The case for educating health care students in professionalism as the core content of interprofessional education

Article in Medical Education · June 2005
DOI: 10.1111/j.1365-2929.2005.02116.x · Source: PubMed

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Retrieved on: 26 July 2016
The case for educating health care students in professionalism as the core content of interprofessional education

Ruth P McNair

BACKGROUND Professional teams are becoming more central to health care as evidence emerges that effective teamwork enhances the quality of patient care. Currently, health care professionals are poorly prepared by their education for their roles on the team. In parallel, there are increasing demands from consumers for health care professionals to serve the interests of society and patients through engaging in effective professional partnerships. Professionalism for health care providers is now being defined as a commitment to standards of excellence in the practice of the profession that are designed primarily to serve the interests of the patient and to be responsive to the health needs of society. Yet, there are multiple barriers impeding the development of professionalism beyond a uni-professional frame of reference.

METHOD Incorporating teamwork and professionalism into health care professional curricula at pre-registration level is proving to be challenging. These 2 areas of learning are brought together in this paper through a discussion of the role of interprofessional education in preparing all health care professional students for the workforce.

CONCLUSION Interprofessionalism is presented as a pre-registration curriculum framework that includes values shared by all health care professionals, which should be learned in order to more adequately prepare students for working in health care teams. It will be argued that interprofessional education provides appropriate methods by which to learn professionalism, and that this will ultimately contribute to overcoming uni-professional exclusivity.

KEYWORDS education, medical, undergraduate/methods; interprofessional relations; patient care teams; curriculum; students, medical/*psychology.

Medical Education 2005; 39: 456–464

INTRODUCTION

Health care work patterns are rapidly shifting towards being team-based. Effective teamwork has been shown to improve the quality of patient care, yet until recently has not been included in pre-registration curricula. As a result, students in health care professions, including students of nursing, medicine, allied health and social work professions, are entering the workforce poorly prepared for the inevitable teamwork in which they will be required to engage. The difficulties encountered in working with professionals from different disciplines arise from a lack of knowledge of different roles, lack of skills in teamwork and variable levels of respect, all of which are amenable to change through education. The Institute of Medicine, USA has recently stated that all health professionals should be educated to deliver patient-centred care as members of an interdisciplinary team. The National Health Service workforce plan in the UK emphasises the need to prepare students for interprofessional practice (teamworking and collaboration between disciplines) and recommends the development of pre-registration common learning programmes. The stated outcomes of common learning programmes include not only the ability to work in interprofessional teams, but also...
Overview

What is already known on this subject

Significant barriers to the development of respectful and effective relationships between different health care professional disciplines exist. These include a largely uni-disciplinary education; distinct professional codes of ethics, which can fuel interdisciplinary rivalry, and the drawing of boundaries around uni-professional knowledge that enhance exclusivity. These barriers are reinforced for pre-registration students through a powerful hidden curriculum of role-modelling of negative attitudes and behaviours towards other disciplines.

What this study adds

It is proposed that professionalism should be redefined as an essential and shared pre-registration curriculum, which includes the learning of shared values, using interprofessional education methods. Methods of evaluation of educational and workforce outcomes are suggested.

Suggestions for further research

Research is needed to determine the most effective methods of evaluation of outcomes for students learning within an interprofessionalism framework.

the ability to substitute roles and have career flexibility.

Alongside the development of health care teams is the shift towards a partnership model of health care between patients and their health care providers. Society demands an increasing level of accountability and co-ordination between health care professionals. This paper will explore reasons for the poor educational preparation for this work and look at the core elements that are needed within curricula to fill the gap. Professionalism will be presented as the missing ingredient, particularly as it applies to interprofessional relationships. The paper will then present a model of interprofessional education that includes professionalism at its core.

Professionalism Defined

Professionalism has a long history, during which it has had multiple meanings, has been discredited and has recently re-emerged as an important element in all health professional learning. Its period in the wilderness during the 1970s and 1980s was underpinned by the dual meaning attributed to professionalism, framed as a conflict between altruism and self-interest. During this period professions were seen as powerful, privileged, self-interested monopolies, which engendered scepticism for the value of professionalism. Similarly, Senhauser describes a shift in the definition of a professional at that time from ‘one who engages in a vocation or occupations requiring a long period of intense study, to anyone who performs specialised work for pay’. Increasing public mistrust of the medical profession has been founded on the belief that the profession exists to protect its members. This protection is seen to extend even to incompetent or unethical colleagues, and has been highlighted in high profile cases such as the Bristol enquiry in the UK.

