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The rural and interprofessional education and collaborative practice interface: Findings from a qualitative study

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ABSTRACT

While rural health-care settings are said to be ideal places for the facilitation of interprofessional education and collaborative practice (IPECP) in students, little is known about the rural-IPECP interface. This study explored this interface through student and clinical educator experiences following implementation of a structured IPECP student placement model. Data were gathered through 11 focus groups with 34 students and 24 clinical educators. Content analysis was used to analyze data and two categories were developed for reporting. The power of place and space, highlighting the importance of flexibility, co-location, and lack of hierarchy in promoting IPECP, as well as the role of shared accommodation in enhancing social connectedness within and outside placement were highlighted. This study unpacks the characteristics of rural health-care settings that make it ideal for IPECP despite the resource constraints. Future studies can investigate the rural-IPECP interface through a patient lens.

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Collaborative practice; interprofessional education; placement model; rural health

Introduction

Rurality is a complex concept to unpack in healthcare (Williams & Cutchin, 2002). The adverse influence of rurality on health-care workforce recruitment and retention, and subsequently on patient and population health are well documented (WHO, 2021). Student placement models promoting interprofessional education (IPE) and collaborative practice (IPECP) in rural health-care settings can be one means of providing students with positive learning experiences, and clinical educators (CE) (i.e., student supervisors) with positive professional challenges, thereby enhancing workforce recruitment and retention opportunities in these underserved communities (McNair et al., 2005). Only limited information is available in the literature on structured rural IPECP placement models (e.g., the RIPE model; McNair et al., 2005; IMMERSE model; Gum et al., 2013), as well as on how the rural health-care setting interfaces with IPECP. A mixed methods study of 14 post-qualification health-care workers in rural Tasmania (Australia) reported both enablers and barriers to IPECP in these contexts and emphasized the importance of organizational readiness (i.e., location) to promote IPECP (Spencer et al., 2015). Some studies have explored only the student or the CE perspectives following interprofessional placements. For example, the IMMERSE study has documented student experiences of rural interprofessional placements in South Australia (Gum et al., 2013). While rural health-care settings are said to be conducive for IPECP (Cragg et al., 2010), no qualitative studies have explored this interface in-depth, from both student and CE perspectives.

The Rural Interprofessional Education and Supervision (RIPES) model was developed and implemented in rural Queensland (Australia) to meet a gap in structured, intentional IPECP learning opportunities. Recruited rural health-care teams were trained in IPECP and its facilitation with students. Each RIPES placement consisted of students from at least two health professions overlapping at the given site for at least 5 weeks. This time was used to overlay structured IPECP opportunities (e.g., weekly skills sessions, joint sessions with clients, joint IPECP projects) on their regular uni-professional placement activities. Detailed descriptions of the RIPES model, and both the process and outcome evaluation, have been published elsewhere (Martin et al., 2021, 2022). The aim of this study was to explore how the rural health-care setting interfaces with IPECP from a student and CE perspective following the implementation of a structured IPECP placement model.

Methods

Qualitative dataset from the RIPES study has previously been analyzed and published (Martin et al., 2022). Whereas, this short report stems from secondary analysis of the dataset to answer a distinctively separate research question, noting themes that have not been previously reported. The RIPES

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study was conducted in five work units across four public health services in Queensland where the RIPES model was implemented. These sites were all non-metropolitan, in Modified Monash Model 4 to 6 locations (DoHAC, 2021). Participants were students and CEs from dietetics, occupational therapy, physiotherapy, and speech pathology. A qualitative design was employed utilizing separate focus group discussions facilitated through a guide (see supporting information) with supervisors and CEs at the completion of the RIPES placement. All focus groups were conducted via Zoom between February 2020 and March 2021 by a researcher with qualitative research experience (MF), with regular debriefing with other researchers. This researcher was independent to the participating health services and was not known to students or CEs outside this role, in order to avoid bias. All focus groups were audio-recorded and transcribed verbatim by an independent typist. Three researchers with experience in clinical education, interprofessional education, and qualitative research (PM, TB, AH) utilized an inductive content analysis process (Elo & Kyngas, 2008) to analyze data and develop categories. To ensure rigor and trustworthiness coding was triangulated between researchers, and the three researchers met regularly to build consensus and refine categories.

Ethics approval was obtained from the Darling Downs Health Human Research Ethics Committee (Reference number: LNR/19/QTDD/54776, Approval date: 4th September 2019), with subsequent site-specific approvals obtained from all involved health services. Written, informed consent was obtained from all focus group participants.

Results

Fifty eight participants (24 CEs and 34 students from seven universities) participated in the RIPES study. Eleven focus groups (six with 18 CEs and five with 19 students) yielded data. Most participating students were in their final year of studies ($n = 28$). Nineteen participating students had previous experience with IPE in clinical settings. Two categories were developed relating to the rural and IPECP interface: The power of place and space, and social connectedness.

The power of place and space

Rural health-care settings were described both by students and CEs as flexible places where there was less hierarchy and formality, and more spontaneity. Co-location of staff and students, small work spaces, and reduced resources were all noted to facilitate IPECP.

