Competent to collaborate: towards a competency-based model for interprofessional education

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Summary *A competency-based model of interprofessional education is commended to remedy weaknesses in knowledge-based and attitude-based models. It distinguishes between 'common', 'complementary', and 'collaborative' competences.*

Key words: *Common, complementary and collaborative competences.*

Introduction

As competency-based models of professional education gain ground in the UK, a competency-based model of interprofessional education is emerging. Similar models for both should enable students to move easily between professional and interprofessional study as complementary components in a planned progression.

Introduction of a new model for interprofessional education is arguably overdue. While existing 'knowledge-based' and 'attitude-based' models may pave the way for collaborative practice, they have yet to demonstrate this convincingly.

The knowledge-based model was developed from the 1970s onwards around curricula deemed to be applicable to education and practice within and between each of the participant professions. Content, whether from policy or the contributory disciplines, incorporated commonalities of language, concept and knowledge designed, in part, to underpin collaborative practice. But some teachers came to see limitations in a model which emphasised commonalities to the detriment of differences. They realised that only when the professions learned to appreciate their distinctive qualities could they call upon one another intelligently and respond more fully to the needs of patients (Bines, 1992; Loxley, 1997; Spratley & Pietroni, 1994). Some courses therefore introduced comparative learning, using interactive methods, to enable students to explore similarities and differences in their respective professional roles and responsibilities (Barr, 1994; 1996).

Such methods had already been piloted in workshops (Jacques, 1986; Jones, 1986; Samuel & Doge, 1981) and pre-qualifying courses (McMichael & Gilloran, 1984) designed to modify reciprocal attitudes and perceptions. This model was grounded in the belief that by learning from and about one another students from different professions would come to

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understand their respective roles and responsibilities better, generate mutual trust and relinquish stereotypes. Rewarding experiences during the course would strengthen relationships (Berkowitz, 1975; Tajfel, 1981), which would be transferred to other members of the same professions, thereby improving collaborative practice.

Attempts to evaluate these claims have so far been inconclusive (Barr & Shaw, 1995).[1] While changes in attitude or perception were sometimes in the intended direction, this was by no means always so (Carpenter, 1995a; 1995b; Carpenter & Hewstone, 1996; McMichael *et al.*, 1984). Nor were improvements sustained when students were followed-up after the course (Shaw, 1994). Disappointment invariably prompted renewed efforts to devise more effective interactive methods in the expectation that students would then come to see other professions in a more positive light. Teachers were, it seems, reluctant to countenance an alternative explanation, namely that the methods worked well enough but the professions did not always like what they revealed about one another. That was not the only problem. Even if interprofessional education prompted changes in attitude, changes in behaviour might not follow (Barr *et al.*, 1995).

But the most compelling reason to question the sufficiency of the knowledge-based and attitude-based models springs not from the dearth of positive research findings, but from changes in the world of work.

Since those models were conceived 30 years ago, the number of professions (and specialisms within them) has multiplied making the web of working relations more complex. Old professions have made room for new, which have claimed enhanced status and extended territory as confidence, competence and credibility has grown. Patients, too, have become more powerful. Shifts in the balance of power between professions, and between professions and patients, have upset the equilibrium maintained by the more established professions. With relations in a state of flux, it has become less difficult, and arguably more necessary, for government to intervene to redraw boundaries and reallocate responsibilities between professions.

Working relations within and between organisations have also become more complex. Small agencies have given way to large, tying the professions more closely into bureaucratic structures and reinforcing the role of management. Competition and collaboration co-exist, with professionals on both sides of the purchaser/provider split, while creation of the mixed economy of welfare has divided professionals between public, private and voluntary sectors. Collaboration now applies not only to teams but also across divisions of organisations and between different types of organisation, as well as involving patients and community representatives, all of which are priorities for a new government (Secretary of State for Health, 1997).

Like collaborative practice, collaborative education must become multi-dimensional and equip professionals for the complexity of the task.