Some suggest that ‘professionalism is an ideal to be pursued’, a cynical perspective implying that professionalism cannot truly exist in a climate of individualism. During the 1990s, the increasingly influential consumer lobby, as well as the outcomes-focused health care education framework, highlighted a need to reclaim professionalism. It has been re-interpreted to incorporate a core humanistic focus, in which the interests of the patient and the community are central. This commitment to social responsibility is increasingly becoming a focus of more responsive educators and universities. Professionalism in this form has since been included among the essential components in the post-registration arena across a range of health professions.

A review of over 30 years of literature on professionalism outlined the core values of professionalism, which will be used as a point of reference for this paper (Table 1).

Interprofessionalism

Various medical bodies have attempted to define medical professionalism, a high-profile example being the ‘Medical Professionalism Project’, which was established to develop a set of principles for all medical professionals. This project was undertaken by the European Federation of Internal Medicine, the American Board of Internal Medicine (ABIM),
and the American College of Physicians and Society of Internal Medicine. The 3 principles in this charter are the primacy of the patient’s interests above self-interest (altruism), respect for patient autonomy, and social justice; these are followed by several professional responsibilities. This definition of professionalism was developed by doctors for doctors, however, it equally applies to any health care professional. Evetts argues that the re-interpretation of professionalism should occur through ideas about interprofessional collaboration and shared social responsibility. The American Association of Colleges of Nursing (AACN) has clearly defined the skills required for collaboration as being negotiation, team building, joint decision making, problem solving and development of joint values. I propose that the elements of professionalism in Table 1 form the basis of this joint value system for interprofessional practice and will be redefined as interprofessionalism in this paper. Interprofessionalism can be learned using interprofessional education and emphasising a patient-centred rather than a profession-centred approach.

**Uni-professionalism**

For the purposes of this paper, uni-professionalism is defined as the pursuit of goals for single health care professional disciplines to the exclusion of other disciplines. Uni-professional collegiality has its place in the necessary formation of a single professional identity and the definition of specific value-systems. Indeed, professions exist, in part, to develop and pass on specific and burgeoning specialist knowledge, which is essential for the effective functioning of the health care system, whatever the discipline. However, the power invested in having control over a distinct body of knowledge and the development of ‘cognitive exclusivity’ creates a significant barrier to effective relationships with other professionals and with patients and, therefore, undermines interprofessionalism. The accompanying status, including differential levels of financial remuneration awarded to different health professions is also a systemic barrier. Evetts suggests that the ‘monopoly use of expert knowledge for economic gain poses real dilemmas for developments in interprofessional collaboration.’

Distinct boundaries have been drawn between the knowledge bases of various health care disciplines in the creation of professional identities. This can become problematic when health care professionals are required to widen their scope of practice. Territorialism can occur and this has been related to the concept of tribalism, where professionals can feel threatened by others who are seen to be encroaching upon their ‘territory’. This is particularly divisive within health care teams, where effective team working requires some blurring of role boundaries.

A further aspect of uni-professionalism is the development of distinct codes of ethics by each discipline. These move beyond discipline-specific knowledge to capture the distinct values of the particular discipline. However, when comparing ethical codes of various health disciplines, the principles are found to be very similar. The distinct codes would not be a problem...
if not for the divisiveness that can result between disciplines when valuing 1 code over another. Ethical codes thus can be ‘used as ammunition in interdisciplinary battles’ by fuelling interdisciplinary rivalry and territorialism.27 (p 616) An example of this is the preamble to the Australian Medical Association’s code of ethics, which states: ‘because of their special knowledge and expertise, doctors have a responsibility to improve and maintain the health of their patients.’28 This implies that doctors have sole responsibility, as there is no mention within the preamble of working with others. Indeed, none of the 4 clauses that follow specifically refer to working with colleagues beyond medical colleagues.

In contrast, the Tavistock Group, a multidisciplinary group of health care and ethics leaders, has developed a set of ethical principles that can apply to all members of the health care team, in ‘recognition that much of health care is multidisciplinary, yet ethical codes usually cover only one discipline’.23 (p 616) Following extensive consultation in the USA and UK, they now include 7 principles: rights (to health care), balance (between individual and population health), comprehensiveness, improvement, safety, openness (honesty, trustworthiness) and co-operation (with patients, each other and other sectors). These principles enact the elements of professionalism. Co-operation is seen as the central principle in recognition of the fact that all of those working in health care depend on each other.

