Journal of Interprofessional Care, (May 2005) Supplement 1: 8–20

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Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept

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Abstract

This paper proposes a new concept and a frame of reference that should permit the development of a better understanding of a phenomenon that is the development of a cohesive and integrated health care practice among professionals in response to clients' needs. The concept is named "interprofessionality" and aims to draw a clear distinction with another concept, that of interdisciplinarity. The utilization of the concept of interdisciplinarity, which originally concerns the development of integrated knowledge in response to fragmented disciplinary knowledge, has caused some confusion. We need a concept that will specifically concern the development of a cohesive practice among different professionals from the same organization or from different organizations and the factors influencing it. There is no concept that focuses clearly on this field. Interprofessionality concerns the processes and determinants that influence interprofessional education initiatives as well as determinants and processes inherent to interprofessional collaboration. Interprofessionality also involves analysis of the linkages between these two spheres of activity. An attempt to bridge the gap between interprofessional education and interprofessional practice is long overdue; the two fields of inquiry need a common basis for analysis. To this end, we propose a frame of reference, an interprofessional education for collaborative patient-centred practice framework. The framework establishes linkages between the determinants and processes of collaboration at several levels, including links among learners, teachers and professionals (micro level), links at the organizational level between teaching and health organizations (meso level) and links among systems such as political, socio-economic and cultural systems (macro level). Research must play a key role in the development of interprofessionality in order to document these linkages and the results of initiatives as they are proposed and implemented. We also believe that interprofessionality will not be pursued without the requisite political will.

Keywords: *Interprofessional education, interprofessional collaboration, interprofessionality, framework.*

Introduction

Interprofessional education and interprofessional collaboration have not often found a place in the education and practices of health professionals. The papers in this supplement provide several perspectives on this situation. Our focus, however, has been to arrive at a comprehensive appraisal of the elements of a collaborative patient-centred practice. Our reflection has led us to formulate some propositions with respect to "interprofessionality". We are effectively proposing a new concept. The goal of the paper is three folds: (1) to draw

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ISSN 1356-1820 print/ISSN 1469-9567 online © 2005 Taylor & Francis Group Ltd
DOI: 10.1080/13561820500081604

a real and useful distinction between this new concept of interprofessionality and the current use of interdisciplinarity, (2) to propose a definition of interprofessionality, and (3) to propose a framework that identifies the processes and determinants of interprofessionality and links those components in a clear and concrete way that is research based.

Interdisciplinarity versus interprofessionality

Interdisciplinarity is a response to the fragmented knowledge of numerous disciplines. Each discipline is based on a sum of organized knowledge, and the emergence of numerous disciplines has resulted in an artificial division of knowledge that does not match the needs of the researchers who are investigating complex research areas (Gusdorf, 1990; Klein, 1990). Interdisciplinarity wishes to reconcile and foster cohesion to this fragmented knowledge. As a result, whole new disciplines may emerge.

In the same manner that disciplines have developed, so too have numerous professions, defined by fragmented disciplinary specific knowledge. Each profession owns a professional jurisdiction or scope of practice, which impacts the delivery of services. This silo-like division of professional responsibilities is rarely naturally nor cohesively integrated in a manner which meets the needs of both the clients and the professionals. The notion of interprofessionality is useful to direct our attention to the emergence of a more cohesive and less fragmented interprofessional practice. This does not imply the development of new professions, but rather a means by which professionals can practice in a more collaborative or integrated fashion. This distinction separates interprofessionality from interdisciplinarity.

Defining interprofessionality

In the health domain, interprofessionality is a response to the realities of fragmented health care practices. Professionals come from different disciplines and from different health care organizations, each carrying different conceptualizations of the client, of the clients' needs, and the type of response needed to address the clients' numerous and complex health care situations. Interprofessionality is defined as the development of a cohesive practice between professionals from different disciplines. It is the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population. Interprofessionality comes from the preoccupation of professionals to reconcile their differences and their sometimes opposing views and it involves continuous interaction and knowledge sharing between professionals organized, to solve or explore a variety of education and care issues all while seeking to optimize the patient's participation. The care provided to the patient and the patient's willingness to participate are key factors in this approach. Interprofessionality requires a paradigm shift, since interprofessional practice has unique characteristics in terms of values, codes of conduct, and ways of working. These characteristics must be elucidated. We believe it important to acknowledge this unique point of view by proposing the concept of interprofessionality. The fact that no term currently exists to capture this particular phenomenon is symptomatic of the state of the knowledge in this area. The concept of interprofessionality makes it possible to specifically study the interprofessional nature of an intervention be it in the field of education or of practice.