In summary, the case for competency-based interprofessional education rests upon the need to:

- Reposition interprofessional education in the mainstream of contemporary professional education.
- Enable students to relate professional and interprofessional studies coherently.
- Enable students on interprofessional courses to claim credits as part of their professional education.
- Gain the approval of validating bodies.
- Attract support from employers.
- Compensate for deficits in existing models of interprofessional education.
- Equip professionals for multi-dimensional collaboration.

- Respond to renewed government calls for such collaboration.

Persuasive though the above arguments may be, they encounter resistance. Introducing competency-based education into the professions has been far from trouble free (Ashworth & Saxton, 1990; Kelly *et al.*, 1990; Tuxworth, 1992). Not until critics have been reassured about developments in their own professions may they be ready to contemplate competency-based interprofessional education. Even then, they may seek reassurance that the intuitive, holistic and reflective qualities of the liberal tradition in interprofessional education (Schön, 1983; 1987) will not be sacrificed on the altar of a technocratic, reductionist and mechanical methodology (Jones & Joss, 1995; Rawson, 1994; Rowlings, 1994).

The makings of a competency-based model

Much of this resistance during the early 1990s focused upon the impending extension of National Vocational Qualifications(NVQs) to higher occupational levels and, by implication, the professions (Barr, 1994). This was the climate in which work started to draft the National Occupational Standards for Professional Activities in Health Promotion and Care (Care Sector Consortium, 1997; Mitchell *et al.*, 1998, p. 157, Weinstein, 1998, p. 169). Their significance lies as much in their purpose and in the process by which they were prepared as in the product. The purpose was to arrive at a single statement of practice standards to which each of the interested professions could subscribe, for itself and for collaboration with the others. The process was consultative, collaborative and consensual, as befitted the purpose. The product is on the record (Care Sector Consortium, 1997). Time will tell how far it succeeds in assuaging earlier fears and in reframing the competency debate, thereby informing the future development of interprofessional education and practice.

Meanwhile, Mitchell *et al.* assure us that collaboration is embedded in the Occupational Standards to promote effective communications, to clarify professional roles and relationships, to build and sustain relationships between professions and agencies and, adds Weinstein (1978) to assist in designing shared learning. The Occupational Standards call upon each profession to value the work of others, respecting the contribution which each makes to optimise holistic health and wellbeing.

The competent practitioner will:

- 'contribute to the development of the knowledge and practice of others'
- 'enable practitioners and agencies to work collaboratively to improve the effectiveness of services'
- 'develop, sustain and evaluate collaborative approaches to achieving objectives'
- 'contribute to the joint planning, implementation, monitoring and review of care interventions for groups'
- 'coordinate an interdisciplinary team to meet individuals' assessed needs'
- 'provide assessment services on individuals' needs so that others can take action'
- 'evaluate the outcome of another practitioner's assessment and care planning process'

While interprofessional collaboration is less than explicit in these statements, the Occupational Standards are about 'professional activity'. 'Practitioner' can then reasonably be taken to include 'professional', as well as other occupations.

In recent years, individual professions have also begun to specify collaborative competences at the point of qualification. A general practitioner should be 'aware of his/her own limitations, the skills of others', have 'the ability to refer or delegate appropriately' and be 'willing to accept appropriate responsibility for patients, partners, colleagues and others' (UKRA, 1996). A nurse (UKCC, 1989) should have 'effective teamwork skills' to participate 'in a

multiprofessional approach to care', with 'appropriate referral skills'. Similarly, a social worker should be able to 'work across organisations with other colleagues and professionals, performing appropriately in multidisciplinary situations' (CCETSW, 1995).

Numerous attempts have been made to formulate knowledge, skills and attitudes (CCETSW, 1992; Jarvis, 1983; Kane, 1976; Stevens & Campion, 1994; Vanclay 1996), or knowledge, skills and values (Weinstein, 1998; Whittington *et al.*, 1994), necessary for collaborative practice. Engel (1994) and Rawson (1994) highlight competence in adapting to change. Beresford and Trevillion (1995) call for skills in creativity, imagination and innovation. Spratley and Pietroni (1994) look for a balance between flexibility and creative thinking, on the one hand, and skills in communication and group working, on the other. Hager and Gonczi (1996) regard formulations like these as a 'richer conception' of competence which is 'holistic' not 'atomistic'.