Professional associations have contributed to creating barriers to professionalism in other ways than through the development of individual codes of ethics. They have dual roles as advocates for the health of the community, and representation of their members, and at times defenders of a specific profession.3,6 This again reflects the duality of altruism and self-interest. The development of distinct systems of accreditation and licensing, although essential for the development and maintenance of competency and professional standards, further alienate the disciplines from one another. A key recommendation of the recent Institute of Medicine report on health professional education in the USA is that the uni-professional accreditation and licensing systems be broken down.3

Uni-professional health care professional education

This uni-professional approach to licensing is merely the end-point of a vertical uni-disciplinary stream throughout the education process from entry.29 This uni-professional academic preparation versus the teamwork required in practice is seen as a ‘profound disconnect’ through which education is failing to adequately prepare students for their professional work.17 (p 30) Medical, nursing and allied health students are found to enter their specific health professional courses with pre-formed and stereotyped ideas about their own and other disciplines.30,31 Negative stereotypes regarding other disciplines can lead to professional arrogance and hamper effective collaborative relationships.32 Social identity theory suggests that identifying with a particular group actively determines interpersonal attitudes and behaviour towards other groups.33 Uni-professional course work perpetuates such stereotypes and resulting behaviours. Group membership can be fluid, however, and amenable to change if there is adequate exposure and interaction with related groups. In this way, interprofessional learning has been shown to positively influence attitudes towards other professionals,34 particularly when introduced early in the course.34 This is congruent with theories of situated learning, which argue that social interaction within learning communities is a critical element of adult learning.35

A hidden curriculum involving role-modelling of negative attitudes can also undermine interprofessionalism.36 The acquisition of negative attitudes towards other health care professionals during the course has been described by recently qualified health care professionals, including doctors, nurses, dentists, allied health professionals and radiographers, who attributed this partly to the influence of attitudes expressed by their tutors and clinicians.37 The USA’s Institute of Medicine highlights the fact that education does not occur in a vacuum: ‘hidden curricula of observed behaviour, interactions and the overall norms and culture of a student’s training environment are extremely powerful in shaping values and attitudes. It often contradicts with what is learned in the classroom.’3 (p 9) Leaviss calls for further study on the impact of the customs, rituals and other structural factors influencing negative attitude formation and maintenance.37

CHALLENGES TO CURRICULUM DEVELOPMENT

Spencer suggests that ‘teaching about professionalism is an idea whose time has come, and given public demands for greater accountability, partnership and better communication, is unlikely to go away.’38 (p 288) His context is medical
professionalism, but his words apply equally to interprofessionalism. However, despite the urgings of senior academics and the pressure of public expectations, inserting professionalism and teamwork into the curriculum is proving to be challenging. This may relate to barriers to the explicit teaching about values, due to an expectation that appropriate values will simply emerge without the need for direction. Similarly, students’ interprofessional behaviours have rarely been observed within courses, let alone assessed or constructively criticised. Yet Cruess et al. emphasise that professionalism must be taught explicitly, and there is increasing interest in and incentives to incorporating ethics, communication and humanism into curricula. Howe has suggested that professional development curricula within medicine suffer from a lack of framework to ensure that students attain appropriate professional competencies. In response, Jill Gordon at the University of Sydney has produced such a framework, based on the ABIM attributes of professionalism, in which the key learning outcome is to foster professional behaviour. The personal and professional development (PPD) curriculum that Gordon has developed includes communication skills and teamwork between patients and doctors, but only a passing reference to interprofessional learning. Spencer suggests that medicine cannot forge change alone and that a contract between society and the (medical) profession must be honest and open. As educators for health care professional practice, we need to acknowledge that the contract must also be between health care disciplines, and incorporate a framework that includes interprofessional values and behaviours.

