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How to Foster Interprofessional Collaboration Between Physicians and Nurses?

Incorporating lessons learned in pursuing a consensus

SUMMARY

In 2010, the Robert Wood Johnson Foundation (RWJF) collaborated with the Institute of Medicine (IOM) to launch the *Initiative on the Future of Nursing*. In 2011, the IOM released *The Future of Nursing: Leading Change, Advancing Health*.

In the fall of that year, RWJF convened 12 leaders from nurses' and physicians' organizations to frame a consensus document on collaboration between the two professions.[1] However, this dialogue ended when the group's draft report became public and several physician organizations withdrew from the project.

In 2012, in this follow-up project, staff from the Center for Applied Research (CFAR), based in Cambridge, Mass., and Philadelphia, reconvened dialogue participants and interviewed them to glean lessons learned and suggest next steps for fostering interprofessional collaboration.

Key Findings

In a report to RWJF, project staff cited these key findings and follow-up feedback from dialogue participants:

- The dialogue produced not only a document but also a new understanding between nurses and doctors, and spurred debate among members of their organizations.
- Interprofessional collaboration is already occurring on the ground—the problem is at the organizational level.
- The consensus and lessons from the dialogue can help improve such collaboration.
- The patient must be at the center of interprofessional collaboration, but challenges remain in applying that focus.

[1] RWJF funded the project under grant ID#s 67630 and 68919. ID# 67630 also supported technical assistance and direction for the *Initiative on the Future of Nursing*. ID# 68919 was a Foundation project.

Funding

RWJF supported this project from April to June 2012 with a grant of $52,983.

CONTEXT

The Future of Nursing: Leading Change, Advancing Health—the 2011 IOM report—advanced a health care model in which nurses and physicians train together at key points in their careers. The report also recommended that:

- Nurses should practice to the full extent of their education and training.
- Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.

In one of its most controversial recommendations, the IOM report called for reforming state scope-of-practice laws, which restrict the role of advanced-practice nurses—those with postgraduate degrees, such as nurse practitioners, specialists, anesthetists, and midwives.

Scope-of-practice laws may "limit or deny altogether the authority to prescribe medications, admit patients to the hospital, assess patient conditions, and order and evaluate tests," the report noted.

A coalition of five physician organizations called the recommendation on loosening such laws a red flag. In response, RWJF convened representatives from 12 professional organizations for nurses and physicians to bridge their differences.[2]

"We hope to find common ground in their joint commitment to patient care and to enhance the unique roles that each profession plays in health care," said RWJF President and CEO Risa Lavizzo-Mourey, MD, MBA, in a statement. She hoped that the dialogue would help participants:

- Better understand crucial differences in each profession's response to the scope-of-practice recommendations in the IOM report.
- Describe the roles and relationships between the two professions without using charged terms such as scope of practice, supervision, and independent.
- Articulate the roles of each profession in delivering patient care to meet the nation's health challenges.

The goal was a public report endorsed by organizations represented by members of the group. "This report," said Lavizzo-Mourey, "should outline opportunities for us to move forward, both individually and collectively, to improve the state of health care."

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[2] Grant ID# 67630

Starting the Dialogue

The Center for Applied Research (CFAR) guided the consensus-building process. Professional organizations represented included:[3]

- American Association of Colleges of Nursing
- American Nurses Association
- American Organization of Nurse Executives (AONE)
- National League for Nursing
- Nurse Practitioner Roundtable.[4]

For a list of nurse participants, see the Appendix.

The group met at RWJF headquarters in Princeton, N.J., three times, and participated in two conference calls, in 2011.

The Draft Report

That process resulted in a draft report in October of 2011, which participants were asked to take back to their organizations. In the draft, participants agreed that:

- The nation has a shortage of primary care providers, and they are not well distributed across the country.
- Nursing and medicine are distinct disciplines and are not interchangeable. Nurses are not trying to be physicians.
- The captain-of-the-ship notion needs to be refined for the 21st century. Participants discussed whether the term supervision should be eliminated from regulations governing advanced-practice nurses, but did not come to an agreement.
- Medicine and nursing "need a shared understanding of common approaches by both professions to accreditation, assessment, certification, and licensure."
- "Medicine and nursing are not the same," but "our common ethical obligations to patients override personal and organizational self-interests."

