the social life of the community in which they live' (WHO, 1981).

Second: How can universities, colleges, institutes, health and social care organisations and governments take professional education out of professional practice siloes and place it in an interprofessional matrix to ensure that graduates truly understand the effects of a broad interprofessional spectrum of health and social care practices, and how they can integrate their IPL into such practices?

Third: How can universities, colleges, institutes, health and social care organisations and governments integrate IPE policy matters—in both education and health, with evidence from scientific enquiry so that such evidence informs interprofessional collaborative practice and care in a coherent, congruent and timely fashion?

Fourth: How can universities, colleges, institutes, health and social care organisations and governments integrate interprofessional education with the health goals espoused in the large number of consultation documents produced by various levels of government in literally every country in the world, for example, the WHO Global Strategy on Human Resources for Health: Workforce 2030 (WHO, 2017a).

Creating cultural change to foster and further the continuum of IPE is the major challenge confronted by leaders of IPE, who are constantly reminded of the apt words of Machiavelli:

> It must be remembered that there is nothing more difficult to plan, more doubtful of success, or more dangerous to manage than the creation of a new system. For the initiator has the enmity of all who would profit by the preservation of the old institution and merely lukewarm defenders in those who would gain by the new one. (*The Prince*, 1513)

Recognising the aptness of this observation, how then do interprofessional education, collaborative practice and the systems of health and education, which comprise the continuum of IPE, exteriorise themselves as real life challenges in universities, colleges, institutes, and health and social care organisations and governments?

Real Life Challenges to Sustain the Continuum of IPE

Funding for the continuum of IPE is always raised as an impediment to integrating educator and practice 'mechanisms'. For example, within post-secondary institutions, funding is generally allocated to silos i.e. by faculty or department, which essentially excludes the possibility of interprofessional co-led programmes. Within health care systems, budgetary allocations tend to be driven by the 'issue of the day' e.g. access, safety, affordability. The health care system as a learning environment receives far less attention than clinical areas in terms of budget, allocation of human resources, space etc. It is clear that developing the continuum of IPE, when faced with these challenges, takes leaders who have a firm understanding of the data on efficacy of interprofessional collaborative practice, and diplomatic skills that elicit recognition and support from senior levels of administration (Gilbert, 2005) Anecdotal evidence from the practice sector shows that many managers and administrators are faced with lack of support (or lukewarm support) when attempting to introduce IPE as a new approach to learning and practice within their organisations. Sadly, despite their critical role in practice (clinical) education, community agencies (e.g. hospitals, health centres etc.) are only now being conceptualised as learning environments, but even when they are, they are almost inevitably inadequately resourced to provide exemplary teaching and learning opportunities for interprofessional person centred collaborative practice. Happily, anecdotal evidence also suggests

that although members of organisations may not have money, they do have imagination, and each other, which together are slowly moving the IPE agenda forward, as will be shown later.

Traditionally, universities, colleges, institutes, health and social care organisations and governments have not imagined dedicated built environments in which the focus is on interprofessional activities It is therefore encouraging that in the past 10 years or so, the necessary interrelatedness of health and social care programmes has been developed in built environments in which the continuum of IPE is being fostered, for example at the University of Colorado in Denver, Dalhousie University in Halifax, George Brown College in Toronto and Ball State University in Indiana. Conceived by visionary leaders, these knowledge locations, along with moves to the flipped classroom, i.e. delivering instructional content online, outside the classroom, then using class time for discussion of that material, have been instrumental in developing new approaches to IPE.

IPE has frequently been misunderstood as an add-on or "non-essential" programme, rather than a new way of learning and a new way of practising. As a result of this misunderstanding it has frequently been accorded a low priority across the spectrum of learning through practice. A leader's challenge is how to correct the misunderstanding. Regulation, accreditation, legislation, the 20-year movement devoted to safety and quality care, a clearer understanding of the social determinants of health and its corollary, population health, have helped considerably in moving the thinking through requirements on curricula to address these major issues, that demonstrate the centrality of IPE, the goal of which is learning together to work together.

