Evaluation and Management of Frailty


Frailty and Interprofessional Collaboration

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Abstract

This chapter underscores the importance of interprofessional collaboration in the care of frail older patients. Hospital-based care is emphasized because interprofessionalism is difficult in that setting since the setting is constantly changing and since multiple healthcare professionals care for many complex, very ill patients, only some of whom are frail older people. Interprofessionalism is particularly important and challenging in teaching units in the acute care setting, where many health professionals practice and learn together and team membership changes frequently. Learning is enhanced and interprofessionalism can enhance learning by viewing the patient as a key part of the teaching team. While ‘best practice’ interventions have been identified for frail older adults who are hospitalized, these interventions are not easily implemented in routine hospital care. Three interdependent processes in clinical practice – representation, sense-making, and improvisation – are described, which contribute to an understanding of how practices change when implemented in a way that takes the local context into account and keeps person-centered care as the central consideration.

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Frail older adults are defined by their multiple, interacting medical and social problems. A range of skills is often required to meet their many complex needs and offer meaningful care. These skills typically are shared by many team members, where ‘team’ expertise evolves through the interdependent and collaborative work of multiple, interdependent disciplines. People in these disciplines need to be able to work together to achieve the best effect. Understandably, bringing together people with different points of view can be a challenge. Perhaps more surprisingly, the challenge is often glossed over. One context in which interprofessionalism and care of the frail older per-
son are infrequently discussed in the literature is the acute care environment, and specifically clinical teaching units (CTUs) where learners from many disciplines could be introduced to and learn about interprofessional collaboration. This chapter contributes conversation to that gap. We begin by introducing the CTU of an academic health sciences center and three frail older patients in that unit. This will situate the reader in a particular context that can be kept in mind as we develop the theoretical elements. We then articulate the case for and some key principles of interprofessionalism (a term that we intend to capture interprofessional collaboration in practice [IPC], education [IPE], and research). Next, we discuss a theoretical framework of practice as a foundation for interprofessionalism and draw attention to three interdependent processes that interact as the practices of/in particular communities: (i) the development and use of practical, locally relevant, evidence-informed practice guidelines and policies (representation); (ii) processes of shared sense-making; and (iii) processes through which the moment-by-moment improvisation is enacted as professionals conduct their practice in the constantly changing clinical environment. Compassionate, person-centered, interprofessional collaborative practices emerge in this interdependent web. We argue that this triad of complex processes (representation, sense-making, and improvisation) constitutes the interdependent process of interprofessionalism in theory and in practice, including practice settings that aspire to provide high-quality care for frail older adults.

**Introduction to the Clinical Teaching Unit at the University Health Center**

The (fictitious) CTU at the university health center described here is a 38-bed inpatient unit in an academic teaching hospital. We will shortly describe three frail older patients who are among many other patients being cared for in the unit. Of the other 35 patients, 9 are over the age of 70 but are not considered frail, and 2 are designated ‘Alternate Level of Care’ and are awaiting nursing home placement. The remaining 24 patients are adult patients with a variety of acute conditions, such as heart and/or renal failure; acute exacerbation of chronic lung disease; stroke; sepsis; community-acquired pneumonia; and failure to thrive related to health issues linked to homelessness, mental health issues, and/or substance abuse.

There is a medical director for this service; she is the attending physician 1 week out of 10 but always carries administrative responsibility for medicine. Direct medical care is provided by nine attending physicians who rotate every week, a chief resident on the service for 1 year, one senior and two junior residents who rotate every 1–2 months, and four medical students who rotate every 4 weeks. The unit manager is a nurse who is also responsible for two other hospital units where patients on the teaching service may also be cared for. There is a unit-based charge nurse on every shift. Registered nurses, registered practical nurses, and personal support workers work 12-hour shifts, rotating through 2 day shifts and 2 night shifts followed by 4 days off.
Other full-time unit-based staff include unit clerks, a physiotherapist, an occupational therapist, reactivation workers, a dietician, a social worker, and a respiratory therapist. Part-time staff include a pharmacist, a chaplain, and the cleaning staff. Other staff come and go and interact with patients, such as phlebotomists, x-ray technologists, psychologists, medical consultants, porters, security personnel, patient support workers, and volunteers. Visiting hours are unrestricted, and since many of the patients are extremely ill, it is common for visitors to be present around the clock.

