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Approaching Interprofessional Education in Medical School

Commentary by Dawn M. Schocken, MPH, Amy H. Schwartz, PharmD, BCPS, and Frazier T. Stevenson, MD

A U.S. medical school has decided to embrace the current health care changes and incorporate exposure to interdisciplinary teamwork into its medical curriculum. As a part of this mission, medical, pharmacy, nursing, and physical therapy students gather for interdisciplinary events a few times throughout the year. The students, all in their second year of studies, are instructed to conduct an interview with a standardized patient and decide on an assessment and plan.

In the spirit of camaraderie, the course directors encourage students from all disciplines to take turns being the consult leader. After a few sessions, many of the medical students begin to approach the course director with concerns, questioning the relevance of this program, inasmuch as they will more often be the leaders and coordinators of a team. They have suggested changing the program to keep the medical students as the consistent consult leaders.

On the feedback surveys, one of the medical students remarked, “we should be trained to be doctors, the nursing students should be trained to be nurses, and the pharmacy students should be trained to be pharmacists. I don’t understand how sitting back and letting the other disciplines lead the consultation helps us with realistic teamwork.”

Commentary

The delivery of high-quality care is a complex endeavor at every health care institution [1]. The rising costs of health care delivery, the complexity of caring for the patients with multiple chronic diseases in an aging population, the myriad choices available in drug and therapeutic managements, and the changing landscape of health care policy together necessitate that physicians be trusted and able team leaders as well as competent clinicians. We have seen leadership training in the business realm for several decades, but the trends in health care just mentioned have recently led academic institutions to realize the importance of educating for leadership in medicine, education that would teach students to recognize and develop strategies for managing the complexities of comprehensive patient care in our strained economic environment.

Literature on leadership in the academic setting points to communication, visioning, strategic planning, change management, team building, personnel management, business skills, and systems thinking as critical skills for the physician leader [2].

Strong leaders are those who can establish positive and trusting relationships and who are as aware of their weaknesses as of their strengths, which encourages them to develop complementary teams that can grow to create optimal patient care delivery.

The emphasis on teamwork in health care increased significantly after the publication of two reports from the Institute of Medicine (IOM) that illustrated quality problems in U.S. health care and called for vastly improved teamwork to help stem the tide of medical errors and preventable conditions [3, 4]. Given the essential need to develop functioning teams, medical education responded with leadership skills and teamwork competencies for training clinicians. At first, the marriage between understanding good leadership and the need to create optimal teams perpetuated a hierarchical model in which the physician leader retained legal responsibility for patient care. A business model of leadership was the basis for physician practice as part of a team, though still as its leader. One of the challenges of this model is that, in practice, team members are ill prepared to manage problems inherent in the hierarchical system. Rarely do team members have the communication training needed to resolve the inevitable tensions that arise over conflicting opinions in patient care. Doctors, nurses, pharmacists and others have different training; clear conflicts arise from their varying expectations about outcomes and individual members' roles and responsibilities.

In 2007, the Association of American Medical Colleges (AAMC) released its strategic priorities to their membership; clearly stating that interprofessional education (IPE) and interprofessional practice (IPP) were key areas of focus [5]. Following this release, many medical schools began to actively incorporate some form of IPE into their curricula to prepare their students for the future of health care in a patient-centered, team-oriented system. [6]. When trying to engage in authentic IPE opportunities in a traditional medical model, many schools merely placed learners from many health care disciplines in the same place at the same time, with little regard to how the students would conceptualize a workforce that functioned in an IPP fashion. This is the situation expressed in our case scenario.

In May 2011, six national associations of schools of the health professions published the Core Competencies for Interprofessional Collaborative Practice [7], which emphasized the importance of understanding the roles and responsibilities of one's own profession first and foremost. Following that, professionals should, the report said, gain knowledge of the roles and responsibilities of *all* health care professionals with whom they will interact. This knowledge base was thought to be fundamental to the later creation of open dialogue about patient-centered, team-based care.

A 2012 review of IPE literature in *Academic Medicine* highlighted several instances of seminal work in Interprofessional education. Among these was a review of leadership in IPE in academic medical education [8]. The authors concluded that, "although physician leadership is not problematic in and of itself, we have found that it raised many issues within Interprofessional teams" [9]. Emerging discussions of clinical democracy and how to overcome ingrained incentives for maintaining

structural hierarchies seemed to open doors for reflection about leadership and collaborative practices.

The vicissitudes of patient care are demanding change in practice modes, and reimbursement structures and health care policy will dictate terms of delivery that require physicians to collaborate with their peers. Even as teamwork becomes the new standard of care, however, responsibility for the continuity of care continues to reside with the physician, who maintains and manages communication with the patient. It is within this structure that medical schools have responded to the need to train physicians for collaboration. The dichotomy in which the physician must be the repository of the patient's care and information, while working collaboratively to achieve better patient outcomes, leaves most traditional medical educators struggling to offer authentic educational experiences to prepare the physician caregiver to work in a team while retaining the leadership role when the care for the patient dictates.

There have been contradictory findings about the effectiveness of health care teams, but these may relate to the actual structure of a team—loose or formal—and the nature of decision-making—hierarchical or egalitarian [10]. The nature of IPE programming allows the medical schools to introduce a collaborative orientation [11], meaning that members of the health care team will work in an egalitarian rather than hierarchical fashion, even in the absence of formal team structures. This new teamwork frame allows for fluidity of roles in the team setting and lends itself to a patient-centered, collaborative care model.

Possible Approaches to Interprofessional Education

Such an approach to leadership, however, can be challenging for IP teams embedded in traditional health care, educational, and medical-legal systems that reinforce the idea that physicians sit at the top of the hierarchy. Effectively implementing IPE into the various curricula in health care takes coordination and planning on the part of all the educators. A commitment on the part of the health care institutions to training their faculty in IPE methodology is critically important in most institutions, as is developing institutional strategy for ensuring the viability and sustainability of all IPE initiatives.

The academic health science center in our case scenario might find it helpful to institute collaboration in clinical patient care first, as one method of assuring the IPE pedagogy is implemented. Course directors could align themselves with IPE-trained faculty to bring the various skills needed for collaborative work into their programs. Seeing a fluid model demonstrated by faculty will foster greater appreciation of both the similarities between professional responsibilities in the health care environment and the complexities they will face when practicing themselves. And having the faculty work side-by-side can allow the faculty to model behaviors to their students.

A second, less faculty-intensive, approach is developing case-based scenarios that reflect the roles and responsibilities of a broader health care team and giving students an opportunity to practice with guidance prior to engaging in real clinical care. The

challenge has been set and the patients are demanding a more unified team approach, but to develop and roll out any version of this curriculum takes much thought, active coordination, and alignment in perceptions and principles of practice.

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Dawn M. Schocken, MPH, is director of the Center for Advanced Clinical Learning and chair of the interprofessional education committee at University of South Florida Health Morsani College of Medicine in Tampa. She is interested in enhancing health professional students' education through simulation and experiential learning.

Amy H. Schwartz, PharmD, BCPS, is the associate dean for curriculum development at the University of South Florida Health College of Pharmacy in Tampa. She is an active member of the USF Health interprofessional education committee and is interested in evaluation of students' learning.

Frazier T. Stevenson, MD, is the associate dean for undergraduate medical education at the University of South Florida Health Morsani College of Medicine in Tampa. His research on the effects of interprofessional education on preclinical learners is funded by the Arthur Vining Davis Foundation.

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