Sustaining the Culture of Interprofessional Collaborative Practice

By definition 'Causing to continue for an extended period or without interruption' (Oxford English Dictionary) has been and continues to be a major challenge to leaders of IPE. For example, the lack of a permanent line item in budgets for IPE related activities; changes in personnel—especially of champions for IPE; changes in the strategic plans

of organisations—each confound the sustainability of system changes for IPE. The concept of IPE as a continuum can only be sustained if a leader of IPE is focused on the complex issues that cross the three broad categories—interprofessional education, collaborative practice and the systems of health and education. Those complex issues include, for example, how to share evidence based models of learning, practice and care amongst and between post-secondary institutions and health and social care agencies; how to articulate structured protocols that clearly set out the rights and responsibilities of all involved in the IPE continuum; how to negotiate agreement on a fair and equitable sharing of operating resources; how to develop clear personnel policies related to IPE across the continuum; and—perhaps most importantly—how to ensure that management practices are supported in budget and planning from the highest levels in the organisations, and championed from the front line of teachers/preceptors/mentors and practitioners.

It is now clearly recognised that because of professional silos and overlapping scopes of practice (CAHS, 2014) there is much duplication of learning and practice across health and social care programmes. Identifying this duplication and building strategies around how to minimise it is imperative. Many adverse events that occur in teams are occasioned by confusion during information transfer (communication) that occurs because of the different languages used by each profession. How to address the major problems in communication should be a top priority for every leader of IPE.

Because professional practices are tied up by scopes of practice, dictated by accreditation and sanctified by legislation, leaders of IPE are constantly confronted with the recurring theme: 'That body part (or that disease) belongs to us. Not to them'. Application of Sir William Osler's aphorism to this problem is apt 'It is much more important to know what sort of a patient has a disease, than what sort of a disease a patient has' (Bliss, 1999). A leader's imperative is to ensure that there is less time protecting turf, and more time given to how to cede pieces of scopes of practice, in order to move out of the legendary silos to better address the needs of the patient/client/customer/service user, and in general, the health and social care needs of the population. To this end, leaders of

IPE have to ensure that the large number of health and social care occupations that are not regulated (e.g. home care assistants) are viewed and accepted as an integral part of interprofessional collaborative practice and care.

As can be seen, although relatively straightforward to enumerate, the challenges facing IPE leaders are complex and legion—simplify access to other professionals; promote and enhance communication among professionals; develop strategies that recognise evidence-based practice and encourage methods that allow each profession to work interprofessionally.

Ultimately, there are personal, interpersonal and intersectoral challenges that leaders of IPE must address. Thus, all professionals, often for good reasons, dislike uncertainty and are fearful of change whether in the classroom or clinic. As professions have developed, they have built both intra- and inter-professional rivalries and misunderstanding, often because of perceived power, income and status differentials, and at the same time with little attention paid to the gendered nature of the workforce (Newman, 2014; WHO, 2018) There are, of course, differing conceptual approaches and models of 'health and care' depending on professional training, and at the same time almost all health and social care professions lack education and training about interprofessional collaborative teamwork. Finally, there are different and competing organisational priorities both within and between academic and training programmes and health care provider organisations, which can lead to a form of undesirable tribal behaviour (Burton, 2011).

It is these matters, and other related concerns not covered in this essay, which lead to a consideration of how to sustain cultural change.

Leading Sustained Cultural Change

> Our doubts are traitors and cause us to miss the good we oft might win, by fearing to attempt. (*Measure for Measure*)

Fisher and Ury (1981/2011) in their classic text *Getting to Yes*, focused on the psychology of negotiation in their method, 'principled negotiation', i.e. finding acceptable solutions by determining which needs are fixed and which are flexible for negotiators. Their method had, and continues to have, a huge impact on the development of leadership skills. The principles they set out are both simple and yet profound: listen to and focus on the problem, rather than on personalities. Explore underlying interests rather than specific positions. Consider options that may open up scope for mutual benefit. These principles can and should be applied to all situations encountered in developing interprofessional collaborative practice; they are fundamental to ensuring that cultural change is sustained. How might the principles be enacted? As may be seen from the multiplicity of monographs on leadership, although different people define leadership differently, one characteristic of leadership which remains undisputed is the rare aura of mystery and charisma which has surrounded successful leaders from almost every sphere of life (Grabo, Spisak, & van Vogt, 2017) In many ways it is this aura that allows sustainability to flourish across the continuum of IPE.

