Establishing Transdisciplinary Professionalism for Improving Health Outcomes: Workshop Summary

DETAILS

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Establishing Transdisciplinary Professionalism for Improving Health Outcomes

Workshop Summary

Patricia A. Cuff, *Rapporteur*

Global Forum on Innovation in Health Professional Education

Board on Global Health

INSTITUTE OF MEDICINE
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Willing is not enough; we must do."
—Goethe

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Martha N. Hill, Johns Hopkins University School of Nursing
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Although the reviewers listed above have provided many constructive comments and suggestions, they did not see the final draft of the workshop summary before its release. The review of this workshop summary was overseen by **Carol Pearl Herbert,** University of Western Ontario. Appointed by the Institute of Medicine, she was responsible for making certain that an independent examination of this summary was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this workshop summary rests entirely with the rapporteur and the institution.

Acknowledgments

A landmark event for the Global Forum on Innovation in Health Professional Education took place in Washington, DC, with the first gathering of the forum members in early 2012. At this meeting, members discussed how they might begin to consider addressing some of the challenges highlighted in the two reports that laid the foundation for the work of the forum. One of these was an independent Lancet Commission report led by Julio Frenk and Lincoln Chen titled *Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World*. The other was a report of the Institute of Medicine (IOM) titled *The Future of Nursing: Leading Change, Advancing Health*. Both the Lancet Commission and the IOM reports provide a high-level vision for the health professions around the world.

Some of the discussions at that first forum meeting were to consider how this group, made up of multiple health professionals representing education and practice from different sectors and drawn from four continents, might come together in deciding on what topics the forum is best positioned to address. An agreement was reached to focus the first year on interprofessional education (IPE). IPE was a particularly appropriate topic given that four members from Canada, India, South Africa, and Uganda were brought into the forum specifically because of their interprofessional work addressing leadership and professionalism—topics that received considerable attention in the Lancet Commission and *The Future of Nursing* reports.

Forum members came together twice in 2012 to attend workshops on IPE hosted by the Global Forum. Presentations at these events highlighted the importance of working together for improved safety and quality of

health care, as well as the importance of collaboration for improving the health of communities and populations. How students and faculty acquire these skills was a key part of the discussions. Discussions also set the stage for the next workshop by grappling with whether health professionals could come together in a unified manner to engage in public discourse with society about the important topic of professionalism.

This workshop stimulated many unique ideas of how society and the health professions might work toward a unified goal and who might lead such an auspicious undertaking. As co-chairs of the forum, we are grateful to all who made this event a resounding success. These include the workshop planning committee co-chairs, Cynthia Belar and Matthew Wynia, along with the planning committee members: Liza Goldblatt, Nancy Hanrahan, Sandeep Kishore, Sally Okun, Rick Talbott, and Rick Valachovic. It goes without saying that the workshop would not have been possible without the adept skills of the IOM staff—Patricia Cuff, forum director; Rachel Taylor, associate program officer; and Megan Perez, research associate. And special thanks go to Patrick Kelley for his leadership in directing the IOM's Board on Global Health, which oversees the Global Forum. Finally, we are deeply indebted to our 45 sponsors and 60 members of the Global Forum for making it possible to hold workshops like the one on establishing a new professionalism.

Jordan Cohen, *Forum Co-Chair*
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1

Introduction[1]

Efforts to improve patient care and population health are traditional tenets of all the health professions, as is a focus on professionalism. But in a time of rapidly changing environments and evolving technologies, health professionals and those who train them are being challenged to work beyond their traditional comfort zones, often in teams. A "new professionalism" might be a mechanism for achieving improved health outcomes by applying a "transdisciplinary professionalism" throughout health care and wellness that emphasizes cross-disciplinary responsibilities and accountability. Transdisciplinary professionalism was defined by invited individual experts[2] as *an approach to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, are worthy of the trust of patients and the public*. This definition was based on the American Board of Medical Specialties definition of professionalism (ABMS, 2013). Such a professionalism would facilitate improved inter-

[1] The planning committee's role was limited to planning and convening the workshop. The views contained in the report are those of individual workshop participants and do not necessarily represent the views of all workshop participants, the planning committee, or the Institute of Medicine.

[2] The individual authors of the definition also assisted with the planning of the workshop and include Cynthia Belar, American Psychological Association; Matthew Wynia, American Medical Association; Liza Goldblatt, Academic Consortium for Complementary and Alternative Health Care; Nancy Hanrahan, University of Pennsylvania School of Nursing; Sandeep Kishore, Weill Cornell Medical College and Harvard Medical School; Sally Okun, PatientsLikeMe; Rick Talbott, Association of Schools of the Allied Health Professions; Rick Valachovic, American Dental Education Association.

professional teamwork (multiple professional disciplines working together, each using its own expertise, to address common problems) and might even synthesize and extend discipline-specific expertise to create new ways of thinking and acting. It would also envision new ways of engaging individual patients and the public in balanced discussions over professionalism and how this approach could potentially improve health outcomes. In this regard, the definition might be updated to include an outcomes perspective. Transdisciplinary professionalism could be defined as "an approach to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, are worthy of the trust of patients and the public *in order to improve the health of patients and their communities*."

Implementing a transdisciplinary professionalism, with shared values and accountabilities, could serve to support patient and public trust in health care, but it would not be easy. To be worthy of such shared trust, diverse practitioners and others in health-related fields would likely need to develop radical new means of thinking and acting collaboratively. This effort might include working with educators in developing innovative and effective ways to transfer collaborative skills, values, and behaviors to students, and providing leadership that fosters ongoing research and innovation for transformative change.

Within this context an ad hoc committee planned and conducted a 2-day public workshop titled "Establishing Transdisciplinary Professionalism for Health." The committee developed the workshop agenda, selected and invited speakers and discussants, and moderated many of the discussions. The issues addressed at the workshop came from the Statement of Task, which provided the structure for the workshop agenda; this statement can be found in Box 1-1.

BOX 1-1
Statement of Task

- How can the "shared understanding" be integrated into education and practice to promote a transdisciplinary model of professionalism?
  - — What are the ethical implications of a transdisciplinary professionalism?
  - — How can health and wellness be integrated into transdisciplinary education and practice?
  - — How is "leadership" taught and practiced within a model of transdisciplinary professionalism?
- What are the barriers to transdisciplinary professionalism?
- What measures are relevant to transdisciplinary professionalism?
- What is the impact of an evolving professional context on patients, students, and others working within the health care system?

CONTEXT

At the May 14–15, 2013, workshop of the Institute of Medicine's (IOM's) Global Forum on Innovation in Health Professional Education, Sandeep Kishore, a fourth-year medical student and workshop planning committee member, compared the collaborative nature of slime molds to a shared social contract. He noted that microscopic amoebas survive as single-celled organisms until their food sources dry up. In that moment, these independently living organisms undergo a transformation in which hundreds or thousands of amoebas join together as one sluglike being known as a slime mold. This slime-coated creature moves with a collective polarity toward a food source to ensure that most amoebas survive (Fields, 2011). If simple life forms can work together for the collective good of their community, then surely health professionals can work together with society in establishing a shared social contract, he said. Of course, one advantage slime molds have over health professionals is that amoebas are not concerned about crossing professional boundaries.

Turf Battles

Interprofessional collaboration requires health professionals to let go of historical differences that have impeded communication and cooperation in the past. Frederic Hafferty, workshop speaker from the Program for Professionalism and Ethics at the Mayo Clinic, termed these historical differences "interoccupational turf wars." These battles over territory define which profession is permitted to perform an intervention or procedure and often, particularly in the United States, this decision is dictated by insurance companies, who determine which profession gets paid and reimbursed for their work.

Along with the turf wars, Hafferty described professionalism as a zero-sum game—in order for one group to acquire professional status or to increase professional status, something has to be taken away from another group that has more professional status (for X to gain, Y has to lose). Usually the loser, the one that is often the target of professional envy, is medicine. His prediction was that to have true transdisciplinary professionalism, health care professionals need to find a way of having professionalism along with notions of its acquisition and loss as being something other than a zero-sum game. In this scenario, all the professions win or, conversely, everybody loses. This will not be easily forthcoming, he said, and pointed to the Truth in Healthcare Marketing Act of 2013, H.R. 1427, to illustrate his point. H.R. 1427 is a bill being driven by the American Psychiatric Society that would curb or clarify which professionals are called medical doctors. The data for the bill suggest that patients are confused about which profes-

sionals are physicians versus Ph.D.-trained professions such as advanced practice nurses, pharmacists, and psychologists. In his opinion, legislation such as this will not foster transdisciplinary professionalism.

In today's complex systems of health and health care, it is proving a challenge to bring different health professionals together even if it is for the collective good of society.[3] However, various speakers at the workshop pointed to the Patient Protection and Affordable Care Act (ACA) of 2010, which attempts to force health providers to come together for more coordinated care. Richard Cruess and Sylvia Cruess from McGill University in Canada discussed how the Canadian nationalized health system has fundamentally changed the dialogue not only among the health professionals but also between health professionals and patients, as well as society. They observed that in the United States, no forum exists that can serve as a venue for this kind of dialogue, whereas in other countries, such as the United Kingdom and Denmark, there are structured interactions between the health professions and the public.

A patient representative at the workshop, Barbara Kornblau from the Center for Participatory Medicine, noted that federally qualified health centers in the United States must have at least 51 percent of their board members drawn from the community they serve (Kornblau, 2006). And to maintain their nonprofit status under the IRS, nonprofit hospitals must conduct a community health needs assessment. As U.S. health professionals work toward implementing the requirements specified under the ACA, they can learn from global neighbors about how their countries have adapted to working more collaboratively to include meaningful engagements with patients and society for improving health, value, and education.

This brief summary represents some of the creative thinking that took place at the IOM Global Forum's workshop titled "Establishing Transdisciplinary Professionalism for Health." Most of the 59 members making up the Global Forum at that time were present at the workshop and engaged with outside participants in active dialogue around issues related to professionalism and how the different professions might work effectively together and with society in creating a social contract.

The structure of the workshop involved large plenary discussions, facilitated table conversations, and small-group breakout sessions. In this way, the members—representing multiple sectors, countries, health professions, and educational associations—had numerous opportunities to share their own perspectives on transdisciplinary professionalism as well as hear the opinions of subject-matter experts and the general public. This

[3] For the purpose of the workshop and this summary report, society could include all persons that make up a local, national, regional, or global community, and/or a special population such as patients.

open discussion of views included invited speakers and panel moderators whose names can be found in the workshop agenda in Appendix A of this report. This format was similar to the two previous workshops hosted by the Global Forum on Innovation in Health Professional Education that is part of the Board on Global Health of the Institute of Medicine, the health arm of the National Academies. In 2012, when the Forum was established, members and the public delved into various aspects of interprofessional education (IPE) in the Forum-hosted workshop series. The first workshop was titled "Educating for Practice: Improving Health by Linking Education to Practice Using IPE," and the second was titled "Educating for Practice: Learning How to Improve Health from Interprofessional Models Across the Continuum of Education to Practice." At these workshops, participants heard from the Global Forum members from Canada, India, South Africa, and Uganda, and about their work in IPE. Known as the Global Forum's Country Collaboratives, these members were selected to join the Global Forum on the basis of their demonstration projects involving at least a school of public health, a school of nursing, and a school of medicine. Brief summaries of the three presentations that took place at this workshop can be found in Chapter 5 of this report, and more detailed descriptions of their work can be found in Appendix C.

ORGANIZATION OF THE REPORT

The following five chapters explore the possibility of whether different professions can come together and whether a dialogue with society on professionalism is possible. A major goal of such an assemblage would be to open a conversation among stakeholders that promotes trust between the health professionals and those they serve. Chapter 2 introduces the discussion by considering different ways one might think about professionalism. One way that was proposed by Hafferty was to think less about the actions and acts of individuals and more about a profession as a whole that parallels notions of collective responsibilities. Some participants clearly agreed with this perspective, whereas others believed that professionalism could only be defined and measured through observable behaviors. How one defines professionalism would impact how the subject is taught to students. Chapter 3 provides examples of how university professors with expertise in psychology, public health, medicine, and business are educating students about professionalism in a single discipline as well as interprofessionally. This chapter also has descriptions of curricula addressing interprofessional leadership and professionalism from Canada, India, and South Africa. Chapter 4 looks at individual behaviors in professionalism and how the Interprofessional Professionalism Collaborative based in Washington, DC, is developing a tool for assessing interprofessional professionalism behaviors. In Chapter 5, the

thoughts and opinions of students and young professionals on inheriting a shared social contract are captured along with a patient's and an educator's perspectives on the discussions of transdisciplinary professionalism that took place at this workshop. Chapter 6 is an attempt to move the discussion from a theoretical construct to actionable next steps based on individuals' views on what might lead to a shared social contract and who might be in a position to lead the charge.

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Part I

Workshop Summary

2

Understanding Professionalism

Neither economic incentives, nor technology, nor administrative control has proved an effective surrogate for the commitment to integrity evoked in the ideal of professionalism.

—William Sullivan (1995)

PROFESSIONALISM

Although three IOM landmark reports—*To Err Is Human* (1999), *Crossing the Quality Chasm* (2001), and *Health Professions Education: A Bridge to Quality* (2003)—highlight the need for professionalism in health care, the word "professionalism" appears only once throughout all of these reports. In fact, the concept of professionalism, according to Frederic Hafferty, from the Program for Professionalism and Ethics at the Mayo Clinic, dates as far back as 400 BC, with Hippocrates's oath of professional ethical standards, and has evolved over time in a series of waves of pulses.

One recent pulse came from Herbert Swick's article identifying nine key behaviors of professionalism that focused on individuals (Swick, 2000). Although the article was very influential, Hafferty reminded the audience that there are other ways of thinking about professionalism. These "other ways" are less about the actions and acts of individuals and more about a profession as a whole that parallels notions of collective responsibilities. Such thinking developed when the American Board of Medical Specialties (ABMS) established a standing committee on professionalism and ethics and charged a subgroup of the committee to come up with some definitional framings that could be adopted by the ABMS. The subgroup consisted

of Frederic Hafferty, Maxine Papadakis, William Sullivan, and Matthew Wynia. Their definition states, "Medical professionalism is a belief system about how best to organize and deliver health care, which calls on group members to jointly declare what the public and individual patients can expect regarding shared competency standards and ethical values, and to implement trustworthy means to ensure that all medical professionals live up to these promises" (ABFM, 2012).

This is the short version of the professionalism definition that formed the basis for a longer, one-page definition used by the ABMS (ABMS, 2013). What Hafferty hoped was apparent in the subgroup's version was the shift from the individual to the collective and from the framing of professionalism now as relational and a dynamic conversation between the professionals and the public. This underscores his belief (one not necessarily shared by the ABMS or the other Global Forum members and speakers) that professionalism is not so much a noun but a verb. It is a dynamic entity that changes over time. The professionalism of yesterday is not the professionalism of today, nor will it be the professionalism of tomorrow. Some core elements are the same, but the shadings change. And what issues get discussed as part of professionalism change as well.

Trust

Matthew Wynia, a co-chair of the workshop from the Institute for Ethics and Center for Patient Safety at the American Medical Association, picked up on the notion of trustworthiness that was cited in both Herbert Swick's and his ABMS definition of professionalism. He commented that it is not merely trust between the clientele or the public and the profession, but that the profession in some way becomes worthy of that trust. Professionalism is the process through which a profession becomes worthy of the trust of patients and the public. This project is well represented in the American Board of Internal Medicine's Medical Professionalism Project. Wynia thinks that in some ways, this concept exemplifies the thinking around how health professionals can ensure they are worthy of trust. They can do so by putting forward a set of practice standards, making the standards public, and listing the standards as specific behaviors to which the health professions will then hold themselves accountable.

Wynia sees these lists of desirable professional attributes as critical for behavioral assessments and for training, but they are not professionalism per se. In his view, professionalism is not the list of things health professionals say they are going to do; rather, it is the reason why the list was developed. Wynia explained his line of thinking about professionalism by looking at it etymologically as described in the following section.

Organizing Health Care

Professionalism starts with "profess," which means to speak out or to declare publicly. According to Wynia, a profession is therefore a group of people coming together and speaking out by making a public declaration of the shared standards and values that govern their work. "Professional" as a noun is an individual member of the group or, as an adjective, an act or behavior that is in conformance with the articulated standards and values professed by the group.

Professionalism is an -ism, like communism, capitalism, socialism, cynicism, Protestantism, or Catholicism. It is a belief system about how the world works or how it ought to work. It is a belief system around the role of professions in delivering an important social good or service and protecting an important social value. In reference to health, professionalism is the belief that professions are the best way to organize and deliver health care, although it is not the only way to think about delivering such goods and services.

Consumerism is an alternative to professionalism. Consumerism has quality assurance through competition. For example, if two pizza parlors are in competition, a consumer can collect information and compare the two options. The bad pizza parlor will go out of business, and the good pizza parlor will stay open, and their business will spread. Consumerism emphasizes transparency in its ethics; it optimizes value with regard to resource allocation. Value is defined by the willingness to pay on the part of individual consumers. It treats health care as a normal good, just like toothbrushes and motorcycles.

Socialism is another way to think about organizing health care or any other social good. In socialism, a primary emphasis is on achieving equity for all, and this can be accomplished through regulatory mechanisms. The socialist agenda is to optimize the overall social benefit of any intervention or project, and it treats health care as a common good, like military protection of the community or environmental protections.

Professionalism is an alternative to both consumerism and socialism. It assures quality primarily through collegial review, not through state regulatory or market competitive mechanisms. There are fiduciary obligations that are the core of health professional ethics, putting the patient's interests first. There is also the balance between individual and social needs and how to garner the trust of both individual patients and the community as a whole.

The reality, according to Wynia, is that most health care systems employ all three of these mechanisms—consumerism, socialism, and professionalism—and, in fact, they blend together. A highly successful profession is one where professional standards are built into the state

regulatory mechanisms, blending and making it difficult sometimes to distinguish the two. In Wynia's opinion, that is the hallmark of a successful profession. In the end, accountability in health care is a balancing act among the three ways to organize and deliver health and health care goods and services.

Health Care Structure

John Weeks from the Academic Consortium for Complementary and Alternative Health Care, pointed out that the role of markets in health care caused a shift in how the U.S. health and educational systems view integrative medicine. When researchers discovered in the 1990s that consumers spent an estimated $21 to $27 billion yearly on complementary and alternative medicines and services, hospitals began offering these as options, medical schools began teaching them, insurers began to reimburse for them, and employers began to add them to their benefits packages (Eisenberg et al., 1998). The evidence had not changed; it was simply that the market became a factor. Once there was an awareness that consumers were willing to pay for these services, it provided professions more flexibility to practice outside of traditional Western medicine.

Payment also came up within the context of state regulation. Wynia talked about the set of rules regarding who gets to do what, and what will be reimbursed and for whom. And broadly speaking, these are issues in which the professions have a tremendous stake but do not make the final decisions; in fact, society decides. Although society encompasses a wide array of actors, the social norms that dictate regulatory and legal mechanisms are how society decides who gets to do what. Issues around scope of practice and other manifestations of professional closure are social conversations as well, not just professional conversations. This observation triggered a comment from Forum member George Thibault from the Josiah Macy Jr. Foundation. He brought up the impingement of the political process on health care, and the real-life example today of Medicaid expansion, where the profession does not get to decide whether low-income people in one state will receive health care coverage—the political process decides. The reality is that the professional desire to serve is limited by the political process.

Workshop planning committee member Nancy Hanrahan from the University of Pennsylvania School of Nursing noted that state regulation and market competition are being represented as the public word. What is missing, in her view, is the patient's voice. Such input from patients would serve as a constant reminder of the financial constraints and social circumstances within which many patients live. Another point Hanrahan raised was the variability in state regulations. Each state can regulate nursing

practice differently and with significant variability, creating a great deal of confusion for consumers and other disciplines.

Workshop planning committee member Sally Okun with PatientsLikeMe reinforced Hanrahan's comments. In her opinion, equating state regulation and market competition as representing societal or patient views seemed a little disingenuous—that possibly some of the state regulatory issues related more to organizational influence, the professional organizations themselves, and their ability to lobby for what they want versus what the public might even understand, and that the market competition is not necessarily fair in health care.

Patients often do not have a sense of the actual cost of health care goods and services and what would be a fair price. Okun believed that this might create an opportunity for a new voice, and that voice could be collective and include consumers who are typically underrepresented in conversations about the structuring of health care services.

Public Discourse

Following Okun's comment, Wynia observed that the U.S. health care system does not appear to be functioning well; however, it is difficult to imagine a structure that does not involve a mix of market, state, and professional forces. He then asked the participants, What is a legitimate way to establish professional standards for practice and shared values that incorporate the voice of the public and individual patients? Forum member Malcolm Cox of the Department of Veterans Affairs, who co-chaired the Josiah Macy Jr. Foundation conference titled "Transforming Patient Care: Aligning Interprofessional Education with Clinical Practice Redesign," responded that the first recommendation from their conference was to form a new partnership between patients and professionals or between communities and professionals. The recommendation reads: "We envision a healthcare system in which learners and practitioners across the professions are working collaboratively with patients, families, and communities and with each other to accomplish the Triple Aim" (Josiah Macy Jr. Foundation, 2013). It was prioritized as the first recommendation because it was by far the most important one. It involves creating a new, unique voice that would be different from those that make up the present system of unstructured input into state decision making that is often driven largely by lobbyists.

Wynia then asked, How does one create such a thing, and how does one prevent it from becoming what we have right now? "After all," he added, "this is in some ways what representative democracy looks like: it's special interest groups, it's loud people, it's vested interests." Workshop speaker Richard Cruess from McGill University in Canada responded to the question by saying that the discourse would need to change. More specifi-

cally, the conditions under which a social contact—that supports the ideal of professionalism—is negotiated would need to change. This change is fraught with challenges because it is currently the health professionals who speak for what the public wants, rather than having patients and society driving the discussion.

Patient Perspective

As a cancer survivor and law professor at the University of Wisconsin Law School, workshop speaker Meg Gaines stated that among the three choices, consumerism, socialism, and professionalism, she places no hope in the market. Because the market is heavily controlled, she said, consumers are not truly influential in the decisions being made. Also, health is a market in which consumers are not skilled purchasers.

Gaines would place greater value in professionalism, although she thinks the best way to structure health care is through socialism as it was previously described at this workshop. Providing the greatest good for society and balancing the needs of society with individuals seem like valuable goals for health care as opposed to generating health care at a profit, she said. But in response to Wynia's question about how to get the new discourse, she responded that patients should be asked their opinion rather than relying solely on professionals to speak for patients' wants and needs.

In acknowledging the importance in bringing patients and the community into the conversation about professionalism, Hafferty admitted to having difficulty in conceptualizing how this would be operationalized in a pluralistic society like the United States. What are patients? What is the public? There are all kinds of publics, interest groups, and other organizations. This is not necessarily how things are in other countries. Hafferty hoped that individuals from other countries could help the United States begin to think about how to accomplish a collective conversation. Hafferty noted the ease with which colleagues from the United Kingdom describe public engagement. But he then qualified the thought by saying that the United Kingdom has a national health care system and that they are a much smaller country, which are significant differentiating factors when compared to the United States.

The United States could also learn from Canada. In Canada, public forums take place around issues of professions and professionalism and issues of practice and quality. Hafferty suggested that the United States could create a series of town hall meetings to engage the public on matters of professionalism. But, he asked, who would represent health and health care at these meetings?

Transdisciplinary Professionalism

The question raised by Hafferty regarding who should represent health and health care in conversations with the public was partially addressed by workshop planning committee co-chair Cynthia Belar from the American Psychological Association. In her opening remarks, Belar described the different ways in which disciplines can work together to address problems. Some of these approaches are better than others in capturing the more unified voice that would be needed for a single representation of health and health care at a town hall meeting. Described more fully in Part II of this report, these approaches go from one professional working alone (unidisciplinary), to multiple professions working individually on an issue or with a patient (multidisciplinary), to multiple professions working together toward a common goal (interdisciplinary or interprofessional), to multiple professions working together under a shared model with a common language (transdisciplinary).

The increased focus on collaborative care in health to reduce errors and improve quality has been accompanied by an increased need to build linkages across the health professions. According to Belar, some warn that with the increased complexity of care, siloed approaches to professionalism may actually undermine safety and quality as well as patient-, family-, and community-centeredness. With this understanding, efforts have been made to conceptualize professionalism not within the silos of an individual profession, but in terms of a set of behaviors and attributes that are uniquely relevant to collaborations across professions. This is known as "interprofessional professionalism" (see Chapter 4 for Jody Frost's description and definition of interprofessional professionalism). The cooperation and communication inherent in interprofessional professionalism cut across the professional boundaries to link common behaviors and attributes but does not jointly link the social contracts. With interprofessional professionalism, each profession has a separate contract with society.

In contrast, transdisciplinary professionalism leads to a social contract that is shared by all the professions through a unifying set of beliefs and behaviors that are professed to the public. This is not the same as transdisciplinary practice, which would indicate a blurring of boundaries with respect to skills, competencies, and practice. As workshop speaker Sylvia Cruess explained in her presentation on the social contract, there are similarities and differences among the health professions' social contracts, but the underlying principles of all health care social contracts are the same. According to Belar, these shared principles would be the foundation on which to build the shared contract with society.

SOCIAL CONTRACT

In their paper (found in Part II of this report), Richard Cruess and Sylvia Cruess, who are physicians from the Centre for Medical Education at McGill University in Canada, explain their perspective on the social contract. They say that within health care, the social contract lays out expectations between society and the health professions—expectations that are constantly evolving as societies and cultures change. The assumption is that each side will live up to the terms of the contract as they are redefined. When one party fails to meet their expectations, there is a loss of trust. For health professionals, this loss of public trust results in decreased autonomy for the profession, as was exemplified in the United Kingdom's Bristol case. In this case, public trust of pediatric cardiac surgeons collapsed following the exposure of exceptionally high child mortality rates at the Bristol Royal Infirmary—about two times the national average in 5 out of 7 years between 1988 and 1994 (Kennedy, 2001). This revelation led to government reforms that stripped the medical profession of its privilege to self-regulate. It occurred, said Richard Cruess, because the medical profession failed to meet the legitimate public expectations in a domain which was under its jurisdiction.