The development of interprofessionality implies a better understanding of the determinants and processes that influence interprofessional education and interprofessional practice. It also involves the understanding of the links between these two spheres of activity. Our hypothesis is that we cannot develop interprofessional practice that will produce

improved results in health care delivery simply by pursuing the work in those two areas separately. We need to look at education and practice across the professions and how education and practice are interdependent upon each other in order to enhance patient-centred care. Interprofessionality is then an education and practice orientation, an approach to care and education where educators and practitioners collaborate synergistically.

Interprofessionality also concerns the environment of practice and the determinants and processes that support a cohesive practice. In this way managers and professionals would benefit from working together. Again our hypothesis is that interprofessional practice cannot be developed on the will of only professionals or only managers. Interprofessionality involves continuous interaction between professionals and managers, in order to understand the appropriate environmental conditions for the development of interprofesionality.

Interprofessionality will be better understood through practice and research. It has the potential to open up a field of inquiry to fully understand the processes and determinants of interprofessional education and of interprofessional practice. To this end, we propose the framework of "Interprofessional Education for Collaborative Patient-centred Practice (IECPCP)" based on the research work done for Health Canada (Oandasan, D'Amour, Zwarenstein et al., 2004). This frame of reference can be seen as a first milestone in the development of this emerging area of inquiry linking interprofessional education with interprofessional practice. It is an evolving framework and denotes that much needs to be learned in this area, this is why it should remain flexible and adapt to changes in education and health systems.

This IECPCP framework should help to identify the determinants and processes that influence educational programs to teach about interprofessional practice as well as the determinants and processes that influence the adoption of interprofessional practice within the health system. Moreover, this framework opens the door to understanding the linkages between these two worlds and the still relatively unknown process of cross-fertilization at work between them. At this point in time, published work on either subject does not mention a frame of reference such as the one we propose. Through effective analysis and implementation of the proposed framework, best practices and better patient-centred care outcomes are hypothesized to be achieved. These results, however, can only be proven through a process of formalized evaluations and research.

Within this paper the terms "patient" and "client" have been used interchangeably, and include the family or community when appropriate. The client/patient/family/community is conceived of as a partner in care delivery, not simply as the recipient or consumer of care. The term "professional" includes the different types of workers who provide the patient/client with preventive, curative and rehabilitative care.

Interprofessionality and IECPCP Framework

As mentioned, the IECPCP framework is designed to highlight the linkages between interprofessional education and collaborative practice (Figure 1). The framework is made of two circles: the first circle for education and a second for practice. The first includes factors that affect a health professional learner's capacity to become a competent collaborative practitioner. It highlights micro (teaching), meso (institutional) and macro (systemic) factors. The learner is at the core of the first circle and is affected by all the factors that influence his or her ability to gain the competencies needed to be able to work collaboratively with other health care professionals.

The second circle is comprised of processes and factors that affect patient care outcomes in collaborative practice settings. Again, the micro (interactional), meso (organizational) and

