How do clinicians' professional bodies characterise interprofessional care?

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ABSTRACT: *Interprofessional care represents international best practice. Despite evidence of what works to promote it, interprofessional care does not always occur. This might be partly because much research myopically examines health or social care teams, health services, and/or education. This study addresses this by examining how clinicians' professional bodies characterise interprofessional care. An examination of the official websites of 25 professional bodies, spanning five professions and five nations found that, with few exceptions, the strategic foci of these professional bodies did not explicitly recognise the role of counterpart professions. Furthermore, references to these counterparts and interprofessional teamwork were somewhat embedded within the websites and not readily apparent. This suggests considerable opportunity to promote interprofessional care via clinicians' professional bodies.*

Keywords: Health workforce issues; healthcare professions; knowledge translation; managing integrated health services; professional identities.

Integrating health and social care is key to reforms in many countries to address the challenges associated with ageing populations and increased chronic diseases at a time of constraining resources (Goodwin, 2015). The World Health Organization (2011) advocates for care that crosses boundaries between primary, community, hospital, and social care, which necessitates interprofessional practice. Despite international support, interprofessional care is not always achieved (Xyrichis & Lowton, 2008).

Interprofessional care represents best practice, explicitly recognising different sources and forms of expertise to ensure complementarity, rather than duplicative effort or worse still, gaps in care. Interprofessional teams include diverse health and/or social care professionals who collaborate as a mutually dependent group to deliver complex care (Reeves, Lewin, Espin, & Zwarenstein, 2010). Yet, creating the mechanisms and ethos to support such care has been challenging (Dickinson, 2014). Interprofessional teams often demonstrate unique cultures given the professional identities represented within the team that might hinder collaboration (Martin & Rogers, 2004). The varied terms for, and definitions of interprofessional care further complicates how it is operationalised (Best & Williams, 2019).

Given the importance of interprofessional care, and the role of professional bodies in maintaining care standards, this study clarifies how some of these bodies characterise interprofessional care, as defined by Reeves and colleagues (2010).

Although patients with complex conditions often need interprofessional care, this does not always occur. Different professions often: have discrete roles in patient care; are based in disparate departments or organisations; have different payers and regulations; and record information into separate data systems. Interprofessional care therefore requires both systemic and personal commitment (Wells, Chuang, Haynes, Lee, & Bai, 2011).

Interprofessional care requires awareness and positive mutual valuation (Gittell, Godfrey, & Thistlethwaite, 2013). First, professionals must be aware of patients' interrelated needs, like the need for additional education to support medication adherence. Additionally, practitioners need to know which other professionals are currently or should be involved in patient care. Further to awareness, positive mutual valuation supports interprofessional care by enhancing motivation to spend the time required for interprofessional communication. Additionally, positive mutual valuation can help patients to appreciate the importance of each practitioner's role.

Many factors affect awareness and positive valuation among practitioners. For instance, tertiary and continuing education for different professions can engender distinct perspectives on: health(care); as well as the expertise, role, and legitimacy of different professions. Professions often compete for domains within patient care, like assessment and treatment planning (Currie, Finn, & Martin, 2009). Furthermore, different organisations often have diverse priorities – while they might all espouse the importance of wellbeing, they might pursue this aspiration by reducing patient costs, reducing societal costs, and/or variations in between (Williams, 2009). To overcome professional fragmentation, there has been an increasing emphasis on patient-centred care (Lavallee et al., 2016) and interprofessional education to coordinate it across professions (Reeves et al., 2016).

Interprofessional care can also be influenced by the professional bodies that represent health and social care practitioners. Many practitioners, and those studying to be, are members of a professional body. Member benefits typically include contemporary information on factors that can affect workplace practices, like trends in patient needs and regulatory changes. Professional bodies also typically provide ongoing member education and often have periodicals to advance practice. Additionally, many hold annual meetings where members establish and nurture relationships with colleagues and learn about developments in their field. Thus, professional bodies have an important role in promoting interprofessional care.

This study sought to clarify how professional bodies promote interprofessional care. Specifically, it considered how they characterised such care, given their influence on professional standards and norms. This was achieved by reviewing the most visible representation of professional bodies – namely, their websites.