In the reverse situation—when society fails to meet expectations of the health professionals—there is a similar loss of trust, although the outcome is less clear. Oftentimes health professionals experience diminished job satisfaction when they feel overburdened by paperwork, excessive regulation, and decreased reimbursement. In these instances, health professions can begin to view their work as a job rather than a "calling."

Elements of social contracts in the United States and Canada have evolved over the last 50 years in parallel with changing societal norms and values. These changes include greater patient autonomy, calls for more transparency in the work of health professionals, and an emphasis on collaborative care. In addition, the financial rewards, particularly in medicine, have increased, leading to more conflicts of interest as providers of care balance patients' needs with potential financial gains. These changes have altered expectations of both society and the professions. Still, the United States would negotiate a very different contract than Canada because of the fundamental differences in the way these societies are oriented. The United States emphasizes individualism and individual performance, whereas Canadians stress collective responsibility. Thus, in Canada, the social contract is dominated by the state, whereas in the United States the corporate sector strongly influences elements of health and health care with additional input from the health professional associations' lobbyists. According to Forum co-chair Jordan Cohen of George Washington University, until American culture recognizes the limitations of individualism, the current heterogeneous chaotic

system is probably going to remain. He later commented, however, that one way to try to develop a coherent dialogue with "society" could be to engage social media. It would be an interesting experiment to try, he added.

SO WHAT?

Greater patient engagement in the U.S. health care system is being called for by society and, according to Forum member Liana Orsolini, is being required by law through the new Patient Protection and Affordable Care Act. In addition, Barbara Kornblau remarked that federally qualified health centers must have at least 51 percent of their board members come from the community they serve and that board members must include patients. Moreover, not-for-profit hospitals are required to conduct a community health needs assessment to maintain their tax-exempt status under the IRS. Patients are not an afterthought, she said—they they are part of everything health professionals do. Educating the next generation of health professionals with this patient-centered focus would better prepare them for work in clinical and community health settings.

Okun also weighed in from a patient perspective on the notion of greater engagement of community members and users of the health system. She said that a shared social contract would not be embraced by the general public unless the message was easily understood and could be conveyed through, for example, a public service announcement. Workshop speaker Jody Frost, who leads the Interprofessional Professionalism Collaborative (IPC), agreed with Okun that interprofessional or transdisciplinary professionalism is a complicated topic that would need to be explained in a language that makes sense to the public. This may be a challenge, however, given that it took more than 2 years for their IPC health professionals representing 14 different professions to agree upon a definition of interprofessional professionalism. Much of the time was spent trying to understand other professions' terms and uses of the language to describe a situation. Although the process was arduous, the exercise of finding a common language provided a unique opportunity that underscored the importance of communication, collaboration, and negotiation across professional boundaries. The work of the IPC focused on professionalism as a resource for promoting skills, values, and organizational structures that facilitate interprofessional care. Likewise, the professionals' joint efforts on addressing competencies that cut across multiple professions promote effective interactions and collaborations that could bridge academic and practice settings and could be modeled and promoted in both environments.

Questions raised by speaker Patricia Werhane (described more fully in Chapter 3 of this report) ask how different health and health care "tribes" might come together to talk and to build a transdisciplinary professional-

ism. In her view, there would have to be a central base that enables effective communication across communities and organizations. Without a common language, she said, silos will persist where instead of talking *to* each other, various stakeholders are talking *at* each other. Werhane emphasized listening as the most important component of communication that could be improved among all parties involved. Listen to the narratives of different people, she said. Translate what everyone says and come to consensus over the basic values. No doubt there will be different viewpoints on how the values are prioritized, which is alright, she said, as long as everyone involved respects this difference of prioritization.

In summary, the individual speakers' reasons to focus on a shared social contract are

- to improve communication and collaboration among health professionals (described by Frost and Werhane) that improve safety and quality of care (pointed out by Belar);
- to respond to the desires of the public to participate actively in deciding the future of their personal health and to influence how health care could be structured (mentioned by Kornblau, Okun, Orsolini, and Weeks);
- to avoid the impingement of the political process on health care (noted by Thibault); and
- to create a health care system in which learners and practitioners across the professions work collaboratively with patients, families, and communities and with each other to accomplish the Triple Aim (described by Cox).

And the reasons professionalism should be the tie that binds health professions to each other and to the public are

- to strengthen the trust among the health professionals and between the health professionals and the public (emphasized by the Cruesses, Hafferty, and Wynia); and
- to hold health professionals accountable to professional standards (stated by Hafferty and Wynia).

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3

Professionalism in Education

We need to be sure that our educational models and systems don't discourage collaborative interactions but in fact become the supporting mechanisms for going forward.

—Charlotte Exner, Association of Schools of Allied Health Professions

TEACHING PROFESSIONALISM

In their presentation on the social contract for health professions and health professional education, Richard Cruess and Sylvia Cruess from the Centre for Medical Education at McGill University in Canada suggested that the concept of a social contract helps in teaching and learning about professionalism. When they teach, they emphasize that health care professionals are both healers *and* professionals, but separating the roles into distinct categories makes the concepts easier to explain to students.

The left side of Figure 3-1 shows attributes of a healer, who is caring and compassionate, insightful about the patient's and the healer's own feelings, open to different cultures, aware of the healer's role in the healing process, and respectful of the patient's dignity and autonomy. Sylvia Cruess then noted that the right side of the figure shows attributes that are not found in the Hippocratic Oath and are not in the healer tradition. These attributes define degrees of professional autonomy that allow health professionals to set their own rules and regulations for entry into the profession as well as the exit from it.

The role of the healer and the professional can at times be at odds with

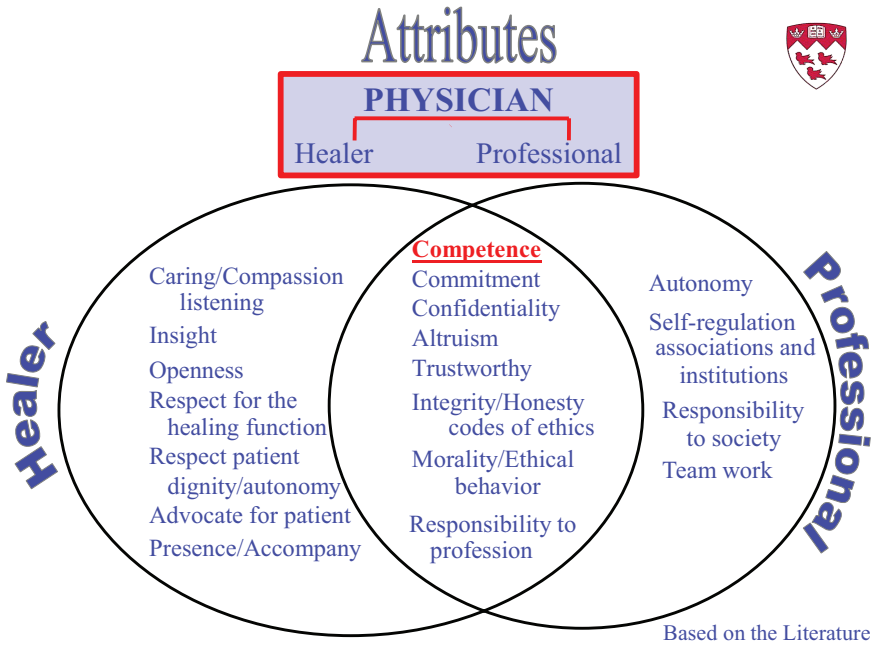

FIGURE 3-1 Healer and professional attributes.
SOURCE: Cruess and Cruess, 2013.

each other, but according to Sylvia Cruess, they are also linked by the codes of ethics that describe the behavior of both the healer and the professional. In the middle of Figure 3-1 is a list of shared attributes, which include a commitment to help the patient, confidentiality, altruism to put the patient's needs above health professional's own, and trustworthiness, meaning that the health professional possesses integrity and honesty.

By learning about professionalism and the social contract, said Sylvia Cruess, students better understand what professionalism is and what their obligations as health professionals will be to society. Students develop their professional identity at this time, and teaching professionalism creates an opportunity to shape their views by looking at where the health professions have failed society. Possibly health professionals are not as altruistic as society expects while they balance lifestyle with altruism and responsibility to society with financial gain. Also, not addressing the distribution of resources among the population may be judged negatively by society, as some may view this as a lack of social justice.

Richard Cruess noted that negotiations are needed between society and health professionals (with regard to issues such as conflicts of inter-

est and financial gains) to address the external stresses that society uses to judge health professionals. But this requires a single coordinated voice and the recognition that there are multiple stakeholders, including some with commercial interests. It also requires somebody with whom to negotiate and a neutral space—typically set up by government—where parties can come together. In this regard, society may determine the nature of the social contract, and therefore professionalism, but because society needs healers, they will need to reach an agreement with the health professionals that preserves trust and satisfies both sides.

INNOVATIONS IN TEACHING ABOUT PROFESSIONALISM AND PROFESSIONAL NORMS

Workshop moderator Charlotte Exner represented the Association of Schools of Allied Health Professions as part of its Interprofessional Education Task Force. She noted that in higher education, a rapid and intense transformation is happening. The use of technology and other teaching and learning methods is forcing faculty to consider new educational models. And there is the driving force of students who learn in different ways and expect their academic programs to reflect the changes taking place in society. For example, there is momentum toward the flattening of hierarchies in the workplace to adopt more collaborative environments. Exner described how greater access to information has altered education around the world through massive open online courses (MOOCs) and has changed the discourse between health professionals and patients, who now have online sources of information readily available to them. Educators can pick up on the momentum to be sure that health professional educational models and systems do not discourage that kind of interaction but in fact support it going forward.

Teaching Interprofessional Professionalism from Psychology

Susan McDaniel from the University of Rochester Medical Center presented an educational model that encourages the sort of interaction recognized by Exner. McDaniel studies, writes, and teaches physicians, psychologists, and other clinicians about the bio-psychosocial approach to medicine, professionalism, and team-based care. She asked, "How do we find new ways to teach about an approach to creating and carrying out a shared social contract that ensures multiple health disciplines working in concert and worthy of the trust of patients and the public?"

According to McDaniel, the response lies in the methods used to teach health care team competencies and begins by selecting students and educators whose values align with those of transdisciplinary professionalism.

This might involve establishing search and admissions committees that include members from other health professions and patients who can identify candidates who possess the attributes and behaviors inherent in professionalism. It also involves communication. McDaniel views communication as one of the central aspects of professionalism; how she incorporates this into her teaching is described in detail in her paper in Part II of this report. Briefly stated, McDaniel uses the child's game of "telephone" to initiate a large-group discussion about the problems with multiple communications and how emotion affects them. She developed a number of other programs that similarly work toward improving communication between professions. One program in particular addresses communication skills and disruption of the hidden curriculum with regard to professionalism. This program, called the Patient- and Family-Centered Care Physician Coaching Program, builds on the concept of feedback that is focused on patient complaints and on the patient experience. It began with the endorsement by the medical center leadership of a set of values that spell out ICARE: Integrity, Compassion, Accountability, Respect, and Excellence. Each profession then developed its own most important ICARE job behaviors that were then compiled into three primary behaviors associated with improved quality in patient satisfaction.

In response to a question raised about communication, McDaniel commented that psychologists on teams often notice when people do not communicate well with each other. Individual professions may use profession-specific terms to convey the need to put the patient at the center of care while working collaboratively. In her opinion, this is not very different from family therapy. Such therapy opens communication, as does interprofessional training that McDaniel strongly advocates. Training students through projects that require different disciplines to work together toward a common goal—for example, a quality improvement or community health project—is an excellent way for different disciplines to learn from and with each other. In looking at the broader picture of the role professional societies might play to advance better communication in support of a social contract, McDaniel believes this interprofessional training is key. Professional associations could influence their members and trainees through education, leadership, inspiration, and projects. In this way, associations could motivate their leaders to come together in agreement and could influence their members to join with other professions in forming a social contract with society.

Professionalism in Public Health Education

Jacquelyn Slomka from the School of Nursing at Case Western Reserve University discussed incorporating the teaching of professionalism into public health courses. She first said that public health is not so much a dis-

cipline as a concept. And as a concept, public health embraces health care delivery, disease prevention, health promotion, and health policy. In the United States, she said, she sees what is sometimes called a medicine–public health divide, which does not exist in other countries. She noted that after the anthrax attacks that followed September 11, 2001, there was a renewed interest in public health and community-level responses, and, at the same time, a renewed attention to public health ethics and professionalism.

The Association of Schools and Programs of Public Health (ASPPH) developed professionalism competencies for the master of public health degree that predates the September 11 attacks. According to ASPPH, students in this degree program are expected to "promote high standards of personal and organizational integrity, compassion, honesty, and respect for all people." They are also expected to "distinguish between population and individual ethical considerations in relation to the benefits, costs, and burdens of public health program" (ASPPH, 2006). At the more advanced level, the doctorate of public health degree, students are expected to be able to manage potential conflicts of interest (ASPPH, 2009).

These competencies, described more fully in Slomka's paper in Part II of this report, can be used as standards for teaching professionalism. Slomka uses them as the backdrop for conveying the differences and similarities between population and individual ethical decision making. She begins by looking at the patient–healer relationship. Patients in the clinical setting are sick and therefore very vulnerable, whereas in public health settings, patients tend to be more ambulatory and are often part of a wider community or population. These different environments alter the responsibilities of professionals, between those to individuals and to the community, ultimately influencing the structure of the social contract.

One difference between professionals relates to language. Clinically based health professions derive their concepts primarily from their use of biomedical thinking, whereas in public health the language and concepts are derived from ethical practice, human rights, and social justice.

For similarities, Slomka highlights those values shared between the clinical professions and public health. These values may involve principles such as justice and respect. There are also shared professionalism processes in that both public health and clinically based professions have to weigh the burdens and benefits in deciding the right course of action in any particular situation.

In discussing teaching strategies, Slomka combines didactic with experiential learning. She requires students to observe health care teams at work to identify the interprofessional values the students discussed in class. The experiences include attending multiple interdisciplinary rounds in an intensive care unit, observing a series of institutional ethics committee meetings, or viewing internal review board sessions where research proposals are

discussed that often have both clinical and public health implications. In this way, students gain a better understanding of how various professionals working together can effectively consider and make decisions.

Slomka also makes full use of literature and film to educate students about public health professionalism. In one example, students read the popular short story "The Use of Force" by William Carlos Williams. The story is about a physician who, during the Great Depression, is trying to examine the throat of an uncooperative sick child whom he believes may have diphtheria and could be the start of an epidemic. Slomka uses this story to address a situation that not only involves ethical decision making with individuals but also has public health implications. She believes that literature and film can educate students not only about compassion but also about their power to influence health care policy to improve community conditions.

Teaching Professionalism at a Business School

Workshop speaker Patricia Werhane is from the Institute of Business and Professional Ethics at DePaul University. Her work in health care focuses on ethical issues in health care organizations. She discussed managerial professionalism, lessons learned, and how professionalism is taught in business schools. Business schools primarily teach skills, according to Werhane, in contrast to teaching intellectual training. Some voluntary codes have been adopted, but there are no general codes, and there are no professional organizations, no prioritization of professionalism, and no enforcement mechanisms. Other than the U.S. Securities and Exchange Commission—whose mission is to "protect investors, maintain fair, orderly, and efficient markets, and facilitate capital formation"—there are no stopping rules[1] (U.S. Securites and Exchange Commission, 2013).

This managerial method of teaching professionalism has led to what Werhane called a "silo mentality," as was described earlier by McDaniel. It occurs within business education as well as in training, so managers do not develop an awareness of ethical issues in the nature of their work. Managers believe that ethics are the responsibility of others. The result is that business schools create good managers but not good leaders, what Rakesh Khurana called "hired hands" in his book about the social transformation of American business schools and the unfulfilled promise of management as a profession (Khurana, 2010).

For a positive perspective, Werhane pointed to examples of systems thinking in global commerce. She cited Paul Plsek's work on the health care system as a complex adaptive system (CAS). Plsek and colleagues define

[1] In this context, stopping rules are pre-established conditions that would dictate termination of an experiment or activity.

the CAS as "a collection of individual agents who have the freedom to act in ways that are not always totally predictable, and whose actions are interconnected such that one agent's actions change the context for other agents" (Zimmerman et al., 1998).

According to Werhane, a number of companies see themselves as integrated within their interdependent health care system. One example is Novartis, the third-largest pharmaceutical company. Novartis embraces the systems stakeholder model, with Novartis at the center of the stakeholders (see Figure 3-2 for an example of this type of model). In contrast, Pfizer Switzerland adopted a systems model view of the health care world, with bidirectional inputs and outputs from the various stakeholders, including their company (see Figure 3-3).

Werhane highlighted ExxonMobil (see Figure 3-4) as an example of the systems-alliance model. This company places energy, which is its primary product, in the middle and with all partners in orbit around the core energy business. It does not put itself in the middle. It puts what it does in the middle, which Werhane finds quite interesting.

The systems approach model becomes very complex and chaotic when it is translated from business to health. Werhane drew on the ExxonMobil

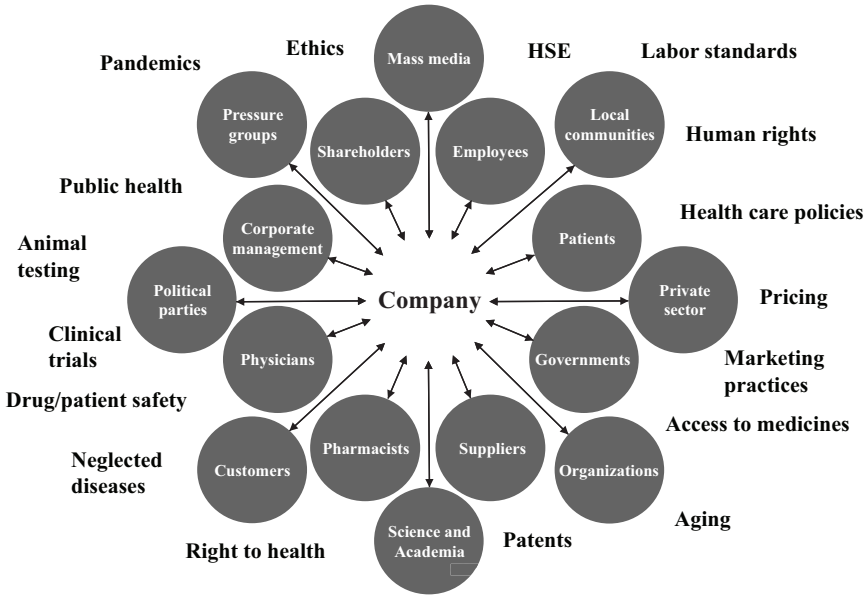

FIGURE 3-2 A systems stakeholder model.
NOTE: HSE = health, safety, and environment.
SOURCE: Adapted from Werhane, 2013.

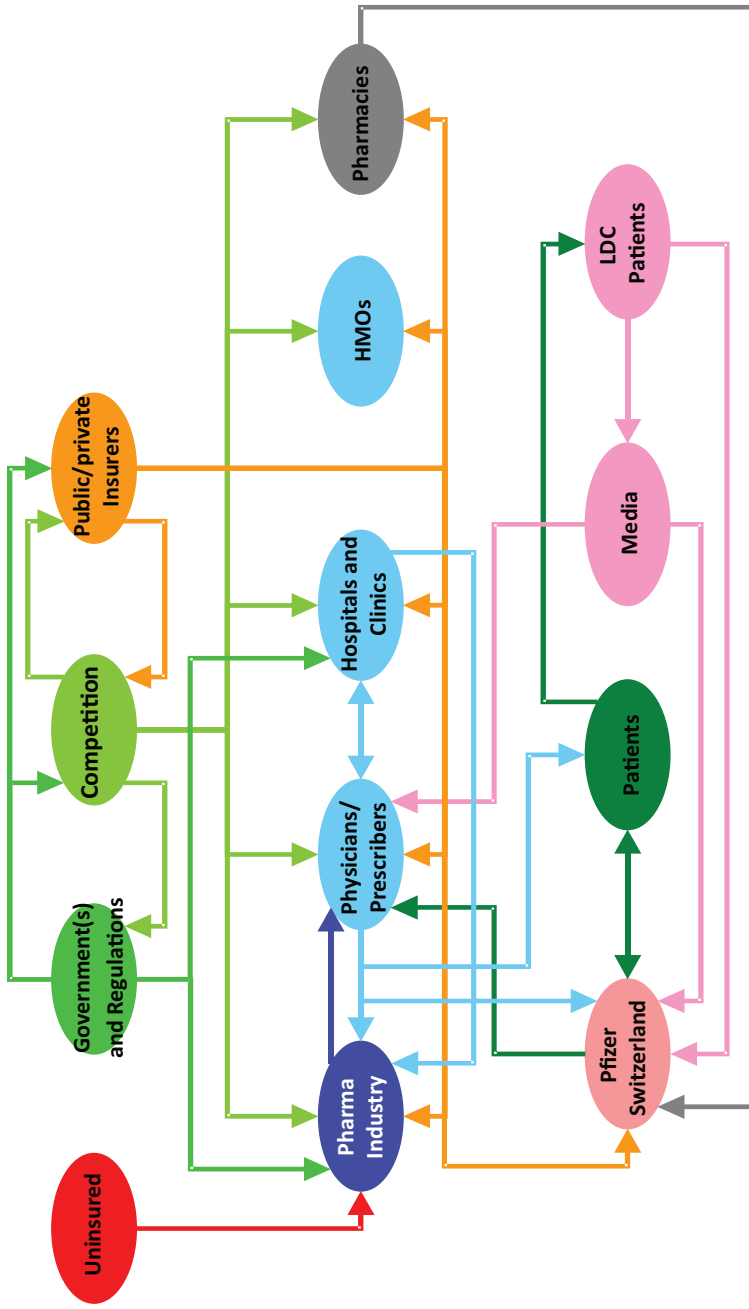

FIGURE 3-3 A systems model.
NOTE: HMOs = health maintenance organizations; LDC = low-density cells.
SOURCE: Werhane, 2013.

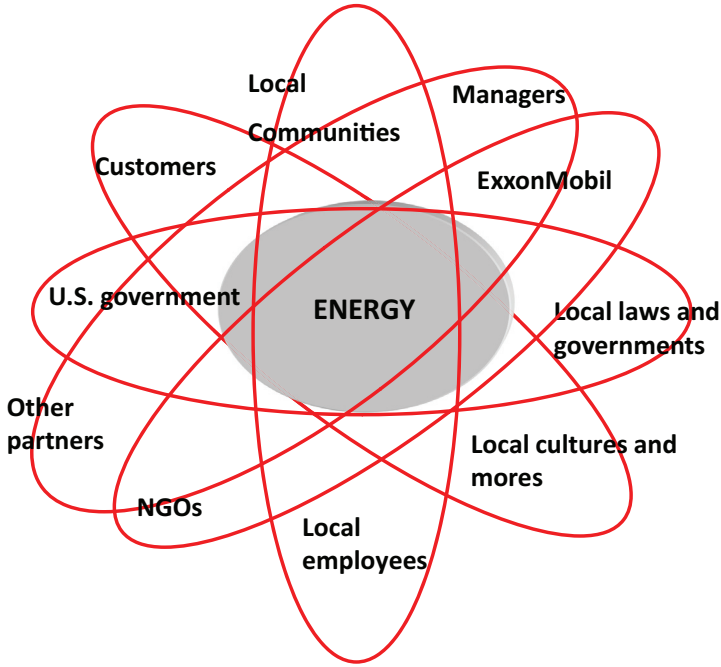

FIGURE 3-4 A systems-alliance model for ExxonMobil.
NOTE: NGOs = nongovernmental organizations.
SOURCE: Werhane, 2013.

example to identify a transdisciplinary approach that establishes an alliance among the health professionals that is tied together by a shared core value of effective health care (see Figure 3-5). For this to be an effective discussion, however, the health professions need a common language that all understand and use to communicate.

To explain her thinking, Werhane referred to the work of a commission in World War II that brought together a wide array of thinkers from various professional backgrounds and sectors. The commission involved engineers, philosophers, social workers, social scientists, and government officials in the development of radar in order to win the war. The commission quickly realized that each professional representative used a jargon unique to his or her profession. They needed to develop a mutually shared language, and by creating a language, they tagged "Creole," the commission was able to work effectively together.

Developing "a Creole" that all health professions can understand is what Werhane believes is needed to create transdisciplinary professionalism. In describing how she teaches this concept, Werhane echoed educational

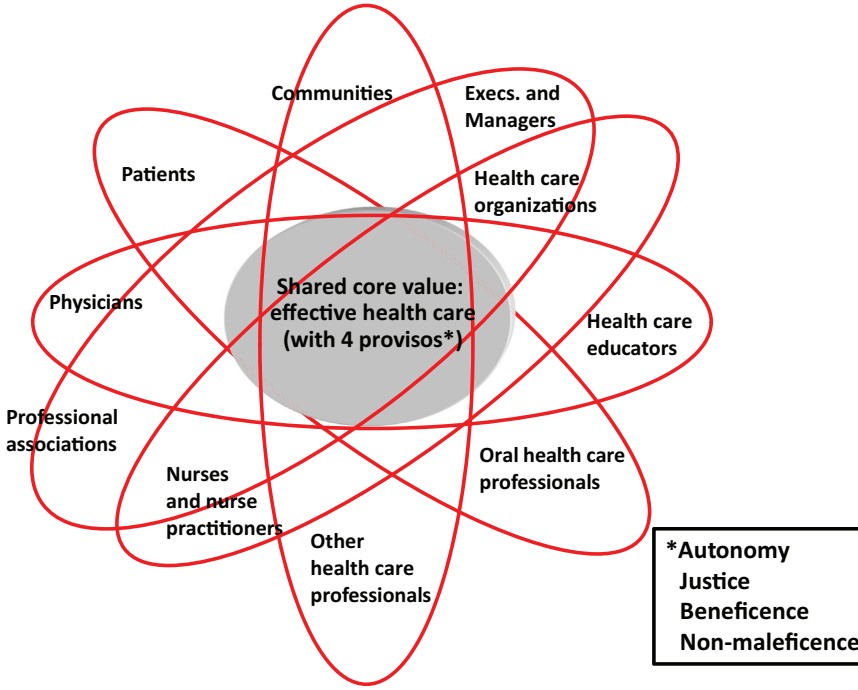

FIGURE 3-5 Shared core values model for effective health care.
SOURCE: Werhane, 2013.

tactics described by McDaniel and Slomka. These tactics include using short case studies and having learners from different health professions share different perspectives. She encourages active listening in order to translate the different perspectives and come to consensus around values. Once the values are established, Werhane believes, then the different professions or sectors can prioritize these values based on the needs of their individual professions. One lesson Werhane teaches her international students is that disagreement on the prioritization of values is acceptable as long as there is mutual respect among groups.

