Équipes d'intervenants en santé familiale

Peut-on enseigner aux professionnels de la santé à travailler ensemble?

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RÉSUMÉ

OBJECTIF Déterminer l'opinion des enseignants de diverses professions de la santé primaire sur le développement et l'utilisation d'équipe universitaires de santé familiale pour faire, enseigner et servir de modèles pour la collaboration interprofessionnelle et sur l'implantation d'une formation interprofessionnelle (FIP) intégrée à la formation universitaire en soins primaires.

TYPE D'ÉTUDE Étude qualitative utilisant des groupes de discussion.

CONTEXTE Établissements d'enseignement supérieur de l'Ontario.

PARTICIPANTS Un échantillon raisonné de 36 participants comprenant infirmières, pharmaciens, orthophonistes, physiothérapeutes, ergothérapeutes, travailleurs sociaux et médecins de famille.

MÉTHODE Les participants devaient participer à des groupes de discussion composés de 6 à 8 professionnels de la santé. Les thèmes ont été identifiés à partir de l'analyse qualitative des données recueillies par la technique de la théorie ancrée.

PRINCIPALES OBSERVATIONS Trois thèmes principaux ont été identifiés : l'absence de consensus sur l'intérêt qu'il y a à ce que les futures équipes universitaires de médecine familiale enseignent la FIP, l'absence d'enseignement formel sur la collaboration interprofessionnelle, le fait que les rares projets en ce domaine sont destinés surtout aux médecins de famille et très peu aux autres professions de la santé, et la confusion qui règne au sein des professions de la santé concernant la définition de la FIP.

CONCLUSION Il y a lieu d'examiner le rôle que des équipes de santé familiale oeuvrant dans un contexte universitaire de soins primaires pourraient jouer pour permettre aux étudiants d'observer le déroulement du travail en équipe et d'apprendre à collaborer. À moins qu'on développe des structures universitaires capables de fournir aux professionnels de la santé la formation nécessaire au travail en équipe, les prochaines générations de professionnels de la santé continueront de travailler comme elles l'ont toujours fait et les efforts de réforme ont peu de chance d'aboutir.

POINTS DE REPÈRE DU RÉDACTEUR

- Comme médecins de famille, on nous incite à travailler en collaboration avec d'autres professionnels de la santé, mais ce type de travail peut-il faire l'objet de formation? Peut-on enseigner aux professionnels de la santé comment travailler en collaboration?
- Cette étude rappelle certains points importants de la formation interprofessionnelle (FIP). Il n'y a pas de consensus sur la nature exacte de la FIP. Il n'existe pas de critères établis pour l'enseignement de la FIP. Les tensions interprofessionnelles persistent, même au sein des institutions académiques qui tentent d'introduire la FIP.
- Des équipes œuvrant en santé familiale pourraient servir de modèle pour enseigner à une nouvelle génération de médecins comment collaborer avec d'autres professionnels de la santé.

Cet article a fait l'objet d'une révision par des pairs.
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First benzodiazepine prescriptions

Qualitative study of patients' perspectives

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ABSTRACT

OBJECTIVE To explore patients' views and expectations regarding their first prescription for benzodiazepines (BZDs).

DESIGN Qualitative study using semistructured interviews.

SETTING Patients were recruited from general practices in the regions of Ghent and Brussels in Belgium and were interviewed at home.

PARTICIPANTS Fifteen family practice patients who had received prescriptions for BZDs for the first time.

METHOD Interviews were audiotaped and transcribed verbatim. Data were analyzed by themes using a phenomenologic approach.

MAIN FINDINGS Patients had asked their physicians for "something" because they thought they were in serious distress and needed help. They seemed to feel a conflict between the need for medication and the negative connotations surrounding BZD use. Patients used 2 strategies to justify consumption of BZDs: maximizing their problems and minimizing use. Patients knew very little about the medication and did not ask about it. Their expectations regarding continued use were vague, even though they seemed to be aware of the risk of psychological dependency and conditioning mechanisms. Patients did not actively ask for nonpharmacologic alternatives, but when they were offered them, their attitudes toward them were generally positive.

CONCLUSION First-time BZD users ask for help with distress, but place the responsibility for solving their problems on their family physicians. Even when short-term users were aware of the concept of psychological dependency, they did not feel the need for more information. Physicians should develop communication strategies to persuade their patients that they take the patients' problems seriously even though consultations do not always end with prescriptions. It is important that doctors clearly explain the risks and benefits of starting BZD treatment and set limits from the start. This will help doctors manage first-time BZD users more effectively and will help patients avoid chronic use.