[3] RWJF has agreed not to identify the physician organizations that participated in this project.

[4] This umbrella organization is composed of the American Academy of Nurse Practitioners, the American College of Nurse Practitioners, the Gerontological Advanced Practice Nurses Association, the National Association of Nurse Practitioners in Women's Health, the National Association of Pediatric Nurse Practitioners, and the National Organization of Nurse Practitioner Faculties.

The Dialogue Falls Apart

The draft—then considered confidential—nevertheless was circulated at an interim meeting of the House of Delegates of the American Medical Association in November. Two physician organizations immediately announced their withdrawal from the dialogue.

In a letter the organization leaders said they took that step because of the premature release of the draft, and reservations about parts of it.

"The final draft document," the letter stated, "disregards our very sincere concerns for patient safety, access to the breadth and depth of physicians' medical expertise, and quality of care over time. It contains too many statements that are inconsistent with or contrary to our organizational policies and fundamental beliefs.

"Specifically, we believe that optimal patient care is delivered via the patient-centered medical home model, where the personal physician leads a team of health care professionals at the practice level who collectively take responsibility for the ongoing care of the patient."

Another physician organization, in a letter signed by its president, said it had "significant concerns with the lack of clarity provided by the workgroup throughout the initial discussions and we disagree with several of the conclusions provided in the draft document."

The American Medical Association, which did not participate in the dialogue, expressed concern in a letter to RWJF that the draft "may be used inappropriately to advocate for the principles contained therein."

In the wake of this reaction, the consensus-building effort came to a halt.

THE PROJECT

To suggest lessons learned and possible next steps, staff from CFAR facilitated a meeting of the consensus-building dialogue participants at RWJF headquarters in February 2012, and a conference call in March. Project staff also interviewed all the participants.

FINDINGS

In a report to RWJF, CFAR staff cited these findings and this feedback from the participants:

- **We don't want our work to be buried.** The dialogue produced not only a consensus document but also a new understanding between nurses and physicians, and spurred debate among members of their organizations. The outcomes are too valuable to be hidden.

"I know this is a journey, and it's okay if you don't get to the end, but there needs to be a baton to pass to the next group. Right now, it's as if this never happened; there's no baton."

- **We remain hopeful.** Participants want the agreements and lessons from the dialogue to help clarify and improve interprofessional collaboration.

  "This is not the end … It is hard for organizations to change, but we'll continue to move forward with the commitment to seeing care being delivered in an interprofessional way."

- **We developed strong respect for each other.** Participants respected each other and RWJF for taking risks.

  "I respected the people that were there from physicians' groups. I know it was risky for them."

  "We had mutual respect and enjoyment of one another. When that happens, you have to reshape the picture in your mind of the other."

- **The patient must be at the center of interprofessional collaboration, although challenges remain in implementing that focus**.

  "Keeping the patient at the center was the north star that brought us together."

  "The best way to deliver care is in a team. And for the most part, people agreed that team-based care is the inevitable future of health care."

  "We agree that the patient should be at the center, but … we're still parochial in that … we have different perspectives on how you honor that focus."

  "People agreed that health care will have to be collaborative … but they disagreed on the definition of this. For physicians, team-based is 'great as long as I'm the leader.'"

- **Interprofessional collaboration is already occurring on the ground; much of the problem is at the organizational level.**

  "We kept the patient at the center, but the challenge was preventing the professional organizations from creeping into that."

  "Rather than try to get the professional societies to say uncle … strengthen the voice of the health systems where [interprofessional collaboration] is thriving and grow from there."

- **Nurses and physicians approach patient care differently because nursing and medicine are two distinct and separate professions albeit with significant knowledge and practice overlap.** Those differences need to be understood more fully.

- **We were too optimistic.** Participants focused too much on areas of agreement, and not enough on potential roadblocks to more collaboration.

  "At first, we had low expectations. Then we surprised ourselves. Maybe we should have slapped each other and said, 'Wake up!'"