INNOVATIONS IN TEACHING LEADERSHIP THROUGH PROFESSIONALISM

Members of the Global Forum who represent schools and institutions in Canada, India, and South Africa have undertaken the development of interprofessional training activities and curricula in the area of leadership for health professionals. Representatives of the Collaboratives participated

Pictured from left to right: Emmanuelle Careau, Canadian country collaborative; Maria Tassone, Canadian country collaborative; Himanshu Negandhi, Indian country collaborative; Sanjay Zodpey, Indian country collaborative; Marietjie de Villiers, South African country collaborative; Sarita Verma, Canadian country collaborative; and (not seen) Juanita Bezuidenhout, South African country collaborative.

in the workshop to educate and to learn from colleagues about curriculum development. In her remarks, Marietjie de Villiers from the South African Collaborative referred to the Cruesses' slide on physician attributes—discussed previously in the report—that parallel desired qualities of a strong leader. The notion that professionalism equals leadership provided her with a deeper understanding of what it means to be an interprofessional leader. To be a good leader, one must also know how to follow. For her, one of the keys to successful interprofessional professionalism and leadership is knowing how to be a humble follower.

South African Collaborative

Juanita Bezuidenhout, also from the South African Collaborative, explained the goal of their project, which is to determine the relevant competencies required for transformational and shared leadership in the context of health teams in South Africa. To start the process, Bezuidenhout interviewed leadership and faculty at Stellenbosch University. She then identified a set of leadership qualities or attributes that provide an enabling environment. These include having a strong value system, building relationships, being able to create meaning, being strategic thinkers, and being able to communicate. She also described a desire for leaders to collaborate and to function as role models through structured mentorship programs designed to develop the next generation of leaders.

Indian Collaborative

Like the South African Collaborative, the Indian Collaborative is undertaking the design and development of an interdisciplinary leadership competency model for training as part of the curriculum for medicine, nursing, and public health students and as a component of in-service professional education in India. Forum member Sanjay Zodpey presented their progress. The Indian Collaborative began by reviewing the various professional curricula and found them to be content specific, as well as lacking in cross-professional competencies such as leadership. Because interprofessional education was lacking, representatives from the health professions partnered to come up with shared and collaborative leadership competencies.

After reviewing the competencies within the wider health systems context and speaking with key stakeholders from education, government, and other professions, the collaborative then developed a training model that was pilot tested. This 3-day interprofessional in-service training program is for medicine, nursing, and public health students and professionals. Members of their collaborative would like to see their training model incorporated into the curriculum for medical, nursing, and public health education as well as into several initiatives, like the National Health Mission Initiative in India, as in-services for professionals.

Himanshu Negandhi, Assistant Professor at the Indian Institute of Public Health–Delhi, described a need for the leadership training and education that Zodpey described. India recently initiated the National Rural Health Mission, which provides an institutional framework for strengthening primary health care. It resulted in a new cadre of public health professionals at the primary level who are overseen by a public health manager. These people implement the health system's national programs and serve as a liaison between the government and the local health needs of the people. They are expected to fulfill the roles and responsibilities of being a public health manager, which requires strong leadership skills. Without the training developed by the Indian Collaborative, however, there would be no formal process for gaining the leadership skills that were discussed by de Villiers and shown in the Cruesses' Venn diagram.

Canadian Collaborative

Maria Tassone and Emmanuelle Careau spoke for the Canadian Collaborative, which is focusing its work on developing systems leaders to enact socially accountable change within their communities. In her remarks, Tassone referred to the previous discussions at the workshop on the social contract. The social contract empowers people to influence change, she

said, which is the root of their work around the development of a collaborative leadership program.

Careau described the extensive systematic literature review of existing curricula on collaborative leadership conducted by the Canadian Collaborative in an effort to understand which competencies are addressed in those curricula, how they are addressed, and what the impacts of those curricula are on learners and the health care systems. The results showed that few educational programs address collaborative leadership. Most of them focus on developing knowledge skills and behaviors of individual leaders. Most of these programs are taught within one discipline, and only 10 percent of the peer-reviewed articles present truly interprofessional education initiatives.

Concerning evaluation, added Careau, most of the programs measure the short-term impacts through the learner's knowledge, skills, and behavior. Few of the programs on collaborative leadership measured the impacts on systems change or on patient and family outcomes. And none of the programs used learner methods and tools to measure their own impacts as leaders once the program was completed.

Following their literature review, Tassone reported that the collaborative conducted interviews of roughly 35 international thought leaders in health professions education in government, in business, in health care, and across the student body. Many of the characteristics of collaborative leaders had been previously identified by other speakers. The set of practices that collaborative leaders draw on is different from current leadership curricula in health care programs, however. These practices include

- co-creating a shared vision with communities as opposed to selling a vision that comes from a charismatic leader;
- using group process to draw on diverse and multiple perspectives, actively listening to those diverse opinions as formal leaders while suspending their own assumptions and beliefs;
- engaging in ongoing self-awareness and self-reflection; and
- dismantling traditional silos in order to connect groups that have not been connected before.

In Tassone's view, collaborative leadership as a philosophy and as a leadership program offers the promise and opportunity to root the work of the health professions in social accountability and to emphasize that the social contract will be more powerful than the paradigm of the lone hero.

Lessons Learned

Forum member and Canadian Collaborative representative Sarita Verma led the discussion about the collaboratives' work. She pointed

out that although the speakers identified a spectrum of approaches, strong leadership was a common theme that resonated with all the collaboratives. Without an enabled and mobilized leadership to recognize and advance a vision, the likelihood of change is minimal. Verma stated that the kind of disruptive innovations discussed at the workshop require courage, conviction, and an ability to embrace uncertainty and complexity while actively collaborating with others.

Verma emphasized the need for an imperative that drives the process. In Canada and India it was a government imperative, whereas in South Africa and Uganda (whose representative could not be present for this workshop) it was more of a social imperative. In each case, a critical point was reached where either the public or society through its government expressed the view that change was necessary. In her opinion, education and health are on the cusp of a "spring" that will be formed through public demand for change. Within the near future, she noted, health professions must be poised to address the demands of reform.

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4

Behaviors of Interprofessional Professionalism

Interprofessional professionalism, when practiced by all professions, will improve health care quality and outcome for patients and clients (and I would add their families and caregivers), promote a culture that values and fosters individual competence, and enhance both education and practice environments.

—Jody Frost, Leader of the Interprofessional Professionalism Collaborative

Workshop speaker Frederic Hafferty described an example of the individually focused definitions developed by Herbert Swick in his influential article *Toward a Normative Definition of Medical Professionalism*, mentioned in Chapter 2 of this report. In his article, Swick identified nine key behaviors of professionalism. The first four (see Box 4-1) focus on individuals.

Forum co-chair Jordan Cohen expressed his agreement with Swick that professionalism as a belief system can be manifested only by behaviors, individual behaviors and institutional behaviors that are the aggregate of individuals. Because institutions do not have behaviors independent of the people who are populating them, the issue is really about individual behaviors that constitute professionalism that can be measured, monitored, improved, taught, and evaluated. The assessment would recognize the personal motivations that influence individuals to behave in the way that is defined by the professions.

Cohen acknowledged that the concept of professionalism is evolving and remains a changing target, but he stressed that, in fact, professionalism is a changing set of *behaviors* rather than a belief system. In order to

BOX 4-1
Four Behaviors Identified by Herbert Swick

- Physicians subordinate their own interests to the interests of others.
- Physicians adhere to high ethical and moral standards.
- Physicians respond to societal needs, and their behaviors reflect a social contract with the communities served.
- Physicians evince core humanistic values, including honesty and integrity, caring and compassion, altruism and empathy, respect for others, and trustworthiness.

SOURCE: Hafferty, 2013.

demonstrate proficiency in this area, professionals must adopt behaviors that can be measured and assessed, rather than beliefs.

Hafferty did not disagree with Cohen but took his thinking a step further. Speaking in terms of the medical profession, Hafferty said, an upstream agreement across all disciplines would lay the foundation for discussing behaviors. The agreement would be an announcement to the public about what society can expect from the professions in terms of competencies and ethics. Once the agreement is formed, all the disciplines could then come together through a singular identity for the formation of competency standards and ethical values that would be manifested among trainees. This would eliminate jurisdictional differences among the individual disciplines and form a foundation on which to build a shared language to improve communication among all the health professions.

Such steps toward establishing a shared language among professionals began less than a decade ago by the 14-member group known as the Interprofessional Professionalism Collaborative (IPC) (see Box 4-2). The group's work was presented by Jody Frost at the workshop. In agreement with the views expressed by Cohen, the IPC is focusing on behaviors that can be assessed.

ASSESSING INTERPROFESSIONAL PROFESSIONALISM BEHAVIORS

According to Frost who leads the IPC, the group's work involves developing a valid and reliable assessment tool for interprofessional professionalism (IPP) behaviors that can be used by educators across all health professions. It took the group 2 years to develop a shared definition of interprofessional professionalism because each of the 14 representatives had to become comfortable with terms used by the remaining 13 other profes-

BOX 4-2
Members of the Interprofessional Professionalism Collaborative (IPC)

Allopathic Medicine (AAMC)
Audiology (ASHA)
Dentistry (ADEA)
Internal Medicine (ABIM)
National Board of Medical Examiners (NBME)
Nursing (AACN)
Occupational Therapy (AOTA)
Optometry (ASCO)
Osteopathic Medicine (AACOM)
Pharmacy (AACP)
Physical Therapy (APTA)
Psychology (APA)
Speech-Language Pathology (ASHA)
Veterinary Medicine (AAVMC)

sions represented on the IPC. Frost emphasized that the terms used in the definition reflected common meaning and purpose to all the IPC members.

Part of the definition found in Box 4-3 was derived from the work of David Stern (2006) describing common values to all health professions. The concept of multiple health professions working collaboratively or the team-based care with an outcome of optimal health and wellness in individuals and communities is central to the IPC work.

After agreeing on a definition, the group then undertook an iterative process to come up with desirable IPP behaviors within six categories. Table 4-1 shows the six categories and a sample of the 26 observable behaviors identified by the IPC. Frost pointed out that no single profession alone could have developed these IPP behaviors because they are grounded in a team concept rather than specific to any one profession. In building this list of behaviors, the IPC professionals struggled and learned from and with each other, considering behaviors from different perspectives in determining the value of the behavior in terms of worthiness and measurement.

Eight years into its initiation, the IPC is now ready to test the validity and reliability of its assessment tool for IPP behavior. If the instrument is found to be psychometrically sound, the IPC will then disseminate its findings and make the tool widely available without a fee. The IPC's vision is that the IPP construct will bridge both academic and practice environments because these behaviors should be taught, modeled, and

BOX 4-3
Definition of Interprofessional Professionalism (IPP)

Consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of, altruism, excellence, caring, ethics, respect, communication, accountability to achieve optimal health and wellness in individuals and communities.

SOURCE: Stern, 2006.

TABLE 4-1 Examples of Desirable Interprofessional Professionalism Behaviors

Behavior	Description
Communication	Communicates with members of other health professions in a way they can understand, without using profession-specific jargon.
Respect	Demonstrates confidence, without arrogance, while working with members of other health professions.
Altruism and caring	Places patient/client needs above own needs and those of other health professionals.
Excellence	Contributes to decisions about patient care regardless of hierarchy/profession-based boundaries.
Ethics	Reports or addresses unprofessional and unethical behaviors when working with members of other health professions.
Accountability	Accepts consequences for his or her actions without redirecting blame to members of other health professions.

SOURCE: Frost, 2013.

promoted in both academic and practice settings. IPP provides a unique emphasis that underscores communication, collaboration, and negotiation across professional boundaries. This vision highlights professionalism as a resource for promoting skills, values, and organizational structures that facilitate interprofessional care. Likewise, this concept is distinct in focusing on competencies, values, and norms that multiple professions have identified as critical to promoting effective interactions in the provision of patient care.

The ultimate goal of the IPC is to create a resource toolkit to help health professionals and faculties understand the concept of team-based, collaborative professionalism and how these concepts could be applied in educational and practice environments.

ASSESSMENT ON THE CONTINUUM FROM EDUCATION TO PRACTICE

George Thibault from the Josiah Macy Jr. Foundation brought up a question about assessing the health professions' education to practice continuum and wondered whether the IPC addressed assessment of professionalism within that range. Although Frost found it an intriguing concept, the IPC had not focused on the bridge between interprofessional education and practice. She added, however, that because the IPC is made up of educators, practitioners, and associations, it is well positioned to consider this domain.

Similar to Thibault's question, Warren Newton from the American Board of Family Medicine asked whether the deliberations of the IPC considered the concept of lifelong learning. More specifically, he asked whether the vision of the IPC moving forward is to incorporate ongoing continuous assessments that are linked to licensure and accreditation. Frost responded that the IPC's IPP assessment tool measures a moment in time but could be used repeatedly throughout a student's education. The IPC also considered assessing recent graduates longitudinally on graduation at 10 years, 20 years, and 30 years. In the view of the IPC, health care quality is a continuum that is enhanced as improvements in professionalism occur through role modeling in practice.

INTERPROFESSIONAL PROFESSIONALISM FOR OPTIMAL PATIENT/CLIENT/FAMILY-CENTERED CARE

Professionalism is not an end in itself, but rather it supports the ultimate goals of patient/client/family-centered care, quality, and patient safety, said Frost. Behaviors that demonstrate IPP impact collaborative teamwork and, when coupled with effective communication, contribute to the ultimate goal of high-quality health care, as seen in Figure 4-1. The potential for professionalism to contribute to safe, high-quality, patient/client/family-centered care is intimately connected to the health professionals' ability to work interprofessionally. Still, Frost believes this connection has not been adequately emphasized in education because of the disciplinary insularity that persists among the health professions. Elucidation of the link between professionalism and care that is provided in a team context by members of different health professions is an urgent priority, she added. Professionalism, combined with cooperation among members of multiple health profes-

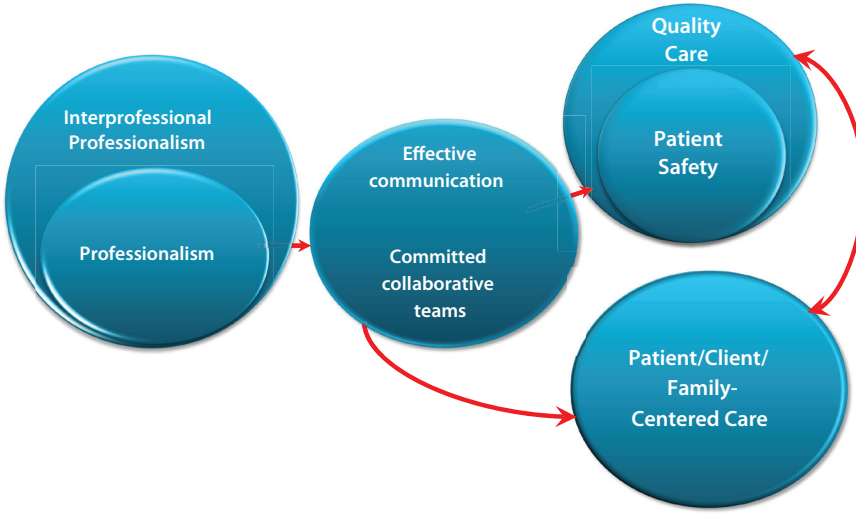

FIGURE 4-1 Relationship between interprofessional professionalism and quality care.
SOURCE: Frost, 2013. Reprinted with permission from Interprofessional Professionalism Collaborative Members.

sions, is key to achieving patient care goals. Despite its critical importance, cooperation is seldom emphasized within professionalism. In the context of increasing complexity of care, focusing narrowly on professionalism without including cooperation may actually undermine quality and safety by distracting clinicians from the need to collaborate effectively across professions.

Aligned with Frost's emphasis on the inseparable linkages between collaboration and professionalism, Madeline Schmitt suggested that in the IPC's figure that demonstrates the relationship between interprofessional professionalism and quality care, professionalism should be the larger circle and interprofessional professionalism the smaller circle. She suggested inverting the two circles so that professionalism is the smaller circle contained within the larger interprofessional professionalism. By reversing them, she said, it forces health professionals to first think collaboratively before considering their individual professions. Figure 4-1 shows IPC's model with the change suggested by Schmitt.

Shifting attention away from individual behaviors of professionalism to behaviors needed for a shared professionalism creates new conversations as professions begin to recognize shared values. Nevertheless, said Schmitt, along with the shift comes the creation of new tensions. For example, within the ethical behavior domain described in Table 4-1, the health pro-

fessions will need to grapple with differing views of confidentiality and will need to gain a better understanding of how the different health professions relate with patients and their families. In thinking through these issues of professionalism collaboratively, said Schmitt, patients and families become the center of the interprofessional team's efforts.

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5

Transdisciplinary Professionalism

I personally believe that this social contract that you are trying to work out, transdisciplinary professionalism, could be the saving grace. It could be a rudder that guides change.

—Judith Miller Jones, caregiver and educator

INHERITING A SHARED SOCIAL CONTRACT IN THE NEXT GENERATION

As an M.D./Ph.D. student and a member of the workshop planning committee who assisted in developing the agenda, Sandeep Kishore was well positioned to lead the discussion on whether development of a social contract—as defined for the purposes of this workshop—will resonate with the next generation. He started his opening remarks by defining transdisciplinary professionalism as *an approach to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, are worthy of the trust of patients and the public*. Such a professionalism would facilitate improved interprofessional teamwork and might synthesize and extend discipline-specific expertise to create new ways of thinking and acting. Kishore asked his panelists to focus their remarks on the basis of this definition of transdisciplinary professionalism.

According to roundtable participant Dave Chokshi, who recently finished his residency in primary care, his starting point in terms of a shared

social contract is thinking about the health professions as service professions. Emanating from that, a shared social contract is about being held accountable both to the patients and to the communities served by health professionals. As a primary care doctor, Chokshi thought this meant integrating patients' values into clinical decision making. For example, the patient's beliefs should be considered in deciding whether to order a prostate-specific antigen test or some other diagnostic test. In terms of being held accountable to the communities that he and other health professionals serve, Chokshi thought the key concept is transparency. Transparency is essential with patients and with respect to governance boards reporting to the community at large. Health professionals must be transparent in gauging success of treatments, sharing metrics, and answering questions honestly.

Through his perspective as a primary care doctor, Chokshi thought his work was particularly relevant to the discussion of establishing a contract with society primary care, he explained, sits at the nexus between the community and the health care system or between medicine and public health. He said he sees it as this fundamental crucible—not just for a discussion of ideas, but also as the operational reality of trying to deliver on a shared social contract.

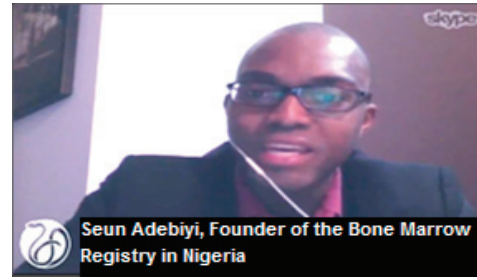
His final point with respect to transdisciplinary collaboration involved a note of caution. He feared that transdisciplinary could at times come into conflict with patient centeredness. The example Chokshi provided involved his desire to lead very efficient patient rounds at the hospital where he was doing his residency. On this particular day, Chokshi was engaged with 18 different health professional learners in an active dialogue outside each patient's room about the particular patient they were caring for. Not until later that day did he realize that although the discussions were spirited for each patient, the patient was not kept front and center during those discussions. In Chokshi's view, a shared social contract involves accountability to the patient as well as to the communities that health professionals are called to serve.

In thinking about Kishore's challenge to focus on the definition of transdisciplinary professionalism, roundtable participant Judith Miller Jones noted that she is a great devotee of interprofessional education (IPE). As the director of the National Health Policy Forum at George Washington University, she has experienced the value of IPE. Her remarks, however, were from the perspective of being the caretaker for her husband, who had late effects of polio. As a caretaker, Jones has firsthand experience in dealing with the health care system. The system, she said, lags behind other industries such as information technology and aviation. Jones had previously worked for

IBM and was an instrument-rated pilot, so she said she understands how much leaders in health and health care could learn from these other industries in terms of communication, teamwork, and safety.

Another point Jones brought up related to her experience with uneven power relationships among the health professionals and how changes in health care are affecting these relationships. For example, changes in reimbursements for what health professionals can charge influence what individual health professionals do and the learning environment that gets created for health professional students. In her opinion, the social contract that the Forum is grappling with, defined as transdisciplinary professionalism, could guide positive changes in health care. Transdisciplinary professionalism (TDP) as defined by Kishore levels the hierarchical structure and engages individuals in determining the structure of their relationship with health professionals.

She said that as a patient and as a caregiver, she wants health professionals to help her make difficult decisions. She does not want decisions to be made without her input, and she does not want to make decisions alone; rather, she wants to be part of the team whose main interest is maintaining or improving the health of her as an individual and her husband as a patient.



As a cancer survivor, Seun Adebiyi also provided a patient perspective to the roundtable discussion. Adebiyi is a lawyer from Nigeria who grew up in the United States. In 2009 he was diagnosed with leukemia and lymphoma and needed to find a compatible bone marrow donor. He learned that African Americans have less than a 17 percent chance of finding a compatible donor partly because of the lack of black donors on the registry and partly because of the greater genetic diversity within the African diaspora.

Through a personal appeal to Nigerian students, Adebiyi did finally locate a compatible bone marrow donor, who saved his life. That experience left him with a strong desire to start a bone marrow registry in Nigeria. He also approached stakeholders in the United States with the same idea, but they realistically said that establishing such a registry would take several years, if not decades, to institute. Working with Kishore and his colleagues within the Global Health Network, he was able to get a fully operational and accredited registry in Nigeria functioning within 2 years.

According to Adebiyi, the most valuable lesson he drew from this experience was the importance of stepping outside the trap of silo thinking. All the people he talked to before launching the registry and before meeting Kishore and his colleagues looked at the complications with starting a registry from the standpoint of their own discipline. The bone marrow transplant doctors looked at the development of a registry from their point of view, and the radiologists had another viewpoint. Few people within the medical community looked at developing a registry from the perspective of patients, the ultimate end-users of the system.

Adebiyi believed this experience serves as a case study for discussions for developing a new framework for thinking and collaborating among the different disciplines and professions. The end goal of this orientation should be designed with the user, the patient, in mind, he said. Patients should have an important voice in developing this framework for collaboration. But when speaking as a lawyer, Adebiyi also described the basic foundation of a contract whereby each party gives something and gets something in return for a contract to be judged valid. When considering a social contract, he said, there must be consideration of what would persuade health professionals to want to enter into the contract.

Eric Cohen spent 14 years as a hematology/oncology nurse before going back to school for a master's degree in nutrition and integrative health at the Maryland University of Integrative Health. His remarks reflected perspectives as a health care provider and a student.

One key point Cohen mentioned was the issue of "territory" and professional boundaries. In his work in oncology, Cohen said, he was reminded of his collaborative relationship with a social worker and the tensions that both he and his colleague felt when either talked about something that was in the other's realm of expertise. In his opinion, much of the tensions arise out of ego. Being able to truly work together in creating a shared vision for a social contract will require letting go of the ego. Educating in a way that takes the ego out of the equation will better ensure that the next generation is equipped to work across disciplines and professions.

Another point Cohen raised was health care literacy. He believed that through educating people, the public will be empowered to know where to go to get answers to health-related questions. In his opinion, the social contract must address health care literacy and provide people with the tools to understand the system. It is no coincidence that navigators are being hired

in the United States to coordinate aspects of a patient's health care and wellness. According to Cohen, navigators are prevalent in oncology because the system for cancer treatment is so complex that it has to be navigated by a third party. Educating patients to understand the health care system is something Cohen thinks should be addressed as part of the social contract.

In making his remarks, Himanshu Negandhi, a professor of public health from India, reported that consumerism is on the rise in India, which impacts how students select their fields of specialization. Indian students can end their medical education at the graduate level and receive an M.B.B.S. degree. Graduates often choose to specialize in internal medicine, cardiology, or radiology, however, because the private sector in India has grown so rapidly that doctors who enter these specialty areas have the potential of making a lot of money.

Jones echoed Negandhi's comment and endorsed a vision of what a reconfigured health care system could be that would empower young physicians and nurses to practice together so that health professionals would be driving the system as opposed to entrepreneurs. Although it may be appropriate for physicians who run big hospital systems to have a high salary, she said, she fears that to a certain degree the money has taken over. She sees professionalism as an empowerment tool for starting this conversation. Chokshi agreed that the United States is at a special point in time; in this period after the passage of the Patient Protection and Affordable Care Act (ACA), the health system is changing rapidly. New models of care, such as the Accountable Care Organization and the Patient-Centered Medical Home are being tested. In his opinion, health professions and education have not kept pace with these rapid transformations. The Department of Veterans Affairs' (VA's) Centers of Excellence and Primary Care Education is one exception, he pointed out. In this demonstration across five medical centers, the VA is providing interprofessional education and aligning curricula and schedules of the medical and nursing schools within a particular specialty.