EDITOR'S KEY POINTS

- Soon after benzodiazepines (BZDs) were introduced, numerous adverse effects were reported: "hangovers," memory impairment, emotional blunting, tolerance, dependency, and increased risk of falling and of having motor vehicle accidents. Despite this, in many countries, BZD use has not decreased.
- To fully understand how to reduce the number of prescriptions for BZDs and to prevent long-term use, it is important to explore patients' attitudes and beliefs concerning initiation of BZD treatment.
- Patients use 2 strategies to justify BZD use: maximizing their problems and minimizing their use of BZDs. Patients place the responsibility of prescribing BZDs on their doctors because they think the situation is beyond their control and possibly because they prefer to transfer responsibility to their doctors.

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Soon after benzodiazepines (BZDs) were introduced in the 1960s as a safer alternative to older hypnotics and sedatives, numerous adverse effects were reported, including "hangovers," memory impairment, emotional blunting, tolerance, dependency, and increased risk of falling and of being involved in motor vehicle accidents.[1,2] Despite this, BZD use has not decreased during the last few decades. A cross-national study in the 1980s showed that Belgium was one of the countries with the highest use of anti-anxiety and sedative drugs.[3] Since then, use of BZDs has further increased.[4,5]

In international family practice guidelines, attention is drawn not only to the problem of chronic use of BZDs, but also to the first prescription as a trigger of long-term use.[6-8] Advice on initial prescriptions is based on expert opinion because there is little published research on new users (in contrast, there are numerous publications on BZD use in family practice, and chronic use in particular). A search of MEDLINE and PsychLit yielded only 7 publications on initial prescription of BZDs. Their focus was primarily on sociodemographic and health characteristics and, to a lesser degree, on attitudes and beliefs.

A few studies have focused on sociodemographic and health characteristics as possible predictors of chronic use of BZDs.[9-11] Two studies found that elderly people had a higher tendency toward long-term use than younger people did.[10,11] On the other hand, Fourrier found that age and sex were not independent predictors of chronic use.[9] The conflicting results of these studies are not surprising, as the studies did not take into account variations in attitude, which can play an important role in explaining chronic use of BZDs.

One study found that first-time users' perceptions of the physician's usual practice with regard to BZD prescribing was an important predictor of their intention to continue to take the drugs.[12] Another study found that continued use was often attributed to difficulties associated with stopping.[13]

Considering the lack of literature on patients' attitudes toward BZDs and on examination of first-time use as a potential determinant of long-term use, this paper is an attempt to fill the gap. In order to understand fully how to reduce the number of prescriptions for BZDs and to prevent long-term use, it is important to explore patients' attitudes and beliefs around initiation of BZD treatment. Our study looked at whether the perceptions of first-time users could lead to chronic use of BZDs, and as a result, have implications for the physicians prescribing them. Our findings might serve to inform interventions that help doctors when they are deciding whether to initiate BZD treatment or to start with alternative treatment.

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METHODS

Our study aimed to search for the meanings of experiences.[14] The approach required could be found in phenomenology. The view in this study design is that the phenomenon being studied means nothing without the interpretation that patients put on their experiences.

Sample

All 180 family physicians from a list of physician-trainers from the regions of Ghent and Brussels in Belgium were invited by letter to participate in the study and were then contacted by telephone to follow up. To protect patient confidentiality, the physicians were asked to invite 1 or 2 patients for whom they had recently initiated BZD prescriptions to participate in the study. Inclusion criteria for patients were age 18 or older, having a first prescription for BZDs, not being treated for psychiatric disease, not taking neuroleptics, and being capable of being interviewed. The interviewers contacted 22 patients from 17 physicians. All agreed to participate.

To allow generalization of themes, respondents had to be representative of a range of populations. Accordingly, patients were recruited from both sexes, various age groups, and various education levels. Our interview sample included more women than men because, according to health statistics, considerably more women than men receive prescriptions for BZDs.[15]

All but 1 patient agreed to be interviewed, but during the interviews it was found that 6 respondents did not meet the inclusion criteria, either because they had been psychiatric patients or because they had taken BZDs before. Therefore, 15 interviews were conducted with 2 male and 13 female patients (age range 18 to 76 years). The patients who took BZDs daily took them for between 3 days and 4 months. The other patients took their BZDs intermittently.

Data collection

The study was approved by the ethics committees of the Ghent University Hospital and the Université Catholique de Louvain Hospital. Written informed consent was

obtained from all respondents. Respondents were interviewed at home. Interviews followed a semistructured schedule of open-ended questions exploring experiences, opinions, attitudes, and feelings in order to obtain a comprehensive picture of perceptions. Interviews were terminated when the interviewer had clarified with participants that there were no further issues to be addressed.

