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Collaborative Practice

Interprofessional collaboration (IPC) has been advanced as a means to promote patient-focused care thereby improving quality of care, patient outcomes, and staff satisfaction.[1,2,3] Few studies of true interprofessional collaborative practice have been published, but some have shown improved quality of care in older adults with Alzheimer disease[4] and reduced admissions for chronic illness exacerbations in community-dwelling seniors.[5] A recent Cochrane Review yielded 5 randomized controlled trials of practice-based IPC interventions.[6] Although general conclusions cannot be drawn from these very different studies with small sample sizes, these preliminary findings suggest that IPC interventions may improve patient outcomes and care processes.

Patients with pulmonary hypertension (PH) suffer from a rare, life-threatening chronic disease with a complex medical regimen and detrimental effect on lifestyle. Many of our patients' problems cannot be solved by one discipline alone. Due to the chronic nature of the disease, these patients are followed for long periods of time, enabling caregivers to develop long-term relationships with patients and families as well as with other healthcare professionals involved in their care. I believe these patients benefit when cared for by a multidisciplinary team whose members embrace interprofessional collaborative practice. The most common "team" may consist of a PH physician specialist and a nurse or nurse practitioner, but respiratory therapists, physician assistants, social workers, physical therapists, and pharmacists also serve as integral members in many teams. For these teams to practice collaboratively, whatever their composition, several key elements must be in place.

Agreement on Mutual Goals

All members of the team must agree on mutual goals for their practice and for individual patients. Clinical pathways, standardized procedures, and protocols that are developed with input from all team members can serve as guidelines for practice and to educate new members joining the team. In setting individual patient goals, the patient and family are integral members of the team.

Knowledge of Roles

One of the biggest obstacles to IPC is a lack of understanding of the role of each healthcare professional in the patient's care. Understanding role expectations and judging competence were major issues for family physicians working in collaborative practice both with nurse practitioners in rural Canada[7] and with registered nurses in an urban setting.[8] Some education about role expectations and the differences between the various healthcare professions is often necessary. Physicians diagnose mental and physical conditions, prescribe medications, and perform surgery or use other methods to treat diseases, injuries, deformities, and other mental or physical conditions. Although there is some overlap between other healthcare professions and medicine, each has its own perspective and independent functions. For example, the California Nursing Practice Act (Section 2725 b) defines nursing as "functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill".[9] Nurses are concerned with patients' responses: assessing the patient/families' responses to illness or treatment and facilitating adaptive responses to illness and treatment.

Mutual Trust and Respect

With clear understanding of role expectations and experience with each other over time come mutual trust and respect. Each discipline is valued for its unique contribution to patient care and its expertise is sought in solving patient problems.

Open Communication of Information

Effective communication is essential but not sufficient for collaboration. Communication of information, or clinical knowledge pertaining to a patient/family, must be openly given and received by all members of the multidisciplinary team. Stein-Parbury and Liaschenko[10] have described a model of types of knowledge used by all healthcare professionals in clinical practice. *Case knowledge*, largely the providence of physicians, is the biomedical, scientific knowledge that uses objective measures as evidence to diagnose and treat conditions. Nurses often serve as the physician's eyes and ears to monitor patients' responses and collect data. *Patient knowledge* comes by understanding a particular person's experience of disease and treatment and is the providence of nursing. By repeated observation and comparison of one patient to another or to the textbook case, or in one patient over time, nurses develop patient knowledge. This type of knowledge is unique to each recipient of care and requires repeated contact with the patient/family over time. *Person knowledge* is the knowledge of an individual; what matters to them and why. This type of knowledge is most relevant in conditions that cause marked disruption in a patient's life and when questions or conflicts arise regarding treatment or end-of-life decisions. Members of the PH team, by virtue of their intimate and long-standing contact with patients and families, develop this type of knowledge about their patients. Conflicts can arise if each type of knowledge is not considered or deemed valuable by other members of the team.

Shared Decision Making

Decisions are made considering the viewpoints of all disciplines

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in collaboration with the patient/family, recognizing the importance of each discipline's specialized knowledge and skills. This may occur in the clinic among the physician, nurse, and patient, or more formally in interdisciplinary patient rounds or in a transplant evaluation committee.

The American Association of Critical-Care Nurses and the American College of Chest Physicians have developed complementary initiatives to promote healthy work environments and patient-focused care in intensive care units.[2] Skilled communication and interprofessional collaboration are common tenets of these initiatives. With attention to the key elements needed for collaboration and a commitment to improving our communication skills we can promote healthy work environments and patient-focused care in our pulmonary hypertension practices.

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