Workshop planning committee member Sally Okun from PatientsLikeMe commented on the discussions of the roundtable. She agreed with the importance of using the social contract to engage the deliverers of care in more effective and productive conversations. But she saw a gap in engaging the receivers of care in the discussion of the social contract. They also have something to give and to get. If there is to be a contract between patients and providers, both deliverers and receivers must be involved. She added that patients are already engaged through social media. For example, 220,000 people are networking through her online website, sharing treatment and disease experi-

ences. In her opinion, receivers of care are not being given the tools they need in order to work effectively with deliverers of care on the social contract. As a result, patients are finding their own mechanisms for networking.

Jones observed that in her work in West Virginia, this motivated online group is not representative of the entire public. She described what has been labeled "Appalachian apathy," which is not unique to Appalachia. People for generations have very low expectations of what they can do for themselves and lack the ability to talk candidly to a nurse and definitely not a doctor. They go along to get along, she said. It is very hard to motivate them to pay attention to their drug regimens, to exercise, or to eat more nutritiously because their families have done fine for generations without such interventions. Jones pointed out that these patients are not interested in going to a Center of Excellence and would not know what one is. They do not know good provider care from bad provider care. The apathy is pervasive, and doctors do not offer options to apathetic patients because they anticipate a negative response. This is unethical, according to Jones. A health provider should, at a minimum, describe the options of care to the patient and explain the risk and benefit of each choice. If the giver just assumes that the receiver will not use the information, then it becomes a self-fulfilling prophecy.

Forum member Madeline Schmitt commented about the flip side of Appalachian apathy, which is "cultural humility." Cultural humility involves a provider's commitment to balancing the power between patients and providers and extends to developing positive partnerships with communities, as well as a desire for self-evaluation and self-critique throughout one's career (Tervalon and Murray-Garcia, 1998). According to Schmitt, the spectrum of apathy to humility demonstrates a lack of a common language. There needs to be a language so that the public understands what transdisciplinary professionalism is and so that health professionals better understand the needs of these populations.

In a similar regard, Jones expressed a need to go beyond the standard academic health training model to include community organizations such as Alcoholics Anonymous and Narcotics Anonymous, as well as families and caregivers. Such an inclusive approach to forming teams would be very empowering to patients at different times in their lives. Okun said this point resonated with her. Giving patients the opportunity to express what they need in ways they are comfortable with will improve the literacy of health providers in working with special populations.

Jones thought that goal-oriented care plans could be created for use in practice environments and for training health professionals that might inspire students to think and act in new ways. Kishore agreed that young people are a potential oasis of inspiration and energy, particularly given all their virtual connections. But he cautioned that many of his colleagues

talk about losing their idealism as they transition from students to young professionals. As a second-degree student, Cohen agreed with Kishore, saying that he has felt the frustration and exhaustion from some of his fellow students. But, he added, a very positive movement is also under way, focusing on prevention-oriented actions that inspire students and create hope for the future.

REFLECTIONS

Patient Perspective

Barbara Kornblau is currently the executive director for the Society for Participatory Medicine. She is an occupational therapist and an attorney by training, although the perspective she provided in her reflective comments came from her experiences as a patient and a caregiver of six children with disabilities and multiple chronic conditions (her comments are shared more extensively in a paper in Part II of this report). She began by describing participatory medicine. In participatory medicine, patients are encouraged to shift from being passive recipients of care to being active members of their health team, all of whom are equal partners on the team. In Kornblau's view, being the driver of one's own care carries with it a responsibility, a responsibility she terms being an "e-patient." "E-patients" are equipped, enabled, empowered, and engaged in their health care and their health care decisions. It is an equal partnership between the e-patient and the health providers and systems that support them (Society for Participatory Medicine, 2013). According to Kornblau, this concept of e-patients needs to be integrated into health professional education.

Looking more closely at the area of patient engagement, Kornblau referred to the Center for Advancing Health, which defines patient engagement as "actions individuals must take to obtain the greatest benefit from the health care services available to them" (Center for Advancing Health, 2010). She also described the importance of patient engagement, which, according to the World Health Organization and others, can improve patients' experiences and satisfaction and can provide clinical and economical benefits to patients, providers, and the health system (Coulter et al., 2008; Coulter, 2012; Hibbard and Greene, 2013).

In particular, evidence shows that engaged patients with chronic conditions are more likely to adhere to treatment regimens (Health Council of Canada, 2011). Kornblau urged educators to extract information for curricula development from the February 2013 issue of *Health Affairs*, which is entirely devoted to this topic. She emphasized that adding patient engagement to curricula does not have to increase the time burden on educators. For example, she says, using actual patients instead of paid actors and pro-

viding interprofessional education—that draws on true patient-interactive experiences from a variety of health professional learner perspectives—makes the teaching of history- and physical-taking very real. This benefits patients, who become part of the education of the next generation of health providers, and it benefits students, who receive more memorable educational experiences.

Kornblau also addressed what "transdisciplinary," "a social contract," "professionalism," and "ethics" might mean to patients. With regard to the idea of transdisciplinary, she said, she believed it was premature to bring the concept to patients, given the current challenges around inter-provider communication for better continuity of care. Regarding the social contract, Kornblau questioned who the contract was being directed toward—society or individual patients. She was also not sure whether society had a contract with patients and who exactly makes up "society." In the area of professionalism, Kornblau thought that patients viewed professionalism as behaviors, not beliefs, and she was uncertain about which comes first. Patients discuss professionals' behaviors, she said, but those behaviors are formed by beliefs, so a case could be made for discussing "beliefs" in the way it was presented by speakers at the workshop. The issue of ethics, for Kornblau, is one that can have lasting effects on communities, such as in the Tuskegee Institute clinical study and the case regarding Henrietta Lacks, where members of a community become fearful of health systems because previous injustices and the lack of trust.

Although Kornblau had to speak for all patients in her remarks, she summarized her views by saying that what patients want is respect by being listened to. They also want information that is relevant to the social context in which they are living that considers a patient's financial, physical, and neighborhood safety conditions. And, finally, patients want to be included. They want to be part of the decision-making process, which could include educating health professional students to understand the various key roles patients have, and could have, on teams and within health systems.

Educator Perspective

As chancellor of the University of the West Indies and director emeritus of the Pan American Health Organization, George Alleyne was well positioned to comment on the discussions and presentations that took place on the social contract for health. His remarks were framed within the context of innovation in health professional education and focused on whether it is possible to educate professions in a transdisciplinary manner and include the elements of a shared social contract. Before beginning, Alleyne admitted his skepticism, saying that he has seen many attempts to change the methods and content of medical education that have not been successful.

In terms of defining a profession, Alleyne was intrigued by the differentiation made by one of the speakers between vocation and occupation. He added that professionalism embraces the exercise of a profession. And almost by definition, health professionals have a formal relationship with three critical groups: patients, other health workers, and society at large. The organization of these relationships and the rules to order them in a formal sense go back about 150 years on both sides of the Atlantic.

Today the nature of the relationship among providers and between patients and providers has changed and continues to change for several reasons. First is the increased complexity. Alleyne posited that this increased complexity has resulted from the prodigious growth of science and an increased understanding of the basis of disease and illness. These advances in the basic sciences have made it impossible for any single discipline to have the knowledge and expertise to address the whole range of illnesses that exist. For that reason, specialty and subspecialty disciplines have developed that focus on a portion of the patient rather than the whole patient. A second reason involves changes in the world's disease profile. Alleyne noted that the chronic noncommunicable diseases have now surpassed the acute communicable diseases as causes of death in most parts of the world. As a result, many societies are adopting models of continuous care that essentially involve the patient, the family, the community, and health care services at different levels. These patients require continuous care from a variety of health professionals over a long period of time. Such care necessitates that respect, understanding, and fluid communication exist among the professions; most important, said Alleyne, is the capacity to listen.

Another cause for changing relationships between providers and patients is the availability of information through a wide array of tools that also affect changes in population health. Alleyne cited the 1992 work of Geoffrey Rose that outlined population-wide interventions from a variety of perspectives, including social and political changes (Rose, 1992). There is now a better understanding and appreciation for social determinants of health at both the individual and the population level, he said. Alleyne also noted that greater expertise on the social determinants of health may reside within the fields of sociology and economics rather than with health professionals. This fact called into question whether such disciplines should be legitimately counted among the health professions. A more critical question, however, is whether the interventions needed for improving the health of populations should be part of the remit of individual health workers or whether it should be exclusively dealt with by the state. For example, in tobacco control the physician has the responsibility to set a good example by not smoking and by advising his or her patients not to smoke, while the state has the authority and the responsibility to raise taxes on tobacco as a deterrent to smoking. This example brings into question

the role of health professionals as advocates for change and whether such advocacy should be part of a health professional's responsibility.

Alleyne then focused on the relationship between medicine and society. This relationship, he said, is where a social contract is needed such as the one described by the Cruesses. Such a contract would embrace the expectations and the contributions of both providers and patients. It would contain societal expectations of the provider and the provider's expectation of society. For physicians, that means expecting trust, a monopoly on practice, and a reasonable measure of status and compensation, and it would mean the expectation of a health system that enables medicine to be practiced efficiently. In return, there is an understanding that physicians will be altruistic, trustworthy, and appropriately self-regulating and that they will address the concerns of society.

Alleyne then posed the following question: "Is it possible to envision a contract, perhaps not a social contract but a contract that is transdisciplinary in the sense that it cuts across all health disciplines?" He noted that a great degree of similarity already exists in the codes of conduct of various health professions, which, he suggested, all contain three essential elements. These elements are a corpus of standards and ethics, a system of registration, and a system of education and instruction. In this way, the relationship between a physician and a patient is not fundamentally different from that between a pharmacist and a patient or a dentist and a patient. These core elements might form the basis of a common approach for all disciplines to come together to form a contract with society. Most likely, such a social contract would be complemented by discipline-specific contracts that take into consideration unique features of individual disciplines and professions.

Considering the pedagogy for teaching a transdisciplinary approach to professionalism, Alleyne cited the Lancet Commission report. In this report, the commissioners stress the nature and the evolution of instructional reform that has moved from informational learning to formative learning and is now shifting toward transformational learning (Frenk et al., 2010). Although the report emphasizes transformational learning through leadership, Alleyne commented that he views it through a slightly wider lens. In his opinion, transformational learning is about acquiring the knowledge and skills beyond those traditionally given in health and instilling in students the importance of health as instrumental for human development. In addition, innovations in learning would be driven by new technologies as well as formal mentoring and role modeling. Such experiential learning does the most to engender relationships with the patients, with other health workers, and with society that must, according to Alleyne, be the bedrock of good health care. In his summative assessment of transdisciplinary professionalism, Alleyne suggested that innovative transdisciplinary pedagogy

can contribute to the formulation of a contract that is transdisciplinary and that a contract with society can exist that embraces all health disciplines.

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6

Making It Real

Trust, the foundation of good communication, requires vulnerability to be open to one another around the mistakes, weaknesses, and fears.

—Susan McDaniel, Psychiatry and Family Medicine, University of Rochester

To better understand how individual members of the forum viewed the notion of an open dialogue between health professionals and the public—which includes patients and care givers—forum members and other workshop participants were separated into four small groups. Each group looked at the issue of transdisciplinary professionalism from a different perspective. The perspectives were as follows:

- Group 1: Patient and Community Roles
- Group 2: Accountability and Leadership
- Group 3: Health and Well-Being
- Group 4: Economic and Physical Infrastructure

The groups were assigned leaders who facilitated discussions on the basis of case studies that enabled an exchange of ideas and experiences from a multidisciplinary perspective. In these groups, opinions were shared about the feasibility of bringing health professionals and the public together and what the mechanisms and requirements might be for accomplishing that goal. Four small-group participants were asked to report back to the larger

forum membership their views that were informed by their group's discussions. The speakers included

- Meg Gaines, Group 1
- Catherine Grus, Group 2
- Mary Jo Kreitzer, Group 3
- Susan Chimonas, Group 4

Table 6-1 provides a summary of their views. The views are then described in greater detail in the sections below.

HOLDING HEALTH PROFESSIONALS ACCOUNTABLE BY PATIENTS AND SOCIETY

Patient and Community Roles in Transdisciplinary Professionalism

Meg Gaines from the Center for Patient Partnerships at the University of Wisconsin Law School provided comments on her group's discussions on the patient and community roles in transdisciplinary professionalism. In her remarks, she discussed the power imbalances between health professionals and individuals and between health professionals and communities. This discussion influenced the way the individual participants in her group thought about whether diverse health professionals could be held accountable for their collective actions by patients and society. The first obstacle, she said, was defining who would be included within patients and society. But assuming a group could be assembled, Gaines added, the group identified three ways in which patients and society could hold health professionals accountable.

The first way was to use community group assessments. She provided an example from India, where patient groups assess all aspects of health care delivery institutions and report on how well organizations are delivering care. For this effort to be successful, however, there would have to be transparency that allows for mutual understanding of the challenges that providers and users of the health care system face. Gaines reported that by involving patients in assessment programs, individuals begin to understand the difficulties involved with delivering health care effectively. Conversely, patient involvement in assessments helps health professionals begin to understand the challenges faced by communities and individuals as members of that community. As a result, providers become more compassionate, and patients become active participants in their own care. The second way in which society could hold the health professionals accountable was through the acquisition of knowledge. Specifically, patients could learn about harmful and wasteful procedures and actions and begin speaking the truth to

TABLE 6-1 Four Individual Perspectives on Elements of Shared Social Contract[a]

Can diverse health professionals be held accountable for their collective actions by patients and society?			
Gaines	**Grus**	**Kreitzer**	**Chimonas**
Yes and No	Yes (with qualifications)	Yes	Maybe
If so, what factors would be needed for this to happen? (If not, why?)			
No • There is not currently a system of collective action Yes • A system of accountability • Transparency • Mutual understanding of challenges faced by all players • Conversations at a local level	Yes • Better understanding of different professions' values • Understanding the role of "organizations" • Good data and knowing the demographics • Ethical boards • An agreed-on system of reimbursement • Educating society about health care and navigating the system • The courts • Moving away from a blaming culture • Patient comfort with teams • Media/consumer advertising • Communication • Knowing the team and each of its members • Involvement of nonhealth workers and professionals • Consideration of power dynamics (hard to hold a supervisor accountable)	Yes • Clarity on professions' roles and responsibilities and scope of practice • Alignment of incentives and rewards (individual vs. enterprise legal accountability) • Understanding and acceptance of cultural differences	Maybe • The notion of "us" would have to be as broad as possible • This diverse group of health professionals, patients, and society can hold each other accountable for their collective actions

continued

TABLE 6-1 Continued

Can diverse health professionals hold each other accountable for decisions made collaboratively?			
Gaines	**Grus**	**Kreitzer**	**Chimonas**
Yes	Yes	Yes	Yes
If so, what factors would be needed to for this to happen? (If not, why?)			
• Shifting from a culture of blame to one of safety (there will be organizational and legal barriers) • Mutual respect among professions (early professional education and socialization together; rethinking the scope of practice from individual to team; assessing learners as individual and as team member) • Reforming organizational behavior in delivery systems and academic organizations (how one is treated influences how others get treated)	• Avoiding blame to achieve outcomes • Understanding the different values held by different professions • Considering power dynamics (hard to hold a supervisor accountable) • Promoting a group identity among students (promote teams and less individual accountability) • Involving nonhealth workers and professionals • Changing employment situations (e.g., 55 percent of doctors are employees) • Improving efficiency and effectiveness of teams • Transparent systems of accountability • Systems that are congruent with other systems • Assessment	• Moving from a blame culture to a just culture (safety and transparency) • Considering moral distress (e.g., collaborative decisions that are not in best interest of the patient) • Consensus decision making • Information • Integrity	• Accountability as trust and team support rather than placing blame • Addressing hierarchy and/or power within professions • An ability to reach consensus • Relational autonomy

TABLE 6-1 Continued

What specific/measurable attributes should *organizations* and training programs exhibit to create and support the preparation of health care providers, patients, and communities for transdisciplinary professionalism?			
Gaines	**Grus**	**Kreitzer**	**Chimonas**
• A culture change (putting patients at the center and letting them lead/guide the team) • Integrating faculty from different professions • Shifting education and training so they are experiential and interprofessional and so they start early and are reinforced often • Rethinking the organizational model from the expert paradigm to one of collaborative leadership (chief executive officers would be made accountable for engaging with communities) • Using patients as teachers and learners (contract concept)	• Culture (addressing the hidden curriculum) • Involving patients and society in the development of health care systems • Creating a structure that considers the whole person and not the individual parts (intergroup identity) • Transparency • Valid data • Orienting training around behaviors • Incorporating behaviors into preexisting measurement tools • Assessing teams, not just individuals • A systems-level approach • Addressing the power structure of organizations	• Just culture • Letting go of ego • Understanding the role of other health care professionals • Self-awareness and self-care • Health and well-being • Respectful and courageous leadership • Courageous conversations • Open communication • Health policy	• Just culture • Setting and demonstrating explicit attributes of a well-functioning team • Shared values • A shared language • Team responsibility

[a] None of the answers to the questions should be construed as representing a group consensus but rather the individual viewpoints of the speakers.

decision makers. The third point was to start the conversation locally or regionally, build momentum, and ultimately develop a national dialogue.

Accountability and Leadership in Transdisciplinary Professionalism

Catherine Grus of the American Psychological Association presented on the constructs of accountability and leadership. A major theme that came up during her group's discussions was whether a team could be held accountable versus an individual. She noted that although current structures such as insurance systems and the courts are unlikely to be considered team-based responsibilities, she thought there were models at the systems level, possibly through root-cause analysis that could address team functioning and could analyze how the team had contributed to a particular outcome. Another point brought up by Grus under the theme of accountability was the need for upfront structures that are transparent so the procedures are clear and everyone understands what is expected of them.

With that background, Grus then went on to describe the reactions of the individual participants in her group as to whether diverse health care professionals can be held accountable for the collective actions by patients and society. Basically, she expressed the view that in this culture, uncertainty exists about whether society had accepted the need for team-based care and whether the general public understood the concept well enough to act on it. Grus believed that this step would get society closer to being able to hold health professionals accountable. For this to work, reimbursement would also need to be redesigned from the individual focus of the past to reflect a new paradigm for team accountability. Many changes would need to be considered, including moving away from a culture of individual blame, enhancing communication, and helping individuals understand how the complexities of the health care system work.

Health and Well-Being in Transdisciplinary Professionalism

In setting the stage for her breakout group on health and well-being, Mary Jo Kreitzer from the Center for Spirituality and Healing at the University of Minnesota reported reviewing case studies that framed two issues. The first issue addresses work–life balance and a culture that supports the setting of boundaries, and the second involves the need for cultures that support the well-being of individuals as well as communities. According to Kreitzer, well-being includes not only health in all of its dimensions—physical, emotional, social, and spiritual—but also purpose. Purpose influences behaviors and decision making and directly impacts well-being. Relationships are also central to health and well-being, so a goal of health professional education is to foster an understanding of healthy relationships and the community that

nurtures and sustains its members. Safety and security are also fundamental to well-being because it cannot exist when individuals live in fear; whether it is organizational or found in some other form, fear immobilizes.

With this orientation to her group's perspective, Kreitzer addressed whether diverse health professionals could be held accountable for their collective actions by patients and society. She responded with a qualified "yes," adding that it all depends on the context and the circumstances. Her group discussed the balance of roles and responsibilities, both individually and collectively, and how these roles overlap with understanding the scope of practice, incentives and rewards, and accountability in the legal sense. Kreitzer also brought up financial reimbursement systems that are shifting to value-based contracts, which reward quality outcomes rather than providers for the volume of services performed. She emphasized that these new models are heavily nuanced and require agreed-on definitions of quality and quality metrics. In contrast, Kreitzer reported that one of her small-group participants from India said that in his country, a mistake is attributed to an individual, and he could never see an instance when such an error might be attributed to a team.

Economic, Physical, and Social Infrastructure for Transdisciplinary Professionalism

Susan Chimonas from Columbia University reported on the economic, physical, and social environment in which community members reside. She emphasized the importance of avoiding assumptions and engaging communities in decision making at all levels, particularly around infrastructure needs. This framing of the issues led to reluctance by her and her group members to consider a system of team accountability. Rather, she reported a preferred method that relies more on the acceptability of health care professionals and society to work together willingly.

HOLDING HEALTH PROFESSIONALS ACCOUNTABLE TO EACH OTHER

Patient and Community Roles in Transdisciplinary Professionalism

In considering whether diverse health professionals could hold each other accountable for decisions made collaboratively, Gaines emphasized the need to shift from a culture of blame to a culture of safety and mutuality. She cautioned, however, that organizational, legal, and financial barriers could impede such a shift. Financial issues driving a system that produces health care at a profit may be in conflict with a culture of maintaining safety and avoiding wasteful practices and procedures.

Gaines also identified mutual respect among professions as important. Respect involves how health professionals are treated and how they treat others within an organization, a delivery system, an academic medical center, or a university or other school. In thinking about reform, Gaines suggested that it could start by educating students across disciplines together from the beginning. In this way, different health professions gain a fundamental understanding of the added value of each team member. Gaines also pointed out that working by one's self seems very lonely. Bringing even just two people together to work through a difficult situation is a powerful connection. This connection among team members, according to Gaines, could lead to a shared identity and mutual responsibility for outcomes. Students could be assessed by their team's performance as well as by their individual knowledge, skills, and ability.

Accountability and Leadership in Transdisciplinary Professionalism

Grus, the leader of the Accountability and Leadership Group, expressed a sense that health professions *should* hold each other accountable. To get to that point, Grus suggested many of the elements that had been previously stated. There is a need for a culture shift away from blaming; power dynamics need to be addressed; the value system of each profession needs to be articulated; and a system of transparency needs to be set up from the start. She also identified a need to operationalize what efficient and effective health care teams would look like and how they would perform.

Health and Well-Being in Transdisciplinary Professionalism

In addressing the second question, that is, whether diverse health professionals could hold each other accountable for decisions made collaboratively, Kreitzer reflected on her group's discussion. She raised the issue of reframing the question to ask whether the collective, which includes individuals, can be held accountable for decisions that are made collaboratively. Regardless of how the question is phrased, however, certain themes became apparent. First was the importance of "just culture" for improving safety and transparency. Just culture could move health professionals from a culture of blame to a culture of learning. But Kreitzer also acknowledged the issue of moral distress. In this instance, if a particular health professional feels ethically challenged or dissatisfied with his or her work environment, how might the other team members handle the situation, particularly if the norm is built around consensus decision making? In her group, Kreitzer speculated that there might be a circumstance where decisions were made that were not in the best interest of the patients or where perhaps patients and families had not been involved in conversations as they should have

been. Other key elements Kreitzer brought up involved information integrity and consensus decision making, both of which she believed would be important factors for this type of accountability to work.

Economic, Physical, and Social Infrastructure for Transdisciplinary Professionalism

Chimonas reported for her group that when holding other health professionals accountable, hierarchy or power would be a major factor. Another key element would be the ability to reach consensus. With such a diverse group of individuals that includes patients, she questioned whether consensus was possible. Moreover, if the team could reach a consensus, how well would it work for patients? Chimonas also brought up the notion of accountability and whether it implies trust and team support or whether it is about placing blame. This question invoked discussions in her breakout group about relational autonomy and whether the roles within an organization or a team are fixed or whether they are shaped by relationships with one another.

MEASURABLE ATTRIBUTES FOR TRANSDISCIPLINARY PROFESSIONALISM

Patient and Community Roles in Transdisciplinary Professionalism

In looking at what specific, measurable attributes organizations and training programs should exhibit to create and support the preparation of health care providers, patients, and communities for transdisciplinary professionalism, Gaines put a "changing culture" first. By changing culture, she said, patients are at the center of care and systems and should be encouraged to lead and guide the process. For education and training, learning should take place with other professions while doing real work that engages patients as teachers.

Gaines drew on her experience as a lawyer in describing a central attribute of a contract known as "consideration." With this, both people entering into the contract have to offer something of equal value in order to have a valid contract. Gaines encouraged the forum members to consider what value patients bring to the contract. In her opinion, the patient's or society's role in a social contract would need to be more than just a promise of respect and financial rewards. It might involve restructuring the current "expert" model of care that assumes one party has all the knowledge. The redesign could start by accepting that patients have expertise that is critical to the mission or the goal of the team. That may be a starting place for what patients have to bring to their side of the social contract.

A final measurable attribute suggested by Gaines involved collaborative leadership. The collaboration would fully engage patients and community members in the leadership of academic institutions, academic medical centers, and other organizational care delivery centers. Academic center chief executive officers (CEOs) would be held accountable for making contact with community CEOs at the highest level, and, for success, there must be accountability for linking communities with health delivery organizations.

Accountability and Leadership in Transdisciplinary Professionalism

On the basis of the discussions in her group, Grus reported that transparency was at the top of the list for organizations and training programs addressing transdisciplinary professionalism. Also important were getting patients' views as a result of providing them with data and establishing a common terminology. She expressed a desire to target interventions at the systems level mainly to deal with such issues as the hidden curriculum to prevent students from internalizing negative attributes from poor role models. And she underscored the importance of involving the community and patients. A main challenge to implementing transdisciplinary professionalism in the workplace is the reimbursement system that focuses on individual diseases and procedures while transdisciplinary professionalism embraces a holistic approach to the individual.

Health and Well-Being in Transdisciplinary Professionalism

In looking at the third question of measurable attributes, Kreitzer brought up a discussion from her breakout group that stressed the importance of education and training. Education and training are core to health and well-being, she said, adding that addressing content areas is similarly critical. In her view, the content could include self-awareness, self-care, health and well-being, leadership, courageous conversations, communication, health policy, the role of other health care professionals, just culture, and the whole notion of the importance of letting go of ego. Another important point she emphasized was respectful and courageous leadership.

Economic, Physical, and Social Infrastructure for Transdisciplinary Professionalism

On the basis of her group's discussion, Chimonas commented for her group that embedding teamwork into the daily operations of an organization would create opportunities for people to come together and share their values. For this to work, a common language would have to be agreed on that allowed the team to communicate about important issues. Chimonas

reiterated that team responsibility is not about placing blame; rather, it is characterized by everybody coming together to understand what went right and what went wrong, or "just culture." The shared goal is trust to gain understanding and reduce future errors.

