

Interprofessional Education and the Common Good: A Reflective Analysis

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INTRODUCTION

There is a renewed interest and call for professionalism across the health professions. How do we best prepare health professions students for current and future roles in meeting societal needs? Although the traditional focus in health professions education is on promoting good or promoting beneficence with individual patients, we argue that there is a need to expand the concept of beneficence to the role of health professions in working in underserved communities where resources are scarce and health professions must collaborate in the delivery of care. In this chapter we use a framework of organizational ethics based on three realms of ethics—individual, institutional, and societal—to take a critically reflective look at interprofessional education (IPE) in the health professions.

The changing and challenging landscape of health care provides the environment in which graduates of health professions education will work. Graduates face a more diverse patient population, a growing number of people living with chronic illness, increasing rates of obesity and diabetes among our youth, and escalating health care costs. Again, we pose this critical question: How do we prepare graduates who have the competencies and skills to work in these challenging times? The response to this question continues to be the need and call for reform in health professions education. Numerous reports conclude that health professionals are neither adequately prepared in

the academic or clinical settings to address shifts in the nation's patient population nor educated together or trained in team-based skills that would enhance their ability to work as part of interprofessional teams.¹⁻⁴

What must our institutions and organizations look like to support IPE? What kind of development activities are necessary for academic and clinical faculty to work in IPE and practice settings? What kind of learning environment and learning experiences are necessary to ensure that graduates can meet these societal needs? As health professionals we are familiar with the concept of promoting good or beneficence with our patients. Professional codes of ethics are grounded in the concept of first, do no harm but promote good or beneficence. In this chapter we argue that there is a need to expand the concept of beneficence by using a systems model to engage in a critical self-reflective look at health professions education across individuals, organizations/institutions, and society. The reflective analysis is done with a focus on the value of beneficence, or doing good, and on the need to "rethink learning" because learning is the essential outcome in health professions education. Green and Luke identify that Dewey argued that the most basic questions about learning include who is learning what, for what purposes, under what conditions, and with what educational, social, cultural outcomes, and consequences for learners, communities, and nations.⁵ We begin the chapter with an overview of the organizational ethics framework for the analysis of interprofessional health professions education. This is followed by a critical self-reflective look at each of the levels: individuals (students, academic and clinical faculty, and administrators), organizations, and society.

ORGANIZATIONAL ETHICS FRAMEWORK FOR ANALYSIS

Why use an ethics framework to take a critical look at IPE? Health professionals have a long history of having a social contract of both responsibility and accountability to meet societal needs. In the health professions, practitioners frequently work with patients who are vulnerable and, in need of help. The health professional possesses knowledge and skill that the patient needs. Patients trust professionals to be competent and to do good work for them as a part of a special fiduciary relationship.⁶ Professionals have also been the target of scandals and cited for highly unethical behavior that has led to public mistrust.⁷ Professional schools are the "portals to professional life" and as such have responsibility for the "reliable formation" of students. Although there is increased awareness and interest in the importance of ethics and human values in professional preparation, there is also a dramatic loss of public confidence in the authority of health professionals, their ability

to self-police, and their authenticity as collaborators in societal efforts to improve the health and well-being of all people.⁷ Health professionals, particularly nonphysician health professionals, practice in a range of health care settings from institutions to home care and communities. The interdependence of patients, professionals, institutions, communities, policymakers, and other stakeholders in this larger organizational and societal context has an effect on health professions education and practice.

The organizational ethics model is based on three realms or levels: individual, organizational, and societal (Figure 2-1).^{8,9} At the level of the individual, the focus is on doing good or beneficence of individuals. One may be weighing the relative importance of various values and needs (e.g., physical, emotional, mental). The level also deals with weighing and balancing values/goods between individuals. In our case we use the individual level to explore individual stakeholders in IPE (students, faculty, administrators, and clinicians). At the organizational level we focus on the organizations in which IPE takes place, such as academic and health care institutions. The primary aim of organizational beneficence is addressing the question, what is the organizational good? How does the organization have systems and structures that respect and promote human dignity and how does the organization attend to