All interviews, which lasted between 35 and 60 minutes, were recorded with patients' permission and transcribed verbatim. Notes were taken concurrently.

Data analysis

Data were analyzed using the principles of thematic analysis and incorporating the data-driven inductive approach as the study sought to promote understanding of individual perceptions rather than prove a preconceived theory.[16-19] First, 2 researchers immersed themselves in the data by independently reading transcripts and field notes to identify principal elements. Coding was done using the constant comparative method, moving back and forth between interview material and analysis and uncovering similarities and differences in data from various interviews.

This procedure generated categories and subcategories; emerging themes became the categories for analysis. Triangulation was used by including a third coder for the final analysis in order to improve the consistency and reliability of analyses.[16,20,21] Regular review and discussion among those coding evolving themes contributed to data synthesis and interpretation. Final analysis involved examining all the data collectively, thus permitting relationships between and among central themes to emerge. Several techniques to promote the credibility and applicability of findings were used, including audiotaping, verbatim transcription, and use of field notes.[20,22] Saturation was reached after the first 10 interviews. The basic elements of the main themes were present as early as the sixth interview.

FINDINGS

First BZD prescription

Respondents were distressed and needed help. They perceived the situation as beyond their control and had a helpless "fix me" attitude. They said they were not able to handle the situation and that their problems were too serious to be allowed to continue. Medication was perceived as the only solution, and, in fact, it brought great relief: "I took the medication as it was my last resort. I also think it was the only solution for me at that particular moment."

Explicit demand for prescriptions

Respondents seemed to have asked for "something" to help them, but not explicitly for tranquillizers: "Yes, I asked for the medication myself, because I know our family physician. He doesn't easily give medication...." A few patients asked explicitly for BZDs and felt particularly strongly about this: "I asked him for a sleeping pill because it had gone too far. I went to see him, and I said, 'Doctor, you have to give me a sleeping pill.' I think he is a good doctor but he doesn't prescribe that easily."

Conflict and ambiguity

There seemed to be conflict between the negative connotations surrounding use of BZDs and patients' actual need for such medication. Respondents expressed negative feelings toward taking medication and seemed opposed to it: "It is a good medicine, but me, I am not a 'pill consumer.'" Patients suggested they wanted to stop taking BZDs to avoid becoming dependent. On the other hand, they were afraid of slipping back into their insomnia or distress. Thus, they were "against" the medication, but at the same time, concerned about the consequences of discontinuing it because they thought the treatment had improved the situation.

Strategies to justify usage

Patients used 2 strategies to justify their use of BZDs. The first was to maximize their problems and to convince themselves that there was no other solution. By labeling the complaint as "really bad," by saying that they had reached the limit of their suffering, by describing it as "vital to take medication," or by viewing prescriptions written in these circumstances as confirming the necessity of drug treatment, they justified taking BZDs. One said, "I could bear it no longer." Another said, "I couldn't handle it any other way at that moment. I could have seen it coming but at that moment there was no other way...."

The second strategy was to underestimate their BZD use. Respondents said they used only small doses, they consumed less medication than prescribed, and they took it only when necessary. One said, "They really are small pills." Another added, "It is really a 'light' medicine. I think that is why I can't sleep through the night because it is so small."

Information on BZDs

Patients said they knew very little about their medication: "I don't know anything about this medication except that it will calm me down." At the same time, patients also expressed no need for information: "I don't want more information. For me the most important thing is that it helps me."

Patients said that the relationship with their physicians was based on trust, thereby explaining why they did not need more information. They said they presumed the doctor would always act in their best interests: "I think it is like when you go to a caterer, we don't ask him how he has made the food. It has to correspond

to our choice. It is the same here. I have confidence in my doctor and in what he prescribes me." On the other hand, the conflict between the need for medication and the negative connotations attached to taking BZDs might explain the absence of a stated need for information. If patients had received more information on their medications, they might have had to give more thought to taking the prescription: "I don't want more information. I am not a hypochondriac, but I know if I read or hear something negative or about side effects I will have to start thinking whether I should continue with it. And I still need it."

Dependency

Even in this sample of first users, psychological dependency seemed to come up very quickly. Several characteristics typical of people who have become dependent on therapeutic doses of BZDs were noted: patients became anxious if their next prescriptions were not readily available; they carried their tablets around with them; and they took an extra dose before an anticipated stressful event. One said, "I need to have it with me, not to take it, but just in case I might need it." Another said, "But I surely won't have enough tablets left, I told him. I already calculated that I will have enough pills to last until April 3rd. So that means I have 23 left, therefore I have to take halves. Then I will certainly return to the family physician."