In health and social care leaders of teams have to continually and continuously focus attention on the fact that their lives are about patients and the health of the population, not about financial returns to shareholders, and that the health and social care workforce is approximately 80% female (Newman, 2014; WHO, 2018). Leadership for IPE, in the service environment, requires a grasp of an organisation's commitment to a culture of person-centred care, how collaborative practice impacts patient and worker safety, and the need for an organisation to be a focus for both service and learning. The cross-cutting themes that touch on all of these, and about which a leader must have knowledge, include operational and performance management, decision making supports, resource allocation, and the infrastructure needed to drive excellence and quality improvement in the organisation. Above all, understanding that in providing services in health and social care, much is achieved by group decision making, rather than management imperatives. People tend to confuse 'managing' for 'leading' when in fact these are two separate domains, although good leaders must be good managers in order to be good leaders (McLaughlin & Olson, 2017).

Leadership in post-secondary environments is much more closely linked to the philosophical foundations of those environments i.e. the furtherance of knowledge through research and scholarship, but senior academic leaders must also be knowledgeable about these cross-cutting themes (McCaffrey, 2010).

Good leaders are not necessarily born—by defining some of the core qualities required for leadership and with determined effort headed in the right direction anyone can, in effect, embark on the journey to become a leader. If the continuum of IPE is to be sustained, then recognising and training future leaders of IPE is imperative. How might this be imperative be approached? What are some of the key lessons that have so far been learned about leadership? 'Our doubts are traitors and cause us to miss the good we oft might win, by fearing to attempt' (*Measure for Measure*). We know that leaders need to experiment more and learn from experience, instead of being too cautious and wary of taking risks.

Leaders who take the trouble to recognise and celebrate even small steps towards a difficult goal (of which there are many in health and social care) can generate much joy. Good leaders do not regard others merely as objects which either help or hinder their path to success or realising certain goals, but instead treat them as real people who have their own hopes and aspirations. In the words of the Golden Rule 'Do unto others as you would they should do unto you.' Good leaders are not afraid to question and challenge authority, and good leaders evolve from 'leading', to helping others 'lead'. Zeiss's (2019) reflected that across the course of her professional career she learned some key lessons 'Leaders add value by serving, leadership develops daily, not in a day. Leaders know how to pursue problems and address conflicts comfortably without expressing anger, attacking, or understating the issue. Leaders need to be both nurturing and supportive persons – though, surprising as it might seem, some people who report to even the most supportive leader may be frightened of her/him. Recognising this characteristic takes a leader with special talent.'

Understanding these key lessons is fundamentally bound up with the philosophy of values-based leadership, which asserts that people are mostly motivated by deep-rooted values and live according to those values. It is values-based leadership that carries the promise that the cultural

change associated with the continuum of IPE can be sustained. Values are our most natural motivators, and possibly the deepest value we hold is that of trust, and it is trust that guides behaviour. It is not surprising that leaders refer to their own values in creating a vision or making decisions (Campbell-Cree, Macdonald, & Lotten, 2018). It thus makes sense for leaders to connect with the values of those they work with since it then makes those individuals more likely to act to sustain the activities of IPE.

It then follows that, because of this value driven behaviour, people's self-expectations will influence how they behave—they want their actions to be in line with their values and their commitments. This idea of value driven self-expectations is of great importance when building a sustainable system for the continuum of IPE when trust is fundamental to best practice and care. That said, there are realities to be faced. We are all averse to loss and quite naturally tend to hang on to what we consider ours. We are not good at computing; when we make decisions we tend to put a lot of weight on recent events and too little on those that are in the future; we don't calculate probabilities well and worry too much about unlikely events; and we are strongly influenced by how the problem/information is presented to us.