- Co-location enables flexibility

Co-location of the health-care team and students was described to be an enabler that promoted spontaneous communication and interaction. These characteristics were said to promote IPECP. Less formal relationships with CEs were noted by students as reducing hierarchies which were previously experienced by participants in metropolitan settings:

> . . . we didn't have to go out of our way to organise too much else because we do sit together all the time, we do have shared office spaces, ongoing communication between each other . . . which I think is a nice thing for the students to see. And it's a good place for them to learn it because there isn't any extra effort on our part, because I think some of it does just come naturally because of our very small teams. We're all kind of forced together, which is great. [CE/Group 2]

- Reduced resources forces collaboration

A lack of resources and the smaller number of health-care workers in the team utilizing generalist models of care produced more collaborative, client-centered, close-knit teams. One CE noted:

> . . . if there's someone with complex discharge planning . . . if they're in [a metropolitan centre], the services for them, when they go home, is endless . . . If the rural team has got someone with a spinal cord injury and they're discharging to a place that's an hour-and-a-half from the nearest town, that just adds a whole other element that requires everyone's involvement and I think that's why we probably work well as an interprofessional team. [CE/Group 6]

- Sense of belonging

Students felt more like equal team members on a level playing field, which facilitated interprofessional communication with and referrals to other health-care workers outside of their profession. Learning was enhanced by the rural setting as students were exposed to and became familiar with different members of the health-care team. Students valued the capacity to establish professional relationships and the ability to ask questions of other team members. One student said:

> You get to know everyone, instead of just a couple of people that are in your discipline, which makes talking to the doctors or everyone else much easier and much more. They seem to know you as well, which makes a big difference. [Student/Group 2]

Another student agreed:

> . . . it all comes back to that understanding of the other professions I think that really makes you feel like rural is a supportive environment and you know a lot more about where everyone is, what they do and scopes. . . [Student/Group 1]

Social connectedness

Participants described the benefits of students working together in the rural health-care setting and living together in student accommodation facilities. This created a sense of "family" for students and ensured peer support both during and outside placements hours, which are essential in small communities. A student while commenting about shared accommodation and its impact on placement said:

> I think it's actually been quite comforting. So obviously, we're all very far from home, it does help to get you a lot more settled into your placement. You get a larger network straight from the get-go. I think that has facilitated how comfortable we feel in our practice as well, because you get settled a lot quicker, I found [Student/Group 5]

The capacity to engage in informal discussions over lunch or within communal spaces were perceived as being helpful by students for developing IPECP competencies:

> It's a very small team, and they [team] all sit in the same office which is really good for collaboration. We also always have lunch together … It's just casual chat. Probably for me, more so the informal interaction has made more of a difference. [Student/Group 6]

Discussion

This study sheds lights on the unique interface between rural health-care settings and IPECP, and highlights that these resource-constrained environments are well suited for IPECP facilitation with students. While previous research has indicated the suitability of rural health-care settings to IPECP, this research confirms this from both a student and CE point of view following implementation of the RIPES model of placement. Given the benefits of IPECP models in attracting the future workforce to rural areas (McNair et al., 2009; Wolfgang et al., 2019), our study is an attempt to further understand the rural-IPECP interface.

The power of place and space in the rural healthcare context cannot be underestimated in the IPECP context. Co-location of the healthcare team including students promotes informal and spontaneous collaboration and learning opportunities as also evidenced in other studies. For example, a study of health-care worker perspectives identified that small close-knit teams are collaborative, therefore providing an ideal context for IPE (Spencer et al., 2015). Our findings have confirmed this from both a health-care worker and a student perspective following their experience with the RIPES model. Our findings also complement previous findings whereby close-knit rural health-care teams provide an ideal environment for CEs to model several IPECP competencies such as communication and collaborative practice (Cragg et al., 2010; Stilp & Reynolds, 2019). Models such as RIPES can capitalize on both formal and informal IPECP learning opportunities that are available in rural health-care settings.

Social connectedness that students grow during placement is further enhanced by shared accommodation facilities. A study of student journal reflections during a rural placement found that shared housing was a great facilitator of social connectedness during and outside the placement (Stilp & Reynolds, 2019). Previous findings from Sweden have also shown that students who live and work together while undertaking rural placements in primary care, learn to negotiate an unfamiliar environment as a team (Tran et al., 2018). Our findings build on this and make a case for the importance of shared accommodation options for building teamwork in students undertaking rural placements.

This is the first-known qualitative study to explore in-depth the rural-IPECP interface through the experiences of students and CEs following implementation of a structured IPECP placement model. This study provides evidence for a continued push for IPECP in resource-constrained rural health-care settings (Martin et al., 2018) where limitations can serve as enablers. Further studies could investigate this interface from a patient perspective, and through using quantitative methods.

Conclusion

This study confirms the suitability of rural health-care settings to facilitate IPECP with students on placement. Resource limitations provide opportunities for collaborative practice that CEs can model, and students can benefit from. Social connectedness, through co-location within the workplace and through shared accommodation, can positively influence the development of IPECP competencies in students through formal and informal learning opportunities.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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