Challenges and opportunities in interprofessional education and practice


LeoPatrizi/Getty Images

See **Health Policy** page 1539

The Health Policy paper by Julio Frenk and colleagues[1] in *The Lancet* on educating health professionals after the COVID-19 pandemic highlights the post-pandemic learning environment, use of technology to improve learning, interprofessional education (IPE), and lifelong continuing education and training for the health professions. The perpetual shortage and maldistribution of health professionals within complex health systems and unmet population health needs may require innovative approaches for the education of health professionals for effective practice. IPE is an educational approach that could positively influence health-care practices and patient outcomes. With its origins in the 1960s, predominantly in the UK and the USA, IPE has since spread to various regions of the world.[2] The application of IPE in different regions and countries varies, ranging from a uniprofessional approach to a seamless incorporation of IPE to the whole learning environment. WHO defines IPE as occasions where students from two or more professions in health and social care learn from, about, and with each other during their education for effective collaboration in future practice.[3] The Interprofessional Education Collaborative proposes four essential competencies for IPE: values and ethics, roles and responsibilities, interprofessional communication, and teamwork and team-based care.[4] These are predicated on each profession also being trained to a high level of knowledge and skill in its own right.

Graduates with IPE experience are expected to work with other professionals in a climate of mutual respect, using theirs and others' competencies and expertise to address the health-care needs of patients and advance the health of populations. Additionally, IPE graduates might be particularly effective in taking part in interprofessional communication to promote health and in applying team dynamics to develop collaborative practices within care teams and with patients. Collaborative practice has been shown to improve patient outcomes, such as reduced length of hospital stay and reduced clinical error rates.[3] However, these aspirations are still to be proven in practice. Some studies highlight similar educational and patient outcomes for IPE and uniprofessional learning groups, whereas others show insignificant changes in the attitudes towards other professions after introductory IPE courses between medical and nursing students.[5] Evidence on the impact of IPE for achieving the Quintuple Aim (better patient care, better population health, better value, better work experience, and better health equity)[6] is rapidly evolving.

Some educators believe that IPE should be integrated in all pre-registration programmes. In practice, IPE integration is tied to geographical and economic spaces, with high-income countries reporting more robust IPE programmes than middle-income and low-income countries.[7] For IPE programmes to be successful, they need to address key practice problems. For example, effective IPE can occur where there are insufficient qualified physicians and the other health-care professionals collaborate with the physicians as a team to improve patient care. IPE can also be useful when it is adopted in specific situations, such as in intensive care units (ICUs), operating rooms, emergency rooms, and women's health-care settings. This approach may avoid some barriers for IPE and interprofessional collaborative practice (IPCP), deriving from organisational, structural, cultural, financial, and curriculum issues.[1] A focus on contextually relevant practice problems that affect patient care could assist in developing professional identity within authentic interprofessional clinical teams in care settings, as shared by Lingard and colleagues in their study with ICU teams.[8]

Another important focus for IPE in some countries relates to the integration between western biomedicine and traditional Indigenous health care. Developing and implementing models for integrating traditional and Indigenous health-care practices and practitioners could improve the value and outcomes of IPE.[9] In places where traditional Indigenous health care is a major source of health care, IPE in inter-cultural training, integrated participation of practitioners in therapeutic encounters, and discussions on health policies have helped make IPE relevant for local health-care contexts.[10] A recent example of effective IPE and IPCP is seen in educational workshops and multidisciplinary teams organised by a university in Nicaragua that linked together the national health policy plan, traditional healers, and the Ministry of Health.[11] The value and impact of IPE could be strengthened

by acknowledging and integrating local sociocultural practices and contexts for the region, institutions, and the corresponding health systems. Regional groupings, networks, or associations might be tasked and supported in developing robust and global evidence on the effectiveness of IPE. Local sociocultural practices and contexts would be central in the development of such evidence within a region and specific health system.