Each weekday, the attending physician, residents, medical students, charge nurse, physiotherapist, occupational therapist, dietician and social worker meet for ‘bullet rounds’. Each patient is discussed in rapid succession, and team members are expected to note barriers to discharge and to recommend a treatment plan for the day. Plans are recorded by the charge nurse but are often not communicated to the point-of-care nurses, and while the written record of the plan for the day is available at the nursing station, few nurses read it, and even fewer medical or allied staff refer to it. New staff or those who tend to be introverted often remain silent, so their contributions are easily missed. Some feel intimidated by the whole process. The unit environment feels hectic and disorganized, though the numbers of reported incidents of medication errors, falls, and injuries to patients and staff are quite low. The reader is invited to keep this busy and somewhat unpredictable context in mind and to imagine how interprofessionalism might be enacted in this unit in the context of the reader’s own experience in the management of frail older patients.

**The Case for Interprofessionalism**

Contemporary health services increasingly serve patients with multiple, complex chronic illnesses, and they require interteam and interagency coordination [1]. For older adults suffering acute illness or injury requiring hospitalization, *every hour and every staff encounter counts* to achieve the best possible outcomes. In Canada, over 50% of acute care hospital beds are occupied by seniors (persons aged 65 years and older) on any particular day [2]. About one third of older persons admitted to acute care are discharged at a significantly reduced level of functional ability, and most never recover to their previous level of independence [3]. Hospital costs rise because of complications associated with hospital care, at least some of which are avoidable. Patients and their families/caregivers may also experience unnecessary financial and social costs associated with recurrent admissions, loss of independence and diminished quality of life. Frustrating gaps in care in the transitions between care sectors introduce additional risks. These multifaceted, intersecting issues represent solvable problems for which the development of sustainable solutions must be a top priority.

Comprehensive, interprofessional geriatric assessment and management strategies can prevent readmission to the hospital, but challenges related to collaboration across
multiple professions in the transition from the emergency department (ED) to inpatient units and subsequent return to the community can lead to functional decline and an increase in hospital length of stay. Prolonged wait times in busy EDs and delays before treatment is activated are common in hospital wards and also increase risk. Interprofessional collaboration is widely thought to be an essential feature of responsive care processes that address the urgent needs of older adults in acute care settings [4]. The complexity of health issues faced by older adults who are admitted to acute care settings is well known and complicated by the fact that less than 50% of all older adults are up to date on preventive health services [5]. In some settings, older adults take an average of 19 medication doses daily and see 5 specialists and 2 primary care physicians in four different locations each year, very little of which is reported on entry to a hospital setting. In the hospital, an older person admitted for a surgical procedure will see 27 different healthcare providers during the hospital stay, and less than half will follow-up with their primary care physician [5]. A face-value argument in favor of a comprehensive, integrated, interprofessional approach to care for frail older adults, including comprehensive geriatric assessment, is justified and has been shown to minimize these risks [6] (see also Chapter 8).

The World Health Organization [4] concluded that research over the last 50 years shows convincing evidence that health services are optimized and health outcomes improved through effective interprofessional collaborative practice. The same report also acknowledged that there is sufficient evidence to draw causal inferences between effective interprofessional education and effective collaboration in practice. At least in developed countries, modern healthcare systems consist of complex and variably integrated systems that deliver care in multiple sectors (e.g. acute care, rehabilitation, primary care, home and community care, and long-term care) and that involve multiple professions and support staff. Unique disciplines and specialty practices within a single profession have grown exponentially. Often, the theory and technical language as well as the professional culture of different professions, and even those of disciplines within a single profession, can be unintelligible across disciplinary borders [7]. This is all the more challenging for frail older adults and their families. Making sense of healthcare services with and for patients is a goal of interprofessionalism that is often unmet.