METHOD

The official websites of 25 professional bodies were examined, spanning five professions and five nations (see Table 1). For this study, a professional body is understood to be 'an organisation with individual members practicing a profession or occupation in which the organisation maintains an oversight of the knowledge, skills, conduct and practice of that profession or occupation' (Science Council, 2019, para. 1). The professions included: general practice, nursing, pharmacy, physiotherapy, and social work. These were purposely selected because of their role in primary care – a sector of growing international significance that requires integrated care delivered by an interprofessional team. The professional bodies spanned: Australia, Canada, New Zealand, the United Kingdom, and the United States. Although these nations have disparate health and social care systems, they were selected because of their shared emphasis on integrated primary care. Given the multiple webpages within the websites of these professional bodies, a strategic approach was pursued to achieve the study aim. Specifically, the content of the following sections was analysed, given they were common to most websites: 'About Us', 'Strategic Plan', 'Benefits of Membership' and/or 'Annual Reports'. Additionally, when available within a website, its search function was used to source references to interprofessional care and other professions and/or professionals. Website content was then extracted into Word and Excel files for analysis, which was

guided by the following lines of inquiry: what is the overarching aim of the organisation; what does it do and how does it do it; who are its members; does it recognise members as part of a team; how are other professions mentioned; and how is interprofessional care characterised?

INSERT TABLE 1

RESULTS

General Practice

The aim of these five professional bodies was to 'improve' (AUS) if not 'transform' (US) healthcare, and ultimately the health of its constituents. They espoused the value of primary care, which was often expressed with references to quality, equitable, community-based care. For instance, the Royal College of General Practitioners strived to 'lead… high quality general practice both as a key element in the future pattern of healthcare, as an invigorating environment in which to practise and as a cornerstone of great patient care' (UK). Similarly, the Royal New Zealand College of General Practitioners endeavoured to 'demonstrate the enduring value offered by general practice and general practitioners in a rapidly changing environment by leading and supporting members and general practice to ensure high-quality, equitable care is offered to all patients' (NZ).

Towards this shared aim, the five professional bodies largely undertook three activities. They undertook and/or commissioned research, and/or developed standards and guidelines to clarify the changing scope of general practice and the conditions that enable quality care; they advocated on behalf of members to champion general practice through, for instance, position statements and/or submissions to government; and they educated and trained (prospective) members via professional development opportunities and/or the accreditation of tertiary education.

Given their aim and the objectives, membership was largely open to registered medical practitioners – nationally or internationally – as well as registrars, residents, or students aspiring to be. Although the College of Family Physicians Canada noted that 'licensed physicians' were also required to have a 'good standing', how this was defined was not readily apparent.

Within key organisational artefacts, like summaries 'About Us' and their strategic plans, some professional bodies explicitly recognised general practitioners as part of an interprofessional team, while others did not. Consider for instance, the Royal Australian College of General Practitioners whose strategic plan was largely silent on interprofessional care and potential euphemisms, like teamwork. Although it endorsed the importance of 'Collegiality', this pertained to intra-, rather than interprofessional relationships. Conversely, the College of Family Physicians Canada was more forthright in its interprofessional interests. Given that general practice is delivered in myriad contexts – 'in the office, the hospital… other health care facilities, or the home' (CAN), this professional body recognised general practitioners as part of an interprofessional team. Although general practitioners had particular skills and competencies, these were complemented by other specialities.

This is not to suggest the five professional bodies, did not recognise or make inferences about interprofessional care – but rather, these references (and inferences) were typically embedded within organisational artefacts, like documents on standards, position statements, or news items. For instance, the Royal College of General Practitioners offered a course on 'Management of Obesity in General Practice' (UK), noting that 'the whole primary care team plays a vital part in the improvement in these patients' quality of life'. Similarly, in a position statement on 'General practice-based pharmacists' (AUS), the Royal Australian College of General Practitioners indicated

that it 'values team-based models of care in which a range of healthcare professionals can contribute towards patient health outcomes, maximising use of their skills within their scope of practice'.

The College of Family Physicians Canada held clear positions on the importance of interprofessional care. In its 'Vision Statement on Inter-Professional Care' (CAN), the College drew attention to the important role of nurses, 'pharmacists, physiotherapists, occupational therapists, dietitians, [and] social workers'. Similarly, other bodies referred to different interprofessional colleagues. Primary attention was directed to nurses and to a lesser extent, pharmacists, with even fewer references to physiotherapists and social workers – largely by the College of Family Physicians Canada and the American Association of Family Physicians. For instance, in a position statement on 'Breastfeeding', the latter noted that 'Providing comprehensive perinatal services to a diverse population requires a cooperative relationship among a variety of health professionals, including social workers, health educators, nurses and physicians' (US).