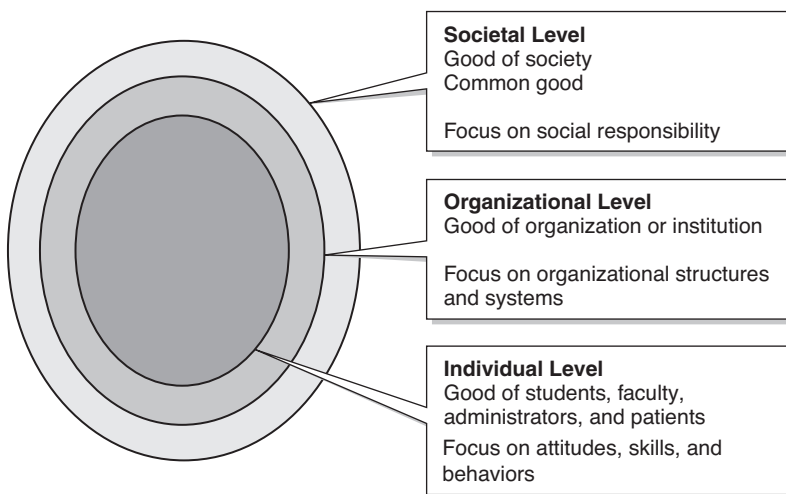


Figure 2-1

The three realms of an organizational framework for ethics.^{8,9} Adapted from Glaser J. *Three Realms of Ethics*. Kansas City, MO: Sheed and Ward; 1994 and Glaser J. Three realms of ethics: an integrating map for the future. In: Purtilo R, Jensen G, Royeen C, eds. *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics*. Philadelphia: FA Davis; 2005.

and promote the common good of the society? Organizational goods must also attend to the organization as well as using the individual to represent the individual health profession. The third dimension is the societal level. Here the central focus is on the common good of society. The common good is what we would see as promoting the well-being of a community. This would include community safety, the integrity of its basic institutions and practices, and the preservation of respect for human dignity.⁸ At this level we look at the profession's role in promoting the common good.

IPE AND INDIVIDUALS

At the individual level where students enter professional preparation, they are quickly introduced to the culture of their chosen profession. The socialization process of students begins immediately as they interact with faculty and fellow students in the professions education environment. Here the attitudes, beliefs, and behaviors begin to take shape in the professional culture. Students in academic health science campuses quickly learn that there are often differences across health professions for resource allocation of space, number of faculty, and staff support. The emphasis in the types of professional knowledge, whether you have more of a social science background or a physical science background, can also contribute to a perception that your professional knowledge is not as rigorous. For example, students may perform differently in foundation science courses depending on the depth and breadth of their prerequisite coursework and how that coursework is integrated into the professional curriculum.^{10,11} This can lead to an early perception among students that some disciplines are "smarter" than others or have more important or prestigious knowledge.

Both academic and clinical faculty are critical players in the early socialization of health professions students. Faculty are powerful role models, and the extent to which they value or devalue their colleagues through attitudes, beliefs, behaviors, and actions has a profound effect on students.^{7,12} Many faculty may see knowledge transmission as paramount and not realize that it is the implicit aspects of what they do in classroom and laboratories that has a long-lasting effect on student learning.¹³ For example, physical therapy faculty members who express to students that occupational therapists are not qualified to work with patients with upper extremity musculoskeletal problems have just planted seeds for potentially noncollaborative attitudes within their students. Clinical faculty are also powerful role models as they interact with students in patient care settings. How clinicians interact with their

colleagues in the delivery of patient-centered care can have a lasting impression with students.

Health professions educational administrators as individuals can have a profound influence on the behaviors and actions of their faculty and students. Do their words and actions support an educational culture of collaboration or competition? Do their administrative structures provide opportunities for department heads to work together to solve problems? Is there a culture that supports respect for the values and needs of individuals and the individual health disciplines?

Rethinking Learning for Individuals in IPE

Professional socialization is a critical component of professional education that begins with the admissions process. If we are serious about the importance and the “good” that will come from integrating the concept of IPE as part of the professional socialization of students, then we must ensure that individual faculty and administrators have the appropriate knowledge, skills, and attitudes to teach and lead.