The complexity of need is often cited to explain why it is so important that we practice collaboratively in healthcare [8, 9]. Both IPE and IPC have an overarching goal of supporting compassionate, person-centered care, a term that we use to point to the importance of including patients and their families as contributing members of the healthcare team and also to the importance of relationships with and between members of the healthcare team. The Canadian Interprofessional Health Collaborative (CIHC) developed a well-known competency framework for collaborative practice (2010). This framework is being widely used internationally as a guide for the development of interprofessional curricula and interprofessional practice standards (fig. 1 [10]).
The 2010 CIHC framework is set against a background of quality improvement and acknowledges the importance of context as well as the continuum of simple to complex circumstances within any given context. The framework then overlays four interprofessional competencies (role clarification, teamwork, collaborative leadership, and interprofessional conflict resolution) on two additional competencies key to all, namely, interprofessional communication and patient-centered care. These six competencies describe the attributes of effective team function and the characteristics required by practitioners to be considered ‘interprofessional practice-ready’. Lingard points out that individual and team competence are not linked in a simple, linear way [8]. She argues that (i) competent practitioners do not necessarily come together as a competent team; (ii) a practitioner may effectively collaborate on one team, but not another; and (iii) an incompetent practitioner may unravel one competent team, but not another. In the enactment of these competencies by/between individual practitioners, interprofessionalism becomes a complex ‘dance’ performed differently in each context and even in multiple ways within a single context as team membership shifts over the course of the day and as the needs of each patient are prioritized considering the needs of all of the patients. Because of this, team principles, practices and strategies for the enactment of interprofessionalism resist ‘universal’ heuristics and instead emerge in both predictable and unpredictable ways as we work together in real time. We will explore this idea of the emergence of the practices of particular communities in more depth shortly.

As stated, the World Health Organization [4] concluded that evidence links effective IPC, at least in part, to effective IPE. IPE often focuses on the competencies (for
example, [10]), which, once mastered, are likely to lead to effective collaboration. Still, it is sometimes easy to lose sight of the patient in this. Bleakley et al. [11] argues that IPE can also be understood as learning ‘from, with, and about patients’, where the patient is the living text. The interprofessional team becomes a resource for learners who have a direct relationship with the patient-as-teacher, which is not mediated by a clinical or academic teacher. Osler’s famous quote also speaks to this way of thinking: ‘... it is a safe rule to have no teaching without a patient for a text, and the best teaching is that taught by the patient himself’ [12].

In caring for frail older adults who are hospitalized, the intent and ideology of patients-as-teachers [13] may be challenged by the ability of the patient and his/her family to fully participate. However, engaging with frail older patients and their families as ‘text’ is a crucial part of creating what Bleakley et al. [1] call a ‘knowledge-generating dialogue’. In this way, the patient can literally speak for him/herself so that the intent of collaborative, patient-centered care can be achieved. The text offered by a patient and/or his/her caregivers that are of most interest to each team member might vary, but each potential focus is an important part of the whole person, inclusive of physical, biological, emotional, relational, spiritual, socioeconomic, and environmental aspects of his/her past, current and potential future life story. We suggest that this notion of ‘knowledge-generating dialogues’ is what crucially distinguishes collaboration from other concepts of team function, such as communication, coordination or cooperation. It is also crucial to understanding the vital role of the patient as part of not only the care team but also the teaching team.

Work by Benner et al. [14] offers three additional principles that are helpful in thinking about (interprofessional) practice. They call for practitioners and teams to develop of a ‘sense of salience’, citing that since it is impossible to identify every possible contingency in clinical algorithms or care guidelines, practitioners and teams must develop a keen ability to understand what is important. This certainly applies to a particular patient, but it also requires a continuing sensibility to the overall context in which care occurs. The multiple competing demands of the CTU described at the beginning of this chapter, for example, comprise a specific risk to the provision of the right care at the right time for frail older adults, whose urgent need for mobility may need to compete with the equally legitimate needs of acutely ill adults in need of urgent procedural interventions. We suggest that it is in this real-world context of competing legitimate priorities that a deep understanding of ‘practice’ is critical to the development of a functional approach to interprofessionalism.