Although all five professional bodies recognised the place of pharmacists in primary care, they did so in disparate ways. For instance, the Royal College of General Practitioners praised 'Initiatives such as the practice-based pharmacists scheme' because of their 'real benefits' (UK). Furthermore, it called for 'wider practice team[s]', which extended to 'pharmacists, extended nurse practitioners & paramedics'. Conversely, the Royal New Zealand College of General Practitioners demonstrated caution. For instance, in its 'POLICY BRIEF' (NZ) on 'Problematic polypharmacy and deprescribing', although the potential value of 'Collaborative prescriber-pharmacist medicine reviews' was noted, evidence for 'pharmacist-led interventions… in primary care' was said to be 'mixed'.

Collectively, these five professional bodies recognise the potential value of interprofessional care. However, some were particularly explicit about the parameters of interprofessional care, ensuring the role of general practitioners was protected.

Nursing

Although the websites of all five professional bodies were examined, that of the Nurses Society of New Zealand was temporary at time of study, offering limited information (see Figure 1). As such, the representation of this professional body within this section is negligible, relative to its counterparts.

INSERT FIGURE 1

Across the five nations, the professional bodies claimed to offer nursing 'a strong collective voice' (AUS) – that is, 'representation' (NZ). Using varied euphemisms, they aimed to 'advance nursing and [relatedly] health' (CAN).

Despite their disparate geographical locations, the five professional bodies collectively represented their constituents via three avenues. They established practice standards, including employment conditions to protect nurse interests; they offered and/or facilitated access to professional development to uphold nursing standards and advance nursing leadership; and they raised the profile of the profession by examining, understanding, and responding to societal changes by, for instance, conferring with government, producing reports, and/or orchestrating campaigns, accordingly (among other efforts).

The efforts of some professional bodies were laudable. Consider the Australian College of Nursing, which – in 2017 to 2018 – submitted '81 POLICY CONSULTATIONS TO GOVERNMENT' and received '84 INVITATIONS TO PRESENT [Australian College of Nursing] ON PROFESSIONAL AND GOVERNMENT

BODIES' (AUS). It also spoke of 'empower[ing] our tribe', with imagery that denoted protection in solidarity (see Figure 2).

INSERT FIGURE 2

Similarly, the Canadian Nurses Association consulted members to (re)develop its 'Primary Care Toolkit' (CAN) and its position statements on matters like 'health human resource planning' – both of which are germane to interprofessional care. For instance, the latter recognised that 'successful human resources planning… requires a collaborative, collective and integrated effort among… health professionals'. The American Nurses Association had an expressed interest in 'transforming' (US) patient perceptions. With references to what might be termed, corporate-speak (Czerniawska, 1997), it vied to intentionally raise the profile of nursing among (prospective) patients by, '**dramatically increase[ing]… nurse-to-consumer positioning and awareness** (US, original emphasis).

Given their aim and objectives, membership across the five professional bodies was largely open to nurses registered by the national regulatory body – these included enrolled nurses and students aspiring to be registered as either. There was limited, if any reference to the prospect of membership among nurses who were registered abroad. However, the Royal College of Nursing was also open to health care assistants for who there are 'no set entry requirements' (NHS, nd, para,. 8).

Notwithstanding the Nurses Society of New Zealand, the professional bodies all recognised the place of interprofessional care. Nursing was largely described as requiring teamwork and as such, nurses were required to know how to communicate, collaborate, and complement. Although most references to interprofessional care were embedded within organisational artefacts like position statements, white papers, and other communiqués, some professional bodies – like the Royal College of Nursing and the American Nurses Association – positioned their collaborative stance within their strategic plans.

For the most part, the professional bodies recognised interprofessional care to involve an array of professions. In addition to general practice, these included: 'allied health professionals' (AUS) – notably, 'physical therapists, occupational therapists, speech therapists, dieticians… social workers, psychologists' (US) – as well as 'pharmacists' (AUS).