We propose that development activities are necessary and needed for both health professions faculty and administrators. Steinert¹⁴ in her article on IPE and faculty development argues that faculty development initiatives must bring about change at both the individual and organizational level. “Clearly, faculty members play a critical role in the teaching and learning of IPE and they must be prepared to meet this challenge.”¹⁴ She proposes seven development approaches for promoting IPE (Table 2-1). The three core areas of content for these development initiatives include IPE, teaching and learning, and leadership and organizational change.

In addition to engaging in IPE faculty development, administrators also need leadership competencies that facilitate the growth and development of IPE. These competencies include the ability to (a) develop a shared vision and focused attention to a shared goal, (b) communicate a sense of purpose and meaning, (c) foster collaboration and cooperation, and, perhaps most importantly, (d) build trust within the organization.^{14,15}

Students follow the lead of their leaders. Students also need structure or a blueprint for their interprofessional learning. Two core competencies from the document *Health Professions Education: A Bridge to Quality*² are central for grounding the learning outcomes for students:

1. Provide patient-centered care: Identify, respect, and care about patients’ differences, values and preferences, and expressed needs; relieve pain

Table 2-1. Seven Approaches for Faculty Development in IPE¹⁴

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1. Aim to facilitate change at the individual and organizational levels.
 2. Target diverse stakeholders.
 3. Address major content areas:
 - a. IPE and collaborative patient-centered care;
 - b. Teaching and learning challenges and opportunities in IPE;
 - c. Leadership and organizational change.
 4. Use a variety of settings, including both informal and formal settings, and strategies.
 5. Model the principles and practices of IPE and collaborative practice in development activities.
 6. Integrate principles of effective teaching and educational design.
 7. Consider use of a dissemination model for implementation.
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Source: Steinert Y. Learning together to teach together: interprofessional education and faculty development. *J Interprof Care*. 2005;15:60–75; 2005.

and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.

2. Work in interdisciplinary teams: Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable. This means students should be able to describe one's role and responsibilities to other professions; recognize the limitations of their role and competence, recognize and respect the roles, and responsibilities of other professions; work together with other professions to effect change and resolve conflict in the delivery of care; and enter into interdependent relationships with other professions.¹⁵

Finally, perhaps the most important learning outcome for students is the ability to engage in critical self-reflection. Students need to develop metacognitive strategies to be aware of their thinking or habits of mind. This is a critical skill for all health professionals. Critical self-reflection on one's

practice can lead students to engage in higher order thinking and the ability to exercise judgment in uncertain situations.¹⁶ Learners who are challenged by their peers in collaborative team settings as found in IPE need these reflective skills. Also, reflection done in an interprofessional group provides an opportunity to make the reflections public across peers. This public sharing becomes an opportunity for a “reflection on the reflection” and can lead to growth of the individual as well as growth of the team.

IPE AND ORGANIZATIONS

Although most often individuals are held responsible for promoting good or allowing harm to occur, organizations are the places in which we do most of our work. Organizations have commitments, claims, relationships, and responsibilities for promoting good. The future growth and success of IPE depend to a large extent on how successful individuals are working within educational, health, and professional organizations.

We start with an examination of the structure of the educational organization. In much of health professions education, individual programs are often physically housed in different buildings on a campus or different floors. The organizational structure of the university usually allows the larger health professions to have their own school (e.g., school of medicine, dentistry, pharmacy, or nursing), whereas the other smaller health professions may be together in a school of health professions. The health professions across schools may indirectly or directly compete for resources. The reporting structure of administrators in the school is usually divided across health disciplines where faculty hold primary appointments in their discipline. Budgets are generally structured around single disciplines and core activities of those disciplines. The role and reward structure of the department, school, and educational institution (university or college) is generally based on individual competence and productivity within a discipline, not interdisciplinary work.