The second principle that Benner et al. [14] call for is integrative thinking. Integrative thinking promotes clinical intuition, in which, through continuing conversations, practitioners draw on propositional and situational knowledge, professional judgment, skilled know-how, and ethical comportment to anticipate the outcome of particular interventions. Doctors do not prescribe analgesics, and nurses do not give these drugs just to see what will happen; they anticipate that the particular pain that a patient is experiencing will be significantly less within a given time, and if it is not, adjustments to dose...
and/or frequency or an alternate view of the patient’s condition can be considered. Effective interprofessional practices build clinical intuition, and team members rely on each other to develop a robust, integrated approach to the generation of relevant clinical knowledge, not only for a particular patient but also for the context in which they are providing care for multiple patients. Integrative thinking is part of what generates the habits and routines of a team and contributes to the development of improvisational skills that are needed among team members to manage multiple emerging demands that cannot be fully predicted. This emergent property of healthcare is described by Bleakley [1] as one in which ‘... stability is replaced by... a permanent state of fluidity, resulting in a complex context that carries with it high levels of uncertainty’. Emerging population demographics and the increasing challenge of hospitalized frail older adults create some of the most complex challenges in healthcare environments that are, themselves, inherently complex. Effective and fluid collaboration among team members is essential.

Finally, Benner et al. call for the development of moral imagination, by which they mean the ability to quickly form effective relationships and to act with compassion, whether imparting news of a difficult diagnosis, talking about options of care, inserting an intravenous catheter, changing ventilator tubing, doing an assessment, or interacting with team members. Most healthcare encounters are brief; many are less than a minute, and this is also true of many encounters between healthcare providers on a team. Developing moral imagination invites a different way to conceive of the importance of these encounters, however brief or technical they might be. Table 1 summarizes the six CIHC competencies and adds the three additional aptitudes suggested by Benner et al.

**Table 1. Key competencies/characteristics of interprofessionalism**

<table>
<thead>
<tr>
<th>Key competencies/aptitudes of interprofessionalism</th>
<th>CIHC interprofessional competencies [10]</th>
<th>Benner et al. [14]</th>
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</thead>
<tbody>
<tr>
<td>Patient/client/family/community-centered care</td>
<td>A sense of salience</td>
<td></td>
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<tr>
<td>Interprofessional communication</td>
<td>Clinical imagination</td>
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<td>Role clarification</td>
<td>Moral imagination</td>
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<td>Interprofessional conflict resolution</td>
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<td>Team functioning</td>
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<td>Collaborative leadership</td>
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**Interprofessional Collaboration Reconsidered**

Interprofessional collaboration is thought to be a phenomenon that is context specific, meaning that there is no single right way [15]; is responsive, evolving and emergent [16]; and involves continuous interaction and interdependence [17]. These characteristics are consistent with ideas put forward by practice and organizational theorists such
as Nicolini [18], Sandberg and Tsoukas [19], and Bourdieu [20]; social theorists such as Flyvbjerg et al. [21]; and medical education and social theorists such as Hodges and Lingard [8]. Not uncommonly, healthcare providers are taught and come to believe that they act independently and have the ability to make unencumbered decisions through independent cognitive and interpretive processes. Moreover, even though there is a broad understanding that ‘best and evidence-informed practice’ must be modified to suit individual circumstances, continued use of the ‘knowledge translation’ metaphor in healthcare suggests that we cling to the hope of stability and standardization that make it is possible to literally translate best practice guidelines into our daily practice. Similarly, standard interprofessional team development typically focuses on gaining agreement on the team’s mission, vision, values and goals, understanding of roles and the scopes of practice of each discipline (which increases understanding of each discipline’s competencies and contributions but may also strengthen professional boundaries and reduce collaboration), generating agreement about the rules of engagement and carefully defining team processes. Collectively, these agreements are often known as ‘team charters’ and align with a ‘will-to-stability’ that may frustrate the ‘will-to-adaptability’ required to accommodate the frequently changing circumstances of the clinical environment [1]. Too often, as we hope that the reader has now noticed, the focus on compassionate and person-centered care has gone missing!