LEADING THE CHARGE

Forum members were asked to reflect on who or what organization might create a forum for health professionals, patients, and other key stakeholders to begin creating an explicit and shared social contract for the health professions. There was a suggestion that the Institute of Medicine (IOM) could fill this role, although the suggestion was met with some resistance. One participant admitted to being in strong opposition to the idea. In her view, the work of the IOM is primarily at the policy level, and she could not envision the IOM constructing a meaningful dialogue at the level of the community or the individual patient or provider. Although Sally Okun from PatientsLikeMe agreed, she also thought that the conversation needs to begin and that the IOM is a place where a conversation can begin. She added that the IOM has a lot of convening power but was concerned about the potential uneven distribution of representatives from the patient community. She also expressed concern about the funding. She said that a funder was needed for this because there cannot be an expectation that people who are giving care will volunteer their time.

Jordan Cohen, a co-chair of the Global Forum, suggested that possibly *Consumer Reports* could be a place to begin the conversation. The organization is increasingly interested in health, and it is the voice of the public. Matthew Wynia, co-chair of the workshop planning committee, agreed and added that what he likes about using *Consumer Reports* is that its leadership understands innovation. Holding focus groups to gather information is not the same as convening leaders who can turn conversation into action.

Forum member Lucinda Maine, who represents the American Association of Colleges of Pharmacy, encouraged the other members to consider engaging specific groups that are already motivated to work together around a particular disease or concern like Alzheimer's. In her view, groups of caregivers and clinicians who are motivated to rally around a specific disease are already in conversation. It would not be unrealistic to bring the providers into a conversation with caregivers and patients about forming a common language that could lay the foundation for a shared social contract. But it would be a social contract in the context of their care and social service delivery system. Their output could possibly form the basis for a national or international debate around a social contract. The initial conversation, said Maine, would have to begin locally.

Although forum member Madeline Schmitt, representing the American Academy of Nursing, saw value in such an activity, she reminded the members that this forum is focused on health professional education. She expressed a desire to link efforts on establishing a social contract to innovations in education. In her opinion, organizational competencies could be developed to assess whether organizations are creating practice climates that support the hypothesized shared social contract. This would be separate from teaching competencies for students. The organizations would look at their own environments and determine whether they support the notion of a shared contract of trustworthiness across all the professions.

Richard Murray, the dean of the School of Medicine and Dentistry at James Cook University in Australia, agreed with this key point, saying that many discussions take place about addressing ethical behavior and teamwork, but unless the talk gets turned into action through reform and structural redesign, then such dialogue will have the same fate as the Travistock meeting. The Travistock meeting, which Maine had mentioned, was a remarkable gathering of high-level people from many organizations who established a set of shared ethical principles that were never able to be operationalized. To avoid this same fate, Murray believed that one needed to address the question of how to set up structures within organizations that institutionalize engagement and reflection and provide opportunities for authentic partnerships. This would open opportunities for people to think differently about how they are allowed and encouraged to build authentic partnerships with community stakeholders.

LOOKING FORWARD

A tremendous gap cited throughout the workshop is the paucity of effective role models that demonstrate the positive attributes of a healer that was cited by Sylvia Cruess; the effective team communication that was noted by Susan McDaniel; and the balanced living that was brought up by Juanita Bezuidenhout. According to Bezuidenhout, some leadership strategies have emerged that are crucial for health teams and for strong health professions education. Part of this strategy needs to include role models and mentoring to become a leader while also being aware that as a role model and a mentor there is a responsibility to develop the next generation of leaders and that negative role models can suffocate learners and those around them. This is why Bezuidenhout emphasized the need for role models and structured mentorship program.

George Alleyne also emphasized the value of good role models, saying that education would benefit from the formal incorporation of mentoring and role model exposure rather than relying on the often random opportunities that make up the current system. In his belief, the mentoring and

following of the role models does the most to engender the formal relationship with the patients, with other health workers, and with the society that has to be the bedrock of good health care.

As Dave Chokshi from the next-generation session commented, a shared social contract is about being held accountable both to the patients and to the communities that health professionals serve. This, he believes, means integrating the patient's values into the clinical processes. From the patient and caretaker perspective, Judith Miller Jones thought a social contract is not necessarily about making the medical decisions herself but about being part of the team that makes the decisions together. And as Maria Tassone, who corepresents the Canadian Interprofessional Health Leadership Collaborative (CIHLC) of the forum, said, their community engagement strategies are grounded in the recognition that local, social, and physical environments fully influence what works and how solutions must be tailored to be effective in particular contexts. The CIHLC program is all about collaborative leadership, but, she added, social accountability and community engagement principles are the anchors of their work. CIHLC members are convinced that these principles, which are reflected in the social contract, will help individuals go beyond self-interest and assist them in reaching a sense of collective intelligence and shared accountability.

Part II

Papers and Commentary from Speakers

Papers and Commentary from Speakers

II.1
INTRODUCING TRANSDISCIPLINARY PROFESSIONALISM

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What is transdisciplinary professionalism? For the purposes of the Global Forum on Innovation in Health Professional Education workshop, it has been defined as "an approach to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, are worthy of the trust of patients and the public." In an effort to promote a shared understanding, this paper provides a broad-brush review of some of the terminology related to the concept of transdisciplinary professionalism.

There has been considerable emphasis in higher education on the relationships among disciplines and how to create new knowledge that addresses the challenges of society. Yet, as Brewer (1999) has noted, "The world has problems but universities have departments." The counterpart to this saying is that "Patients and their communities have health problems, but health care has guilds." There are different ways in which disciplines can work together to address problems, and some approaches are probably better than others, depending on the issue. The following definitions are based on the work by Rosenfield (1992):

- **Unidisciplinary—**Professionals from a single discipline work together to address a common problem.
- **Multidisciplinary—**Professionals from different disciplines work independently, each from a discipline-specific perspective, with the goal of eventually combining efforts to address a common problem (in practice, this is "parallel play," and it describes most of outpatient health care delivery).
- **Interdisciplinary—**Professionals work jointly, each from a discipline-specific perspective. This is an interactive way to address a common problem (in practice, interdisciplinary work is common in rehabilitation and specialized teams and units such as organ transplant and burn units. It is increasingly common in primary care).
- **Transdisciplinary—**This approach synthesizes and extends discipline-specific theories/concepts/methods to create new models/language to address a common problem. It is an integrative process (in practice, it refers to the blurring of disciplinary boundaries and the overlapping of roles and functions).

When issues related to health education and practice are discussed, however, the word "profession" is often used, rather than "discipline." This is done for at least two reasons: (1) not all health professions are actually academic disciplines, and (2) some health professions refer to their internal practice specialties themselves as disciplines. Simply stated, the words "profession" and "discipline" do not have consistent usage in the literature, and we will not resolve those issues here. But it was found that the term "interprofessional" seems to be used more often than "interdisciplinary" in describing the interactive team process in patient-centered collaborative care—so, "interprofessional" is the term used here to reflect that concept. This term may convey more depth of mutual involvement among the professions than the word "interdisciplinary," but it also could exclude members of the health care team not labeled "professionals." However, because the focus of the Global Forum is on health professional education, we believe it will suffice. The term "interprofessional practice" is the current terminology for "two or more professions working together as a team with a common purpose, commitment and mutual respect" (Freeth et al., 2005). Members rely on one another to deliver high-quality health care.

Another core concept in our discussions is that of professionalism. This concept is fundamental to all professions, although standards for professionalism are articulated within the silos of the professions. Definitions abound and include descriptions of attributes, behaviors, and values that professionals should exemplify, such as accountability, altruism, beneficence, compassion, competence, integrity, non-maleficence, respect, and sensitivity to diversity. Professionalism also serves as the basis for a

profession's relationship to society, characterized as the social compact or social contract. A profession "professes" to the public that it will be altruistic, competent, self-regulating, and address societal concerns in return for its autonomy, prestige, and the public trust. As described by planning committee co-chair Matt Wynia from the American Medical Association, professionalism transcends a list of desired behaviors and codes of ethics; it is the reason for creating such lists and acting in accordance with them. Professionalism is also a belief system, an ideology.

Many health professions articulate professionalism as a core competency to be developed and ensured through education and training programs. Indeed, there is a considerable literature across professions addressing issues related to their social contracts with society and how they perceive their roles and responsibilities—which change over time. Figure II-1 provides one way to depict these relationships.

With the increased focus on collaborative care as a means to reduce error and improve quality, there has also developed a need to examine bridges across the health care professions. Rather than conceptualizing professionalism totally within the silos of the professions, efforts have been made to articulate elements of professionalism that are uniquely relevant to collaboration across the health professions. The term "interprofessional professionalism" refers to the "consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of, altruism and caring, excellence, ethics, respect, communication, accountability to achieve optimal health and wellness in individuals and communities" (Stern,

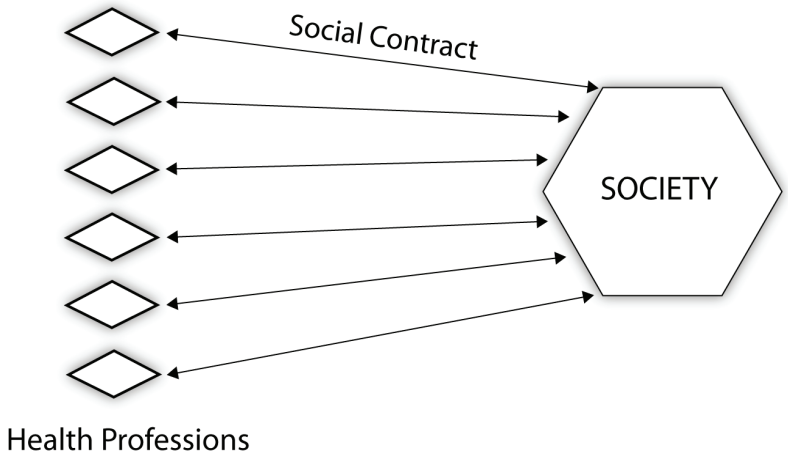

FIGURE II-1 Professionalism.
SOURCE: Belar, 2013.

2006). Interprofessional professionalism underscores cooperation and communication across professional boundaries (see Figure II-2).

Proponents of interprofessional professionalism warn that, given the increased complexity of health care, siloed approaches to professionalism may actually undermine safety and quality as well as patient/family/community centeredness, as was described by workshop speaker Jody Frost. Our question is, If a well-developed interprofessional professionalism is ever reached, will it lead to a transdisciplinary professionalism? Will there be movement toward a shared social contract that transcends all the professions but is connected to all the professions by a unifying set of beliefs and behaviors that they profess to the public? (See Figure II-3.)

Will the multiple health disciplines/professions work together to ensure that they are worthy of the trust of patients and the public? It is important to note that transdisciplinary *professionalism* is not the equivalent of transdisciplinary *practice*. It is not assumed that disciplinary boundaries are "transcended" at the level of knowledge, skills, or competencies in patient care. As noted before, transdisciplinary practice is a concept that describes a blurring of professional boundaries, where health professionals take on aspects of each other's roles. Rather, transdisciplinary professionalism has to do with a transcendent ideology. What would that mean for the education of future health professionals?

The Global Forum's workshop on transdisciplinary professionalism may have raised more questions than it answered, but we do not see that as

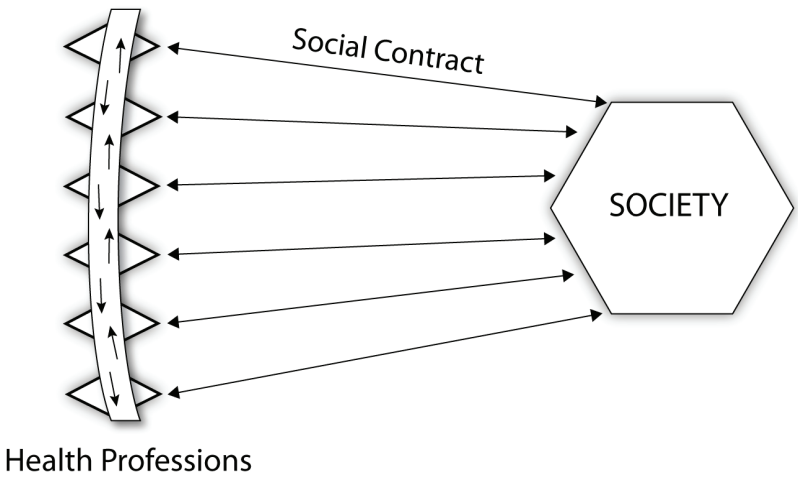

FIGURE II-2 Interprofessional professionalism.
SOURCE: Belar, 2013.

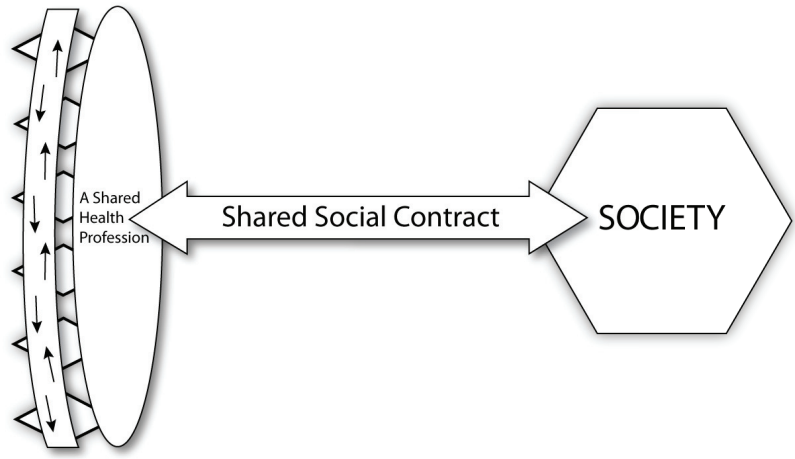

FIGURE II-3 Transdisciplinary professionalism.
SOURCE: Belar, 2013.

a problem. The Global Forum's convening mechanism is an opportunity to go where Forum members have not gone before; we cannot predetermine its outcome. That depends on the views of the participants who represent numerous professions and perspectives. Will it be possible to develop a shared social contract with society for the next generation of health professionals? If so, how will it be modeled, and how will it be taught? This workshop may only be an initial step.

II.2
PROFESSIONALISM AND MEDICINE'S SOCIAL CONTRACT[1]

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Paul Starr appears to have been the first to describe the relationship between medicine and society as contractual. In his 1982 book, he wrote that the contract between medicine and society was being redrawn in

[1] This paper is based in part on work previously published in *Perspectives in Medicine and Biology* 51:579–598 (2008).

response to dramatic changes in health care and that the changes were "subjecting medical care to the discipline of politics or markets or reorganizing its basic institutional structure" (Starr, 1982, p. 380). Subsequently, many observers, including social scientists (e.g., Pescosolido et al., 2000; Stevens, 2001; Hafferty, 2003; Sullivan, 2005), lawyers (e.g., Rosenblatt et al., 1997), policy analysts (e.g., Iglehart, 2005), bioethicists (e.g., Bloom, 2002; Kurlander et al., 2004; Williams-Jones and Burgess, 2004; World Medical Association, 2005; Wynia, 2008), and physicians (e.g., Inui, 1992; Cruess, 1993; Rettig, 1996; Ludmerer, 1999; Gillon et al., 2001; Benson, 2002; Barondess, 2003; Davies and Glasspool, 2003; Gruen et al., 2004; Smith, 2004; Wells, 2004; Cruess and Cruess, 2008), turned to the historical concept of the "social contract" as being a useful and accurate description of the relationship. The idea that the relationship between medicine and society involved reciprocity has been extant in the United Kingdom for some time. In discussing the establishment of the UK National Health Service (NHS), Klein (1983) proposed that a "bargain" had been struck in which the medical profession preserved its autonomy and privileged position in return for supporting the new health care system. Following this, others have used the term "implicit bargain," particularly during recent years, because, they pointed out, the bargain appeared to have broken down. Two new terms have recently emerged as Ham and Alberti (2002) and others (Edwards et al., 2002; Rosen and Dewar, 2004) called the relationship an "implicit compact" and the Royal College of Physicians of London refers to a "moral contract" (2005). None of these terms has roots in either philosophy or political science.

The Changing Nature of Health Care, Professionalism, and the Social Contract

The social contract between medicine and society that existed until the middle of the 20th century was relatively simple (Starr, 1982; Krause, 1996). Medicine was practiced by solo practitioners treating individual patients who were generally responsible for paying for the services received. There were many opportunities to demonstrate altruism because of the large numbers of medically-indigent patients whom physicians often treated for free. Accountability rested with the patient, with minimal accountability for the wider society. Individual physicians and the medical profession were trusted and had unquestioned authority. As medicine became a "mature" and established profession, it became inherently conservative and often defended what it regarded as the substance of its professionalism based on an understanding of the social contract of that era. Hafferty and Castellani (2010) have labeled this "nostalgic professionalism" and pointed out that it is not applicable to the contemporary practice of medicine. They also

propose that the basis of the current social contract is being pushed toward different forms of professionalism, including "lifestyle" and/or "entrepreneurial" professionalism. What is eminently clear is that the social contract of the early 21st century is very different from that of 50 years ago.

The Social Contract—Its Origins and Evolution

The early philosophers who developed the concept of the social contract did so in response to the injustices that existed in a time of hereditary monarchs (Gough, 1957; Crocker, 1968; Masters and Masters, 1978; Bertram, 2004). It sought to explain the origins of the state and society and to delineate their relationship. A contemporary definition of the term "social contract" is

> a basis for legitimating legal and political power in the idea of a contract. Contracts are things that create obligations, hence if we can view society as organized "as if" a contract has been formed between the citizen and the sovereign power, this will ground the nature of the obligations, each to the other. (Blackburn, 1996, p. 335)

Although not all philosophers or social scientists endorse the application of the term "social contract" to the field of health care, there is a respected and influential group that does (Rawls, 1999, 2003; Bertram, 2004; Daniels, 2008). Rawls proposed that the organizing principle in society should be justice based on fairness. Although he did not classify health as a "social primary good," he did believe health is necessary for individuals to be "normal and fully cooperating members of society over a complete life" (Rawls, 2003, p. 174) and that this constitutes an entitlement to health services. Daniels (2008) endorsed this point of view and expanded it by stating that health care was essential as a means of access to "fair equality of opportunity in society."

It is important to emphasize that no formal contract exists in the legal sense. Rather, as stated by Gough, the rights and duties of the parties to the contract "are reciprocal and the recognition of this reciprocity constitutes a relationship which by analogy can be called a social contract" (Gough, 1957, p. 245). Contemporary interpretation of contract theory leans heavily on the idea of "legitimate expectations" as being fundamental to mutual understanding (Rawls, 2003; Bertram, 2004). Obviously, a failure of one party to meet the legitimate expectations of the other has consequences in the attitudes and hence the responses of the other.

In placing health care in the context of the social contract, it can be located within what has been labeled a "macro" contract (Donaldson and Dunfee, 1999, 2002), which includes all essential services required

by citizens. Another approach suggests that there are a series of "micro" contracts that apply to individual services that must conform to the "moral boundaries" laid down by a macro contract (Donaldson and Dunfee, 1999, 2002). Health care could be included in the overall relationship, as Rawls and others have suggested, or, given its importance to the well-being of both individuals and society, it could be governed by its own micro contract. It appears to us that this latter approach better describes the reality of the relationship. It has the further advantage of allowing health care issues to be addressed in isolation from other issues in society within the context of the overall macro contract.

Finally, it is obvious that the details of the social contract between medicine and society differ substantially between countries, being influenced by cultural, economic, and political factors. Although there are many documented commonalities, there are also significant differences in the funding and organization of health care (Ferlie and Shortell, 2001; Schoen et al., 2004; Anderson et al., 2005), in how professionalism is expressed, and in the expectations of the general public (Vogel, 1986; Hafferty and McKinley, 1993; Krause, 1996; Tuohy, 1999; Cruess et al., 2010; Hodges et al., 2011). What probably does not differ is the role of the healer, which has been present as long as mankind has existed and which answers a basic human need in times of illness (Kearney, 2000). Those elements of the social contract that refer to the healer's role will therefore be relatively constant across national and cultural boundaries, while those that refer to how the services of the healer are organized, funded, and delivered will vary (Cruess and Cruess, 1997).

Medicine's Social Contract

Although it is clear that no written social contract exists between individual physicians and the medical profession and society, it is apparent that the contract is a mixture of the written and the unwritten. The written portions are numerous, and many impose legal obligations on the profession and its members. These include licensing laws and documents mandating the organizations responsible for self-regulation, including licensing, certifying, and accrediting bodies, as well as the medical education establishment. Codes of ethics are publicly available documents governing the behavior of physicians. The laws outlining the nature of the health care system in every country are explicit expressions of important parts of the social contract in that country.

These legally binding portions of the contract are very important. However, of extreme importance to both patients and physicians are those portions of the social contract that cannot be legislated or imposed. They spring from the inherent moral nature of the medical act (Pellegrino, 1990). Care,

compassion, altruism, and commitment are an essential part of the professional identity of every practicing physician, and they clearly represent fundamental expectations of patients and the public. Expressing them must spring from a sense of who physicians are, rather than just what they do.

A frequent statement in the literature is that "a social contract exists between medicine and society," implying that each side is monolithic. This is not true. We have proposed an outline of the nature of the social contract between medicine and society (see Figure II-4), one that differs from the only other published outline of which we are aware (Ham and Alberti, 2002). As can be seen, the medical profession consists of individual physicians and the many institutions that represent them, including national and specialty associations and regulatory bodies. Within the circle chosen to represent the medical profession are found a myriad of firmly held opinions, vested interests, and political orientations. Individual physicians often dis-

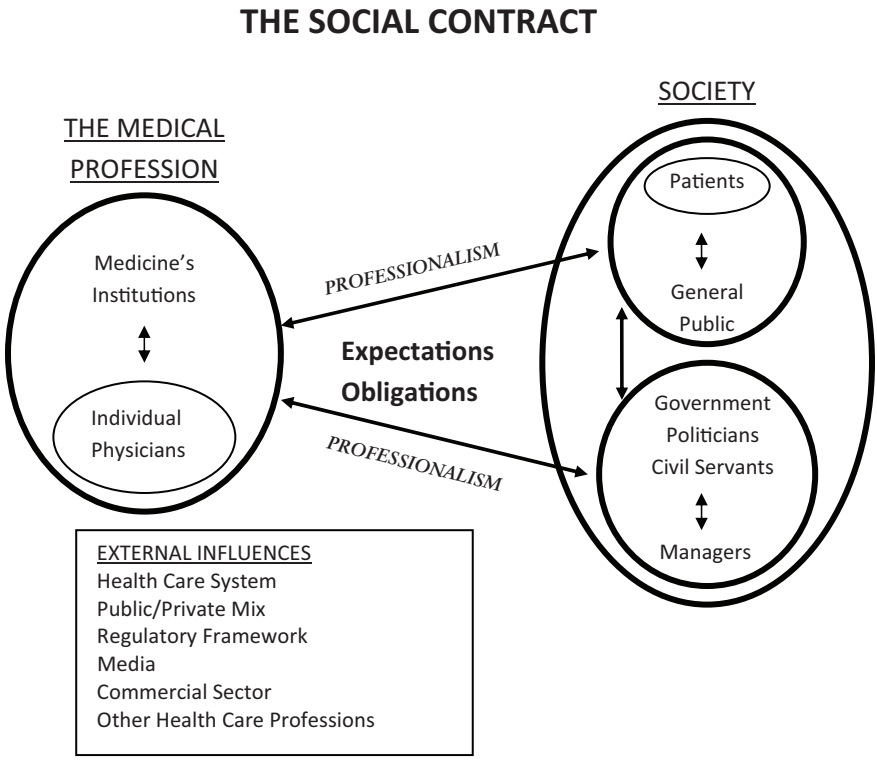

FIGURE II-4 A schematic representation of medicine's social contract with society. SOURCE: Cruess and Cruess, 2008.

agree with the associations that represent them, generalists and specialists may have different approaches, and there are often regional differences in opinion. Nevertheless, in most countries, some form of consensus emerges within the medical profession when it is negotiating the details of its social contract, although this term is almost never invoked to describe the process.

A democratic society is even more complex. It consists of citizens and those whom they chose to govern them. When one focuses on health care, citizens can be designated as patients and members of the general public. Obviously, members of the general public have a clear and personal interest in the relationship with the medical profession, because virtually every citizen will eventually need the services of the healer. For patients, the need is immediate. Although there may be tension between patients and patients' groups and the wider public, their needs and desires are generally not dissimilar as they approach the negotiations.

As health care in most countries has come to be regarded as a right, governments have become responsible for ensuring that minimal levels of care are available to their citizens, thus giving them a major and often determining role in setting the terms of the social contract. However, governments are not monolithic, and there are many vested and often conflicting interests within them. Elected politicians are answerable to their constituents, civil servants are responsible for the proper functioning of the system, and managers in the field have their own responsibilities and desires. Government policy results from a dialogue among these hierarchically organized parties, with elected politicians being ultimately accountable.

Within the circle representing society, the relationship between patients and the public and government is primarily political, with the public in democratic societies expressing its satisfaction or dissatisfaction with government policy in health through the electoral process. It is reminiscent of the original meaning of the social contract.

Professionalism has been defined as "a set of values, behaviors, and relationships that underpins the trust that the public has in doctors" (Royal College of Physicians of London, 2005, p. 14). Trust is absolutely essential if the social contract is to function (Sullivan, 1995; Goold, 2002). Society's expectations of both individual physicians and the medical profession are based on both trust and understanding of these values and behaviors. This explains why professionalism is the basis of medicine's social contract with society. Society expects physicians to behave professionally in return for their privileged position. If they fail to do so, society will alter the contract.

Mediators of the Social Contract

Although the primary social contract for medicine involves the profession and society, there are structures and powerful stakeholders with

legitimate and vested interests in the overall health care system who have a profound impact on medicine's social contract (Rosen and Dewar, 2004). The nature of the national health care system is undoubtedly the most powerful. Other structures and stakeholders include the regulatory system, the commercial sector, other health professions, and the media.

