

Chapter 8

Utilizing curriculum renewal as a way of leading cultural change in Australian health professional education

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Preface

Health systems globally are engaged with major reforms focused on the need to deliver more responsive, effective and sustainable health services. Interprofessional practice (IPP), and the development of interprofessional educational (IPE) targeted at enabling IPP, sit at the heart of many of these reforms. IPP enabled by IPE could be argued as the practice foundation for achieving new and more effective forms of health service provision and health professional practice (World Health Organization, 2010; Gittell, Godfrey & Thistlethwaite, 2013).

This increasing policy and practice focus on IPP and IPE is underpinned by a growing understanding that effective professional practice in health is a social and situated negotiation and achievement occurring between several different health professionals, and, critically, between this group of health professionals and the patient, carer/s, and other professionals and support services involved. In this sense effective practice is a larger concept requiring individual practitioners to be able to work effectively together (Matthews *et al.*, 2011). This broader concept of practice contrasts with a more particular and limited view of effective practice as defined primarily in terms of disciplinary or uni-professional knowledge and expertise delivered by individual professionals operating primarily from within their own sphere of knowledge and expertise. In fact, in Australia the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015 (HWA, 2011) suggests that if the Australian healthcare system is to meet future workforce needs, it must adopt a 'shared leadership' model that is typical of IPP. Shared leadership is characterized by a distribution of tasks and activities across a range of individuals that might otherwise have been the responsibility of a 'sole leader'. In stretching the

leadership boundary, a range of diverse talents and skills become more available to contribute to and shape outcomes, thus resulting in a service and/or intervention which is greater than the sum of individual actions (Lamb & Clutton, 2014). Similarly, the importance of and need for particular forms of interprofessional pedagogy and education to enable this development is also a constant of health service redesign, workforce development, and health professional education within the higher education sector.

Introduction

The aim of this chapter is to provide an overview of an ambitious initiative that has sought to demonstrate leadership in building new knowledge, increased capacity and shared direction within the area of IPE curriculum development in Australia. In doing this we describe and discuss three studies, generically referred to as a program of curriculum renewal studies (CRS), which were designed and implemented as an integrated approach to achieving national curriculum renewal and change. Whilst providing a brief outline of the three studies we foreground one particular study, the National Audit Study (NAS), as a way of illustrating our approach to national leadership and leading change. This approach and leadership methodology draws on theorizations that emphasize practice and change as social, material, and cultural formations that are negotiated, achieved, stabilized, and evolved in the complex organizational settings of professional practice and education (Fenwick, 2012; Fenwick & Nerland, 2014; Kemmis, Edwards-Groves, Wilkinson & Hardy, 2012; Schatzki, 2002). At the level of practical implementation and project management we made use of a wide range of participatory methods to enable change.

The CRS (curriculum renewal studies) program

The three projects that make up the CRS program are:

1. Curriculum Renewal for Interprofessional Education in Health. The overarching study. Funded by the Office for Learning and Teaching (Interprofessional Curriculum Renewal Consortium, Australia, 2013a).
2. Interprofessional Education: a National Audit Report to Health Workforce Australia. Funded by Health Workforce Australia. (Interprofessional Curriculum Renewal Consortium, Australia, 2013b).
3. Interprofessional Education for Health Professionals in Western Australia: Perspectives and Activity. Funded by Western Australian Health. (Nicol, 2013)

We were ambitious. In addition to achieving particular study outcomes for each study, including a substantial report and various resources, the team was committed to using the opportunity of the three studies as a mechanism for leading and enabling system-wide change for interprofessional education. Our starting point engaged with a series of design questions: what would the program of studies need to look like, what would we seek to achieve, what methods would we use, how would activities be sequenced, how would we engage with stakeholders, how would the findings be disseminated, and how would we achieve the maximum impact?

The team

We were a diverse group drawn from different professional and organizational backgrounds – medicine, nursing, and allied health, and represented a number of very different university environments (nine in all). A not-for-profit organization, the Australasian Interprofessional Practice and Education Network (AIPPEN), was also involved. The expertise we drew on ranged across health professional education,

educational research and curriculum studies, clinical practice, management in health, health policy development, and social policy. The team role modeled our commitment to interdisciplinary and interprofessional practice. We also worked closely with our three funding bodies, government agencies involved in: (1) higher education development, OLT; (2) health service provision and policy at a state level, WA Health; and (3) the lead national health workforce agency, HWA. The CRS leadership team drew extensively on the support and guidance of an international advisory group.