The conditions under which team members must act, particularly in acute care CTUs, change faster than it takes particular ways of acting to become habitual or routine. Acute care contexts in particular are plagued with frequent changes in practice occasioned by new practice guidelines, new equipment, or new policy. Often, the sense is that one change is barely implemented before the next one comes along. Or the next patient comes along. Or one of the patients whom we are responsible for takes an unexpected turn. Or a staff member calls in sick and is replaced by someone not familiar with the caseload or the service. Or a relationship that is tenuous at best erupts into overt hostility. Or a patient falls and is injured. Or an in-service education session takes six staff off the floor. Or there is a shift change. The imagined stability of formal, well-defined team processes cannot take into account the degree to which the practices of any given community face frequent shifts in priorities as the moment-by-moment clinical circumstances emerge in ways that are not always predictable. Specific practices in a care community (such as the CTU that we described) arise and become articulated through algorithms and best practice guidelines but are enacted through processes in which team members (including patients) together make sense about what is needed and what is possible and through processes in which team members (including patients) then negotiate action on clinical decisions within the complex and changing clinical circumstances they encounter [22]. We argue that algorithms and guidelines give us guidance about what to do, but making sense of the way in which guidelines apply in particular circumstances and how we work together to enact them is a critical element of collaborative practice and should be given equal weight when thinking about our practices. Figure 2 shows person-centered care in the intersection between all three process domains.
Three Interdependent Processes of Practice

Practitioners simultaneously act in all three of the process domains described above. We do not mean to imply a specific starting point or sequence, but suggest that actions in all three domains are likely to occur simultaneously and iteratively. We do mean to show how different ways of knowing and acting influence our collective and individual practices. This will help us to understand teamwork and interprofessionalism as emergent contextual actions undertaken by practitioners and patients, and not as a stable set of idealized principles. Practice theorist Theodore Schatzki [23] argues that practices provide the ‘conditions of intelligibility’ for action; that is, the practices of particular communities [24] explain why certain actions make sense and others do not. These conditions define, to some extent, what can and cannot be seen, said or done and explain why, for example, practices can be different between different units in one hospital and between similar services in one hospital compared to another, even though similar services rely on the same ‘best practice guidelines’ and organizational policies. Practices – what Bourdieu [20] calls ‘habitus’, or the way in which people in particular contexts tend to act – largely arise from the ongoing interactions between the members of a particular community of practice, and much less from the correct translation of science, the blind enactment of policies, or the perfect execution of strategic plans or professional competencies designed to generate specific outcomes [25]. We do not mean to imply that guidelines, policies and competencies are unimportant or that they do not influence practices. It is just that approaches to changing practice must also take...
into account the importance of the processes of sense-making among interdependent people as they negotiate and improvise their work. An important reason for taking this more complex view is that we do not generally experience ‘perfect’ patients, with the one problem for which these policies, competencies, or best practices were designed.

Figure 2 shows the three domains of practice that we have been discussing. Practices, including interprofessional practices, are a thoroughly social and emergent phenomenon constituted by interdependent and iterative processes of representation (such as policies and practice guidelines), sense-making (through negotiation and reflective and reflexive practices), and improvisation (deciding how to act in the circumstances at the point and in the moments of care) [22]. In the following sections, we briefly outline some elements that are likely to influence practice in each of these process domains. Compassionate, person-centered care is the central focus in this scheme. We use the term ‘person-centered care’ (as opposed to ‘patient-centered care’) to reflect care processes and decision-making that include a broad concern for inclusion of and respectful, knowledge-generating relationships with patients and families and between staff (including physicians).

**Processes of Representation**

An outcome of the dominance of modern scientific tradition is the search for more precise, more ‘accurate’ descriptions (‘representations’) thought to come closer and closer to a final ‘truth’, or the pre-given essence of a thing (see fig. 3). This approach values objectivism and hypothesis-driven deductive scientific methods. Findings are represented in documents such as best practice guidelines, clinical algorithms and practice guidelines, policies, professional regulatory guidelines, and even strategic planning; particularly in healthcare, reliance on these methods has also resulted in the development of ‘implementation science’ [26], such as Roger’s *Diffusion of Innovation* [27]. Clinically, this way of thinking includes the use of various technically based forms of assessment, including metrics like lab values and imaging, which represent the state of health of an organ or physiologic system. Aristotle referred to this way of thinking as ‘episteme’, from which the modern term ‘epistemology’ (scientific knowledge) is derived [21]. When interprofessional teams are described in documents in terms of such aspects as roles and responsibilities, the scope of practice, strategic plans, goals and objectives, policies and procedures, and rules of engagement, this representation of ‘teamness’ reflects a will-to-stability and predictability [1] and ignores the complex and changing contexts in which team members must practice. Even so, these clinical and team representations in practice are helpful in terms of orienting thought and activity, establishing a sense of shared purpose and effort, and postulating ideals that teams might strive toward. What a document cannot do is make sense of the contingent and unique circumstances in which they are to be applied or reform itself in response to the generation of new practice-based knowledge [28].
Processes of Sense-Making