Another suggestion to improve IPE is the integration of virtual interprofessional education (VIPE). This approach could enhance inclusivity for students in institutions without structured IPE programmes and where internet access and electronic devices are available. VIPE could potentially tackle collaborative silos and promote excellence across a region.[12] The COVID-19 pandemic accelerated the application of VIPE in some settings. Comparing groups before and after the pandemic, VIPE clinics confer similar benefits in terms of competence development among health-care students compared with in-person training in community clinics.[13] VIPE could therefore have a role in the development of interprofessional competencies. Shamputa and colleagues reported that of 206 students who attended a synchronous didactic presentation on IPE competencies and discussed a simulated case in interprofessional groups of eight students and two faculty facilitators, 99 students indicated on the Interprofessional Collaborative Competency Attainment Survey that the virtual IPE activity was effective in facilitating the development of interprofessional competencies for first-year health-care students.[14]

The structure of the health-care service and the roles assigned to different professions and their support staff is another key factor relevant to IPE. The role of IPE in relation to task shifting (redistribution of roles and responsibilities), particularly in primary care, is an area of tension and recurrent debate.[15] Existing conventional medical practice models, which are in place in most regions, could be a major impediment for the development of IPE and IPCP to support task shifting and task sharing.[15]

For IPE to be successful, educators could be most impactful by engaging, creating, and modelling interprofessional collaboration for and among students, as works successfully for education in professionalism. Although this approach is likely to require capacity development and institutional support through long-term training and service development, it may also require a change in practice so that students can observe effective team working in patient care.

Early approaches to IPE show promise, but, as is often the case in social science, evidence of the benefits of IPE is scarce and not easy to attain due to the multiple variables involved. Further research is needed, including contextual analyses of the feasibility of IPE, the relevance of IPE for improving clinical practice and patient outcomes, and the effects of IPE on other areas of the medical curriculum. Furthermore, the role of IPE and who is responsible for its delivery and outcomes across health professional schools is yet to be resolved. Educators who design curricula and health policy makers must be familiar with institutional health-care demands and legal requirements in delivering care if they are contemplating implementation of IPE and IPCP. If such policies do not address the broad scope of IPCP that would enhance patient outcomes, policy makers must actively engage in improving care collaboration.[16] Implementing such changes is complex and challenging but necessary to advance IPE and IPCP. The potential role of IPE for achieving the Quintuple Aim is enormous and further research is needed to offer better evidence to advance this agenda.

We declare no competing interests.

*Dujeepa D Samarasekera, Champion N Nyoni, Eliana Amaral, Janet Grant
dujeepa@nus.edu.sg

Centre for Medical Education, Yong Loo Lin School of Medicine, National University of Singapore, 117597 Singapore (DDS); School of Nursing, University of the Free State, Bloemfontein, South Africa (CNN); Department of Obstetrics and Gynaecology, School of Medical Sciences, University of Campinas, Campinas São Paulo, Brazil (EA); University College London Medical School, London, UK (JG)

1 Frenk J, Chen LC, Chandran L, et al. Challenges and opportunities for educating health professionals after the COVID-19 pandemic. *Lancet* 2022; **400:** 1539–56.
2 Barr H. Interprofessional education as an emerging concept. In: Bluteau P, Jackson A, eds. Interprofessional education: making it happen. New York, NY: Palgrave Macmillan, 2009: 3–23.
3 WHO. Framework for action on interprofessional education and collaborative practice. Geneva: World Health Organization, 2010.
4 Interprofessional Education Collaborative. Core competencies for interprofessional collaborative practice: 2016 update. Washington, DC: Interprofessional Education Collaborative, 2016.
5 Tong R, Brewer M, Flavell H, Roberts LD. Professional and interprofessional identities: a scoping review. *J Interprofessional Care* 2020; published online Feb 13. https://doi.org/10.1080/13561820.2020.1713063.
6 National Academies of Practice. Position paper: interprofessional collaboration. April 26, 2022. https://ipe.umn.edu/sites/health1.umn.edu/files/2022-06/NAP%20Position%20Paper%20on%20IPE%20IPCP%20-%20published%204.26.22.pdf (accessed Oct 18, 2022).
7 Khalili H, Lackie K, Langlois S, Wetzlmair LC, Working Group. Global IPE situational analysis result final report 2022. InterprofessionalResearch. 2022. https://interprofessionalresearch.global/wp-content/uploads/2022/10/Global-IPE-Situational-Analysis-Final-Report-October-2022-1.pdf (accessed Oct 14, 2022).

8 Lingard L, Espin S, Evans C, Hawryluck L. The rules of the game: interprofessional collaboration on the intensive care unit team. *Crit Care* 2004; **8:** R403–08.

9 UN Department of Economic and Social Affairs Indigenous Peoples. State of the world's Indigenous peoples. 2021. https://www.un.org/development/desa/indigenouspeoples/publications/state-of-the-worlds-indigenous-peoples.html (accessed Oct 14, 2022).