Learning and teaching for interprofessional practice in Australia (L-TIPP)

The starting point for generating answers to the above design questions was to return to an earlier national scoping and development study conducted in 2007-2009 by some members of the CRS team, the L-TIPP study (Dunston *et al.*, 2009). L-TIPP had focused on understanding Australian IPE from a national perspective. It was the first Australian study that had sought to grapple with and represent this emerging area of curriculum development from the perspective of all relevant universities and educators. However, given the complexity of Australian IPE and the limited funds available, L-TIPP had been a skim across the surface of Australian educational practice. We had used a short survey and had consulted with a number of key colleagues in the areas of curriculum development, IPE delivery, health service provision, and health workforce development.

We did, however, learn much from the L-TIPP study. Two particular things stood out. Firstly, the identification of what we referred to as characteristics of IPE in Australian higher education. Each of these characteristics provided us with guidance as to what

we might target as part of our capacity building work. Participants identified Australian IPE as existing on the margins of the curriculum, as locally designed and implemented, as minimally connected across different universities, and, for the most part, reliant on the input of local champions rather than being embedded in curriculum structures.

What was also evident from L-TIPP was the lack of any system wide (national) description of IPE as it was occurring in and across different universities. It seemed to us that any attempt to develop a coherent national approach would be highly problematic without a national understanding of the phenomena in question – IPE pedagogy and educational practice. Put simply, outside the individual organizations in which IPE educators worked, there was little understanding of what others were doing.

Addressing this deficit would be essential to inform and resource any attempt at national change. It would also establish a base line of shared understandings and shared data. We also believed that an approach that sought to build and share understandings about IPE practice in different universities would model an interprofessional approach and lay the foundations for a more connected national community.

The NAS (National Audit Study)

Building a national profile of IPE across the Australian higher education sector became possible through the strong support and funding of Australia's lead health workforce development body HWA. This support was an immense opportunity and

meant we could significantly expand our initial ideas about what was possible in the area of resourcing curriculum renewal. Although not addressed in this chapter, we were also able to undertake an in-depth qualitative study of IPE development in four Western Australian universities (Nicol, 2013). The WA study complemented the more structured and comprehensive national survey.

However, questions about how to build a national profile engaged us through many meetings; in particular, we discussed what kinds of data we should collect and what kinds of analyses we should develop. It was clear that there was immense diversity in how Australian IPE was being conceptualized and developed. Historically and in terms of capacity, number of professions involved and exposure to IPE, different universities were in very different positions.

Such diversity had significant implications for how we needed to think about 'data' and about what was possible to collect and, importantly, what would be useful.

Clearly our ability to collect and compare data would need to be developed at a high level of generality. Whilst this would be useful by allowing some cross organizational comparison, it would lack detail. To represent data diversity and richness we would need other methods. We agreed on five forms of data collection. Firstly, we would conduct a national survey. This involved 26 Australian universities. In total we received 83 discrete IPE curriculum program/units to review. Secondly, we would conduct at least two rounds of consultations through interviews with key stakeholders in higher education, in health practice, in health policy and workforce development, with the professions, with regulatory bodies and with government. One consultation was conducted as part of the NAS and one follow-up consultation

occurred as part of the overarching CRS that aimed to verify our interpretations and draw conclusions in and through discussion. We wanted this consultation process to provide individuals and organizations with an opportunity to present their experience. Additionally this interactive process would build connections. In total we conducted 32 formal consultations. These were audio recorded and, in some cases, transcribed. Thirdly, we also thought it crucial to represent what people were doing at the development level. These data became the 'exemplars' and 'case study' focus of the NAS and its final report. We invited education and service organizations to provide details of IPE developments they had initiated and/or been involved with. This invitation was distributed through the study newsletter and through relevant networks. Fourthly, a broad based documentary analysis of national and international policy, curriculum and IPE development policies, guidelines and research was undertaken. Finally, some team members had been engaged with a method known as future scenario planning (Sayers, 2010). Two future scenario planning events were held, one in Perth and one in Sydney.

We hoped that these different forms of data and our inclusive and invitational approach to sampling would do justice to what was occurring in practice and would additionally provide a useful baseline understanding for designing the future of Australian IPE.

The 4 Dimensional Framework (4DF)

One final and critical element of the design of the CRS program involved the development of a conceptual framework that would provide a structured way of locating, analyzing, and communicating data from the studies. Given the national

focus of these projects and previous findings about diversity, gaps, and inconsistencies in IPE understanding across the country and professions, it was imperative that our dispersed conversations be guided by a common conceptual understanding about the dimensions underpinning IPE curriculum development.