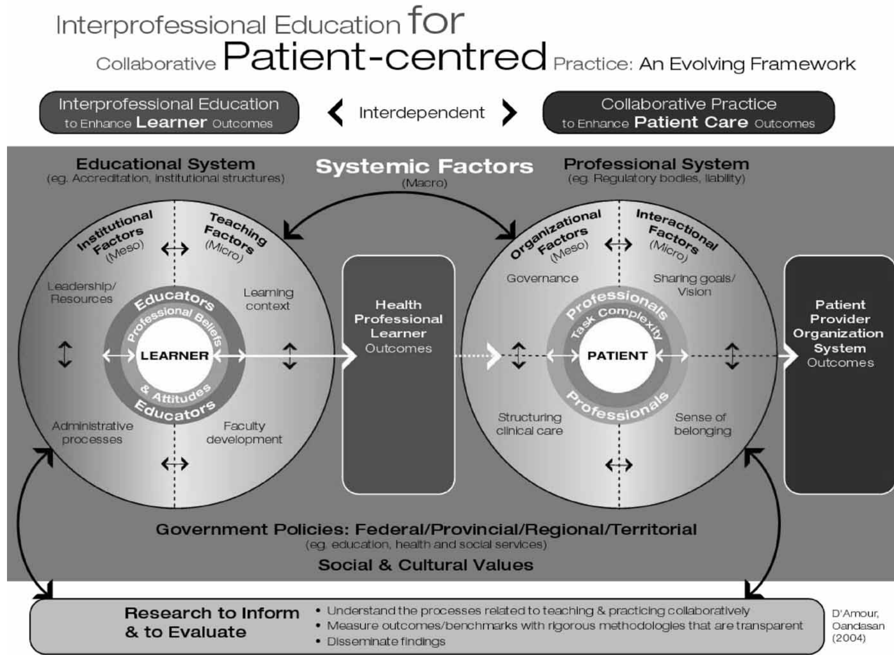

Figure 1. Interprofessional education for collaborative patient-centred practice.

macro (systemic) factors are highlighted. The circle shows the processes through which health professionals structure their collaboration. These processes are complex since they concern human interaction between professionals from different world-views within a complex changing environment. The patient is at the core of the second circle, and his or her health care outcomes will be affected by the professionals' collaborative practice. To be effective, patient-centred care must address the needs of the patients and their wishes, in that their readiness and willingness to collaborate in their care must be understood.

Research, including evaluation, informs both interprofessional education and collaborative patient-centred practice. It provides feedback that encompasses micro, meso and macro levels and helps stakeholders bring improvements to both the educational and practice environments. Below is a description of each of the components of the framework.

1. Interdependency between interprofessional education and collaborative practice

If interprofessionality is to be studied, it is necessary to make a distinction between *educational initiatives to enhance learner outcomes* and collaborative *practice to enhance patient outcomes*. Creating such a distinction within the framework provides an opportunity for stakeholders, like the government, licensing bodies, hospital and academic institutional leaders, educators, learners, health professionals and the public, to examine the factors that influence specific outcomes of both fields while acknowledging their interdependence. Separating education from practice provides clarity about the structural determinants and processes affecting the advancement of interprofessionality at both a micro and meso level. At all levels, but perhaps even more so at the macro level, stakeholders must recognize the interdependent nature of interprofessional education and collaborative practice. With this theoretical understanding, distinctions between these two fields can be made yet its linkages

clearly understood. This theoretical understanding is the underpinning that can pave the way for advancement of this complex domain.

Interprofessional education requires collaborative practice settings where learners can be exposed to educational experiences. It is believed by many that if we train competent collaborative practitioners, more collaborative practice settings will be developed over time. With increased numbers of settings, more opportunities for learning and teaching collaboration are envisioned. Hence practice is linked with education.

Zwarenstein, Reeves and Perrier (2005) have found that there is mounting evidence that collaborative practice interventions indeed improves patient outcomes on specific populations studied to date. However, in this same review, little evidence that formalized interprofessional education initiatives, particularly at the pre-licensure level, has improved patient care outcomes. Caution must be noted in interpreting this finding as linking pre-licensure education with patient care outcomes is not an easy task. The framework which we propose, illustrates that there are many factors that act as determinants for collaborative practice to be realized of which D'Amour, Ferrada-Videla, San Martín Rodríguez and Beaulieu (2005) have ably described. There are those that question the necessity to find evidence of effectiveness of collaborative practice and interprofessional education and whether we must expend energy in researching outcome measures. Yet, this information can drive change and indeed can influence health care professionals and those in leadership positions within government and health/academic institutions to make strategic decisions to supportive initiatives to enhance interprofessional education for collaborative patient-centred practice.