THE CASE FOR USING AN INTERPROFESSIONAL EDUCATION FRAMEWORK TO LEARN INTERPROFESSIONALISM

Interprofessional education (IPE) is defined as ‘occurring when 2 or more professions learn with, from and about one another to facilitate collaboration in practice’. Core IPE content was outlined initially by the World Health Organisation and includes competencies for effective teamwork, such as the development of respect between professionals. Further elements include learning about professional roles, conflict resolution, leadership, health care systems and ethics. Barr comments that ‘IPE was conceived as a means to overcome ignorance and prejudice amongst health and social care professions’ (p 10), and several authors have shown that IPE can influence attitudinal change in improving perceptions of other health care professionals. Hammick argues that IPE not only creates an opportunity to integrate knowledge from various disciplines, but also to create a ‘new terrain of knowledge’. What is this new terrain, however? Are IPE curriculum designers merely repackaging pre-existing learning?

Interprofessional education has been criticised for lacking ‘conceptual clarity’ and, therefore, being merely a trend in medical education. Finch suggests that training courses will continue to marginalise IPE until a clear and unified set of objectives are agreed upon. Campbell and Johnson also challenge proponents of interprofessional learning to develop a robust conceptual basis with agreed (and measurable) goals. In a climate of increasing pressure on all pre-registration health care curricula to deliver more content in less time, it is not surprising that, without a strong argument that IPE content is unique and essential, a significant proportion of senior faculty will continue to resist its incorporation. The content of IPE described above can easily be repackaged within the broader framework of interprofessionalism. Assuming that it is accepted that learning the shared values, skills and knowledge of interprofessional practice and professionalism should be core to the pre-registration curriculum, such content becomes the unique, new terrain sought by IPE proponents and required by senior faculty.

CURRICULUM RECOMMENDATIONS

I will now present a suggested model for learning professionalism as it applies to interprofessional practice at a pre-registration level (Table 2). The elements listed should be seen as a shared curriculum for health care professions, incorporating curriculum outcomes that are meaningful for future health care practice. The curriculum material would be new to some health professional courses, or would partially replace uni-professional curricula. Rather than using competencies, which tend to measure a student’s ability against a set of minimum standards, a capability framework has been chosen, which is more dynamic. Capability is ‘the ability to adapt to change, generate knowledge and continuously improve performance’. It includes principles of reflectiveness and lifelong learning, and uses immediate feedback about performance to enhance capability. The Sainsbury capability framework has been used as the basis for the proposed model.
has 5 areas, starting with ethical practice, followed by knowledge, the process of care (which is largely about teamwork), interventions (which include bio-psycho-social care), and, finally, application to various health care settings.

The capabilities are listed in Table 2 in order of acquisition. This is designed to be incorporated throughout the pre-registration course, alongside the necessary uni-disciplinary learning. The ultimate aim of a professionalism curriculum should be for students to adopt a value-based perspective that will then have a powerful influence on professional behaviour; therefore, the model starts with values.

'Virtue ethics' suggests that behaviour is determined by internally adopted qualities or values (in this context, the shared elements of professionalism) rather than by concepts or external rules. It moves beyond a desire purely for attitudinal change as a learning outcome, which remains difficult to measure and highly vulnerable to the influences of the 'hidden curriculum'. Ethics educators emphasise the dynamic nature of ethics teaching and learning: 'ethics offers a place for the consideration of values and for dialogue across boundaries and between different perspectives.' (p 205) Similarly, social identity theory suggests that group membership is dynamic and context-dependent, in that the group

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**Table 2 A framework for learning professionalism and interprofessional practice**

<table>
<thead>
<tr>
<th>Areas of capability*</th>
<th>Interprofessional and interprofessional practice curriculum</th>
<th>Methods of evaluation of outcomes†</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Values</td>
<td>The elements of professionalism which form the joint value system (see Table 1)</td>
<td>Observation of interprofessional behaviour during shared tasks as measure of values</td>
</tr>
<tr>
<td></td>
<td>Attitudes towards collaboration</td>
<td>Longitudinal tracking by student reflective diary through course</td>
</tr>
<tr>
<td></td>
<td>Attitudes towards other disciplines</td>
<td></td>
</tr>
<tr>
<td>2 Ethics</td>
<td>Interprofessional ethical principles (e.g. Tavistock: rights, balance, comprehensiveness, improvement, safety, openness and co-operation)</td>
<td>Self-appraisal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer appraisal</td>
</tr>
<tr>
<td>3 Knowledge</td>
<td>Understanding of health care professional roles</td>
<td>Pre- and post-questionnaires of perceived learning</td>
</tr>
<tr>
<td></td>
<td>Principles of effective teamwork</td>
<td></td>
</tr>
<tr>
<td>4 Skills for the process of care</td>
<td>Interpersonal communication between disciplines</td>
<td>Objective structured clinical examination involving interprofessional practice</td>
</tr>
<tr>
<td></td>
<td>Skills for collaboration, and teamwork including dealing with error and joint decision-making</td>
<td>Observation and group appraisal of shared tasks such as problem solving and group presentation of learning task</td>
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<tr>
<td></td>
<td>Skills for appropriate and respectful leadership including change management</td>
<td>Reflective diary</td>
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<td></td>
<td>Reflectiveness</td>
<td></td>
</tr>
<tr>
<td>5 Application</td>
<td>Adaptability across a range of health care settings and health care teams</td>
<td>Teamwork: quality of meetings, leadership, division of roles, measured by peer appraisal and external observation</td>
</tr>
<tr>
<td>(mostly post-registration)</td>
<td>Ability to shift personal role in different teams</td>
<td>Clinical audit cycle</td>
</tr>
</tbody>
</table>