The current social contract between medicine and society represents the "bargain" that has been established. It is based in part on historical practices and in part on direct negotiations between medicine and society and is heavily influenced by the input of the many stakeholders who have legitimate vested interests in how health care is organized and delivered. Because both health care and society are in a period of rapid change, how this contract will change and how it will be renegotiated becomes important.

The Negotiations Leading to Expectations and Obligations

Norman Daniels in *Just Health* (2008) discusses the process of "social negotiation," which determines the nature of physician's obligations and powers. He states that negotiation consists of "various forms of interaction between professional organizations and broader political institutions. It may lead to . . . specific legal arrangements . . . or there may be broader understandings that emerge from public debate about specific issues" (p. 225). He points out that there is a socially negotiated ideal of "the good physician" and that at any given point in time physician behavior is constrained by the nature of this ideal. Upon joining the profession, an individual must accept this concept and is not free to pick and choose among the obligations which result from it. However, the concept of the good physician is not immutable and is being constantly renegotiated as "conditions inside and outside medicine change." For example, the paternalistic model of the doctor–patient relationship has gradually altered as the patients' rights movement firmly established the principle of patient autonomy in decision making (Emanuel and Emanuel, 1992; Truog, 2012). The negotiations that led to this change took place in a decentralized fashion over many decades.

Other changes can occur more precipitously. The introduction of national health plans in the United Kingdom (Klein, 1995) and Canada (Marchildon, 2006) changed medicine's social contract the moment the legislation was enacted. In both instances, prolonged negotiations involving the profession preceded the change. Recently, the perception of both the general public and the government in the United Kingdom that the medical profession had failed to exercise the authority delegated to them to self-regulate caused the government to withdraw some of that authority. The regulatory framework in the United Kingdom is now substantially different, and as a result the nature of the social contract, and of the substance of medical professionalism, has changed (Secretary of State for Health, 2007).

It should be stressed that at any moment in time, negotiations are taking place that will lead to an alteration in medicine's social contract with society.

Who Negotiates the Social Contract?

As should be clear, there are a host of issues that, together, make up medicine's social contract. The nature and substance of the health care system itself is without doubt the most tangible expression of this social contract, and it imposes the distinctive characteristics that are found in different countries and cultures (Hafferty and McKinley, 1993; Krause, 1996). Because professionalism in any given country is based on the social contract, it is not surprising that differences are found in the nature of professionalism across national and cultural lines (Cruess et al., 2010; Ho, 2011).

With one prominent country serving as an exception, the negotiations that result in the social contract are carried out at national or regional negotiating tables. Society is usually represented by members of the government or an organization mandated to act on the government's behalf, a situation that has been present because most countries in the developed world established national health plans. Medicine is usually represented by a national or regional medical association. In Canada, where responsibility for health is a fiercely protected provincial jurisdiction, each province or territory has its own health care system which, while adhering to national standards, can accommodate differing regional needs (Marchildon, 2006). The provincial medical associations are either unions or quasi-unions and are mandated to negotiate on behalf of the medical profession. In Europe, medical unions are the norm. Although the term "social contract" is almost never used during the negotiations, fundamental aspects of the social contract are negotiated directly between the medical profession and government.

The exception to the rule is of course the United States, which until recently had not introduced a true national health plan. As pointed out by Stevens (2001, pp. 329–330), in the United States "there has been no similar concentration of responsibility for universal health insurance at national, state, or local levels and no single government agency responsible for delegating formal power to medical organizations in relation to organized payment and service systems," a situation that still appears to be true. With its long history, the American Medical Association (AMA) would appear to have the mandate to represent medicine, but well under one-third of practicing physicians belong to the AMA. The AMA therefore lacks credibility in attempting to speak for the medical profession (Wolinsky and Brune, 1994). Most physicians are more comfortable being represented by their specialty associations. The lack of a national health plan has led to the absence of a central negotiating table at which the social contract can be addressed.

Negotiations in United States are carried out at many levels, with the commercial sector having substantial input into the nature of the contract. Of course, this does not mean that a social contract does not exist in the United States. The contract that does exist, as pointed out by Hafferty and Castellani (2010), is less well defined, because it is impacted by the many pressures found in American society. The contract, and the professionalism derived from it, stresses individualism and individual responsibility and must accommodate the necessity for practicing physicians to function as entrepreneurs in a competitive marketplace. Medicine is often treated as a commodity, and physicians have been described as often serving as double agents, with fiduciary duties to patients conflicting with legal obligations to employers or insurers (Angell, 1993; Schlesinger, 2002). As has been noted, a social contract implies reciprocity, with rights and privileges accompanied by obligations for the other parties to the contract. The impact of the commercial sector results in a social contract in which there are tensions between patients' expectations and physicians' complex obligations.

The Expectations of Medicine and Society: "Each to the Other"

All contracts impose obligations on the parties to the contract, and social contracts, in spite of their amorphous nature, are no different. The expectations of one party to the contract lead to the obligations of the other party. It thus becomes important that all parties to the contract understand the expectations of the other parties. If medicine fails to meet the legitimate expectations of society, society will wish to change the contract. On the other hand, if what individual physicians and the medical profession regard as their legitimate expectations are not met, they will respond by either attempting to alter the contract or perhaps by changing their own behavior.

In a previous publication we proposed an outline of the obligations between physicians and medicine and patients and the general public, between physicians and medicine and government, and between government and patients and the general public (Cruess and Cruess, 2008). This analysis was based on a review of the literature. Patients' expectations of individual physicians and of medicine are well documented. They want accessible care within the context of a health care system that is value-laden, equitable, and adequately funded and staffed. They want their physicians to be competent, caring, and compassionate, to listen to them, to be accountable, and to demonstrate qualities that lead to trust. They want to be able to preserve their own dignity and autonomy in decision making. Finally, they want some input into public policy. Government expectations, although less explicitly documented, are made known. They make assumptions upon which public policy is grounded, and these assumptions serve as the basis of their expectations of medicine (Le Grand, 2003). As long as the privilege of self-

regulation is granted to the medical profession, they expect the profession to assure the competence of its members. They require compliance with laws related to health care and also expect that members of the medical profession will be trustworthy. They believe that professions should serve as a source of objective advice—even if this advice is often ignored—and they believe that because of the privileged position of the medical profession, the profession and its members must be devoted to the public good. Finally, they require new levels of accountability (Wynia et al., 1999) and want the profession to practice team health care, expectations that have become much more important in recent times.

It is interesting that the expectations of individual physicians and of medicine as a whole are rarely made explicit in a coherent fashion. This is somewhat surprising, because it is quite legitimate for physicians to have expectations of patients, of the general public, and of governments. However, one can infer these expectations from the negotiating stances of the profession and from surveys of physicians that document levels of satisfaction and dissatisfaction (Cruess and Cruess, 2008). An important expectation of medicine is sufficient autonomy for physicians to exercise independent judgment in giving advice to patients. Physicians also expect to be trusted, because the role of the healer requires such trust. Because of their expertise, physicians expect a role in forming public policy in health. There is also considerable evidence that physicians, like patients, want a health care system that is value-laden, equitable, adequately funded and staffed and with reasonable freedom within the system. Although this is rarely articulated, physicians clearly want the monopoly granted to them through licensure laws to be maintained. In many parts of the world, the profession's ability to self-regulate remains a significant expectation. The recent changes in the United Kingdom will certainly alter expectations in that country, and, in this global world, other countries may well re-examine self-regulation. Finally, physicians expect rewards—both financial and non-financial. Several surveys indicate that autonomy and respect rather than increased remuneration are important to physicians.

Significance

One might legitimately ask why it is necessary or desirable to invoke the concept of the social contract in describing the relationship between contemporary medicine and society. What are the benefits to medicine or society?

There is consensus that events of the past few decades have resulted in a situation in which neither medicine nor society is satisfied with the relationship (Dunning, 1999; Sullivan, 2005). There is also agreement that medicine's professionalism is under threat, with the threats coming from two well-documented but separate sources (Starr, 1982; Krause, 1996;

Freidson, 2001; Sullivan, 2005). The first series of threats arises from the failure of the medical profession to meet some of the legitimate expectations of both patients and society in areas over which the profession exercises independent authority. Self-regulation and the belief that physicians are not as altruistic as were their forefathers are examples (Freidson, 2001; Jones, 2002). Because these issues lie within medicine's control, direct action by the profession is necessary, and, indeed, the profession has reacted. Regulatory procedures are becoming more rigorous and transparent. Maintenance of competence, re-licensure, and/or re-validation are being considered or implemented throughout the world (Irvine, 2003). Attempts are being made to inform physicians of their obligations through educational programs whose purpose is the explicit teaching of professionalism (Cohen, 2006; Cruess and Cruess, 2006).

A second series of threats arises from the society that the profession serves and the health care systems within which medicine must function. Society and the health care system can either support or subvert professional values, and in many instances the latter appears to be true (Cohen et al., 2007). Obviously, medicine has no direct control over society or the health care system. An obvious recourse is to negotiate for a health care system that actually supports professional values, a direction that can benefit both medicine and society (Wynia et al., 1999; Sullivan, 2005; Cohen et al., 2007). Framing the discussion in terms of negotiating medicine's social contract has several advantages.

First, the very use of the word contract implies negotiation. Second, it recognizes the principle of reciprocity. The central idea included in the discourse in the social sciences—that medicine was granted a privileged position on the understanding that it would behave in ways that benefited society—is both legitimized and formalized. In this way, medicine's professional obligations become both logical and understandable. Third, it implies that there will be consequences if the terms of the contract are not met. If medicine fails to meet legitimate societal expectations, society will wish to change the contract, perhaps withdrawing some of medicine's privileges, as happened in the United Kingdom. However, the converse is true. If physicians feel that their legitimate expectations are not met, individual physicians and the profession will react. One possible response is a change in physician behavior. For example, the physician entrepreneur may emerge (Hafferty and Castellani, 2010).

Finally, the concept of the social contract can be beneficial in teaching professionalism to current students, trainees, and practitioners who no longer respond to obligations framed as "thou shall" or "thou shall not" (Twenge, 2009). They wish to know why they must behave in a certain way, and framing the discourse terms of a social contract provides a logical answer.

William Sullivan, a social scientist who is a firm believer in the presence of a social contract between medicine and society, is worth quoting to close this paper. "The expectations of high standards of competence coupled with public responsibility have been established in large measure through the profession's own efforts during the past century to establish secure social contracts with the public. The contract has been worked out gradually in statute and custom. In the process professionalism has evolved as a social ideal" (Sullivan, 2005). Negotiating the social contract within this context should be a principal objective of the medical profession and can assist the profession as it attempts to meet the ideal.

II.3
INTERPROFESSIONAL PROFESSIONALISM: LINKING PROFESSIONALISM AND INTERPROFESSIONAL CARE[2,3]

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Introduction

Professionalism has typically been defined as a set of noncognitive characteristics (such as empathy) or as a set of humanistic values and behaviors through which clinicians express a commitment to excellence and compas-

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[3] The authors wish to acknowledge the members of the Interprofessional Professionalism Collaborative (IPC), whose unique and ongoing collaboration has laid the conceptual groundwork for this paper. The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper. To learn more about the IPC, visit http://interprofessionalprofessionalism.weebly.com.

sion (Stern, 2006). Its importance is underscored by the widespread adoption of language and policies by associations, accreditors, and regulatory agencies across the health professions that require clinicians to be trained and assessed on professionalism (Greiner and Knebwl, 2003). Yet, a critical conceptual gap remains in defining how professionalism contributes to improved patient outcomes, especially in the context of interprofessional care environments.

Elucidation of the link between professionalism and interprofessional care is an important issue to examine. Although contemporary clinicians do not practice in social isolation, development of the professionalism concept has neglected its link to collaborative care. In the contemporary context, professionalism contributes to safe, high-quality care primarily by supporting and fostering effective interprofessional care (Gilbert et al., 2010). We believe that persistent disciplinary insularity in health professions education has prevented this connection from being adequately emphasized.

The Interprofessional Professionalism Collaborative

In 2006, representatives of seven American national professional and educational groups convened to explore the concept of professionalism that could transcend and bridge the health-care professions. The group's initial motivation was to identify or develop public-domain educational and assessment tools to promote professionalism. The group quickly recognized that there were many parallel, overlapping efforts to support professionalism within professions, but that little work had been done to develop a shared professionalism framework across professions. By 2009, the group expanded to 11 organizations representing 10 doctoral health professions: optometry, dentistry, psychology, veterinary medicine, pharmacy, physical therapy, audiology, nursing, and allopathic and osteopathic medicine. Currently, this group is called the Interprofessional Professionalism Collaborative (IPC) (Clark, 2006). The IPC began to focus on defining interprofessional professionalism and identifying its behavioral components. Though the group was kept small to foster interaction, collaboration, and consensus building, an effort was made to include a broad range of health professions to ensure the generality of the resulting model. It was expected that there would be opportunities for feedback and contributions from other professions through presentations, discussions, surveys, and publications.

Interprofessional Professionalism

The terms "interprofessionalism" and "interprofessional health care" are used primarily to describe the delivery of care by members of differ-

ent health professions (Stern, 2006). Although these concepts describe the interactions between health professionals as the context in which interprofessional professionalism arises, they do not capture the idea of this distinct phenomenon in its entirety.

Likewise, "interprofessional professionalism" is distinct from professionalism. Professionalism, as defined within disciplinary "silos," can be misused to justify unchallenged autonomy and can inhibit cooperation across professional boundaries. Interprofessional professionalism, in contrast, is a transcendent phenomenon that works across the professions to support coordination in communication and care for the benefit of patients, clients, and families.

Interprofessional professionalism overlaps conceptually with broader definitions of professionalism, and it builds upon previous research on team functioning, interprofessional education (McNair, 2005; Clark, 2006), interprofessional care, and relational coordination (Gittell et al., 2008). The IPC's goal is to develop and articulate those elements of professionalism that are uniquely relevant to collaboration across health professions.

The IPC's vision is that when interprofessional professionalism is practiced by all professions, it will improve health care quality and outcomes for patients/clients, will promote a culture that values and fosters individual competence, and will enhance education and practice environments. Borrowing language from Stern (2006), the IPC defines "interprofessional professionalism" as

> consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of altruism, excellence, caring, ethics, respect, communication, and accountability to achieve optimal health and wellness in individuals and communities.

Though these concepts appear in various definitions of professionalism created within professions, interprofessional professionalism provides a different emphasis that underscores communication, collaboration, and negotiation across professional boundaries. This emphasis highlights professionalism as a resource for promoting skills, values, and organizational structures that facilitate interprofessional care. Interprofessional professionalism is distinct in focusing on competencies, values, and norms that multiple professions have identified as critical to promote effective interactions in the provision of care. The vignette in Box II-1 describes a healthcare scenario that exemplifies interprofessional professionalism in action.

Professionalism is not an end in itself, but supports the ultimate goals of patient/client/family-centered care, quality, and patient safety. While broader discussions of professionalism frequently endorse these outcomes, they seldom emphasize cooperation among members of multiple health

BOX II-1
Interprofessional Professionalism Vignette

A team of health professionals consisting of an internist, nurse, dentist, physical therapist, optometrist, and nutritionist are collaboratively managing [patient] JP's obesity and diabetes care with secondary complications related to dental, visual, and skin integumentary conditions. The team is a shared collaborative in which leadership of and membership within the team are not based on hierarchy or profession but shift in response to JP's needs.

Recently, an ethical dilemma has surfaced among the health professionals in relation to the management of JP's care. Following a health crisis, one of JP's practitioners has become frustrated and communicated to the team that she proposes to "fire" JP for poor adherence to his treatment. When challenged about this decision, the practitioner argues that she does not have time to deal with "patients who are not interested in helping themselves." While the team members respect and value each others' professional autonomy, expertise, and cultures, they identify that a candid dialogue about this ethical concern is warranted. Subsequent discussion reveals that an additional, though not critical, concern is that the patient is unable to pay for his care. Because the practitioner in question is a partner in a small practice with limited resources, she is frequently under pressure from other partners to drop patients who cannot pay for services. She believes that she cannot ethically divert resources from "more deserving" patients to JP, who does not appear to be committed to getting better. Some individual members of the care team vehemently disagree with this posture. But rather than requiring each team member individually to make adjustments to deal with the implications of the decision, the team takes a collaborative approach to this problem. During a conference call, the team members openly discuss the situation and begin exploring alternative arrangements that can be made to provide JP with the needed care.

One of the team members proposes to have a frank discussion with JP about his needs, goals, and resources. JP's low income and low educational status emerge as significant contributing factors to his poor adherence to treatment. He cannot afford his medication, does not understand how it works, and therefore only takes it sporadically. He also has poor nutrition and limited opportunities to exercise. In an e-mail exchange, these problems are raised and the team discusses how failure to address JP's socioeconomic issues may now be detrimental to his care. The team elects to shift priorities, resulting in a plan of care that is based on a more realistic assessment of JP's goals, needs, and resources. The clinician who wants to drop JP is undeterred; however, one of the team members persuades her to continue care until JP can be referred to a different practice. Others help JP enroll in affordable and accessible community-based education and health services to help him manage his care more effectively. Once a practice is found that will accept JP as a new patient, the team builds ties with the new care providers, explains JP's clinical history, and integrates the new providers into the team's ongoing activities to implement the new plan of care.

professions as a mechanism to achieve them. In the context of increasing complexity of care, narrower definitions of professionalism may actually undermine quality and safety by distracting clinicians from the need to collaborate effectively across professions.

Interprofessional professionalism, in contrast, promotes effective collaboration and communication—fundamental requirements for the delivery of safe, high-quality patient/client/family-centered care in contemporary practice settings.

Concluding Comments

The interprofessional professionalism concept is ripe for development. The IPC plans to develop a tool kit including teaching materials, assessments based on observable behaviors that are targeted at the level of entry into the health professions, and links to other resources. We welcome research and collaboration to further refine the interprofessional professionalism concept and integrate it with national and international health policy initiatives and competency frameworks.

II.4
A PATIENT PERSPECTIVE

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"Where's the patient?" This is the first question one asks upon reflection of the experts' presentations at the Institute of Medicine (IOM) workshop Establishing Transdisciplinary Professionalism for Health. Presenters put much thought and analysis into the roles professionals play in "collaborative care," "interprofessionalism professionalism," "transdisciplinary practice," and related themes. However, the patient's role, perspective, and very being was notably absent from the discussions as they progressed through the day, while a concerted effort was made to include questions from students.

Patients need to be a part of the iterative process because they are stakeholders in the process. In fact, several laws, regulations, and policies guarantee this role for patients. For example, under federal law, the governing boards of federally qualified health centers (FQHCs) must be consumer-driven, with at least 51 percent of members coming from consumers of the

FQHC.[4] Under the Patient Protection and Affordable Care Act, for a hospital to maintain its tax-exempt status, it must conduct community health needs assessments, and the assessments must include members of medically underserved populations or patients.[5]

Patients are integral members of the transdisciplinary health care team—not an afterthought. Health professionals of all flavors and students in all fields should be taught participatory medicine as the standard of care. Participatory medicine is a movement in which networked patients shift from being mere passengers to responsible drivers of their health, and in which providers encourage and value them as full partners (E-Patient Dave, 2013). Participatory medicine supports the notion that listening to another professional or caregiver's opinion of the patient is not as valuable as the firsthand information one obtains from most reliable source of that information—the patient (or the caregiver when the patient is unable to convey the information).

When patients become the drivers of their health care, they are responsible for becoming "e-patients." E-patients are patients who are equipped, enabled, empowered, and engaged in their health and health care decisions (Ferguson, 2007). The patient–provider relationship becomes an equal partnership between e-patients and health providers and the systems that support them (Ferguson, 2007). Angelina Jolie is a recent example of a famous e-patient. When faced with a high probability of developing breast cancer as a result of her BRCA gene status, she became equipped, enabled, empowered, and engaged in her health and health care decision making. Armed with knowledge, she made the decision to have a prophylactic double mastectomy (Jolie, 2013).

Tom Ferguson was the thought leader who developed the concepts of participatory medicine and the e-patient movement together with the E-patient Scholars Working Group after Ferguson lost his battle with cancer (Ferguson, 2007). In 2001, in its groundbreaking report *Crossing the Quality Chasm: A New Health System for the 21st Century*, the IOM listed "patient-centeredness" as one of six key needs to improve the quality of health care in the United States (IOM, 2001). The IOM defined patient-centeredness as "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (IOM, 2001, p. 40). Ferguson put that concept of patient-centeredness on steroids, moving from respect and responsiveness to patient's values to respect for the patient's role as an equal member of the team.

The Center for Advancing Health defines patient engagement as "actions individuals must take to obtain the greatest benefit from the health care services available to them" (Center for Advancing Health, 2010, p. 2).

[4] Public Health Service Act § 330, 2010.
[5] Affordable Care Act § 9007, 2010.

Evidence shows that patient engagement improves health outcomes, lowers costs, improves patient care, and decreases medical errors (Center for Advancing Health, 2010; James, 2013). Evidence also shows that patients with chronic conditions who are engaged in their health care are more likely to adhere to treatment regimens (James, 2013). The cumulative findings are so striking that Kish has called engaged patients "the blockbuster drug of the 21st century." However, "engagement does not mean compliance" (Gruman, 2011).

My Story

I am an e-patient. I am equipped, enabled, empowered, and engaged in my health and health care decisions (Ferguson, 2007). With two chronic conditions almost no one has ever heard of, I have had to become an expert in my conditions. I even became a certified pain educator so I would be knowledgeable about my conditions. I frequently consult with Dr. Google and Dr. Twitter. I rely on social media to learn about and share information about my conditions. On one social media site, I network with more than 8,000 people worldwide who also have one of my conditions. From this group, I learn about the latest research and treatment for my condition. I often share this information with my health care providers.

I read blogs by people who blog about pain issues and general patient advocacy issues,[6] and I follow people on Twitter who tweet about these issues as well.[7] I also follow Pinterest for books about patient advocacy issues written by members of the Society for Participatory Medicine.[8]

I take my medical records with me to my medical appointments. I explain my two chronic conditions to the providers, and leave them copies of published research or information I obtained online. I also bring a copy of my genetic metabolite testing with me. With this in hand, when I tell providers that I can only take one particular pain medication, I can assure them that my request is not drug-seeking behavior but an evidence-based decision. Often, this occurs after I explain genetic metabolites and genetic metabolite testing to the provider. As an e-patient, I play a significant role in the transdisciplinary team that treats me.

I am also a caregiver. My 93-year-old mother has been diagnosed with terminal lung cancer 5 times during the past 12 years. However, in reality, she has never had cancer at all. My mother was in the Army in World War II. She was stationed where prisoners of war arrived from Europe.

[6] See, e.g., http://www.cfah.org/blog and http://www.painaction.com.

[7] See, e.g., http://twitter.com/PainResource and http://pinterest.com/s4pm/blogs-written-by-s4pm-members.

[8] See http://pinterest.com/s4pm/books-written-by-s4pm-members.

The prisoners were not in the best of health when they arrived. On many occasions, they lined everyone up and gave them the "inoculation du jour." During this process, my mother was exposed to tuberculosis (TB). She never knew she actually had TB, but the evidence remains in my mother's lungs—encapsulated TB.

Every time my mother sees a new doctor and/or has a chest X-ray, the doctor informs her that she has terminal lung cancer. Why? The reason is simple. None of the doctors who have diagnosed her cancer accepts caregivers as part of the transdisciplinary team. If other team members do not consult caregivers and respect them as members of the transdisciplinary team, they will not have the proper history and other information necessary to properly diagnose and treat the patient.

As a caregiver, I keep 12 years' worth of imaging with me and a carefully prepared history of my mother's health conditions. I have had to beg radiologists to compare my mother's current imaging film to previous ones or simply read the previous reports—something one would think is pretty obvious in light of her history. Like other patients learn, I have learned that the existence of an electronic health record is no guarantee that it will be read.

I have had many arguments with physicians who wanted to biopsy the "tumor" (and expose my mother to active TB), remove her lung (at 85+ years old with a pacemaker), or put her in hospice with a diagnosis of terminal lung cancer (which she does not have). Without a caregiver on the transdisciplinary team, my mother would have died from one of the good-intentioned physicians' treatment plans, based on these repeated absurd diagnoses. As I tried to explain to a misdiagnosing physician on one occasion, "with a doubling rate of 3 months, if my mother had this alleged lung cancer tumor the first time she was incorrectly diagnosed by a physician who would not listen to me recite my mother's history, her tumor would be the size of the entire state of Florida by now." As a caregiver, I play a key role in the transdisciplinary team that treats my mother.

What Does "Transdisciplinary" Mean to Patients?

So what does "transdisciplinary" mean to patients? Patients see many providers who do not talk to one another. Efforts to seek transdisciplinary teams puzzle patients when we cannot get one provider to talk to another provider in the same profession. Patients cannot get providers to read their histories. Further, patients see more of a transdisciplinary team than the presenters at the IOM workshop reflected. The presenters were mostly physicians, and reality today includes primary care providers who are nurse practitioners and physician assistants, plus many other providers who are on the team. Patients spend more time with occupational and physical therapists, speech pathologists, and providers other than physicians.

Several presenters spoke of the social contract as a contract with "society" or a contract with "the public." Patients view the social contract as a contract with patients—as a duty owed directly to them as patients, as opposed to society or the public as a whole. Health care is personal. Public health is a contract with society.

Several presenters raised the issue of professionalism as behaviors versus beliefs. Patients see professionalism as behaviors. Although these may be the outcomes of behaviors based on one's beliefs, patients are concerned with the outcome—the behaviors. How is the health care provider treating me?

Speakers stressed professional autonomy as an issue within the context of the social contact and the development of a transdisciplinary team. However, no one mentioned patient autonomy as a key principle. Patients want to make decisions about their own care. Patients want a transdisciplinary team that empowers them and allows them autonomy.

Patients want ethical behavior from all team members. As the Tuskegee syphilis experiments caused mistrust of the medical establishment among African Americans due to ethical breaches, Rebecca Skloot's recent best-seller *The Immortal Life of Henrietta Lacks* may reinforce that distrust among a broader audience (McCallum et al., 2006). Providers should be prepared to discuss these issues with patients, especially if they are involved in research.