Next Steps

This consensus process should focus on enlisting agreement among individuals rather than on winning agreement from physician associations, said RWJF Senior Advisor for Nursing Susan Hassmiller, PhD, RN, FAAN. "The associations are dug in. If we were to do it again, it would have to be with people on the ground level."

Participant Stephen Weinberger, MD, FACP, of the American College of Physicians, cautioned, "I don't know at this point that it's going to be possible to resurrect what we had, with the 12 people coming together." However, he underscored that "physicians can't work in isolation, and nurses can't work in isolation. The best health care is delivered when they're working together on a team basis with other health professionals."

To continue the dialogue, he appeared on a panel at a meeting of the American College of Nurse Practitioners, and hopes to invite nurse leaders to join panels at meetings of his organization.

Publishing a paper with the backing of even one major physician organization might help lift legislative and regulatory barriers to nurses "practicing to the highest level of their training," suggested Susan Apold, PhD, RN, ANP-BC, FAAN, professor of nursing and health studies at Concordia College. An alternative is to start with the "lowest-hanging fruit. Find the organizations most inclined to work together and hammer out these issues."

RWJF is now contributing to a new federal effort by the Health Resources and Services Administration (HRSA), the Coordinating Center for Interprofessional Education and Collaborative Practice. It is also supported by other foundations. (See Afterward).

LESSONS LEARNED

1. **Physicians and nurses can find common ground more easily than their professional associations.** "You can get them to work together on the front lines," said RWJF's Hassmiller. "At the association level, there's a lot of guild protection."

   "It's a whole different conversation when you have people talking face to face," agreed the American College of Physicians' Weinberger. "When you have people dealing in isolated organizations, the other profession can become a black box that's easy to rail against."

Debbie Bing, of the Center for Applied Research, noted that "There was a lot of goodwill, and aspirations were high" among dialogue participants. However, "the politics outside the room had a life of their own."

2. **Steer clear of buzzwords that mean different things to different people and seek definitional clarity before deciding you know what they mean.** "Leadership was a real buzzword," Weinberger said. "The traditional viewpoint of physicians is that clinical teams—or at least the clinical component of what the team does—should be led by physicians. The nurses felt it should be context-driven. In certain cases, it's more appropriate for a nurse to be directing what's going on."

   "Independence was another buzzword. For nursing, independence means nurses practice nursing without statutory oversight from any other profession. Physicians assumed it meant that nurses would work without physicians. There are ways to discuss these things without using buzzwords."

3. **Don't assume that confidential documents will remain so.** "In a consensus-building process, there's always a way to share information outside the process," said Bing. The unauthorized release of the report "wasn't that surprising a development," to her.

   Malachi O'Connor, the center's vice president, said that "There's always a question of trust, and it broke too easily. Because so much emphasis was placed on the document, it became the carrier of everything."

4. **Anticipate worst-case scenarios that could derail a consensus process.** Participants wished they had spent more time considering what to do if something went wrong. (from a Report to RWJF)

5. **To sustain trust, share communication from one participant with all participants.** When nurses did not immediately hear about a letter to the Foundation from a physician organization, they believed that doctors were receiving information faster. (from a Report from the Center for Applied Research)

6. **Physicians and nurses need to know more about nurses are educated.** "Physicians have a sense of distrust about nurses' level of training," Weinberger observed.

AFTERWARD

HRSA's Coordinating Center for Interprofessional Education and Collaborative Practice, will:

- Develop, manage, and evaluate programs to enhance such collaboration.
- Engage leaders in education, practice, and policy in this work.
- Identify innovations and disseminate lessons learned.

RWJF has committed $1 million in funding for the center through a new $3 million program, *Enhancing Interprofessional Collaboration in Education and Practice*, which runs to December 2014, and not only supports the center, but other work as well.

The program is synthesizing the evidence for interprofessional education (IPE) and interprofessional collaboration (IPC) and outlining a plan to coordinate efforts nationally to advance interprofessional collaboration in education and practice. Deliverables include: (1) convening education, practice, and funding stakeholders on an IPC agenda; (2) engaging a consultant and working with other funders on creating an IPC coordinating center; and (3) producing and disseminating the evidence on IPE/IPC.

Other funders include:

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APPENDIX

Dialogue Participants

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