Although the accrediting agencies for the health professions have some criteria that address the importance of interprofessional teams, these criteria generally are more about providing students with opportunities to participate in interprofessional teams than about focusing on core competencies and robust learning outcomes. Part of the challenge with accreditation and IPE is that IPE is often poorly understood.¹⁷

Within the department, curriculum is the organizational structure that provides the guiding map for the courses, learning experiences, and learning

outcomes. Curriculum design reflects the input from many difference sources, from accreditation agencies to licensure standards, clinicians, professional associations, faculty, and students.¹⁸ Perhaps the most critical element of curriculum design and continued evolution of the curriculum is understanding the critical importance of the presence or absence of faculty-shared beliefs and values as a basis for deliberation and design decisions.¹⁹ One of the core goals in IPE is collaborative practice, yet if faculty and administrators do not share that belief, moving forward with IPE will be difficult. Often, we have a few champion faculty within disciplines who value collaboration and are not threatened by the notion of sharing resources, including time with other professions. Although these champion faculty cannot transform an organization, they are critical resources in the curriculum deliberative process because they challenge strong traditions in health professions curricula that maintain our “silo” mentality. A silo mentality keeps us working only within our own disciplinary perspective, i.e., disciplinary silos.

Rethinking Learning for Organizations in IPE

Organizations are the structure in which most of our work occurs in health professions education. If we believe that IPE is an important “organizational good,” then what must we do to promote change? We suggest that educational organizations in the health professions should aspire to become “learning organizations.” Learning organizations are defined as

Organizations where people continually expand their capacity to create results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together (p. 3).²⁰

Learning organizations need to have a high capacity for learning and for implementing change. Innovative learning organizations engage in systems thinking in that they see how the key elements of the system connect and work interdependently. Problems are not caused by someone else but need to be recognized through feedback and analysis systems. In trying to implement IPE, seeing the health professions as an interdependent system within the educational organization versus disciplinary silos would be an important first step.^{20,21}

Organizations depend on the learning of individuals, but that does not ensure organizational learning.²⁰ Organizations need to build a shared vision

and engage in team learning. How is this done? Leaders in learning organizations are responsible for building organizations where people expand their ability to learn, clarify, and contribute to the vision. Leaders are seen as designers of a shared vision, stewards of the collective vision, and teachers who are fostering learning within the organization to develop this systematic understanding of the organization.²⁰ If we see the role of educational organizations in the health professions to work toward a more collaborative, interdependent model of care delivery, then we need educational leaders at all levels from curriculum chairs, to directors of clinical education, department heads, and academic administrators to aspire to becoming learning organizations.

IPE AND SOCIETY

This third level of analysis, the societal level, deals with the common good of society. Remember, as defined earlier, the common good represents the good life, how we would all like to live in safety and well-being.⁹ Glaser citing Hardin shares a simple story of how the common good can conflict with the good of individuals.²² Think of a group of herdsman who share a grazing pasture. As long as there is enough pasture to feed the cattle, each herder is satisfied without jeopardizing the common good. If at some point there is overgrazing from individuals increasing the size of their herds but only looking at the impact the increase has on his individual herd, it will be difficult to identify and resolve the problem. Eventually, the pasture will be ruined and not meet anyone's needs.

What does society need from the health professions? Are we able to meet the common good health care needs of our citizens? Patients in the United States are becoming more diverse, are aging with increasing numbers of chronic diseases, and at the same are more likely to seek health information. The number of uninsured adults continues to grow. Uninsured adults have less access to care, are less likely to get needed care or preventive care, are less likely to manage chronic conditions, and are more likely to have poor health outcomes.²³ Once in practice, health professionals are asked to work in interdisciplinary teams often in the area of chronic disease, but the depth and breadth of health professions education in IPE varies across institutions.²

What is the interdependence of health professions when it comes to health care goods? Are we more likely to focus on our internal professional needs and defend our turf when it comes to societal needs in health care, or do we work to form coalitions that bring about the most good for patients? Are we