What is clear from all of the work that has been put into, and is being put into building and sustaining the continuum of IPE is that everyone engaged in the process needs to feel involved in the process and know that they can effect a change—just giving people incentives and information is not enough to effect change. Other people's behaviour matters—people do many things by observing others and copying; people are encouraged to continue to do things when they feel other people approve of their behaviour. The notion 'We've always done things this way and they mostly work' is deeply bound up with habits that are hard to change. Our behaviour is probably the hardest of all human attributes to change and habits constantly compromise attempts to really move IPE forward. So how have we moved away from 'We've always done things this way.'?

Looking back across the past 10–12 years of intense work across the continuum of IPE, it is encouraging to see how good leadership has transformed the field. Looking at this interprofessional transformation, it is possible to assess the transformations that have occurred. We can

get a crude but nonetheless profound sense of the difference by considering five questions: Are there signs of more learning together? Are there indications of new forms of collaboration? Are safety and quality of care being improved because of IPE? Is it possible to see how new management structures are steering change? And is the IPE transformation steering the management of change? The first three of these questions are directly linked to the CAIPE definition of IPE; the last two questions are linked to the final part of the definition '… to improve … the quality of care and services'.

The time between the National Academy of Sciences report *Educating for The Health Team* (1972) and the report of the Health Professions Accreditors Collaborative *Guidance on Developing Quality Interprofessional Education for the Health Professions* (2019) is replete with examples of the many ways in which good leadership has pushed into all of the corners of the IPE continuum. As will be seen, these examples provide a variegated set of answers to the five questions.

So, are there indications that IP transformation is leading to more learning together? It was clear from the earliest days of IPE that both academic and health care organisations would need to configure space in order that students and practitioners could learn together, i.e. a need to find ways of breaking down the physical barriers of the silos. The concept of a built environment that would provide knowledge locations in which to learn and practise was envisioned, in which there would be small spaces dedicated to interprofessional group teaching, projects, forums, seminars etc. and that would allow all parts of the continuum to be addressed in a coherent and congruent fashion (Smith & Costello, 2018). Professor Nishant Manapure, an architect, has described the built environment as 'All structures people have built when considered as separate from the natural environment. Surroundings created for humans, by humans, to be used for human activity' (Manapure, pers. com). As indicated earlier there are now a number of such spaces, developed by inspiring leaders and collaborative teams of health and social care professionals.

The movement for 'transforming education to strengthen health systems in an interdependent world' was spearheaded by *The Lancet* (Frenk

et al., 2010) in its seminal study Health Professionals for a New Century, and in the same year the publication of the WHO's Framework for Action on Interprofessional Education and Collaborative Practice (WHO, 2010), then, in 2013, the WHO's publication of transforming and scaling up health professionals education and training (WHO, 2013). Health Canada made a major investment in cross country studies of IPE from 2002–2005 which motivated both academic and practice changes, many of which continue (Gilbert, 2010) Reports of study groups (Cox, Cuff, Brandt, Reeves, & Zierler, 2016), conferences, and other forums initiated by leaders in IPE have followed that have assessed the changes e.g. Measuring the impact of interprofessional education on collaborative practice and patient outcomes (IOM, 2015); Lessons from the Field: Promising Interprofessional Practices from the Robert Wood Johnson Foundation (CFAR Inc., Tomasik, & Fleming, 2015).

It was, however, the development of interprofessional competencies by an ever larger cohort of leaders (Chuenkongkaew, 2018; CIHC, 2010; IPEC, 2011) that effected profound changes in IPE curricula, which was also driven by an ever increasing number of studies published in the *Journal of Interprofessional Care*, the *Journal of Interprofessional Education and Practice*, the *Journal of Research in Interprofessional Practice and Education* and journals advancing medical and nursing education—journals with outstanding leaders as editors whose vision enabled, and continues to enable, the development of a discipline through research and scholarship.