Collectively, these five professional bodies recognise the potential value of interprofessional care. However, some were particularly explicit about the parameters of interprofessional care, ensuring the role of nurses was protected and their remit, secured

Pharmacy

The professional bodies for pharmacists largely emphasised: community health, using pharmacy as a vehicle towards this; and/or the role of this profession in health improvement. For example, the Australian Pharmaceutical Society aimed to 'improv[e]… health through excellence in pharmacy care' (AUS), while the Canadian Pharmacists Association looked to 'advance health and wellbeing of Canadians through excellence in pharmacy care' (CAN). Conversely, the Pharmaceutical Society of New Zealand aimed to support pharmacist delivery of best practice. The American Pharmacists Association demonstrated an external facing role, stressing the importance of being the 'voice of Pharmacy' (US), while the Royal Pharmaceutical Society aimed to ensure it was at the 'forefront of healthcare' (UK). Only the Royal Pharmaceutical Society identified international ambitions, claiming a desire to become 'a world leader in safe and effective use of medicine'. Like its Canadian counterpart, the Australian Pharmaceutical Society aimed to help pharmacists to realise their full potential.

All of these professional bodies advocated for members, offering professional development opportunities. The Royal Pharmaceutical Society claimed to promote the profession to the media and government. The Pharmaceutical Society of New Zealand specifically noted its offerings of professional development on leadership. Only the Canadian Pharmacists Association emphasised health promotion and disease prevention. Several bodies promoted professional practice standards and guidelines, with the American Pharmacists Association 'disseminating timely relevant information' (US) and also generating 'state of the art' tools and resources. This body also emphasised its role in networking. Only the Australian Pharmaceutical Society drew attention to the impact a strong membership has on 'enhancing the society's influence' (AUS).

Members of each professional body included pharmacists – be they students, those who were qualified, or those who had retired. Additionally, the American Pharmacists Association offered a 'Corporate Supporter Program' (US) to promote discussion between companies and leaders in the American Pharmacists Association.

Only the Canadian Pharmacists Association and the American Pharmacists Association mentioned working with others. The former cited 'collaboration with member organisations' and 'other health providers and stakeholders' (CAN). The latter described members as 'medication experts in team based patient centred care' (US).

Across the five professional bodies, counterpart professions were not specifically mentioned. According to the Canadian Pharmacists Association, teamwork was aimed at patients and business partners with a range of pharmaceutical companies noted as 'organisational affiliates' (CAN). Similarly, the Pharmaceutical Society of New Zealand did not name specific professions – however, integration was identified as one of four pillars of strength. This body then noted others in two of its six key objectives – namely, 'technicians, interns and other health professionals' (NZ).

Physiotherapy

Several of the professional bodies for physiotherapists focussed on the service user, with the Chartered Society of Physiotherapy aiming to 'transform the health and wellbeing of individuals and communities by empowering members' (UK). The American Physical Therapy Association went further, seeking to 'transform society by optimizing movement to improve the human experience' (US). The Australian Physiotherapy Association also focussed on consumers – however, it offered a different perspective by focusing on ensuring the community 'recognise the benefits of choosing Physiotherapy' (AUS). Others concentrated on physiotherapists – rather than the community – with the Canadian Physiotherapy Association striving to offer 'exceptional service, valuable information and connections' (CAN). However, this body was alone in suggesting it aimed for international influence.

All of the professional bodies offered education to members, with the Australian Physiotherapy Association also striving to 'educate and motivate the consumer' (AUS). Advocacy was also important among the professional bodies, with the American Physical Therapy Association, the Chartered Society of Physiotherapy, and the Canadian Physiotherapy Association wanting to ensure access to physiotherapy. The first of these three bodies sought to 'collaborate with government to improve access' (US), while the last claimed to 'ensure equitable access' (CAN). Across the five professional bodies, championing physiotherapy featured prominently, with the Australian Physiotherapy Association 'looking to champion new models of care' (AUS). Similarly, the Canadian Physiotherapy Association 'champion[ed] excellence, innovation' (CAN). The American Physical Therapy Association stood out with its strong collaboration with a range of stakeholders, including

patients and practitioners. Through collaboration, they had grand ambitions to 'solve the health related challenges that society faces' (US).

Membership of the professional bodies was largely open to qualified and impending physiotherapists. In some instances, membership extended to associate or assistant physiotherapy staff members.

As noted, the American Physical Therapy Association emphasised collaboration, stating that it 'foster[ed] interprofessional approaches to meet consumer needs and instil team values' (US) among its members. The Australian Physiotherapy Association also stressed teamwork; yet this was more confined to primary care – for example, in musculoskeletal services.

