Problems and Solutions for Interprofessional Education in North American Dental Schools

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KEYWORDS

- Interprofessional relations • Interprofessional education • Professional education
- Professional education, dental • Patient care team • Professional competence
- Education, dental • Patient-centered care

KEY POINTS

- Interprofessional education (IPE) must be clinically relevant to our students. Therefore, IPE cases must promote teamwork, be applicable to dental care, and be authentic.
- Relevance and learning are enhanced by moving from the classroom to clinical care and by the use of actual or simulated cases.
- There is no need to reinvent the wheel, but assessments should be calibrated and evidence based. Learning objectives and assessments can be adapted from high-quality preexisting resources.
- Learning in a community setting promotes recognition of discipline-specific biases and can help to create sustainable interprofessional resources.
- Sustainability is enhanced by an effort to overcome institutional barriers and by embedding IPE/interprofessional collaborative practice in the fabric of the institution.

INTRODUCTION

Interprofessional education (IPE) and interprofessional collaborative practice (ICP) are relatively new to most health professional schools in North America. Dental accreditation authorities in Canada and the United States recognize their importance to good patient care and in 2013 adopted new accreditation standards, which mandate that IPE be part of dental education. Standard 2-19 of the 2016 Predoctoral Accreditation Standards of the USA Commission on Dental Accreditation states, “Graduates must

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be competent in communicating and collaborating with other members of the health care team to facilitate the provision of health care."[1] Dental schools face some unique problems because unlike MDs or nurses, most dentists do not participate in hospital-based practice, and many IPE activities simulate hospital scenarios. Furthermore, in North America, oral health care often follows a different track from general health care, including practice locations, practitioner attitudes, and billing practices, reinforcing the false impression that the mouth is not part of the body. Oral health can be fully integrated into ICP only if all providers fully understand its importance to our patients' overall health.

Just as graduate dentists concentrating on treatment of dental disease may need to be reminded about basic medical science, general physicians and other health care professionals need to be reminded about the oral cavity's place in the body and to think of the teeth as well as the toes[2] when they consider patient health. All health care workers, not just dentists, need to change the conversation from *oral health is connected to systemic health* toward *oral health is integral to overall* health because characterizing it as a connection rather than a synthesis is an understatement.

We also need to change the culture of dentistry from only addressing the *what* (the procedure to be done) at the exclusion of the *why* (the diagnosis and reason for treatment). It could be argued that attempts to simply integrate oral health into primary care via nurse practitioners (NPs) and physician assistants (applying fluoride varnish, learning to do oral examinations, and so forth) is detrimental to ICP because it does little to alter the reciprocal education needed to truly understand and respect each other's roles. The dental team needs education, collaboration, and practice with other health care professionals; other health care professionals need education, collaboration, and practice with us.

Palatta and colleagues[3] say "IPE and collaborative practice have surfaced as among the most significant changes to health care education and delivery in the 21st century." Nonetheless, its implementation in dental schools faces numerous hurdles. Palatta and colleagues[3] surveyed dental schools and found the most important perceived barriers to IPE implementation include funding limitations, lack of curricular time, and assessment of student learning. Rafter and colleagues[4] found similar results when they interviewed leaders at 7 key academic health centers who stated that the major hurdles include lack of curricular time, funding limitations, lack of scientific evidence for effectiveness of IPE, and lack of support by faculty and administration, including poor communication between health profession schools and the perception that IPE is a fad. Dental hygiene schools seem to face similar barriers. Furgeson and colleagues[5] surveyed US dental hygiene schools and identified that the most important anticipated future barriers are scheduling and logistics, lack of programs with which to collaborate, and lack of administrative support.

This article attempts to turn the conversation toward solutions. Diverse Canadian and US dental schools report the range of problems that they have faced during their introduction of IPE and discuss the solutions that they have found in a brief format. These contributions are shown next.

PROBLEM 1: HOW DO WE MAKE INTERPROFESSIONAL EDUCATION CLINICAL REQUIREMENTS MORE RELEVANT AND FLEXIBLE?

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The University of Toronto (UT) IPE curriculum for 11 health profession programs requires students to interact with each other's professions. The IPE component in

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