2. Interprofessional education to enhance learner outcomes

Interprofessional education to enhance learner outcomes highlights the learners as central to interprofessional educational processes (Figure 2) (Oandasan & Reeves, 2005). The interface between the learner and the educator is an essential element of interprofessional education. Within our framework we situate socialization issues as a key component that must be addressed in the development of interprofessional education. By socialization we mean that the professional and cultural beliefs and attitudes that develop among health professionals can affect their willingness to collaborate with other health professionals (Perkins & Tryssenaar, 1994; Zungalo, 1994). Learners enter health professional programs with already formed stereotypes of their own professional identity and stereotypes of others (Tunstall-Pedoe, Rink & Hilton, 2003). This identity can be further shaped by their educators/mentors, who act as role models (Gill & Ling, 1995; Parsell & Bligh, 1998; Waugaman, 1994). Therefore, the professional beliefs and attitudes of educators with respect to collaborative practice play a critical role in student training. Students, in turn, influence educators, and there may be a bi-directional socialization process that occurs over time and across generations. This is depicted by the bi-directional arrows between the learner and the educators in the left hand circle. Educators can either be enablers or barriers to learners' opportunities to gain collaborative competencies. Recognizing that professional and cultural beliefs and attitudes are often fostered through system influences like the media and through public perceptions, we situate professional values and beliefs as a macro- issue within our framework as well as a micro issue that must be acknowledged between learners and educators. This will be further discussed later in this paper.

Teaching factors (micro level) and institutional factors (meso level) can influence the professional beliefs and attitudes of faculty and learners towards interprofessional ways of learning and practicing. These micro and meso level factors, which are integral components of interprofessionality, are interactional. This is depicted in Figure 2 by four small arrows in

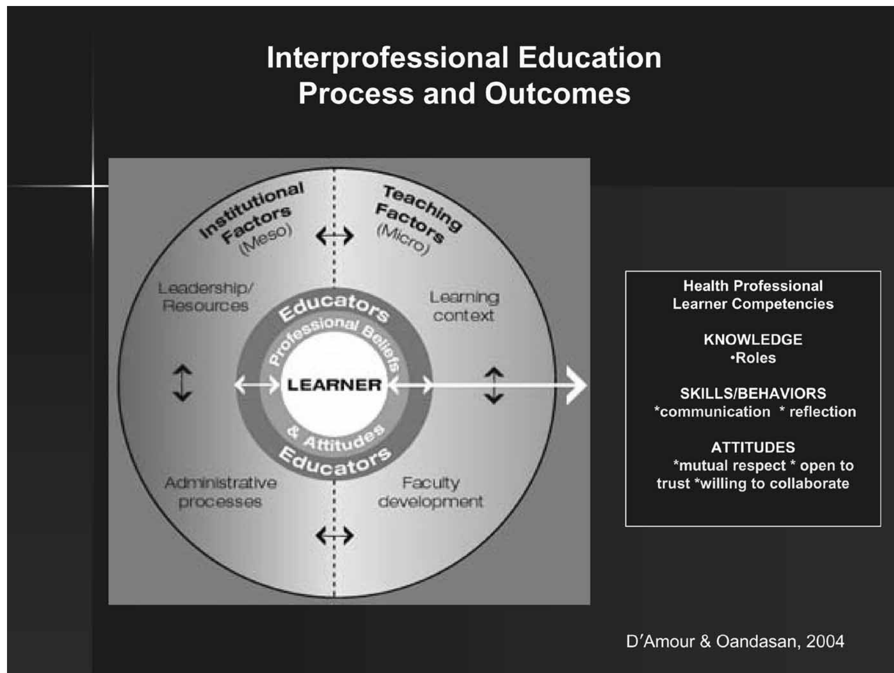

Figure 2. Interprofessional education: Processes and outcomes.

the circle: they are dynamic and hence represent a circular motion. The factors influence and inform each other, and may act as catalysts or barriers. Oandasan and Reeves (2005) provide an in-depth description of each of the factors that are listed below in their paper found within this supplement:

2.1 Teaching (or micro level) factors include:

- Learning context, which encompasses how to teach interprofessional collaboration and addresses questions of the "who, what, where and when" of interprofessional education.
- Faculty development, which addresses: the faculty's needs to learn how to facilitate interprofessional education and how to recognize one's own professional beliefs and attitudes towards collaboration.

2.2 Institutional factors (or meso-level)

In this instance, institutions are defined as higher-education academic institutions or academic hospital environments. Without the development of a vision of interprofessionality at the institutional level, it will be difficult to mobilize the need for change. Hence administrators and leaders must be actively involved in moving the IECPCP agenda at their institutions. This is consistent with the literature on change management captured by Ginsburg and Tregunno (2005) in their review of the literature on organizational change. The following institutional facets can influence interprofessional educational opportunities:

- Leadership and resources, which include: administrators with the power to move the agenda forward by providing resources and champions to carry the vision.