10 Dowell S, Charnetski M, Tarbet A, Palaganas JC. Cultural considerations in interprofessional education: a scoping view. *JRIPE* 2022; **12:** 1–13.

11 Carrie H, Mackey TK, Laird SN. Integrating traditional Indigenous medicine and western biomedicine into health systems: a review of Nicaraguan health policies and miskitu health services. *Int J Equity Health* 2015; **14:** 129.

12 Showstark M, Sappio EM, Schweickerdt L, Nyoni CN. AFRI-VIPE: simulated patients (SPs) role in virtual interprofessional education (VIPE). *J Interprofessional Educ Practice* 2022; **26:** 100492.

13 Watts SO, Tuggle FJ, Sewell J, Slay JL, Ellison KJ, Frugé AD. Achievement of interprofessional competencies in live and virtual community clinics: a comparative study. *Nurse Educ Today* 2022; **119:** 105578.

14 Shamputa IC, Kek B, Waycott L, et al. Exploring the efficacy of a virtual first year interprofessional education event. *Healthcare (Basel)* 2022; **10:** 1539.

15 Efendi F, Aurizki GE, Yusuf A, McKenna L. "Not shifting, but sharing": stakeholders' perspectives on mental health task-shifting in Indonesia. *BMC Nurs* 2022; **21:** 165.

16 Girard MA. Interprofessional education and collaborative practice policies and law: an international review and reflective questions. *Hum Resour Health* 2021; **19:** 9.

Improving access to contraception and abortion in Romania in the context of the conflict in Ukraine

Health reform has often been borne out of crisis.[1] The scale of the humanitarian crisis created by Russia's invasion of Ukraine is staggering. According to the UN Refugee Agency, UNHCR, an estimated 15·7 million people require urgent humanitarian assistance and more than 7·1 million people had been displaced by June 24, 2022.[2,3] There are approximately 5·2 million refugees from Ukraine across Europe, and the EU swiftly activated the temporary protection directive granting refugees access to essential services such as health and education.[4] Attempts to address some of the barriers to accessing these services are being developed and shared across the region.[5]

More than 1 million refugees from Ukraine have crossed the border into neighbouring Romania. The majority of these refugees move on to other countries and, as of June 28, 2022, 83 321 have remained in Romania.[2] The Romanian Government, like many hosting countries, has extended health coverage to refugees from Ukraine. Although this generosity is welcome, as with the other EU countries, it comes with limitations.

Health outcomes in Romania have improved substantially over the past two decades, but remain below the EU average for measures such as life expectancy, infant mortality, and health spending.[6,7] Access to sexual and reproductive health (SRH) services is a particular concern.[8] SRH encompasses a wide range of services, including abortion, family planning, contraception, sexual health, cervical cancer screening, and gender-based violence care.[9] In Romania, while there is presently no SRH action plan in place nor any coordination of family planning, efforts are underway to rejuvenate previous national programmes. In terms of current access to family planning and contraception, most Romanians and Ukrainian refugees in Romania must pay for contraception and few long-acting reversible contraceptives, such as intrauterine devices or implants, are readily available. Abortion is legal in Romania up to 14 weeks of pregnancy and up to 24 weeks for medical reasons. However, in reality, access to abortion care is limited, and abortion rights are being challenged. For example, surveys in 2019 and 2020 found just over 25% of 158 public hospitals provided abortion on demand and only 5% of 171 hospitals provided medical abortion.[8] Paradoxically, abortion rates in Romania are among the highest in Europe,[10] as are adolescent pregnancy rates, with the associated risks to the health of the mother and child.[11]

Women and girls are often disproportionately impacted by conflict, and the war on Ukraine is no different.[12] About 90% of displaced people from Ukraine are women and girls,[13] and there are multiple reports of gender-based violence, including rape, in the conflict in Ukraine.[14] Protection and psychosocial support services together with the provision of holistic health care, including access to contraception and abortion, are an essential part of the response. Women's rights organisations and non-governmental organisations in Romania have a crucial role in the response and require support for this work on the global stage and through flexible funding mechanisms.[15] However, in the long term, the national

Andreea Campeanu/Getty Images

Published **Online**
July 8, 2022
https://doi.org/10.1016/S0140-6736(22)01275-2