Physiotherapy New Zealand cited other professions in relation to teamwork. For example, the roles of speech therapists and occupational therapists were noted in the context of rehabilitation, while that of dieticians and social workers were noted in the context of managing chronic obstructive pulmonary disease. The Chartered Society of Physiotherapy also referred to a range of professions, though usually in its professional magazine. For example, occupational therapists and nurses were recognised as part of multidisciplinary teams in the contexts of community rehabilitation, trauma, primary care, and stroke rehabilitation.

Social Work

Although all five professional bodies for social workers supported their members, each did so differently. Despite their collective interest in social justice, the Aotearoa New Zealand Association of Social Workers stressed the need to enhance social work for the benefit of 'individuals, family, and communities' (NZ). Among the aims of the National Association of Social Workers was an emphasis on enriching members' professional growth and development to maintain professional standards and advance social policies (US). The British Association of Social Workers stood out, noting they were the 'independent voice of social work' (UK).

Most of these professional bodies promoted the profession and social justice. Specifically, they campaigned and lobbied, with the British Association of Social Workers encouraging members to also do so. The Australian Association of Social Workers and the British Association of Social Workers stressed collaboration with international colleagues, while the Canadian Association of Social Work noted its role in assessing international social workers. Several bodies – like the Aotearoa New Zealand Association of Social Workers and the Canadian Association of Social Work – offered its members professional indemnity. The National Association of Social Workers emphasised how its advocacy efforts benefit all social workers – yet these efforts were solely funded by members. Several professional bodies highlighted the professional development opportunities they provided – in the case of the Aotearoa New Zealand Association of Social Workers, this included networking. The Canadian Association of Social Workers also monitored the media. Both the Australian Association of Social Workers and the Aotearoa New Zealand Association of Social Workers explicitly recognised Indigenous communities, with the values of the latter firmly centred on 'bi-culturalism' (NZ).

Across all five bodies, membership was limited to qualified social workers and those in training. This included internationally-qualified social workers whose qualification was locally-recognised.

The public faces of these professional bodies did not explicitly speak of social workers as part of a multidisciplinary team. However, these could be sourced via additional resources. For instance, the Canadian Association of Social Workers recognised multidisciplinary teams in the context of

managing HIV and AIDS. Similarly, the British Association of Social Workers offered a hyperlink to access information about the Social Care Institute for Excellence, which recognised social workers as part of multidisciplinary teams.

Each professional body focussed on social workers, occasionally mentioning other professions. In contrast, the Canadian Association of Social Workers recognised others' roles, including practitioners who 'generat[ed]… referrals' (CAN). These included 'spiritual leaders, family physicians, nurse practitioners, psychiatrists, social and human services providers, guidance counsellors, community centers, lawyers, child care providers'.

DISCUSSION

Integration within the health sector represents a key policy driver and interprofessional care is an important component of this, representing international best practice (Best & Williams, 2019; Goodwin, 2015; Reeves, et al., 2010). Yet such care can be: elusive; difficult to manage; and challenging to deliver (Dickinson, 2014). This is partly due to: varied disciplinary cultures among different practitioners who are expected to collaborate; and their disparate perceptions of their, and each other's roles (Hall, 2009). These (and other) factors can contribute to 'uni-professional silos' (Mitchell, Parker, Giles, & White, 2010). Given their roles, professional bodies might influence the culture of the profession they represent and promote interprofessional care. Yet there is a dearth of scholarship on the role of professional bodies in interprofessional care – this study addresses this void.

The 25 professional bodies, spanning five professions and five nations, demonstrated considerable variation in how they characterised interprofessional care, with nuances between the professions and nations. For instance, those that represented general practice cautiously protected its professional boundaries from perceived competition, like pharmacy. Although they spoke of interprofessional care and recognised its importance, some – like the Royal New Zealand College of General Practitioners – were protective. Others however, were less so – consider for instance, the College of Family Physicians Canada, which was supportive of counterpart professions.

Although nurses' professional bodies advanced their profession, they collectively recognised interprofessional care, all while protecting their remit. This might partly reflect growing interest in the role of nurse practitioners and other nursing specialties (Van Soeren, Hurlock-Chorostecki, & Reeves, 2011). With the exception of the Canadian Pharmacists Association and the American Pharmacists Association, pharmacists' professional bodies paid little explicit heed to counterpart professions. Although physiotherapists' professional bodies also advocated for their profession, they also advocated for consumers, reflecting extant research (Reeves, Freeth, McCrorie, & Perry, 2002). Furthermore, they espoused the importance of teamwork – however, this was largely limited to other rehabilitative professions, like occupational therapy, speech therapy, and nursing. As others have suggested (Barr, Freeth, Hammick, Koppel, & Reeves, 2006), social workers' professional bodies traversed the divide between health and social care as they espoused their profession and social justice for clients. However, notwithstanding the Canadian Association of Social Work, they did not explicitly speak of social workers as part of a multidisciplinary team, and only occasionally mentioned other professions. This is curious, given expressed interest in social justice and equity.