- Administrative processes, which comprise: the methods for implementing initiatives, including logistical decisions and financial incentives.

2.3 Interprofessional education outcomes.

As discussed earlier, it is important to have clinical settings where collaborative practice is modeled for learners. Through the inquiry of interprofessionality, a body of knowledge will be created that describes the types of competencies that are required of health practitioners to work optimally in collaborative practice settings. This body of knowledge can be utilized to help describe the competencies that need to be taught. At this time these competencies (or the knowledge, skills, attitudes) shared by collaborative practitioners are still being defined. Much can be learned from two literature reviews on the conceptual models of collaboration and on the determinants of collaboration in this supplement (D'Amour et al., 2005; San Martín Rodríguez, Beaulieu, D'Amour & Ferrada-Videla, 2005). From these literature reviews, specific processes and determinants are identified. As they are grounded in empirical research, we feel they can aid educators in understanding the types of competencies that learners should obtain to function collaboratively. An extrapolation of these processes and determinants can provide an understanding of some of the knowledge (group functioning, roles and responsibilities of different professionals. . .), skills (communication and reflective practice, leadership. . .) and attitudes (mutual respect, willingness to collaborate, openness to trust. . .) that should be learned. Clear competencies or learner outcomes are necessary for the development of formalized teaching innovations at both pre-licensure and post-licensure levels. More research will be required to help further define these competencies for the future.

Few formal learning opportunities at the pre-licensure level currently exist to teach health professionals to be collaborative practitioners. Yet, there are many health professionals who have acquired collaborative competencies without formal training, working in health care. It is for this reason that a dashed arrow can be found within the framework extending from the learner competency outcome box to the collaborative practice setting circle (Figure 1). By identifying health professionals who are working collaboratively, we are able to learn from them and can operationalize ways of teaching and practicing collaboration based upon research findings from the practice settings from which they work.

2.4 Post-licensure teaching and learning for health professionals.

There have been many formalized educational methods used to enhance post-licensure health professional's opportunities to acquire specific interprofessionality competencies as found in the Jet Review (Freeth, Hammick, Koppel, Reeves & Barr, 2002). Some of these methods fall under the categories of staff development, faculty development and still others in the area of continuous quality improvement initiatives (CQI). There is some debate particularly, within medical education, over the specific terminology that should be used to describe educational methods within the post-licensure arena: should it be called professional development or continuing medical education? We have chosen to use the term "professional development" to depict types of educational methods that can be used to teach collaborative competencies to post-licensure health professionals, because it underscores the practitioner's role as a learner. Learners can thus be either within the pre-licensure or post-licensure levels of training but the micro and meso-level factors that need to be addressed related to interprofessional education initiatives remain consistent.

It is unclear what impact formalized competency-based educational initiatives would have in the practice setting when the learners are post-licensure health professionals. As was discussed

earlier, what has been hypothesized by many, but not yet proven is the idea that education to provide collaborative competencies to both pre-licensure and post-licensure health professionals will improve patient care outcomes if the professionals work in an environment that supports collaborative practice. More research is needed to come to a definitive conclusion.

3. Collaborative practice to enhance patient outcomes

Collaborative practice to enhance patient care outcomes highlights the patient/client as central to collaborative processes. As indicated in the circle the professionals and the patient/client are in an interdependent relation. Figure 3 lists the key elements of a collaborative practice in health care organizations. Such practice takes various forms and the make-up of each team depends on the complexity of the needs that it addresses. The circle depicts the interactional processes and organizational factors that have to be taken into account when professionals work collaboratively.