Are we seeing transformation through new forms of collaboration? The committee for interprofessional education in health professions is an example of leadership in Germany, Austria and Switzerland coming together from medicine, nursing, and the diagnostic and therapeutic health professions (Walkenhorst et al., 2015). The Committee on Interprofessional Education and Practice of the American College of Surgeons set as its goals, to: Comprehensively address the educational needs of allied health professionals as members of surgical teams; Educate surgeons regarding the role of allied health professionals; Support and assist allied health professionals involved in the surgical care; Participate in defining duties of allied health professionals; Assist with the process of accreditation of their respective educational programmes (https://

www.facs.org/about-acts/governance/ace-committees/18). The WHO is actively facilitating new forms of collaboration through e.g. the inclusion of IPE as a framework for learning about how to address social determinants of health across a wide variety of health occupations. Remarkable leaders of student organisations, in Canada, the USA, and elsewhere have been powerful advocates of new forms of collaboration and particularly effective in carrying that message forward through the Health Care Team Challenge movement, an event started at the University of British Columbia in Canada, which now is held annually in many countries (Newton et al., 2015).

Is interprofessional transformation leading to improved safety and quality of care? There is no doubt that the Institute of Medicine's report, *To err is human* (Kohn, Corrigan, & Donaldson, 1999), was hugely important in recognising dysfunctional health and social care teams, and inherent problems of communication between health and social care professionals. It is tempting to think that this report was the stimulus for the Lancet Commission review. The downstream effects of that review, on conceptualising interprofessional teams, have been carried forward by great leaders across the spectrum of health and social care. The development of checklists, simulation, patient safety goals, quality of care can now be seen in interprofessional competencies and curricula (Kitto, Reeves, Chesters, & Thistlethwaite, 2011). Equally significant has been the development of the patient's voice in her/his own care, and in research (Thistlethwaite, 2015). Although the influence of interprofessional collaborative practice and care on improved quality of care is observed anecdotally, quantitative data are still being accumulated, an area in which the lens of implementation science would be of great value (Bauer, Damschroder, Hagedorn, Smith, & Kilbourne, 2015).

Is IP transformation leading to new management structures? What can be seen is that curricula change towards IPE has seen the appointment of managers within post-secondary institutions and health and social care organisation who now have the title, mandate and responsibility to develop IPE e.g. professorships and directorships, and frontline professionals who are charged with interprofessional collaborative team development. In Canada, the position of Vice-President, Professional Practice now more and more frequently has the additional title "and

Interprofessional Education". Transformation is also being engineered through, for example, the WHO Global strategy on human resources for health: Workforce 2030 (WHO, 2017a) and Framing the health workforce agenda for the Sustainable Development Goals (WHO, 2017b).

Finally, is IP transformation steering the management of change? Evidence for the genesis of a global movement is provided by Barr (2015) and for advances occasioned by change management in the BEME systematic review (Reeves et al., 2016). Management is also using social media, webinars, conferences, newsletters, infographics and online meetings that clearly demonstrate the ways in which IPE is steering the management of change. Over the past decade, systematic investments in developing faculty and practitioners to teach teamwork skills (Hall & Zierler, 2015); developing sound evaluation and measurement methodologies (Kitto et al., 2011) and expanding publication sources for research are demonstrating that IPE is an evidence-based discipline which covers the continuum from learning to practice and care.

Perhaps more than any other mechanism, it is the organisation of interprofessional research programmes and publication of the results of such programmes in ever increasing numbers that are pushing change. The development of Interprofessional.Global, a confederation of regional interprofessional organisations that will sustain cultural change, and Interprofessional.Global. Research, will continue to build the research base of the discipline.

As we look at the growing culture of IPE and its spreading circle of influence, the words of Bill Gates of Microsoft fame are apposite: 'We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten. Don't let yourself be lulled into inaction.' Early leaders of IPE across its many sectors were keenly aware that the system change they were working for would not happen in two years; they have been amazed at what has occurred in ten years—and come to realise that 'Keep track of gradual improvements. A small change every year can translate to a huge change over decades' (Rosling, 2018) as they aim for a system in which workforce planning is led by leaders in IPE, who recognise that in order to bring about system change, education and practice must be designed around

patients and the health of the populations—not around the mandates of professions.

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