* Adapted from the Capability Framework.
† Includes measures of effective teamwork described by Borrill et al.

boundaries can shift. So it is possible for students to learn values applicable to their own distinct discipline, as well as those that apply to all health care disciplines, and in this way see their own discipline merely as a subgroup, broadening the group boundaries to regard themselves as members of the more inclusive ‘group’ that is the health care profession.

Students may begin to learn elements of this shared curriculum within their uni-disciplinary courses; however, students from different disciplines must be brought together periodically to create a true interprofessional learning community. The IPE method used would vary according to the sophistication of student understanding and could include everything from class-based, common learning tasks, to combined clinical placements and shared patient-care activities. At regular points throughout their courses students would also ideally have opportunities to learn and apply the shared curriculum in an interprofessional clinical setting. A brief proposal for methods of evaluation of educational and workforce outcomes is presented in Table 2. Learning objectives and their linked assessment tasks would overtly include the interprofessional curriculum, with an emphasis on measurable outcomes. The assessment should be behavioural, in order to observe students enacting the values in their day-to-day practice with each other, their patients and professional colleagues. As part of this behavioural approach, students can be encouraged to recognise role models as negative or positive and to make active and reflective decisions about their own behaviours.

CONCLUSION

The call to develop a unified set of objectives for IPE has not gone unheeded. The model presented is an attempt to do just this by placing the values of interprofessionalism that can apply to all health care professions at its centre. This will enable students to learn within a common framework. The momentum is present at a uni-disciplinary level, with, for example, endorsement from the Australian and British Medical Councils for the inclusion of professional development in core undergraduate medical curricula. The first step is to achieve agreement at an undergraduate level that different health care professional curricula can share such objectives. Development of core capabilities for interprofessional practice at post-registration level has started, but there is no such agreement yet at the undergraduate level. Even in the UK, where there is now government policy and considerable funding supporting undergraduate IPE programmes, there is not yet a shared framework for what should be delivered or how.

Meanwhile, the interdisciplinary barriers that have developed between our various uni-professional curricula, with our distinct codes of ethics, bodies of knowledge and profession-specific skills, may seem almost insurmountable to individual curriculum designers and educators. International groups such as Tavistock have demonstrated that it is possible to develop a core set of shared ethical principles between health care professionals, while recognising that application at curriculum level is difficult. As educators, can we overcome the exclusivity of our own discipline that has been embedded into us from our own undergraduate training? Our challenge is to establish a situated learning environment ‘where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together’.50 (p 51)

Unless we respond to these challenges, we will continue to set our students up to fail in their roles as collaborative health care professionals. We must place due emphasis on the many values we all share. A core set of values for professionalism can provide an agreed framework through which our students can form respectful relationships not only with their patients, but also with the other health care professionals with whom they will work.

Acknowledgements: thanks are due to Professor Amanda Howe, University of East Anglia, UK and Dr Jane Sims, University of Melbourne, Australia for their valuable editorial advice, and to the team at the Combined Universities Interprofessional Learning Unit (CUILU), Sheffield University for introducing me to the Sainsbury Capability Framework and highlighting its application to IP learning.

Funding: none.

Conflicts of interest: none.

Ethical approval: none sought.

REFERENCES


Received 5 May 2004; editorial comments to author 16 June 2004; accepted for publication 22 July 2004