3.1 Needs of the patient/client and task complexity.

Patients are at the center of collaborative care, since they are the initial reason for the interdependency between professionals (Evans, 1994; Henry, Schmitz, Reif & Rudie, 1992; Liedtka & Whitten, 1998). Patients are at the same time active members of the team and recipients of the care provided by the team (Golin & Ducanis, 1981). According to these authors, the patients' needs determine the interactions between professionals (Golin & Ducanis, 1981). Their privileged position in the team nevertheless depends on their willingness and ability to participate in the planning and delivery of health care. However, D'Amour et al. (2005) found little evidence that researchers had conceptualized the client or

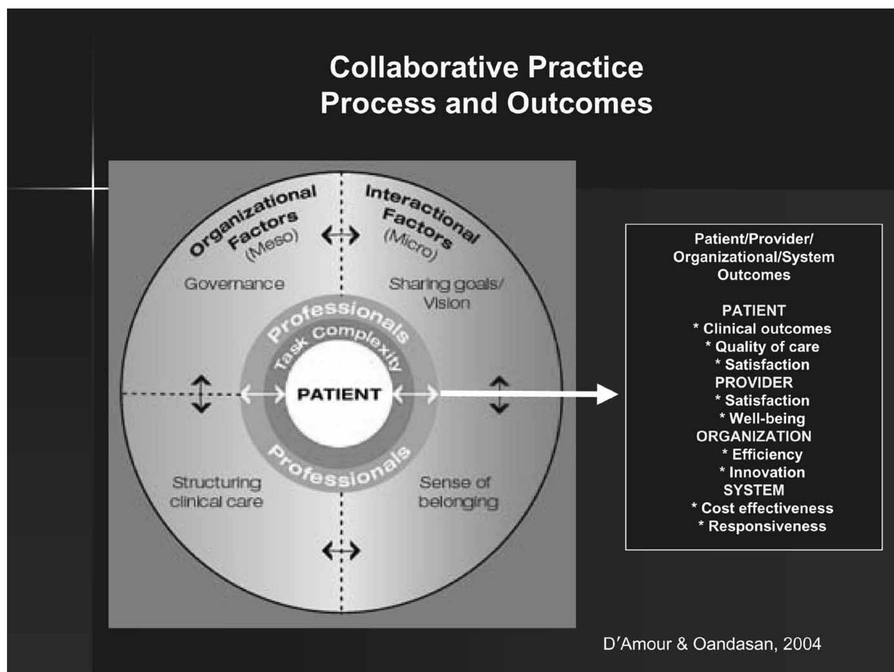

Figure 3. Collaborative practice: Processes and outcomes.

family as participants in interprofessional collaboration. Attention will clearly need to be paid to this area as interprofessionality is developed.

This focus on patient is necessary but not sufficient. The collaborative practice is above all processes made of complex interactions: interactions between individuals and interactions between individuals and the organization which present many constraints to individual action. The literature review of the frameworks on collaboration in this supplement (D'Amour et al., 2005) has identified seven frameworks of collaboration among which three present stronger theoretical and empirical bases that can help to understand the processes and determinants of collaboration (D'Amour, Goulet, Pineault, Labadie, & Remondin, 2004; Sicotte, D'Amour & Moreault, 2002; West, Borrill & Unsworth, 1998) The three of them could possibly be used to fit in this framework of IECPCP to tackle the issue of collaborative processes since most of them integrate the perspective that collaboration is made up of processes influenced by human relationships and organizational constraints. We choose to draw on D'Amour's model, which is a strong model that expresses our way of conceptualizing collaboration (D'Amour, Sicotte & Levy, 1999). D'Amour's model proposes four dimensions to collaborative processes, two of which are related to human interactional processes and two that are tied to organizational factors.

3.2 Interactional processes.

As far as the interactional dimensions are concerned, sharing common goals and a common vision are of prime importance (Cohen & Bailey, 1997; Evans & Dion, 1991; Liedkta & Whitten, 1998). Shared patient-oriented goals emerge when the team is focused on the patient/client, but at the same time one must recognize the diverse interests and the asymmetry of power of the various partners in care and the negotiations that result (Corser, 1998; Henneman, 1995; Sullivan, 1998). The other interactional dimension refers to the bonds that develop between team members and their willingness to work together, elements that contribute to a sense of mutual trust among the health professionals working in a team. In order to build trusting relationships, professionals must know each other personally and professionally (Das & Teng, 1998; Jones & Georges, 1998; Williams, 2001). To know each other professionally means to be familiar with each other's conceptual models, roles and responsibilities. Collaboration is not possible if this basic requirement is not fulfilled. It allows participants in the team to transcend their inclination towards exclusive professional "turfs" and share common professional territories.