People, and not guidelines, make sense of the representations of practice in both clinical and team function contexts (see fig. 4). The importance of this self-evident truth is easily dismissed even though guidelines and other representations of practice are developed from questions that arise in practice. Stacey [25] draws attention to the fact that practice and theory are not dichotomous – that is, separate entities wherein in one moment, we practice, and in another, we theorize – but rather are paradoxically two aspects of the same phenomenon in which both are always at play. This makes sense when we think about the difference between a novice and an experienced practitioner or between a seasoned team and one recently formed to provide a new service. The novice practitioner or new team might rely more heavily on representations initially but will soon begin to reform theory based on experience. In the team context, interprofessional collaboration is supported by making explicit the processes of understanding the application of guidelines or policies in the context of specific patients or circumstances.

The processes involved in sense-making include activities such as reflective and reflexive practices, discussing and coming to agreement on shared goals, collaborative decision-making, discernment of the salient features of complex circumstances, use of multiple ways of thinking, and the development of clinical and moral imagination [14, 22]. A feature that distinguishes collaboration from other processes, such as communication, cooperation or coordination, is the idea of knowledge-generating dialogues [1] between team members, including patients and families. Communication transmits information, cooperation is a relational stance for mutual benefit, and coordination is a sequencing strategy. Collaboration consists of conversation in which new knowledge that did not previously exist is (or could be) generated and informs further deliberation.
and/or action in ways that no one person would have come to on his/her own. With this understanding of collaboration, we see that not every clinical circumstance or team function need be collaborative. It is perfectly appropriate at times to simply communicate or coordinate, and most of the time, tacit agreements around cooperation are part of the social contract of our practices. A face-value argument can be made, stating that the work of true collaboration – or of knowledge-generating conversations – would not be productive if applied in every situation. Complex situations in which diagnosis and treatment options are not at all clear or in which managing challenging interpersonal dynamics within teams or between providers and patients is difficult to get through would benefit from a collaborative approach. Much of what we call interprofessional collaborative practice is not true collaboration and does not need to be. The fact that collaboration is not needed in all circumstances and that it is not generally understood as knowledge-generating dialogues may contribute to the frequently expressed sentiment that it is difficult to find model collaborative practice settings where students can experience and learn to apply what they have learned about IPC in educational settings.

The intellectual tradition that Aristotle most closely associated with sense-making is ‘phronesis’ [21]. Aristotle thought that phronesis (practical wisdom) was the most important of the intellectual traditions, and unlike for episteme (which translates to the modern term ‘epistemology’) or techne (which translates to the modern terms ‘technique’ and ‘technology’), there is no modern translation of the word. However, it is an intuitive truth that all healthcare practitioners rely on practical wisdom more and more as they gain experience that re-forms their theory. It is the complex, interacting needs of frail older patients in the hospital that are forcing us to re-think how models of care and care plans can be used to help practitioners gain experience in dealing with those issues, which goes beyond best or evidence-informed practice.
Fig. 5. Processes of improvisation.