Jones and Joss (1995) devise a cyclical model from the work of Kolb (1984), Gibbs (1988) and Schön (1987) which distinguishes between types of competence required at experiential, reflective and conceptual stages. Competences, they argue, are not discrete, but organised in structured sets required by a given situation. Others distinguish between competences at different levels (Engel, 1994; Hager & Gonczi, 1996; Hornby, 1993), which need to be related to levels of practice and management.

Interprofessionalism, says Bines (1992), necessitates the deconstruction of professional knowledge and identity and its recasting in new forms of knowledge and action. While the professions are accustomed to coming together to learn from the same contributory disciplines, competency-based approaches, she says, shift the emphasis to interprofessional collaboration and the skills needed for it. Drawing upon methodologies from one another's professions, students can explore similarities and differences in their working worlds. Interprofessional courses need to address the social as well as the epistemological aspects of interprofessionalism. These include the development of skills in communication, teamwork and the management of conflict within an understanding of the professions and their histories.

Competences characterise teams as well as individuals. They can be assessed during audit and taken into account in deploying and redeploying tasks, appointing new members, releasing members for training with an eye to overall as much as individual performance (Øvretveit, 1997; West & Pillinger, 1996, West & Slater, 1996).

Types of Competence

Whilst several sources classify competences (Hornby, 1993; Jarvis, 1983; Jones & Joss, 1995), none does so with particular reference to collaborative practice. What follows is an attempt to fill that gap by distinguishing between common, complementary and collaborative competences.

- *Common* Competences held in common between all professions.
- *Complementary* Competences which distinguish one profession and complement those which distinguish other professions.
- *Collaborative* Dimensions of competence which every profession needs to collaborate within its own ranks, with other professions, with non-professionals, within organisations, between organisations, with patients and their carers, with volunteers and with community groups.

The utility of this classification depends upon finding ways to distinguish between common and complementary competences. One person's common competence is another's complementary competence. Common competences may differ in their application, depending upon

role, responsibility, clientele and work setting. Complementary competences may best be identified in a well-functioning team where members have learnt when and how to call upon one another (Engel, 1994).

Collaborative competences then need to be formulated for each dimension, taking into account different levels of practice and management. Competences for collaboration between professional practitioners might, for example, be defined as the ability to:

- Describe one's roles and responsibilities clearly to other professions and discharge them to the satisfaction of those others.
- Recognise and observe the constraints of one's own roles, responsibilities and competence, yet perceive needs in a wider framework.
- Recognise and respect the roles, responsibilities, competence and constraints of other professions in relation to one's own, knowing when, where and how to involve those others through agreed channels.
- Work with other professions to review services, effect change, improve standards, solve problems and resolve conflicts in the provision of care and treatment.
- Work with other professions to assess, plan, provide and review care for individual patients, and support carers.
- Tolerate differences, misunderstandings, ambiguities, shortcomings and unilateral change in other professions.
- Enter into interdependent relationships, teaching and sustaining other professions and learning from and being sustained by those other professions.
- Facilitate interprofessional case conferences, meetings, teamworking and networking.[2]

Postscript

Four years ago I speculated that the extension of competency-based education to include the professions would encourage joint courses and common studies, but neglect comparative learning to improve collaborative practice (Barr, 1995). With luck, I shall be proved wrong, but there is a long way to go.

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Notes

[1] A systematic search of data bases is in progress to find reported evaluations of interprofessional education anywhere in the world which satisfy strict criteria laid down for a Cochrane Review. Findings will be reported in a future issue of this *Journal*.

[2] Reactions to this formulation will be much appreciated, through the *Journal* and its web site.

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