3.3 The organizational factors.

However, it is important to recognize that collaboration exists not only within a team, but also in the context of a larger organizational setting and more and more frequently, between organizations as in health care network, which exercises significant influence on the team. The two dominant organizational dimensions of the model are governance and formalization. Governance is, in that respect, a key element, and it includes the role played by leadership. Different levels of leadership should be considered, such as central, local and expert leadership. In the context of interprofessionality, collective leadership and interprofessional leadership need thorough study (Denis, Lamothe & Langley, 2001). The formalization dimension refers to structuring clinical care in a more systematized way. Efforts to formalize include the development of information exchange, protocols, procedures... (Bodewes, 2002; Freeth et al., 2002; Sicotte et al., 2002). These efforts constitute a key element of the organizational dimension, since they clarify expectations.

The interactional and organizational factors influence one another. This is indicated by small arrows inside the circle, which are meant to represent circularity in the relationship between interactional and organizational factors.

Other factors external to the organization must also be taken into account, such as the structure of health care delivery and the degree of integration between different organizations. On a broader level, structures such as those found in professional and educational systems have a significant impact on the development and regulation of professional boundaries. These boundaries can be among the main obstacles to collaboration in the health care system, and can promote a competitive mindset in professionals instead of fostering a spirit of collaboration (Abbott, 1988). On the other hand, social values and/or societal pressures can drive innovative ways of working and can compel professionals to be more open to new orientations and new approaches to practice.

3.4 Outcomes of collaboration.

According to the literature review on the models of collaboration (D'Amour et al., 2005), interprofessional collaboration has a four-fold impact that takes into consideration patient, professional, organizational and system outcomes (Corser, 1998; D'Amour et al., 2004; Miller, 1997; West et al., 1998). The effects of collaboration on patient outcomes are discussed by Zwarenstein, Reeves and Perrier (2005). Providers' outcomes take the form of job satisfaction (Corser, 1998; D'Amour et al., 2004; Miller, 1997) and team member mental health (West et al., 1998). Health organizations also benefit from collaborative care, since professionals work more efficiently (West et al., 1998). The expected effects on the overall health care system are reduced cost and greater responsiveness (D'Amour et al., 2004).

4. Systemic factors – macro level

As captured by Ginsburg and Tregunno (2005) change management strategies need to be explored that would affect systemic changes at the macro level. These efforts would include creating a shared vision for health, social and educational systems that would be in keeping with interprofessionality. Ideally, policies developed by various levels of government would support interprofessional education for collaborative patient-centred practice. For example, decision makers could reflect upon the structural and financial segregation of post-secondary health professional training programs and consider ways to alleviate the current climate of segregation between professions. The professions themselves have a role in impacting change particularly through health professional regulatory bodies. These bodies are responsible for defining scopes of practices and dealing with issues of liability. They can positively influence interprofessionality through policy implementation which may impact how professionals choose to practice. Lastly, accreditation at institutions where health professionals work or are trained can act as powerful forces for change and can be a strong lever for advancing interprofessionality if they choose to monitor for collaborative practice and structured interprofessional educational activities.

Earlier it was mentioned that the interface between health professional educators and learners should consider the effects of both parties' professional cultural values. Often health professionals fail to recognize that they carry with them stereotypes or misconceptions of other health professionals that negatively impact opportunities to teach and/or practice collaboration. The effect of professional cultural values at the micro level of teaching is important to take into consideration. However, as discussed earlier, it has been found that learners enter their educational programs with cultural beliefs, attitudes and values about the

profession they are entering, developed well before they have engaged in formal training. Recognizing this reality, we felt that it was important to acknowledge that professional socio-cultural beliefs are prevalent at both a macro level and a micro level. At the macro level, professional socio-cultural beliefs weave its effects into the meso and micro levels of both education and practice. As noted earlier however, we feel it important to particularly note its effect at the educator/learner interface, as role modelling is so important to learners. However, patients/clients or the public are also affected by professional stereotypes that prevail systemically. They are often developed through the media or inherited historically. This public perception of the roles of health professionals can impact the comfort level of individuals in seeing health professionals other than, for example, a physician within a team, as point of first contact within the health care system.