So, what else do patients want? Patients want respect. They want to be part of the transdisciplinary team. They want a role in decision making. They want health care providers to listen to them. Patients want information. In fact, there is a movement on Twitter with its own hashtag, #GMDD, which stands for "Gimme My Damn Data." Some of the #GMDD followers are patients with implanted devices that transmit data to which they have no access (Campos, 2012).

Patients want explanations in language they can understand. Patients do not understand terms like "magnet hospital" or "interprofessional professionalism." Patients want the privacy to which they are legally entitled. Patients who are individuals with disabilities prefer to be referred to as "people," or "individuals" rather than "patients." Patients want providers to consider context in treating them. What is their home environment? Do they have transportation to get to the provider to whom you referred them? How do they communicate?

Patients want a seat at the table, board, and committee—whether that is a hospital or academic program. As e-patient Dave stresses, "let the patient help" (E-Patient Dave, 2013). Patients can help with diagnoses by providing their history to providers and team members willing to listen to them. Patients can help with medical education. Allow patients with real ailments, disabilities, or chronic conditions to serve as the "subject" or "patient" in history and physical classes as a "real patient" instead of a paid actor.

Some speakers spoke of the problem of finding patients to help improve health care or participate in research. The answer to this is simple—patients are ubiquitous. Patients are found in waiting rooms. They are community leaders. Hospitals, university health centers, and others are all familiar with their "frequent fliers." FQHCs are a good source for patients because their boards much come from 51 percent of the consumers they serve—patients. Providers and institutions that want input from patients can also find them in online communities, through social networking sites such as Twitter, PatientsLikeMe.com, Inspire.com, groups.yahoo.com, Facebook, and others. One also can contact disease- or chronic condition–specific groups such as the Multiple Sclerosis Society. The Society for Participatory Medicine also makes connections between its patient members and health systems, universities, app and device developers, and others.[9]

Final Thoughts

I often hear "disability" used in the context of a bad outcome. Disability is not a bad outcome or result. For many people with disabilities and chronic conditions, it is a way of life. Health care providers need to understand that ethically and legally, people with disabilities and chronic conditions are entitled to be treated like everyone else.

The World Health Organization measures health in terms of participation. Transdisciplinary team members should consider this. What do the patients do? Do they participate in the life and rhythm of their communities? What would they like to do? A provider's desired outcome is not necessarily the patient's desired outcome. How can the transdisciplinary team, which includes the patient, facilitate participation?

Another way of looking at the social contract from a patient perspective is to understand that the social contract facilitates the quality of life of individual patients. Quality of life is a measure of participation or occupational autonomy—the ability to do what you want to do when you want to do it (Kornblau, 2006). As a member of the transdisciplinary team, individuals or patients can inform the team members of their goals and desires, and the social contract helps them achieve their goal.

The bottom line is that individuals, whom the medical model refers to as "patients," are not bystanders in their care. The evidence shows that engaged patients improve their care, decrease medical errors, and, as part of the transdisciplinary team, can help to improve health care. The most important thing for members of the transdisciplinary team to remember is that patients matter.

[9] See http://www.participatorymedicine.org.

II.5
THE CASE FOR INTEGRATING HEALTH, WELL-BEING, AND SELF-CARE INTO HEALTH PROFESSIONAL EDUCATION

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Historically, the emphasis in health professional education has largely mirrored the focus of the health care system and the perceived needs of society—the diagnosis and treatment of disease and disability. Physicians, nurses, physical therapists, mental health care providers, and the other allopathic practitioners have been educated within their disciplines with minimal to no interaction with other professions. Historically, they have been educated to function in a hierarchical system in which the patient is expected to be a passive recipient of care. Although the five licensed complementary and alternative medicine (CAM) fields (chiropractic, acupuncture, naturopathic medicine, direct-entry midwifery, and massage therapy) are not as hierarchical as conventional medicine and more often approach patients as partners in healing, they too have been mostly educated in silos. Although much of the education and training in conventional medicine occur within hospitals in the United States, the licensed CAM fields are educated primarily in outpatient clinics. This differs from countries such as China where acupuncture and Traditional Chinese Medicine (TCM) providers are trained in TCM hospitals.

Within the allopathic health community, although nursing has had more of a whole-person focus than some of the other disciplines, and principles of community and public health have been integrated into medical, nursing, and other health professions curricula, the overwhelming focus has been on disease and the acquisition of technical knowledge and skill. Health promotion, disease prevention, well-being, and the importance of self-care have been largely absent. With a few exceptions, although institutions educating professionals in integrative health disciplines, which include the five CAM fields and some conventional medicine practitioners, have had significantly more focus on the whole person and on health and wellness, self-care continues to be absent from or minimal in their curricula as well.

Impact of Stress on Health Professional and Patient Outcomes

Overall, within the health care fields, the lack of emphasis on self-care contributes to health professionals unprepared for the rigors and stress of practice. Burnout, a response to stress characterized by emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (Maslach and Jackson, 1982), is rising. According to a recently-published national survey of physicians (Shanafelt et al., 2012), almost half of medical doctors (45.8 percent) reported at least one symptom of burnout, a significantly higher rate than among the general working population. Physicians in frontline care such as emergency medicine, general internal medicine, and family medicine reported burnout levels near 60 percent. Studies have frequently reported moderate to high levels of burnout among nurses (Oehler and Davidson, 1992). In a large national study, more than 40 percent of hospital staff nurses scored in the high range for job-related burnout, and more than 1 in 5 nurses reported that they intend to leave their hospital jobs within 1 year (Aiken et al., 2001). In addition to the detrimental impact of burnout on health professionals and the costs associated with illness, lost productivity, dissatisfaction, turnover, and premature exit from the profession, burnout also has an adverse impact on patient care. Williams et al. (2007) found that stressed, burned out, and dissatisfied physicians report a greater likelihood of making errors and more frequent instances of suboptimal care. In a recent study linking hospital infection rates and nurse staffing and burnout, Cimiotti et al. (2012) reported that hospitals in which burnout was reduced by 30 percent had a total of 6,239 fewer infections, for an annual cost savings of up to $68 million. Although the published literature is scant in documenting the incidence of burnout among integrative health care providers, anecdotal evidence suggests that the phenomenon of burnout is endemic among all health professions.

Why Well-Being?

Well-being is not a new concept, but it has been overshadowed by the focus in many health care systems around the world on disease and pathogenesis (factors that cause disease). In 1946, the World Health Organization defined health as a state of complete physical, mental, and social well-being—not merely as the absence of disease or infirmity. More than 30 years ago, Aaron Antonovsky (1987), a professor of sociology, coined the term "salutogenesis" to describe an approach that focuses on factors that support human health and well-being, rather than on factors that cause disease. Although pathogenesis rather than salutogenesis has dominated conventional medicine, it is interesting to note that indigenous healing tra-

ditions throughout the world have always focused on well-being and health as well as on the diagnosis and treatment of disease.

Well-being has been the object of study in a broad array of disciplines. Psychology, sociology, public health, and economics have all spawned a variety of theories about the nature of well-being and how to measure it, as well as a long list of possible contributing factors. The Gallup organization (Rath, 2010) has identified five elements of well-being—career, social, financial, physical, and community—that appear to be universal across faiths, cultures, and nationalities. Rath reports that although 66 percent of people are doing well in at least one of these areas, only 7 percent are thriving in all five.

Martin Seligman, father of the positive psychology movement and author of *Flourish* (2011) writes that his goal was to shift the focus of psychology from trying to relieve misery to understanding well-being. He describes well-being as an active state of exploring what makes life worth living and then building the enabling conditions of such a life. According to Seligman, there is no single measure that captures well-being; rather, there are a number of elements that contribute to it, and the gold standard for measuring well-being is flourishing.

In educating the next generation of health care providers and designing new systems of education and care, a fundamental shift is required that goes well beyond shifting from disease to health or from illness to wellness (Kreitzer, 2012). A shift to a focus on well-being would represent a transformative societal change that would touch every aspect of people's lives and the communities in which they live. As noted in Figure II-5, well-being is impacted by a number of interrelated factors that contribute to flourishing, including

- **Health:** physical, mental, emotional, social, and spiritual health
- **Purpose:** meaning and a sense of purpose
- **Relationships:** love and intimacy, caring, and connectedness
- **Community:** resources, social fabric, diversity
- **Safety and security:** living with ease versus living in fear, socioeconomic factors
- **Environment:** clear air and water, freedom from toxins, and access to nature

Teaching health professional students from a well-being perspective would reframe their role as one of supporting and maximizing human and system capacity and potential, whether they are diagnosing and treating disease or focusing on ways to promote salutogenesis. A curriculum that focuses on self-care and uses well-being as a lens could be an innovative strategy both for teaching content on well-being and self-care and for pre-

FIGURE II-5 Model of well-being.
SOURCE: Kreitzer, 2012.

venting and reducing burnout and promoting interprofessional education designed to lead to collaborative care.

In a recent *Wall Street Journal* article titled "The Simple Idea That Is Transforming Health Care," Landro (2013) articulates the benefits derived from a perspective that focuses on well-being and quality of life rather than on disease alone, noting that numerous studies show that when people have a greater sense of well-being, they have fewer hospitalizations and emergency room visits, miss fewer days of work, and use less medication. They are also more productive at work and more engaged in the community. Simply put, well-being is critically important in motivating people to make changes in their lives to improve the way they feel and function.

Advancing Well-Being and Self-Care in Health Professional Curricula

The topic of self-care is rarely included in required curricula for programs preparing health professionals. In a document titled *Core Competencies for Interprofessional Collaborative Practice* (IPEC, 2011), sponsored by six associations affiliated with education of conventional health care providers (allopathic and osteopathic medicine, dentistry, nursing, pharmacy, and public health), a number of interprofessional competencies are

identified that focus on areas such as values and ethics for interprofessional practice, roles and responsibilities, interprofessional communication, and teams and teamwork. Self-care is not implicitly or explicitly identified as a core competency. Content on self-care is being offered in elective formats, often as mind/body skills training or as part of a popular course in medical school called *The Healer's Art*. The issue of stress, burnout, and lack of self-care is such a profound problem, however, that groups such as the AMA are including resources on their website that focus on physician health and resilience.[10]

Parallel to the efforts of the Interprofessional Education Collaborative (IPEC), which produced the competencies noted above, the Academic Consortium for Complementary and Alternative Health Care, which represents the five licensed CAM fields, engaged in a process of identifying core competencies for practicing in an integrated health care environment (ACCAHC, 2011). In addition to endorsing the competencies developed by IPEC, several competencies were added, including the ability to demonstrate personal behaviors and self-care practices that reflect optimal health and wellness.

Adding required curricula on health, well-being, and self-care at every level of health professional education would be a bold and transformative innovation that could both improve the health and well-being of care providers and better prepare them to focus on these issues as they care for patients. A well-being curriculum could focus on topics such as

- determinants of well-being;
- self-awareness and resilience—mindfulness, mind/body skills, purpose, spirituality;
- stress-reduction skills—mind/body, meditation, tai chi, yoga, QiGong;
- healthy lifestyle behaviors—eating, exercising, sleeping, managing stress, work/life balance;
- healthy relationships—personal and collegial; and
- overall socioeconomic and social justice (safety and security).

Although it is challenging to imagine overcoming institutional and logistical barriers, it would be ideal if content promoting a well-being approach could be taught in an interprofessional context that would promote team-based care and collaborative practice.

[10] See http://www.ama-assn.org/ama/pub/physician-resources/physician-health.page.

Summary

Education of health care professionals has traditionally occurred in venues in which students have had limited exposure to other fields, and rarely has self-care been a focus within required curricula. Given the global challenge to improve health outcomes and reduce the cost of care, a focus on health, well-being, disease prevention, and health promotion is both critical and timely. It would help students improve personal health outcomes and equip them with the knowledge and skills to educate patients on how to better assume personal responsibility for their health and well-being. Well-being content is ideally suited for interprofessional education.

II.6
INNOVATIONS IN TEACHING ABOUT TRANSDISCIPLINARY PROFESSIONALISM AND PROFESSIONAL NORMS

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Health professional training and socialization has traditionally focused on the knowledge, skills, and attitudes needed by each health profession to perform its respective duties in caring for patients. This siloed approach to education and training typically includes little information or training on the work of other professions and how they fit together to make for successful team practice. We need to find new approaches to teach about transdisciplinary professionalism, defined for the purposes of the IOM workshop on Establishing Transdisciplinary Professionalism for Health as "an approach to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, worthy of the trust of patients and the public." We want methods to demonstrate to all health professional students: shared understanding, new forms of leadership, team support, and communication (Olueliyawa et al., 2009). This paper will offer some thoughts and examples drawn from training to integrate behavioral health into primary care and other areas of health care.

One of the first issues in changing the attitudes and skills of the health professionals of tomorrow involves how they are selected in the first place—admissions and hiring. Traditionally, medicine and psychology select people who value autonomy—highly competent individuals who prefer to control

their own work and distrust administration. Selecting for these attributes produces the workforce we have today. The alternative is to include in search and admissions committees members from other health professions, as well as patients, and select for mission-centric, team-ready, emotionally intelligent faculty and students—people who will align their practice with the values of transdisciplinary professionalism. After we have identified such students and professionals, we need to help them develop both strong professional identities and strong collaborative skills—whether they are physicians, psychologists, nurses, nutritionists, pharmacists, physical therapists, secretaries, or medical assistants. There are many barriers to this approach, ranging from financial segregation to the tribalism that is inherent in each discipline's socialization—tribalism that can result in an "I'm okay, you're not" approach to other disciplines.

Challenging Tribalism: Consciousness-Raising Exercise and Video

One exercise to raise the consciousness of professionals working to integrate psychologists into primary care is to ask the primary care professionals to provide adjectives that represent the public's stereotypes of psychologists, then ask the psychologists to do the same for physicians. People typically go for more of the negative stereotypes, with just a few of the positive. This exercise has been used hundreds of times[11] in more than 20 countries, including China, Germany, Mexico, and Romania. These are countries with vastly different cultures, languages, and systems to finance their health care. Surprisingly, the adjectives are universal. As a sampling: physicians are cold, controlling, arrogant, pressed for time, and technicians; psychologists are cerebral, impractical, touchy-feely, weird, and, according to a physician in London, "right-brained and left-winged." If these stereotypes affect health professional behavior in any way, it is no wonder that teams are unable to effectively respect or work together.

A brief teaching video for providers illustrates this point further. The video shows a real family physician, Thomas Campbell, trying to work with a real psychologist, Susan H. McDaniel, to care for a fictitious patient (McDaniel and Campbell, 1986). Questions after the video include "Who is most realistic? The physician or the therapist?" Typically, the physicians say that no physician really behaves the way Campbell did in the video, but assert that the therapist was very realistic (though perhaps not crazy enough). The psychologists say that no psychologist is that nutty but argue that the physician was quite realistic (though perhaps not harsh enough). In mixed audiences, this response then produces good data for discussion about how each profession can be perceived. This satirical video articulates

[11] By Thomas Campbell, M.D., and Susan H. McDaniel, Ph.D.

the many ways we can go wrong in trying to work together and is one way to address professional tribalism—by elevating, examining, and challenging it. This teaching model can be extended to stereotypes of all health professions.[12]

Improving Interdisciplinary Team Communication: The Team Collaborative

Eduardo Salas, a psychologist who studies team functioning across industries, including air transportation, the defense system, and health care, emphasizes the importance of what he calls "task interdependence." Salas found that team training requires information, demonstration, practice, and feedback, but the most important of these elements are practice and feedback (Salas et al., 2005). An example of training that focuses on these elements comes from the University of Rochester Department of Family Medicine's "Team Collaboratives," a monthly meeting in which all teams explicitly work on team relationships and communication skills and share quality-improvement projects so that they can be generalized across the practice. In consultation with Stephen Schultz, residency program director, and a committee of staff advisors, Tziporah Rosenberg, a family therapist, has been running these interactive meetings of 120 people since she finished her postdoctoral fellowship in 2008. She provides information, addresses process, teaches task interdependence, models transdisciplinary professionalism, and highlights successes in an entertaining format.

Often, the Team Collaboratives focus on an essential aspect of professionalism: communication. For example, in one meeting, Rosenberg directed the teams to play the children's game of Telephone. She gave each team the following message to convey down the line of people, each member whispering into the ear of the next:

> *Tuesday last week, there was the most incredible rainstorm. It seemed like it would never stop. I remember it was Tuesday because my car was in the shop and I needed to catch the bus; I started on the 11 and picked up the number 1 before I finally got the 14 to get to the mall. I needed to do some last-minute back-to-school shopping.*

By the end, most communications were down to about 8–10 words with few of the significant points. For example, one team's final communication was *It was raining, it was raining. I had to catch the bus.*

[12] A similar satirical video of a large interdisciplinary team case conference was produced as part of the Primary Care Policy Fellowship. See McDaniel et al. (1999).

In the second round, the message included affect:

> *Last week on Tuesday, the day of the big rain, you told me that you were going to take care of that issue that I talked to you about. I told you it was really important to me. You said it would be no problem, and you could finish it before you left for the day, but you didn't. I'm confused about what happened and frustrated it's not done yet.*

One group's final communication was *You said you would take care of it, but you didn't.*

After a large group discussion about the problems with multiple communications and how emotion affects them, the entire Team Collaborative developed "Communication Pearls" they could all agree to:

1. Keep it short.
2. Actively check for understanding.
3. Electronic health records really are better for some communications.
4. It is important to be kind when giving feedback.

Team Trust Exercise: Tell Us About Your Background

Patrick Lencioni, a business consultant, focuses on corporate team building. His five prerequisites of great teams are trust, conflict management, commitment, accountability, and a focus on results (Lencioni, 2002). Trust, the foundation of good communication, requires vulnerability to be open with one another around mistakes, weaknesses, and fears. It is important to clear out political and hidden motivations. Lencioni emphasizes that for trust to develop across disciplines, it is especially important for leaders not to promote the myth of invulnerability.

Sharing personal information helps to promote trust and provide new perspectives for individuals working together in teams. Lencioni (2005) suggests telling each other where you grew up, your birth order, your cultural background, and an important or challenging thing you had to deal with in childhood. The following is an example from McDaniel:

> *I grew up in South Florida, the oldest of three girls in a Southern WASP [White Anglo-Saxon Protestant] family. One of the most influential events for me was racial desegregation of the schools when I was in junior high. It challenged the stereotypes I had heard all my life, set me on a path to study stereotypes in college, and led me to work on cross-disciplinary teamwork in health care.*

Another example involved a physician who was quite disruptive in team meetings. In this exercise, he said:

> *I grew up in a poor neighborhood in Jamaica with a lot of illegal activity, racism, and violence. I learned to hurt people in order to survive, but came to realize this was wrong. The hardest thing for me has been to socialize myself, to learn not to behave that way anymore, to treat people with respect.*

This revelation changed the way his teammates understood him and changed the way he functioned in the team as a result.

Conflict-Management Exercise: How Did Your Family Air Differences?

Managing conflict is a key competency for transdisciplinary professionalism. Productive, even passionate, debate is important for healthy team functioning. Getting all ideas out on the table and being able to control discomfort, rather than dismiss differences, is more likely to yield positive outcomes. This kind of communication requires patient, active listening, and basing arguments on substance, not politics, pride, or competition. It means going after the best solution, rather than trying to win.

An exercise to work on conflict management begins with the following questions: "How did your family air differences? What are your preferences about acceptable and unacceptable behavior during debate and disagreement? (including language, tone of voice, emotional content, and whether you tend to participate or not)" (Lencioni, 2005). After discussion, the team works to develop its own norms for managing conflict and for what is acceptable and unacceptable behavior.

Issues of hierarchy and power inevitably arise in interdisciplinary work. We want a collaborative practice in which the power of each party is fully recognized—the power of the physician, psychologist, and other health professionals to diagnose and suggest treatment; the power of the patient to make sense of the illness experience and decide and embark on treatment; and the power of the family or social group to provide a healing environment.

In a paper called "Why Men Resist," William Goode (1980) described how the sociology of superordinates states that there are predictable feelings and behaviors experienced by those higher in the hierarchy as well as by those perceived as lower. In particular, those who are higher tend to experience their position in terms of feeling burdened and responsible rather than powerful, blessed, or lucky. Those who are lower can feel that their talents or accomplishments go unrecognized. They are vulnerable to feeling invisible, unappreciated, disrespected, and eventually resentful.

It is important to study what counteracts these problems. In his book *Outliers*, Malcolm Gladwell (2011) gives a compelling description of how Korean Air transformed its safety record from one of the worst to

one of the best by understanding how culture and hierarchy had resulted in flawed and incomplete cockpit communication. Desperate to fix the problem, Korean Air examined cockpit recorders and found that, consistent with their culture, power and authority were never challenged. They found that, worldwide, planes are safer when the least-experienced pilot is flying, because it means that the second pilot is not afraid to speak up. After identifying the problem, Korean Air set about creating a different kind of culture in the cockpit, one in which hierarchy is flattened, first names are used, and the copilot is rewarded (rather than dismissed) for disagreeing or speaking up. The same principles of communication and flattened hierarchy have been found to increase safety in surgery and other health care teams.

Encouraging Feedback: A Physician Communication Coaching Program

Many issues of power and communication are taught through the so-called hidden curriculum in professional training, that is, what students see modeled by professors, regardless of what is taught formally (Hundert et al., 1996). Changing the hidden curriculum means creating a culture that welcomes, rather than avoids, feedback.

To increase communication skills and change the hidden curriculum around issues of professionalism, McDaniel developed and directs a physician communication coaching program at the University of Rochester. This program was developed in response to patient complaints and patient experiences as a driver for reimbursement.

To begin this program, leadership endorsed a set of professionalism values (integrity, compassion, accountability, respect, and excellence), and physician faculty articulated 32 physician behaviors associated with these values. They then voted for the top eight, and McDaniel culled these down to three primary behaviors associated in the literature with improved quality and patient satisfaction (Gerteis et al., 1993; Stewart et al., 2000; National Quality Forum, 2003; Wolf et al., 2008): (1) introduce yourself and your role to new patients and families; (2) ask about patient and family concerns early in the interview; and (3) check for understanding about the diagnosis and treatment plan. Trained coaches complete an expanded version of the Cambridge Patient-Centered Observational Coding sheet (Kurtz and Silverman, 1996) for each physician–patient encounter. The observation period typically lasts 4 hours. A report is written to provide quantitative information (e.g., "You asked about the patient's concerns directly with 6 of 10 patients"; average time spent per encounter), qualitative descriptions (e.g., "Your relationship-building skills are very strong. You typically ask each child what their career plans are."), and a list of strengths and concrete behavioral suggestions for improvement. The report

is then sent to the physician and is not shared with anyone else. After reading and digesting the report, the physician meets with the coach to discuss his or her reactions, what was expected, what was a surprise, and plans for improvement (including a future coaching session).

This program started with McDaniel coaching the senior associate deans, clinical chairs, and other senior clinicians. It now includes faculty who wish to be coached to improve their skills, faculty whose leaders wish for them to improve their skills, and new faculty.

Physician response has been almost universally positive in evaluations solicited through an anonymous survey. Sixty percent of physicians in the first year (2012) gave the coaching a rating of 5, "Very Helpful," on a scale of 1 to 5; 40 percent rated it a 4, "Helpful." No participants gave any lower ratings for the experience. Comments included "I believe this type of experience is valuable since habits (good or bad) creep into communication. . . . Very professional and insightful. I would like to do this again" and "Very helpful indeed, even though it was truthful!"

In order to increase coaching capacity and meet the needs of the medical center, the coaching team, headed by McDaniel, now includes five coaches from different disciplines. One of these coaches, psychologist William Watson, remarked:

> An advantage of coaching is that (1) it is innovative, (2) [it is] interdisciplinary, and (3) it vividly conveys the important idea that a necessary foundation of transdisciplinary professionalism is openness to feedback, diminishment of professional hubris, and respect for the value that other disciplines bring—the idea that we all have blind spots, do not know everything, are constantly missing things, can improve our practice in critical ways, and, most importantly, can learn from others who are not of the same discipline. One could say that coaching is subversive (in a good way) to the dominant culture of the disciplinary silo. (Personal communication, W. Watson, 2013)

Next steps include research to evaluate the effectiveness of coaching and other exercises to inform the teaching of transdisciplinary professionalism (McDaniel, in preparation), as well as studies that bear directly on physician–patient communication and teamwork (see "Physicians Criticizing Physicians to Patients," *Journal of General Internal Medicine*, 2013). Improving the level of transdisciplinary professionalism requires innovation in education, training, and research as a significant part of health care practice and educational transformation.

II.7
TOWARD TRANSDISCIPLINARY PROFESSIONALISM IN THE TEACHING OF PUBLIC HEALTH

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Professionalism and Public Health

Teaching transdisciplinary professionalism to students in the clinical professions presents a multitude of challenges. Extending this teaching to encompass students in the field of public health involves a somewhat different set of issues and modes of thinking than in clinical professions. This paper elicits and describes some of these issues by briefly reviewing the current standards regarding professionalism and public health. Next, some of the differences and similarities in professionalism across public health and clinical medicine will be highlighted as a means of targeting areas amenable to the shaping of transdisciplinary professionalism. Finally, strategies and challenges involved in teaching transdisciplinary professionalism to public health students will be identified.

In the United States, professionals as well as the general public are often unsure about what public health is, exactly. Clinicians have been heard to define public health as "not (clinical) medicine." Public health has been viewed by some as government-funded health care—that is, Medicaid, Medicare, or so-called safety-net care. Schools of public health are concerned with public health in a pedagogical sense, as a discipline distinct from clinical fields such as medicine, nursing, and allied health. In considering transdisciplinary professionalism, it may be useful to think of public health not as a discipline per se, but as a concept or a unifying idiom that spans health care delivery, disease prevention, health promotion, and health policy. Transdisciplinary thinking, then, would imply attention to the connections and dynamic relationships among clinical care, measures to prevent disease and promote health, and policies that direct and support the health of the public.