A conditioning mechanism related to the fear of returning to a state of distress or insomnia if they stopped taking the medication was observed: "I think he knows that if it wasn't necessary I wouldn't take it. But if I don't take it, I am awake for more than an hour and I think I really shouldn't be stopping this medication."

Nonpharmacologic alternatives

Respondents indicted that their doctor-patient relationships were based on trust and confidence. A good conversation with their family physicians helped patients a lot and was viewed as something very positive. The advantage of talking with their family physicians was that they knew the patients' histories and family situations:

> I like the fact that once in a while I can talk to my family physician. After all, he maintains confidentiality and you can't tell everything to your family. He also knows my family history. You already have a connection, and if you go to someone else you have to start all over again.

Patients themselves made no explicit demands for nonpharmacologic approaches to their problems. Because of good doctor-patient relationships, patients were more willing to accept what their family physicians suggested. They were, however, reluctant to take the initiative of going to see a therapist because of the stigma surrounding it: "The family physician suggested that I should go and see a psychologist. But initially you think 'I have always been healthy,' so you don't think 'OK, yes I am going to go'...."

Once introduced to it through their doctors, they became actively involved in changing their behaviour and experienced the change as something very positive.

> The doctor suggested that I should go and see a psychologist. I think it is very important to stimulate patients to go, to give them enough information and tell them that it can really help and work. People are really afraid of it and have big questions about it but in fact, it is not all that bad.

DISCUSSION

We found that patients had ambiguous feelings about taking BZDs. They expressed a high level of distress and a need for help when they consulted their family physicians, but they also expressed an aversion to medication. They justified taking BZDs by maximizing their problems and underestimating their consumption. An aversion to medication seemed to be clear in this study, but expressing such an aversion could be a socially approved way of talking about medicines that has little to do with what people really think about their medications.[23]

Patients placed the responsibility for prescribing on their doctors, because they thought the situation was beyond their control. Patients assumed that prescriptions were necessary because they were written by their family physicians whom they trusted. This was how they justified their use of BZDs. It is important for physicians to be aware of this process and to guide patients toward more realistic expectations of their treatment options. These findings are similar to those found in other studies on physician prescribing. For example, a qualitative study of patients with unexplained medical symptoms[24] found that when they apparently sought to engage their physicians by conveying the reality of their suffering, the physicians responded with investigations, prescribing medications based on symptoms, or referral.

A doctor's perception of what a patient wants has a strong influence on prescribing,[25] but doctors' assessments of patients' expectations are often based on an intriguing variety of cues.[26] Therefore, it is of utmost importance to clarify patients' exact expectations. Doctors' incorrect perceptions of patients' expectations or unvoiced agendas might result in unnecessary prescriptions.[27]

A study by Britten et al[27] showed that prescriptions written in these circumstances often served to confirm

to patients the necessity of drug treatment. This finding was also confirmed in our study.

According to patients, little or no information was given to them. This is in agreement with other findings in the literature. In consultations about psychosocial problems, family physicians gave less information than they did in other consultations,[28] and patients generally did not ask questions.[29] A possible explanation for the fact that physicians do not give information on alternative treatments is because they know little about these options. Cormack's study on factors linked to prescribing BZDs found that physicians would like to obtain more expertise in psychology.[30]

The literature warns that dependency can develop within a few weeks or months of regular or repeated use of BZDs.[31] Duration of treatment is an important factor in exposing patients to the risk of dependency. In our study, we found that psychological dependency could arise very quickly, and physicians needed to be aware of it. A transition from focus on symptoms to focus on therapy (use of medication) seems to occur. The mechanisms that patients use to justify taking BZDs are also important for doctors to take into account when they want to talk about stopping the medication. Patients might think doctors fail to appreciate the severity of their problems if they "take away" their BZDs.

Limitations

We could not recruit patients without consulting their family physicians because of doctor-patient confidentiality. Physicians might have selected patients whom they perceived as amenable to participation in the study, so the results might not adequately reflect the views of a full range of patients. We need to be cautious about making generalizations. Also, it is not clear from the interviews whether prescriptions were issued during patients' first consultations for insomnia, anxiety, or stress.

We did not look at the reasons for medical visits when analyzing our data; our main focus was patients' views on initiation of BZD use. It would be interesting for future research to see whether patients with different complaints (insomnia, anxiety, and stress) behave differently. It is also possible that physicians might have tried to avoid prescribing BZDs during previous consultations and only done so as a last resort or because of patients' persistence at this visit. Determining this was not an objective of the study. Future research should look at the history leading up to the first prescription.