The framework highlights the need to foster collaboration with the involvement of patients/clients and health care professionals, learners and educators and institutional leaders and policy makers. Through the development of legislative and regulatory reforms at a macro level, setting priorities and demonstrating flexibility in providing support and funding for interprofessional education and collaborative practice initiatives at a meso- institutional level and enhancing competencies and work environments to support collaborative practice and education at a micro level, this framework helps to highlight the determinants required for transformation. Health professionals working together under this framework may require new roles and responsibilities that may affect the current scope of practices as they work together directly impacting patient care. This framework provides the rationale that collaborative competencies (knowledge of roles, good communication skills and collaborative attitudes) will not necessarily improve patient/client, provider, organization and system outcomes if micro- meso- and macro- level support are not aligned at practice settings. With the concept of interprofessionality, this framework proposes some of the determinants required for both education and practice to positively impact outcomes including patient care.

5. Research to inform and evaluate

Research is an important factor that must be recognized within this evolving framework. The findings from rigorous research in this area will underpin our understanding of interprofessionality and can advance this area further in the future. The large arrows in the framework (Figure 1) represent a circular motion, highlighting the iterative feedback loop that crosses all micro, meso and macro levels for categories of both interprofessional education and collaborative practice. The arrows also recognize that research in interprofessional education can inform research in collaborative practice, and vice versa. Research informs and can evaluate the processes involved in interprofessionality.

We are still acquiring a body of knowledge on interprofessional education and collaborative practice. Through additional research from different paradigms, we will be able to expand the knowledge base of interprofessionality. Developing clear outcomes and benchmarks through the application of rigorous methodologies in both the learning and practice environments will produce a better understanding of interprofessionality and its outcome in these settings. Further research in this field is needed to provide guidance with respect to which populations can benefit from a collaborative approach, which health professionals should be involved, and how health professionals should collaborate with each other. The answers to these questions will help inform strategies employed in the teaching environment and help trainees become competent collaborative practitioners.

Research in the area of interprofessional education and collaborative practice has had few frameworks that could serve as guides in developing research questions and methodologies.

The dissemination of findings has been haphazard, and there have been problems achieving transparency in the initiatives developed and evaluations used. We need to ensure that findings are widely disseminated and that the methodologies used are written in a way that they are easily understood and reproduced (Hammick, 2000; Freeth, Hammick, Koppel et al. 2002).

Conclusions and recommendations

We have proposed interprofessionality as a new concept and a new area of inquiry, to make explicit the links between two inseparable fields of study, interprofessional education and collaborative practice. Through the IECPCP framework, we propose an integrated vision of a group of factors derived from the structures that influence interprofessionality and from the collaborative processes that will enable educators and practitioners from different professions to work together. The framework specifically includes the clients as partners in care delivery. This important partnership has not yet been fully recognized in interprofessional education and practice. The foundations of this framework will be built through research. Without research, the concepts proposed cannot be rigorously developed, implemented and tested. As a result, transformation of health care systems to support interprofessional education for collaborative patient centred practiced may be delayed. The research methods used must be able to cross and intersect all of the determinants at the macro, meso and micro levels to ensure that the answers needed to move interprofessionality forward are addressed. Key decision-makers and policy-makers can use the research findings to develop policies that will ultimately improve collaboration by impacting all three levels identified in the framework.

We would like to conclude on the fact that this scientific and theoretical agenda has to be supported by political stakeholders since many factors that influence interprofessionality have political components. If we are to advance interprofessionality, there is a need for collaboration among educators, practitioners, researchers, policy-makers and the public. These stakeholders must believe that fundamental change is needed.

Acknowledgements

The authors would like to thank Health Canada through the Office of Nursing Policy that coordinates the ‘‘Interprofessional Education for Patient Centred Care’’ initiative and provided the funding for the environmental scan and literature review that culminated in the development of the conceptual framework presented in this paper. We would like to give special thanks to Leticia San Martin Rodriguez and Marcela Ferrada Videla who brought a major contribution to discussions related to the numerous iterations of the framework. We would also like to thank our colleagues who were part of the overall research team: Louise Nasmith, Merrick Zwarenstein, Marie-Dominique Beaulieu, Scott Reeves, Keegan Barker, Carmela Bosco, Margaret Purden, Lianne Ginsberg, Deborah Tregunno and Laure Perrier whose work provided the substrate from which this framework was envisioned. In addition, special acknowledgement must be made of Yanick Maufrand who was instrumental in the graphic design of the framework.

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