Processes of Improvisation

Representation processes expose what we believe that we ought to do in a general and acontextual sense. Processes of Sense-making occur between people who are deeply engaged in a given practice to understand what the next step is, given the unique circumstances in the particular situation in which they must act. Processes of improvisation are those of application (see fig. 5). This is where the rubber hits the road: where best practice has been carefully considered in light of contingent circumstances that we face and where we bring to bear our experience, knowledge (tacit and explicit) and skills and, finally, take the next step. We take action, action that, in every clinical encounter and every team encounter, calls on us to know more than we were taught and that we have never before experienced in quite the same way. There is, of course, a great deal more carryover of thinking and action compared to what might be new. Thus, there is no intent to imply that our actions are random, entirely invented, or without the strong foundation of knowledge, skills, and attitudes. However, improvisation is always needed: what priorities are most important, what equipment is or is not available, what state of mind the patient is in, whether other practitioners have completed tasks that are prerequisite to the action that you must take. We almost always act with others, and this calls on us to negotiate differences in focus, professional and personal values, professional identity and power potential; that is, to attend to our own sense of what needs to happen, balanced with ethical considerations, professional regulation, and policies and guidelines. Processes of improvisation recognize the interdependence of these and other factors that influence what decisions and action are available for us and then help to decide what the next action to follow might be.
Aristotle’s final two intellectual traditions, techne and metis, influence improvisation most. ‘Techne’ has been translated to our modern notions of technique and technology, or psychomotor skills and aptitudes. ‘Metis’ refers to something like practical wisdom but additionally refers to a kind of ‘cunning’, such as a sense of when to perform an action that, in most circumstances, would not be consistent with ‘best practice’. A practitioner might, for example, rely on metis to start or stop a particular treatment when he/she is still unable to quite say why he/she is making that decision, or the ‘gut feel’ decision that all seasoned practitioners make that they sometimes find difficult to explain to students. This is particularly relevant to managing end-stage disease in frail older people, when what ‘ought’ to happen may be difficult to say with any certainty.

We suggest that these three interdependent process domains are what we are doing when we work together in a particular practice community: that is, interprofessional collaboration in a particular practice setting. In the concluding section of this chapter, we will return to reflect further on the context that we described at the beginning, namely, a CTU in the acute care setting, and to explore the notion of whether or not there is a single best practice for the interprofessional management of frail older adults in this setting.

Summary

Over the last two decades, there has been growing evidence for specific ‘elder-friendly’ interventions and models of care in single care locations within a hospital, such as the ED [29, 30] and inpatient settings [31–33]. These studies have demonstrated both economic and social benefits of interprofessional care, including reductions in length of stay, readmissions and inappropriate resource utilization. Even though many successful interventions have been identified as best practice and have good evidence to support their development and broad implementation [34], effective interventions are not always easily transferred from clinical studies and implemented in routine hospital care [35]. We argue that the ‘representation’ of practice established in these studies is only the first step. Locally relevant modifications must be made in each care setting through local processes of sense-making and ‘improvisation’ and then re-presented as new theory derived from practice wisdom. Many traditional models of implementation of care plans (typically within the nursing discipline) or geriatric consultation services (typically physician-driven) may fail to engage the care team in the collaboration (knowledge-generating dialogues) required for truly person-centered care. Particularly in a setting with many competing demands and priorities, such as a CTU, we speculate that practices are especially challenging to articulate and change. The ‘reciprocal mentorship’ implied by the notion of collaboration as knowledge-generating dialogues invites interprofessionalism into the learning and practice environment in its broadest sense. Our individual and collective experience contributes to
the evidence informing our best practice as that ideal applies to THIS patient in THESE particular circumstances; there is no universal magic bullet. If we genuinely understand and accept that there is no magic bullet, we would need to completely re-think how practices change and to take very seriously how the three interdependent processes of practice interact every day through every encounter to build our theory/practice paradigms. We suggest that multiple models of care intersecting in complementary ways are needed to effectively address the complex practice and education issues, including competing priorities that get in the way of providing appropriately responsive care for management of the urgent needs of frail older adults. The question of whether it is best to manage hospitalized frail older adults as a cohort population is complex and will be even more so as older adults comprise a larger and larger proportion of the hospitalized population. Will it even be possible to consider older adults as a cohort going forward? Will there be sufficient numbers of geriatricians and other healthcare personnel skilled and interested in the management of frail older adults, or will we need everyone to understand and manage this population, no matter where they are located? Integrating specialized geriatrics services within general populations seems to be a more likely strategy and will require the deep understanding of and engagement with the integrated processes of practices that we have proposed.

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