Conclusion

First-time BZD users asked for help with their distress, but placed the responsibility for the solution on their family physicians. Physicians should develop communication strategies to persuade patients that they take their problems seriously even though consultations do not always end with prescriptions. Patients justify BZD use by maximizing their problems. Even if concern about psychological dependency is detectable in short-term users, these users do not ask for information or feel the need for more information.

It is important that family physicians clearly explain the risks and benefits of initiating BZD treatment and set clear limits from the start. These elements will help them manage first-time BZD users more effectively and will assist in avoiding chronic use.

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Contributors

Ms Anthierens *and* **Ms Habraken** *contributed to concept and design of the study, analysis and interpretation of data, and preparing the article for submission.* **Dr Petrovic** *and* **Dr De Maeseneer** *contributed to concept and design of the study and critically revised the article for submission.* **Dr Deveugele** *contributed to analysis and interpretation of data and critically revised the article for submission.* **Dr Christiaens** *contributed to concept and design of the study, acquiring funding for the study, and interpretation of data, and critically revised the article for submission.*

Competing interests

None declared

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Family health teams

Can health professionals learn to work together?

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ABSTRACT

OBJECTIVE To learn what educators across the health professions involved in primary health care think about the use and development of academic family health teams to provide, teach, and model interprofessional collaboration and about the introduction of interprofessional education (IPE) within structured academic primary care.

DESIGN Qualitative study using focus groups.

SETTING Higher education institutions across Ontario.

PARTICIPANTS Purposeful sample of 36 participants from nursing, pharmacy, speech language pathology, occupational and physical therapy, social work, and family medicine.

METHOD Participants were invited to join focus groups of 6 to 8 health professionals. Themes were derived from qualitative analysis of data gathered using a grounded-theory approach.

MAIN FINDINGS Three major themes were identified: the lack of consensus on opportunities for future academic family health teams to teach IPE, the lack of formalized teaching of interprofessional collaboration and the fact that what little has been developed is primarily for family physicians and hardly at all for other health professionals, and the confusion around the definition of IPE across health professions.

CONCLUSION The future role of family health teams in academic primary care settings as a place for learners to see teamwork in action and to learn collaboration needs to be examined. Unless academic settings are developed to provide the necessary training for primary health care professionals to work in teams, a new generation of health care professionals will continue to work in status quo environments, and reform initiatives are unlikely to become sustainable over time.

EDITOR'S KEY POINTS

- As family physicians, we are told we should be working in collaboration with other health professionals, but can teamwork be taught? Can health professionals be taught to work collaboratively?
- This study highlights some important issues in interprofessional education (IPE). There is no consensus on what IPE really is. There are no standardized criteria for teaching IPE. Interprofessional tension, even within academic institutions developing IPE initiatives, is still a reality.
- Family health teams might offer a way to teach a new generation of physicians how to work together with other health professionals.

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In many countries around the world, government and health care sectors have placed importance on developing collaborative patient-centred practices to improve the health of their populations.[1-4] Collaborative practice involves health care professionals working and making decisions together. Collaboration is "an interprofessional process of communication and decision making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided."[5]

Collaborative patient-centred practice is designed to "promote the active participation of each discipline in patient care. It enhances patient and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision making within and across disciplines, and fosters respect for disciplinary contributions from all professionals."[1]

In Canada, much discussion has focused on changing the way health care providers are educated and trained.[6] Interprofessional education (IPE) has been formally defined as teaching health professionals how to work collaboratively. This form of education is described as "occasions when members (or students) of 2 or more professions associated with health or social care engage in learning with, from, and about each other."[7]

There is a call for changing the way health professionals are educated so that they will have the knowledge, skills, and attitudes to carry out collaborative patient-centred practice.[2,3] Funding has been allocated for IPE by the federal government through Health Canada's Interprofessional Education for Collaborative Patient-Centred Practice initiative.[8] Quite recently, the Ontario government provided another $5 million for IPE initiatives.[9]

If health care professionals are expected to work together and share expertise in a team, then their education and training should take place in a team environment to prepare them for this type of working arrangement.[2] For Ontario, the solution to the growing recognition that population health needs are diverse and complex and thus best met by teams of health professionals is the development of family health teams (FHTs).[10] An FHT is an approach to primary care that brings together various health care providers to coordinate the highest possible quality of care for patients.[10] Family health teams consist of doctors, nurses, nurse practitioners, and other health professionals who work collaboratively.