Despite the value of the aforesaid findings, two methodological limitations warrant mention. First, their currency is likely to be limited, given the cross-sectional study design, in which a snapshot of discourse on interprofessional care was captured at one time-point. Second, given limited familiarity with the websites that were analysed, it is possible that pertinent content was inadvertently

overlooked. Although key sections were purposely reviewed – including the précis of each professional body and their strategic plans – and although the search function of each website was used, when available, to source references to interprofessional care and/or other professions, it is possible that content on interprofessional care was unheeded. Nevertheless, it would appear such content was not salient, given the approaches used to comprehensively source relevant content.

Notwithstanding these limitations, the findings from this study have implications for professional bodies and scholars. For professional bodies, the findings suggest there is considerable opportunity to explicitly promote interprofessional care. Although the dominance of medicine is well-established (Bleakley, 2013; Wranik & Haydt, 2018), each profession has a role in redressing power differentials. This is not to suggest they dilute or relinquish their expertise – but rather, they have shared aims and shared objectives to achieve these. This will require role clarity, trust, confidence, a capacity to overcome differences and adversity, as well as collective leadership (Bosch & Mansell, 2015), all of which might be cited within strategic plans and reinforced by incentivising interprofessional development opportunities. For scholars, the findings forge a path for future research. This might include an examination of how professional bodies engage and interact with different stakeholders – within and beyond their profession – to promote interprofessional care, as well as the associated effects. Further to this are opportunities to include: additional professions – like dietetics, occupational therapy, and psychology; additional nations – notably, those with different health systems; as well as additional professional bodies that represent the same professions within the same nation.

Given the importance of interprofessional care, this study is both timely and important. Yet, it also reveals how professional bodies and scholars can further the cause.

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TABLES AND FIGURES

Table 1: Professional Bodies

	Australia	Canada	New Zealand	United Kingdom	United States
General Practice	Royal Australian College of General Practitioners	College of Family Physicians Canada	Royal New Zealand College of General Practitioners	Royal College of General Practitioners	American Association of Family Physicians
Nurse	Australian College of Nursing	Canadian Nurses Association	Nurses Society of New Zealand	Royal College of Nursing	American Nurses Association
Pharmacy	Australian Pharmaceutical Society	Canadian Pharmacists Association	Pharmaceutical Society of New Zealand	Royal Pharmaceutical Society	American Pharmacists Association
Physiotherapy	Australian Physiotherapy Association	Canadian Physiotherapy Association	Physiotherapy New Zealand	Chartered Society of Physiotherapy	American Physical Therapy Association
Social Work	Australian Association of Social Workers	Canadian Association of Social Work	Aotearoa New Zealand Association of Social Workers	British Association of Social Workers	National Association of Social Workers

Figure 1: Nurses Society of New Zealand Website

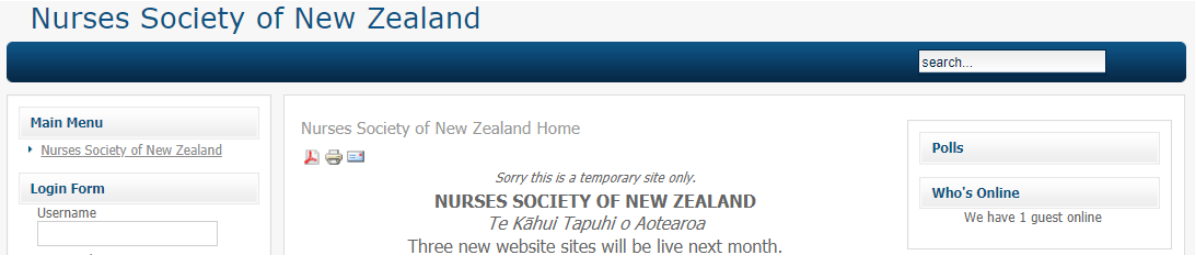

Figure 2: Images from the Australian College of Nursing Website