A four dimensional curriculum framework, the 4DF, was developed to connect the design of curricula to the bigger picture around health professional education, practice and policy. The four dimensions are interdependent and together provide a comprehensive picture of the dynamic interplay between curricula elements, which are often considered in isolation to one another when developing interprofessional courses. Dimension One asks curriculum developers to consider the purpose and fundamental importance of a course. In doing so, the interplay between the curriculum and its social, political, economic, professional, and educational influences is acknowledged and encoded into the course's design. Dimension Two encompasses the specific knowledge, skills and capabilities that define competency in a particular area. Often, this is the *only* dimension that is considered during curriculum development. As Lee, Steketee, Rogers and Moran (2013, p. 65) write '... the term "curriculum" tends to be used in its limited sense, often referring to the development of written syllabi for courses where learning objectives, activities and assessment are identified for localized needs. In this regard, little systematic attention is paid to the curriculum development process and to the impact of the curriculum decisions on the health of citizens or the future development and sustainability of the health professions.' Dimension Three explores how curriculum is to be delivered in terms of the teaching, learning and assessment practices. Elements of the previous two dimensions are considered in determining these

practices and how they drive the practicalities associated with the selection and sequencing of learning activities. Finally, Dimension Four addresses the often overlooked aspects of local implementation and the cultural norms, protocols and procedures that shape curriculum development at the local level.

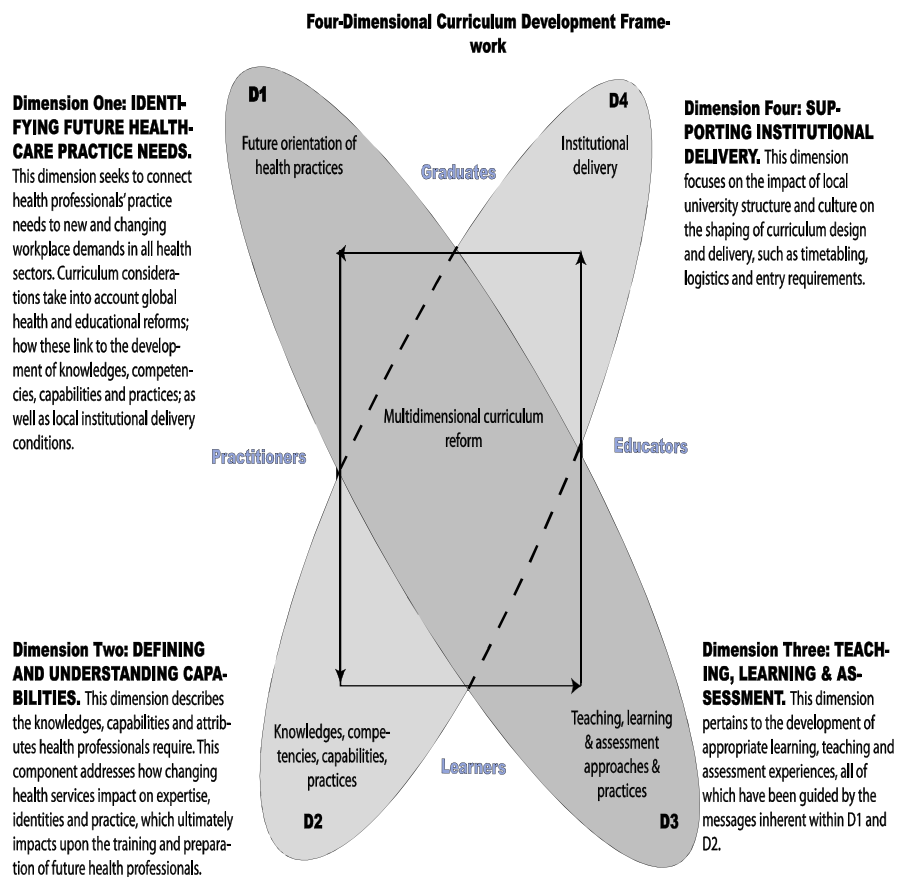


Figure 8.1

The national picture

As a way of presenting something of the diversity and richness of Australian IPE we provide a brief overview of some of the data, findings and analysis drawn from the

different methods used. If we were to identify an overarching characteristic of what we learned it would be diversity: conceptual diversity, diversity in the framing of curriculum, diversity in when and how IPE operates in the curriculum, diversity in teaching methods, and diversity in assessment. In terms of the survey data we identified twenty findings. A few examples follow.