Implementation of FHTs does not address the gap between education and practice, however. The literature reveals that health care educators sometimes do not feel confident teaching future physicians and other health professionals how to be good collaborators in patient-centred care.[11] Should teamwork be taught at all? The Royal College of Physicians and Surgeons of Canada states that the collaborator role is one core competency role in which all specialists must be proficient before graduating. For some time, teamwork in health care has been thought of as something magical without specific definable competencies. In the last few years, this notion has changed, and an art and science of teaching collaboration through IPE have emerged.

Teaching IPE remains challenging, however. No established faculty development programs in the country train faculty how to teach collaboration.[12] There are no curriculums for teaching collaboration. Our educational knowledge base does not include ways to train both faculty and students in how to practise interprofessional collaborative patient-centred care. If there is a movement toward interprofessional collaborative patient-centred practice, we need to address these deficiencies. This study aimed to explore the current understanding of IPE among primary health care educators working in various faculties; the opportunities and challenges of implementing and advancing the teaching of collaborative patient-centred care in curriculums in primary health care in Ontario; and whether development of FHTs in academic settings in Ontario could provide an environment to model, teach, and train future family physicians and other health professionals working in primary care to be competent collaborators.

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METHODS

Design

Qualitative methods[13] were chosen to better understand how educators in various health professions view iIPE in the realm of primary care. Using focus groups capitalized on dynamic communication between participants and proved to be an efficient way of gathering information on participants' experiences and opinions.

Setting

Six higher education institutions, primarily universities across Ontario, that had academic faculty teaching in primary care disciplines.

Sample

Purposeful sampling[13] was used to recruit 36 participants from nursing, pharmacy, speech language pathology, occupational and physical therapy, social work, and family medicine. All participants were faculty members from the 6 universities in Ontario (including the future Northern Ontario Medical Education Centre). Among participants, 11 were from medicine, 11 from nursing, 7 from rehabilitation sciences, 5 from social work, 1 from pharmacy, and 1 from health administration.

All participants had an interest in IPE or were affiliated with the departments of family medicine at the universities. Before each focus group, written consent was obtained from each participant. Participation was voluntary. Explanations of audiotaping stressed anonymity and confidentiality. Two experienced facilitators used a semistructured interview guide to provide a consistent framework for each focus group. Field notes were used to capture observations and nonverbal information during the focus groups. Audiotapes of each focus group were transcribed and analyzed sequentially before the next focus group. The focus group guide was modified between sessions to concentrate on areas requiring further exploration. Each participant received a gift certificate as a token of appreciation.

All audiotapes were professionally transcribed. Using the grounded-theory method, the research team organized and analyzed the data in an inductive manner.[5] Each investigator independently analyzed transcribed data from the focus groups. Using the constant comparative method,[14-16] the research team derived, modified, refined, and agreed upon a coding scheme that captured major themes in the data. This inductive process ensured that findings were grounded in the data collected. The computer software program QSR NVivo was used to support nonnumerical unstructured data indexing.[17] Overall dominant themes were then identified.

The University Health Network Research Ethics Board, the University of Toronto, Queen's University, the University of Ottawa, Lakehead University, McMaster University, and the University of Western Ontario all granted ethics approval.

FINDINGS

Analysis of the data revealed 3 main themes: lack of understanding of IPE; lack of formalized IPE initiatives at higher education institutions; and lack of consensus on the idea that future academic FHTs could model and teach IPE.

Lack of understanding of IPE

Many participants believed that there was a lack of consensus on what IPE truly was. The lack of consensus was partly due to the ever-changing nature of knowledge: "I also think what complicates the whole situation is that each discipline evolves each year. So the disciplines are changing themselves." Lack of consensus continues because confusion remains over the definitions of such concepts as interprofessional, interdisciplinary, and multiprofessional.

> We talk about interprofessional education and professional practice, but sometimes it's not interprofessional, it's more multiprofessional. So I think our goal is interprofessional but we may not actually fully achieve that.

This in turn leads to a lack of understanding of how each discipline can contribute to collaboration in a meaningful way.

> [It's] not so much ignorance but a lack of education and knowledge on other health professionals' parts that may be a problem because it's not integrated in the academic level.... I wasn't taught about the absolute areas that OT covers or what exactly is the difference between an ophthalmologist and an optometrist.

Through this discussion we discovered that defining and understanding the role of each health professional was not something that came naturally. It had to be taught, and when it was not, there was confusion and discomfort when people tried to collaborate on initiatives and on patient care.

One participant said, "So there's really no forum set up for people to collaborate outside of just dealing with a patient that they have to talk about or dealing with research. It's almost like if you don't have the time...." Another participant commented, "It's quite clear that different professions have different domains of knowledge and different ways of organizing knowledge and different ways of approaching similar aspects of the same person."