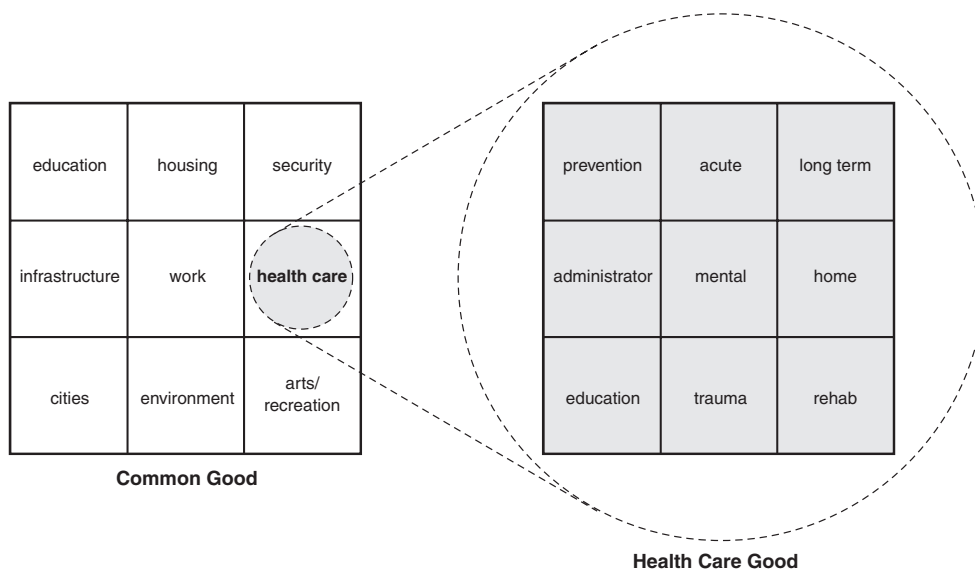
individual herders on the common pasture who are only interested in increasing the size of our own herd regardless of what may happen to that resource?

Rethinking Learning for IPE and the Common Good

All health professions share the responsibility for promoting good for their individual patients as well as for promoting “good” or the health of society. Sullivan⁷ argues that “professional schools have too long held out to their students a notion of expert knowledge that remains abstracted from context.” He challenges professional education to promote the professional life where the professional is working toward improving the quality of life, particularly for those in most need. To that end, he encourages professional schools to focus on developing habits of mind:

Since professional schools are the portals to professional life, they bear much of the responsibility for the reliable formation in their students of integrity of professional purpose and identity. In addition to enabling students to become competent practitioners, professional schools always must provide ways to induct student into the distinctive habits of mind . . . basic knowledge must be expanded to include an understanding of the moral and social ecology within which students will practice.²⁴

The context that is critical for all health professions students is understanding the meaning of social responsibility and concern for the common good in health care. Promoting the common good in health care requires health professionals to work together as stewards of scarce resources to deliver quality care, to take responsibility for shaping health policy that ensures access to care and promotes health. A central challenge for health professionals in understanding the common good is the ability to see the multiple dimensions of common good, particularly in underserved communities. Although health care may be the focus for the health professions student or IPE team, in underserved communities it is only one of several needs, including basic needs such as housing, safety, and education (Figure 2-2). Furthermore, the health care team needs to realize that resources in health care are scarce and the ability to promote good or beneficence is a distributive justice dilemma. Members of the health care team in IPE must be adaptive and flexible in meeting diverse needs. Ideally, health professionals must see their role as moral agents in assuming the responsibility and authority for taking action in promoting the common good in health care.

**Figure 2-2**

A description of the possible “competing” elements that underlie the concept of common good in communities and health care.^{8,9} Adapted from Glaser J. *Three Realms of Ethics*. Kansas City, MO: Sheed and Ward; 1994 and Glaser J. Three realms of ethics: an integrating map for the future. In: Purtilo R, Jensen G, Royeen C, eds. *Educating for Moral Action: A Sourcebook in Health and Rehabilitation Ethics*. Philadelphia: FA Davis; 2005.

CONCLUSION

IPE is an essential pedagogical strategy for preparing health professionals for present and future practice. Reform in health professions education in the United States is a complicated and challenging process. We believe that IPE is the key to changing what is to what could be. Working together as a community of health professionals to create a healthier society requires that we also begin learning together. IPE is a tool for addressing those basic questions about learning raised by John Dewey—who is learning what, for what purposes, under what conditions, and with what educational, social, cultural outcomes, and consequences for learners, communities, and nations?⁵ We must work at all three levels; societal, organizational, and individual, to promote and support meaningful change that will promote good or beneficence for the patients and communities we serve.

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