Competencies and learning outcomes – dimension 2 of the 4DF

Despite an international focus on specifying the knowledge and practice characteristics of IPP competencies, the majority of cases, 61.4%, did not specify such competencies (Interprofessional Curriculum Renewal Consortium, Australia, 2013b. p. 29). At the level of learning outcomes (or aims and objectives) this picture altered significantly with 77.1% of cases including learning outcomes (Interprofessional Curriculum Renewal Consortium, Australia, 2013b. p. 30). What also became clear from the way these initial questions were answered was that different educators held different understandings and used different terms to comment on competencies, capabilities, learning outcomes, learning objectives etc. What also became clear was that the significantly different views and understandings held by educators as to the meaning of IPE and pedagogy have major implications for the development of IPE.

Not surprisingly an analysis of the competency and learning outcome responses reflected the knowledge and practice areas well identified in the literature. These included teamwork, understanding and respecting the role of others, the ability to clarify role expectations, understanding of IPE, and reflection or reflective practice (Thistlethwaite & Moran, 2010). In a separate 'linguistic analysis' conducted by one

member of the team what stood out was an underpinning focus on 'relational' activity, that is, a focus on knowing and practicing in relationship with others (Interprofessional Curriculum Renewal Consortium, Australia, 2013b. p. 34).

Teaching, learning and assessment – dimension 3 of the 4DF

Moving to the domain of 'teaching, learning and assessment' (the third dimension of the 4DF) we found similar levels of diversity. The critical questions of 'when' and 'how' to introduce, locate and develop IPE within the curriculum were viewed very differently by different institutions and educators. The key stakeholder consultations identified that an array of factors were at work in shaping the particular curriculum approach of IPE: '...curriculum design decisions that should be understood with reference to not only pedagogical rationales utilized but also the organizational context – the politics, culture, funding, staff capabilities – existing at a particular point in time' (Interprofessional Curriculum Renewal Consortium, Australia, 2013b. p. 37).

A range of IPE interactional methods were being used across the nation, including case based 46%, problem based 28%, experiential learning 27% and simulation 23%, and while a majority, 59%, were offered to students from a range of years, one third were delivered exclusively to final year students. (Interprofessional Curriculum Renewal Consortium, Australia, 2013b. p. 43)

One of the defining characteristics underpinning the educational process is assessment. Across all survey responses the process of assessment was identified as occurring in only just over half (58.6%) of reported cases. What was also notable

was the diversity of methods utilized to inform the assessment process, with individual participation and written assignment constituting the two most frequently used methods (Interprofessional Curriculum Renewal Consortium, Australia, 2013b. p. 55).

Enablers and Constraints – the lived experience of IPE

Whereas the survey required participants to respond to particular questions with specified kinds of answers, the consultations were more fluid and flexible. We were interested to understand the ‘on the ground’ experience: what is it like to design and implement IPE, often in organizational settings where there is minimal support and understanding, where the legitimacy of IPE is often questioned, and where IPE often exists as an optional curriculum element?

In seeking to represent the experience of the key stakeholders we used the distinction between ‘enablers’ and ‘constraints’ as an overarching way of organizing what we were being told. From there the interviews often developed their own shape. Many of the issues discussed will be familiar to colleagues nationally and internationally and are also well identified in the literature. Broadly, comments were able to be grouped in terms of ‘curriculum and course design’; ‘leadership’; ‘stakeholder and industry links’; ‘funding and support’; ‘collaboration and communication’; and the implications of ‘the university structure’. Respondents commented on the disjunction between the prominence of IPP/IPE in the policy and health reform literatures and the variable ways in which IPE existed as part of universities’ curricula. They pointed to the lack of clarity in how IPE was conceptualized, understood and communicated, and, critically for ongoing

development and sustainability, the over-reliance on local champions with minimal capacity who tended to commit because of their enthusiasm for IPE. Such a situation created significant vulnerability and, not infrequently, burnout amongst those involved.

The 'overcrowded curriculum' was a constant theme in consultations. Educators often discussed the competing demands for space within the curriculum. This was also an issue when discussion turned to the kind of pedagogy required to generate learning from relational activity – a pedagogy that required smaller numbers of students engaged in educational activities, i.e. group work and more time. The legitimacy, knowledge and evidence base of IPE, or rather the difficulties in these areas, were frequently discussed as making claims for greater centrality and more curriculum space difficult to argue. Finally, the theme of career long learning in the area of interprofessional and collaborative practice was an area of concern. Many educators discussed the need for continuous learning in the area of IPP and their concern that what was learned in pre-registration education was often undermined by the strong silo type experiences that are reported as still defining many areas of health care practice.