In addition to requiring a working knowledge of role definition and understanding, health professionals need to learn how to work in collaborative practice. Participants in the focus groups discussed how health professionals from different disciplines were not going to be able to work with one another without a process that facilitates collaboration.

> So, we happen to be in the same room, here's the doctor, here's the social worker, figure out what they do. You can't just throw people together and say, Okay, figure it out, learn. You have to have some objectives and goals and move that forward.

Participants described a need for assistance in learning how to model interprofessional teaching, learning, and collaboration. There was a genuine desire to learn how to integrate better with each other and to understand the inner workings of a team.

> Our request was to actually train to be able to be IPE facilitators. I think we assumed that our experience is that many of us bring reasonably strong facilitation skills, but when you get into an IPE setting where there is a number of professionals and there's lots of conflict happening.... So those types of skills need to be there.

Participants believed that, if health professionals were going to be in an interprofessional setting, they would need to have faculty development training in the area of collaboration and facilitation. They suggested a "train the trainer" model as a way of training faculty and perpetuating those skills to everyone "on the ground."

Initiatives in IPE

Participants discussed how the culture of institutions in general played a role in willingness to foster IPE collaboration among various health disciplines. Some participants thought the universities were not facilitating IPE at the institution level or functioning interprofessionally at the teaching level.

> I think we're [educators] getting onto it [IPE learning] fairly slowly... there's been lots of angst in making some kind of IPE thing work.... I think universities are more built around silos. So we've got our social work silo, we've got these professional silos that at universities don't connect,... and I think that's part of university culture.

We found that each academic institution had its own organizational structures that either supported or discouraged IPE initiatives. Institutions that encompassed all health disciplines under one umbrella (eg, the faculty of health science included medicine, dentistry, and all other health professions) appeared to have more opportunities for IPE.

> In the medical education right from the get-go, they [students] are used to us [allied health professionals] being around and they are used to us contributing.... So there isn't the sense of marginalizing other professions.

Participants from institutions that had a split between medicine and all other health professions reported very few, if any, IPE initiatives. The following quote illustrates the desire for IPE initiatives from allied health professionals and the lack of response from medicine.

> I think that students pick this up from their faculty as well—the power, the lack of valuing of other people.... I think not just at the student level, they are also picking this up from what they are learning from their own medical professors.

Allied health professionals have often felt that, when they have been included, it was only to enrich the teaching of residents and medical school students.

> And I think that is a point to be made about interprofessional education. It is not about enriching medical education. It is about enriching everyone's education. This isn't just about having us as guest lecturers to enrich their education.... It has to be useful for all of those students, and they all have to feel respected because my experience is that when you get nursing students and physician students in a room, they sit differently and you can tell, you can cut the power with a knife in that room.... So just to put them in a room and say it is interprofessional education is not going to work.

All participants agreed, however, that for IPE opportunities to flourish, the involvement of medicine was essential.

> But we are talking here about a major shift in the working relationships between physicians and other disciplines. And coming from a nursing perspective, this is a 150-year-old problem. And there has to be a will on the part of medicine to give up power; it is not really giving up power, but that's the way they will see it. And if they don't want to do that, then interprofessional education is not going to work, even if you put all the disciplines in a room and you have all of these different disciplines teaching, it is still going to be us and them.

Some institutions have initiated interprofessional learning (doctors learning from nonphysicians), which was viewed as a positive move toward interprofessional ways of learning and modeling future practice.

> And so the students are used to learning from me, a non-doctor, and are becoming familiar with what social workers know and don't know. And so that is the beginning of their mind-set as they enter medicine. I think that is very powerful.

Family health teams

Most participants believed that FHTs had the potential to be excellent for teaching, learning, and modeling IPE initiatives and collaboration. They expressed caution, though, with respect to structures for decision making within these FHTs.

> I mean, from my perspective as a pharmacist, it is certainly an incredible opportunity for us to get more directly involved in patient care and certainly with collaborative practice. I think that ultimately it is going in the right direction. And I think there are going to be some problems, some turf stuff, you know,

> and ultimately who is the decision maker. But overall, I think each team... will evolve into finding their way to work together and I think that that is exciting.

There was concern regarding decision-making authority and how that would work in the new FHTs.

> I think that one of the things that is important in terms of the structuring is that the decisions need to be made by everyone and not just by the doctors. And if the decisions are just made by doctors then all we have done is create doctors' offices.

Participants were optimistic about teaching and learning interprofessionally by having FHTs in academic family medicine.

> Well I think that there is common ground where people can learn, and then there are specific medical pieces that can be taught to the residents by an interprofessional group as opposed to just a physician teaching them. So I think in terms of ... small-group learning, it should happen for all learners, not just for residents.

Participants stressed the need for support in the form of faculty development courses so that health professionals could learn how to work in FHTs. As one said, "We need courses on how to become a FHT." Another said, "We need supports in place to help FHTs... learn how to work together to create good models for trainees."

Our results indicated a lack of consensus about opportunities for future academic FHTs to teach IPE. There are opportunities, but they must be pursued with the appropriate vision so that they will include all health professionals.

DISCUSSION

There is a clear mandate federally and provincially to move IPE for collaborative patient-centred practice forward in Canada. The Health Council of Canada report[3] recognized that educating and training students collaboratively would be required to support a shift toward interprofessional teams in practices. In pursuit of improved quality and increased efficiency in health care, several reports and commissions have singled out FHTs as an important means of achieving better health outcomes.[3,4] Yet provincially, particularly in Ontario where FHTs are developing, it is not clear what role academic family medicine training has in preparing health professionals to practise in teams. Our findings illustrate that faculty might not be prepared to teach health professionals how to practise in FHTs.

First, IPE is not clearly defined, a fact that is evident in discussions about the importance of IPE for collaborative patient-centred care. There is still confusion between the concepts interprofessional and multiprofessional. "Multi" can refer to partners working independently toward a purpose.[18] Multidisciplinary or multiprofessional refers to teams where members function in parallel because they work relatively independently and have little communication among them. "Inter" is used to describe partnerships in which members from different professions, disciplines, modalities, and domains work collaboratively toward a common purpose.[19] Since IPE would help to generate effective collaborative practice,[3] attention will clearly need to be paid to this area as it develops.

Second, health professionals' roles and responsibilities in primary health care remain ambiguous. Interprofessional tension is a reality that stems in part from a lack of understanding of the roles and identities of the various health professions. Those who collaborate are often seeking role clarification with respect to boundary issues with a goal of ensuring that the most appropriate mix of providers is giving care. The medical profession has provided guidelines to its members to ensure that delegating an act does not compromise a doctor-patient relationship. It has further cautioned, "If medical acts become incorporated into the accepted scope of practice of other disciplines, the boundaries of medical practice may change."[20]

One of the challenges of interprofessional collaboration is ensuring clear definitions of providers' roles and expectations with regard to shared care. Defining roles and responsibilities will enhance the positive elements of collaborative interprofessional care and reduce misunderstandings regarding protocols, procedures, responsibilities, and authority.[19] Recognizing why these tensions exist and taking educational action to resolve conflict through teaching facilitation and teamwork skills can lead to improved collaboration. Issues related to sex, status, power, and authority and how these determinants affect collaboration need further consideration.

Third, IPE has not been formalized across professions. We found only limited initiatives and opportunities for health professionals to learn with and from each other in all higher education institutions in Ontario. Although some initiatives cited by participants attempted to engage learners in an interprofessional manner, these initiatives were neither formalized nor standardized. Health Canada[8] is leading the way with its Interprofessional Education for Collaborative Patient-Centred Practice initiative as part of the Pan-Canadian Health Human Resource Strategy. The strategy aims to support and facilitate training in this area across all health care sectors. To date, research conducted at the prelicensure level of training has lacked the rigour needed to give us an understanding of its effect on patient care.[21] Evidence does indicate, however, that

collaborative practice initiatives that occur at the postlicensure level of training improve quality of care and patient outcomes in specific populations.[22]

If interprofessional patient-centred collaborative practice is the vision of the future, then education and training for health professionals must reflect that vision. Not having a clear definition of IPE, not having standardized criteria for teaching IPE or collaboration across primary care health professions, and not having formalized educational initiatives have led to a lack of consensus on whether having academic FHTs is an effective way to provide IPE.

Conclusion

Educational leaders from the health professions need to come to a consensus on what role, if any, IPE should have in preparing health professionals to practise in FHTs in Ontario. As collaborative patient-centred care is both a federal and a provincial mandate, we suggest that leadership across the country is needed to move IPE forward in primary health care. The future role of academic family medicine training sites as places for all primary health care practitioners to learn needs to be carefully considered. It could offer a tremendous opportunity for academic family medicine training sites to teach a new generation of health care practitioners to work collaboratively.

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Contributors

Ms Soklaridis *contributed to concept and design of the study; data acquisition, analysis, and interpretation; and drafting and revising the manuscript.* **Dr Oandasan** *contributed to concept and design of the study and to critically revising the paper for important intellectual content.* **Ms Kimpton** *contributed to data acquisition, analysis, and interpretation and to critically revising the paper for important intellectual content. All the authors gave final approval to the manuscript submitted.*

Competing interests

None declared

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