Recommendations

What the above data also allowed us to do was to identify seven 'key development areas' and the need for a 'national approach'. In all the work we have undertaken as a team, we have always concluded with an attempt to articulate what has been learned and what this means for future action and development. Our learnings from the NAS were articulated as follows:

Key Areas for Development and National Capacity Building

1. Establishment of a structure and process to provide national leadership and national coordination across higher education, health, the professions and government
2. Agreement on a common language for the development of IPE curricula in Australia
3. Agreement on an Australian statement of core competencies and learning outcomes for IPP
4. Adoption of IPP/IPE requirements in the accreditation standards of all Australian health professions
5. Adoption of IPP/IPE in the continuing professional development (CPD) requirements for ongoing registration
6. Development of a national approach to building curriculum and faculty capacity, knowledge and research in IPE
7. Development of a national approach to IPE/IPP knowledge management and information sharing and learning (Interprofessional Curriculum Renewal Consortium, Australia, 2013b. pp. 111-116).

The National Forum

As a further part of our leadership strategy, we sought and received a small amount of additional funding to bring key stakeholders, both individuals and organizations, together at the end of the CRS to reflect on the question of where to from here? We used the idea of national work plan as an organizing framework. This event, what we called a 'National Forum', was highly successful. It allowed for reflection and a consideration of how we might maintain our commitment and energy and, above all, be able to act interprofessionally. We are currently processing the data from the

National Forum and plan to use this as a basis for scoping a next step in the national development process.

Discussion

We believe there have been a number of significant benefits derived from the design, conduct and findings of the NAS. Importantly and critically for the possibility of further national development in the area of IPE, the findings of the survey have for the first time provided a system wide and national picture of IPE as it existed in 2011 and 2012 in Australian higher education. Developing a national data set for the first time within the Australian context has made it possible to think about policy and education futures informed by a diverse range of data sources both quantitative and qualitative. Together with a number of other reports and consultations we have developed, and the important work conducted by many colleagues, for example, the 'Learning and Teaching Academic Standards' study (O'Keefe, Henderson & Pitt, 2011) and the Harmonization (O'Keefe *et al.*, 2014) we have observed the way that the national focus and data foundations lend a certain legitimacy and status to what they comment on. We have been surprised by how many people have engaged with and could comment on the overall findings of the NAS. These developments have, we think, contributed to a shift in IPE discourse from predominantly local conversation to a national conversation.

In parallel with this development, what we have also observed and heard comment about is the further development of a more connected and informed community of interest and practice. As with the shift from the local to national stage identified above, we have observed a shift in the focus of IPE networks from (and including)

local to national. A further area of significant development that we believe the CRS process has contributed to is that of learning or rather, shared learning. The L-TIPP study identified the lack of connection and learning for many IPE educators. IPE worlds were local. Taking a national approach to data development, sharing, consultation, and processes of data verification and dissemination have all led to more expansive connections, to an exchange of data and narratives and to discussions focused on shared learning. What has also been affirming and exciting about the work, as it has developed, is the strong interest from many other universities to become involved in the development of a national collaborative.

Conclusion

We present the work of CRS as a design-led and collective leadership approach to IPE development and capacity building in Australia. Underpinning the design of each of the three studies in the CRS program is the theoretical position that professional practice and practice change are far more than simple technical or procedural accomplishments. On the contrary, we view practice and change as complex social and cultural formations that are negotiated over time in specific sites of education and practice. These negotiations engage with issues of power, status and control – with the existing order of things. Given this framing it is our view that a participatory, inclusive and interactive approach to leading change will always be required. Significant change cannot, in our view, be prescribed without the participation of those involved and affected.

The NAS is presented as a way of illustrating this thinking and related methodology. We believe a similar approach may be of benefit in building connection, capacity and shared direction in other settings.

In summary, the CRS program was an important step in building a connected community; in representing IPE as a national object rather than just as local phenomena; in generating a 'currency' (data) that has political status; in making visible the creative and innovative work of many IPE educators; in facilitating shared learning amongst the IPE and workforce development community; and in focusing a small number of national development directions.

Reflective questions:

The following four questions ask readers to reflect on the usefulness of key strategies developed as part of the CRS program for their own education and national context.

1. Might consideration of the major strategies used across Australia (collaborations, outreach, inclusivity, networking, etc.) be useful in the development of IPE with the reader's educational and state context?
2. Might the development of a reflective and research for learning approach to building IPE capacity be useful for the development of IPE with the reader's educational and state context?
3. Is there a well-developed approach to curriculum development that links the practice context to curriculum design and implementation in the reader's educational and state context? If not might the 4DF approach be useful?

4. Are there opportunities for small projects, led by an interprofessional team, to be used as a mechanism for building increased levels of connection, communication and capacity development across all health professions?

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