Our tendency in the United States, however, is not to focus on such connections and relationships. More commonly, debates have involved whether public health is part of medicine or whether medicine is part of a broader notion of public health. For many decades, thinking about public health has implicitly or explicitly involved a divide between medicine and public health (Lasker et al., 2001; McGinnis, 2006). In the early days of medicine, when infectious diseases were rampant and scientific knowledge

was limited, public health measures were essential in keeping populations healthy. But as infections became controlled and clinical knowledge advanced, the focus on public health faded as a more powerful and prestigious clinical medicine assumed the dominant meaning of health care in society (Starr, 1982). The 9/11 terrorist attacks, rapid advances in medicine and information technology, and broad socioeconomic changes in health care led to renewed interest in public health processes and modes of thinking and recognition of a need for collaboration and cooperation across medicine and public health (McGinnis, 2006). In a sense, medicine is also public health: the successful or unsuccessful delivery of health care in a clinical setting affects the public's health, just as public health processes and policies can influence care provided in the clinical arena. In working toward a transdisciplinary professionalism, then, it is critical that students understand "public health" as a concept encompassing all aspects of health care—delivery, prevention, promotion, and policy. With such understanding, similarities and differences in ethical and professional duties and obligations of clinicians and public health professionals and the relationships among these duties and obligations can be further scrutinized.

Standards for professionalism in clinical fields such as medicine, nursing, and allied health are generally found in the ethical code for a particular profession. Compared with medical and nursing codes, an explicit code of ethics for public health is relatively new. The public health code, *Principles of the Ethical Practice of Public Health*, was developed by the Public Health Leadership Society in conjunction with the Centers for Disease Control and Prevention in 2002 (Public Health Leadership Society, 2002). This document states values and beliefs underlying 12 ethical principles of public health, provides interpretive notes for each principle, and operationalizes each principle by linking it to essential public health services. The *Principles* differ from other clinical codes in their focus on the community as well as individuals and on the obligations of public health institutions, programs, and policies. At the same time, the *Principles* share qualities of other codes; for example, the notion of beneficence or "doing good" is expressed in an aim to "prevent adverse health outcomes" (Principle 1), and a duty to respect others is conveyed in the principle that community health should be achieved by respecting the rights of individuals (Principle 2) (Public Health Leadership Society, 2002).

In addition to the public health code of ethics, the Association of Schools and Programs of Public Health (ASPPH) has developed competencies in public health professionalism and ethics for both the master of public health (ASPPH, 2006) and doctor of public health (ASPPH, 2009) graduate training levels. At the master's level, professionalism is considered a "cross-cutting" competency, that is, one that is essential in all five core areas of public health. For the master's level, basic competencies such as promoting

high standards of personal integrity and respect for individuals are identified, while advanced competencies (e.g., managing conflicts of interest) are formulated for students at the doctoral level (ASPPH, 2006, 2009).

Strategies for Teaching Transdisciplinary Professionalism in Public Health

One aspect of teaching transdisciplinary professionalism to public health students is engaging them in the critical examination of a "medicine–public health divide" and encouraging evaluation of an alternative perspective of "public health" as a holistic system encompassing all of health care—the public's health. Students can then identify the commonalities and interrelationships among values and ethical obligations that transcend individual professional groups. Public health students who enter a program of study at the graduate level often already hold a professional degree, for example, in medicine, nursing, social work, or law. Students can begin by reflecting on professionalism and ethics as defined by their own professional codes and compare and contrast values, duties, and obligations stated in these codes with those included in the public health principles and competencies. One contrast, for example, is that in clinical settings, students in medicine and nursing become socialized into patient-focused care during their training, in which the locus of professionalism is a professional–individual patient relationship. Public health professionals, on the other hand, often train in community settings, with advocacy or social justice as a potential focus. The locus of professionalism for public health could be viewed as a professional–community relationship. Students then can be encouraged to explore these relationships further and identify their implications—for example, when a professional's duty to the individual might "trump" his or her duty to the wider community/society, and vice versa, and how professionals can work together to uphold values of both individuals and communities.

An examination of sources of language and discourse used in ethics and professionalism across professions could also lead to recognition of common values and obligations. In medicine and nursing, for example, language and concepts of professionalism are derived from philosophy-based bioethics, while public health language and concepts of professionalism are often found in the ethical practice of public health and human rights and social justice perspectives (Slomka et al., 2008). Another resource for discussing transdisciplinary professionalism is the IPEC Expert Panel's proposed interprofessional values/ethics competencies. These 10 statements focus on values, primarily mutual respect and trust, which underlie relationships and communication among professionals, patients, health care service delivery, and policy (IPEC Expert Panel et al., 2011). These competencies, involving both individual patients and populations, could promote discus-

sions of the implications of "interprofessional professionalism" in contrast to "transdisciplinary professionalism."

In addition to more theoretically-oriented discussions around transdisciplinary professionalism, public health students can engage in practice-oriented experiences to identify, critique, and learn professionalism in collaborative relationships across professions. One such experience is a "Professionalism in Practice" assignment, in which students have the opportunity to observe and critique over time an interprofessional team in practice. Ideally, such teams would include those that are required to make decisions in which differing viewpoints, values, and professional responsibilities must be negotiated. For example, institutional review boards may have to decide research questions when the law is silent about a particular issue. Or a hospital ethics committee or interdisciplinary intensive care team may face end-of-life care issues. Students can reflect on the communication, cooperative relationships, and underlying values they observe as a basis for group discussion.

Creative literature related to health care has often been used in teaching medical humanities, ethics, and professionalism, and it can be a useful resource in teaching transdisciplinary professionalism to public health students. In addition to books and short stories, television programs (fictional and nonfictional), social media, current events, and film are sources for discussion topics. Cases from students' and faculty's clinical experiences and from the scientific literature are readily available, and "paradigm" cases with multiple and complex elements can be identified as models for dealing with future cases. For example, a case on the topic of global HIV-prevention research would involve issues of cross-cultural communication, differing values of multiple stakeholders, implications for leadership and respectful interaction, accountability, and reciprocity in the "social contract" between professionals, patients, and the public.

Teaching transdisciplinary professionalism as part of the public health curriculum involves a number of challenges. Time constraints due to a full curriculum are inevitable, but can be managed by incorporating transdisciplinary professionalism topics into individual classes if a full-length course is not feasible. Skilled faculty can support and share their knowledge with educators who may interested in teaching professionalism but are reluctant due to lack of confidence in their abilities. Students who enter public health graduate programs without another professional degree may find clinical aspects of health care discussions intimidating. These students may not be attuned to issues such as "fiduciary relationships" or relationships of trust between health professionals and patients and may need additional experience in the clinical aspects related to transdisciplinary professionalism.

Finally, an innovation such as the teaching of transdisciplinary profes-

sionalism should be studied in view of its potential for improving patient/public health outcomes. An additional challenge will be to identify desirable outcomes and decide how best to measure them. The incorporation of transdisciplinary professionalism into public health will require changes in thinking by health professionals and the public. Attitudes and behaviors may be difficult, but not impossible, to change, especially in a health care system in which change is constant and inevitable.

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Appendixes

Appendix A

Workshop Agenda

ESTABLISHING TRANSDISCIPLINARY PROFESSIONALISM FOR HEALTH
MAY 14–15, 2013

Statement of Task

Efforts to improve patient care and population health are traditional tenets of all the health professions, as is a focus on professionalism. But in a time of rapidly changing environments and evolving technologies, health professionals and those who train them are being challenged to work outside their comfort zones, often in teams. Today, a "new professionalism" is needed that applies throughout health care and wellness and that emphasizes cross-disciplinary responsibilities and accountability to achieve improved outcomes.

This need has prompted consideration of developing a "transdisciplinary professionalism"—defined as *an approach to creating and carrying out a shared social contract that ensures multiple health disciplines, working in concert, are worthy of the trust of patients and the public.* Such a professionalism would facilitate improved interprofessional teamwork (multiple professional disciplines working together, each using its own expertise, to address common problems) and might even synthesize and extend discipline-specific expertise to create new ways of thinking and acting.

Implementing a transdisciplinary professionalism, with shared values and accountabilities, could serve to support patient and public trust throughout health care, but it would not be easy. To be worthy of such

shared trust, diverse practitioners would need to develop radical new means of thinking and acting collaboratively. They would also need to work with educators to develop innovative and effective ways to transfer collaborative skills, values, and behaviors to students; and they must provide leadership that fosters ongoing research and innovation for transformative change.

It is within this context that an ad hoc committee will plan and conduct a 2-day public workshop on Establishing Transdisciplinary Professionalism for Health. The committee will develop the workshop agenda, select and invite speakers and discussants, and moderate the discussions. The issues to be addressed at the workshop include the following:

- How can the "shared understanding" be integrated into education and practice to promote a transdisciplinary model of professionalism?
  - What are the ethical implications of a transdisciplinary professionalism?
  - How can health and wellness be integrated into transdisciplinary education and practice?
  - How is "leadership" taught and practiced within a model of transdisciplinary professionalism?
- What are the barriers to transdisciplinary professionalism?
- What measures are relevant to transdisciplinary professionalism?
- What is the impact of an evolving professional context on patients, students, and others working within the health care system?

Workshop Objectives

- To explore and define what professionalism means and the impact this has on collaboration among health professions within and between education and practice around the world.
- To discuss opportunities for teaching and promoting professionalism in a variety of environments and settings that include clinical, community, and population health.
- To engage the forum members in the development of a transdisciplinary framework for professionalism.
- To consider the possible impact of implementation of a cross-disciplinary code of ethics on different stakeholders (students, patients, community, hospital staff, and administration) and improving trust among them, as well as improving quality and efficiency in care.

DAY 1: TUESDAY, MAY 14, 2013

9:00 am **Welcome**
- Cynthia Belar, *Forum Member and Workshop Planning Committee Co-Chair*
- Matthew Wynia, *Workshop Planning Committee Co-Chair*

SESSION I: UNDERSTANDING TRANSDISCIPLINARY PROFESSIONALISM

9:05 am **A Continuum of Relationships: Multidisciplinary to Interdisciplinary to Transdisciplinary**
Cynthia Belar, American Psychological Association

9:20 am **Professionalism in Education and Practice**
Frederic Hafferty, Mayo Clinic

Q&A (student questions first)

10:00 am **BREAK**

10:30 am **Interprofessional Professionalism: Today and in the Future**
Moderator: Lucinda Maine, American Association of Colleges of Pharmacy

Jody Frost, Interprofessional Professionalism Collaborative

Q&A (student questions first)

11:30 am **Facilitated Table Discussion**
Facilitator: Matthew Wynia, Institute for Ethics, American Medical Association

12:30 pm **LUNCH**

SESSION II: SHARED SOCIAL CONTRACT FOR PATIENTS' AND PUBLIC'S TRUST

1:15 pm **Move to small rooms for breakout groups**
Small-Group Breakout Sessions
Key Areas Within Transdisciplinary Professionalism
(use of case studies and focus on milestones)

1. **Accountability and Leadership in Transdisciplinary Professionalism**
   Leader: Elizabeth Bernabeo, American Board of Internal Medicine
   Assisted by Rick Valachovic and Nancy Hanrahan, Workshop Planning Committee Members

2. **Economic and Physical Infrastructure Needed to Accomplish Transdisciplinary Professionalism**
   Leader: Susan Chimonas, Columbia University
   Assisted by Rick Talbott, Workshop Planning Committee Member

3. **Patient and Community Roles in Transdisciplinary Professionalism**
   Leader: Meg Gaines, Academic Affairs and Experiential Learning; Center for Patient Partnerships, University of Wisconsin
   Assisted by Sally Okun, Workshop Planning Committee Member

4. **Health and Well-Being in Transdisciplinary Professionalism**
   Leader: Mary Jo Kreitzer, Center for Spirituality and Healing, University of Minnesota
   Assisted by Liza Goldblatt, Workshop Planning Committee Member

2:45 pm **BREAK (reconvene in large group)**

3:15 pm **The Social Contract of Health Professions and Health Professions Education**
Introduction by Jordan Cohen, *Global Forum Co-Chair*

Speakers: Richard Cruess and Sylvia Cruess, Centre for Medical Education, McGill University, Montreal

Q&A (student questions first)

4:15 pm **Shared Social Contract for the Next Generation**
Roundtable Moderator: Sandeep Kishore, *Workshop Planning Committee Member*

Stakeholder perspectives:

- Eric Cohen, Master's Student in Nutrition and Integrative Health; Inova Life with Cancer
- Himanshu Negandhi, Public Health Foundation of India
- Seun Adebiyi, Founder of the Bone Marrow Registry in Nigeria
- Dave Chokshi, Primary Care Physician Innovator
- Judith Miller Jones, National Health Policy Forum, George Washington University

5:30 pm **ADJOURN**

DAY 2: WEDNESDAY, MAY 15, 2013

8:00 am **Breakfast**

8:00 am **Roundtable Discussion: Innovations in Teaching Leadership Through Professionalism That Highlight the Idea of the Social Contract**
Moderator: Sarita Verma, Co-Lead, Canadian country collaborative

- Juanita Bezuidenhout, South African country collaborative
- Marietjie de Villiers, South African country collaborative
- Sanjay Zodpey, Indian country collaborative
- Himanshu Negandhi, Indian country collaborative
- Maria Tassone, Canadian country collaborative
- Emmanuelle Careau, Canadian country collaborative

9:00 am **Panel: Innovations in Teaching About Professionalism and Professional Norms**
Moderator: Charlotte Exner, College of Health Professions, Towson University

- Susan H. McDaniel, Psychiatry and Family Medicine, University of Rochester
- Jacquelyn Slomka, School of Nursing, Case Western Reserve University
- Patricia Werhane, Institute for Business and Professional Ethics, DePaul University

Q&A (student questions first)

10:30 am **BREAK**

11:00 am **Report-Back from the Small Groups**
Moderator: Cynthia Belar, *Workshop Planning Committee Co-Chair*
- Catherine Grus, Group 1 Participant
- Susan Chimonas, Group 2 Leader
- Meg Gaines, Group 3 Leader
- Mary Jo Kreitzer, Group 4 Leader

11:55 am **Reflections**

A Patient Perspective
Introduction by Sally Okun, *Workshop Planning Committee Member*
- Barbara Kornblau, Society for Participatory Medicine

A Social Contract
Introduction by Patrick Kelley, Board on Global Health, Institute of Medicine
- Sir George Alleyne, Chancellor, University of the West Indies, and Director Emeritus, Pan American Health Organization

1:00 pm **LUNCH/ADJOURN**

Appendix B

Speaker Biographical Sketches

Seun Adebiyi, J.D., is a graduate of the Yale Law School and a practicing attorney of the New York Bar; founder of the Bone Marrow Registry in Nigeria; a Nigerian Winter Olympics contender; and a cancer survivor/advocate. In June 2009, Mr. Adebiyi was diagnosed with two rare and aggressive blood cancers, leukemia and lymphoma. His survival hinged on a stem cell transplant, but he was unable to find a matching bone marrow donor due to the scarcity of African donors. Mr. Adebiyi began recruiting bone marrow donors even as he underwent intensive chemotherapy and continued training for the Olympics. He helped recruit more than 10,000 donors around the world and organized the first-ever donors drive in Nigeria, registering more than 300 people in 1 day. Two years later, he also launched the first Bone Marrow Registry in Nigeria so that more people of African descent could receive a lifesaving transplant. Mr. Adebiyi eventually received a transplant when a Nigerian couple donated the umbilical cord from their healthy newborn baby. Now in remission for 3 years, Mr. Adebiyi has resumed training for the Winter Olympics. He hopes to encourage more Nigerian youth to exercise, participate in sports, eat a healthy diet, and adopt other behaviors that can prevent cancer. He also seeks to inspire other cancer patients and survivors with his motto: "Never let reality get in the way of your dreams."

Sir George Alleyne, M.D., FRCP, FACP (Hon.), D.Sc. (Hon.), a native of Barbados, became director of the Pan American Sanitary Bureau (PASB), Regional Office of the World Health Organization in 1995 and completed a second 4-year term in 2003. In 2003, he was elected director emeritus

of the PASB. From 2003 until 2010 he was the United Nations Secretary General's Special Envoy for HIV/AIDS in the Caribbean. In 2003 he was appointed chancellor of the University of the West Indies. He currently holds an adjunct professorship in the Bloomberg School of Public Health, Johns Hopkins University. Sir Alleyne has received numerous awards in recognition of his work, including prestigious decorations and national honors from many countries of the Americas. In 1990, he was made Knight Bachelor by Her Majesty Queen Elizabeth II for his services to medicine. In 2001, he was awarded the Order of the Caribbean Community, the highest honor that can be conferred on a Caribbean national.

Cynthia D. Belar, Ph.D., ABPP (*Forum Member*), is executive director of the American Psychological Association's (APA's) Education Directorate and leads the association's efforts to advance education in psychology and psychology in education. Directorate initiatives are focused on advancing quality in high school, undergraduate, graduate, and continuing education in psychology, as well as K–12 education. Before joining APA, Dr. Belar was professor and director of the clinical psychology doctoral program at the University of Florida, where she is now professor emerita. Her research has focused on pain, applied psychophysiology, and reproductive endocrinology. Prior to this position, she served as chief psychologist and clinical director of behavioral medicine at the Kaiser Permanente Medical Care Program in Los Angeles, during which time she developed a number of integrated care services and maintained an independent practice. Dr. Belar has chaired the Association of Psychology Postdoctoral and Internship Centers, the Council of Chairs of Training Councils, and the Council of University Directors of Clinical Psychology. She was president of APA's Division of Health Psychology and of the American Board of Clinical Health Psychology. She has chaired three national conferences that developed education and training policy for internships, postdoctoral residencies, and scientist–practitioner programs in professional psychology. Among her awards are the APA Award for Distinguished Contributions to Education and Training in Psychology, the Division 38 Award for Career Contributions to Health Psychology, and the American Psychological Foundation Timothy Jeffries Award for Outstanding Contributions to Clinical Health Psychology. Dr. Belar received her Ph.D. from Ohio University in 1974, after an internship at Duke University Medical Center. After graduation, she developed academic and clinical tracks in medical psychology at the doctoral, internship, and postdoctoral levels in the University of Florida Health Science Center's department of clinical and health psychology.

Elizabeth Bernabeo, M.P.H., Ph.D. Candidate, holds an M.P.H. in community health education from Temple University. She is currently a doctoral

candidate at the Graduate School of Social Work and Social Research at Bryn Mawr College. Ms. Bernabeo is also an adjunct professor at LaSalle University and Immaculata University, having taught numerous courses including *Social Welfare Policy*, *Research Methods*, *Introduction to Sociology*, *Sociology of the Family*, and *Social Problems*. Ms. Bernabeo has been at the American Board of Internal Medicine for almost 7 years, where she leads a wide range of qualitative research projects. Her areas of expertise are professionalism, shared decision making, faculty development and feedback, and medical education.

Juanita Bezuidenhout, M.B.Ch.B., M.Med., Ph.D., is a professor of anatomical pathology and deputy director, research, in the Centre for Health Professions Education, Faculty of Medicine and Health Sciences, Stellenbosch University and National Health Laboratory Service, South Africa. She is involved in service, under- and postgraduate education, and research in the university and nationally. She is a Foundation for the Advancement of International Medical Education Research (FAIMER) fellow and co-director of the Sub-Saharan Africa FAIMER Regional Institute, focusing on capacity development in health professions education in Sub-Saharan Africa. She is deputy editor of the *African Journal of Health Professions Education* and a regular reviewer for both pathology and health professions education journals. She is an active member of the South African Association of Health Educationalists.

Emmanuelle Careau, Ph.D., is an assistant professor in the rehabilitation department at the Faculty of Medicine of Université Laval (Québec, Canada). She is also an affiliate assistant professor at the College of Health Disciplines at University of British Columbia. Dr. Careau received her Ph.D. in experimental medicine from Université Laval and completed a postdoctoral training on evaluation of interprofessional education and practice. She has given much training on this topic at health care organizations and has been invited as a guest speaker at many universities from the province of Québec. Dr. Careau is currently the lead for Université Laval on the National Steering Committee of the Canadian Interprofessional Health Leadership Collaborative.

Susan Chimonas, Ph.D., earned a Ph.D. in sociology from the University of Michigan in 2000 and worked as a postdoctoral researcher at Rutgers University's Institute for Health, Health Care Policy, and Aging Research. Dr. Chimonas is a national expert in the field of physician–industry relationships and conflict of interest in clinical care. Her work explores the implications of physician–industry ties for professionalism. She has written extensively about the issues in peer-reviewed journals and has played a criti-

cal role in the development of stronger conflict-of-interest policies at health care organizations around the country.

Dave Chokshi, M.D., M.Sc., is a primary care physician with interests in public health and innovation in health care delivery. Dr. Chokshi currently serves as a White House Fellow with Secretary Eric Shinseki at the U.S. Department of Veterans Affairs. He recently completed an internal medicine residency at Brigham & Women's Hospital and Harvard Medical School. He practiced at the Southern Jamaica Plain Health Center, where he was a member of the Youth Health Equity Collaborative. Dr. Chokshi's prior work experience spans the public, private, and nonprofit sectors, including positions with the New York City Department of Health, the Louisiana Department of Health, a startup clinical software company, and with nonprofit organizations seeking to advance global health. Dr. Chokshi helped grow the nonprofit Universities Allied for Essential Medicines (UAEM), dedicated to improving access to medicines in developing countries; he was a founding member of UAEM's board of directors. He has done clinical work in Botswana, Ghana, Guatemala, India, and Peru. Dr. Chokshi has written extensively on medicine and public health in journals, including the *New England Journal of Medicine*, *JAMA*, *Health Affairs*, and *Nature*. He received his M.D. with Alpha Omega Alpha distinction from the University of Pennsylvania and his M.Sc. in global public health as a Rhodes Scholar at Oxford, and graduated summa cum laude and Phi Beta Kappa from Duke University.

Eric Cohen, R.N., is program manager for Patient Education Services at Inova Life with Cancer in Northern Virginia. He has been a hematology-oncology and bone marrow transplant nurse for more than 14 years and is completing his master's of science in nutrition and integrative health. He approaches food as medicine and is interested in the nutritional aspects of managing chronic illness, fatigue, fluctuating weight issues, chronic pain, headaches, and insomnia. Mr. Cohen combines his strong oncology nursing knowledge with a holistic view of health and wellness. Mr. Cohen is a member of the American Society for Nutrition and the Oncology Nursing Society, and presents nationally on wellness for survivors of cancer and chronic illness. In 2013, Mr. Cohen was named Hematology/Oncology Nurse of the Year by the National Capitol Chapter of the Leukemia and Lymphoma Society of America.

Jordan J. Cohen, M.D. (*Forum Co-Chair*), is professor of medicine and public health at George Washington University and president emeritus of the Association of American Medical Colleges (AAMC). He also serves as chairman of the board of the Arnold P. Gold Foundation for Humanism in

Medicine. As president and chief executive officer of the AAMC from 1994 to 2006, Dr. Cohen led the association's support and service to the nation's medical schools and teaching hospitals. He launched new initiatives in each of the association's mission areas of education, research, and patient care; expanded and modernized the AAMC's services for medical students, applicants, residents, and constituents; strengthened the association's communications, advocacy, and data-gathering efforts; and established many initiatives for improving medical education and clinical care. Prior to his leadership of the AAMC, he served as dean of the medical school and professor of medicine at the State University of New York at Stony Brook and as president of the medical staff at University Hospital. Before that, Dr. Cohen was professor and associate chairman of medicine at the University of Chicago-Pritzker School of Medicine and physician-in-chief and chairman of the department of medicine at the Michael Reese Hospital and Medical Center. Dr. Cohen currently serves on the board of the Morehouse School of Medicine and the Qatar Foundation for Education, Science & Community Development. He chairs the National Academic Affiliations Council of the Veterans Administration. He is a former chair of the American Board of Internal Medicine and of the Accreditation Council for Graduate Medical Education, served as president of the Association of Program Directors of Internal Medicine, was a member of the Board of Directors of the Josiah Macy Jr. Foundation of New York and the National Library of Medicine, and served as chair of the Journal Oversight Committee of the *Journal of the American Medical Association*. Dr. Cohen is a graduate of Yale University and Harvard Medical School and completed his postgraduate training in internal medicine on the Harvard service at the Boston City Hospital. He also completed a fellowship in nephrology at the Tufts-New England Medical Center.

Richard L. Cruess, M.D., graduated with a B.A. from Princeton University in 1951 and an M.D. from Columbia University in 1955. He is professor of orthopedic surgery and a member of the Centre for Medical Education at McGill University. An orthopedic surgeon, he served as chair of orthopedics (1976–1981), directing a basic science laboratory and publishing extensively in the field. He was dean of the faculty of medicine at McGill University from 1981 to 1995. He was president of the Canadian Orthopedic Association (1977–1978), the American Orthopedic Research Society (1975–1976), and the Association of Canadian Medical Colleges (1992–1994). He is an officer of the Order of Canada and of *L'Ordre National du Québec*. Since 1995, with his wife Dr. Sylvia Cruess, he has taught and carried out independent research on professionalism in medicine. Drs. Cruess have published widely on the subject and have been invited speakers at universities, hospitals, and professional organizations throughout the world. In

2010, McGill University established the Richard and Sylvia Cruess Chair in Medical Education.

Sylvia R. Cruess, M.D., graduated with a B.A. from Vassar College in 1951 and an M.D. from Columbia University in 1955. She is an endocrinologist, professor of medicine, and member of the Centre for Medical Education at McGill University. She previously served as director of the Metabolic Day Centre (1968–1978) and as medical director of the Royal Victoria Hospital (1978–1995) in Montreal. She was a member of the Deschamps Commission on Conduct of Research on Humans in Establishments. Since 1995, with her husband Dr. Richard Cruess, she has taught and carried out research on professionalism in medicine. Drs. Cruess have published extensively on the subject and have been invited speakers at universities, hospitals, and professional organizations throughout the world. Dr. Cruess is an officer of the Order of Canada, and in 2011 McGill University established the Richard and Sylvia Cruess Chair in Medical Education.

Marietjie de Villiers, Ph.D., M.B.Ch.B., M.Fam.Med., FCFP (*Forum Member*), is deputy dean of education in the Faculty of Health Sciences (FHS) of Stellenbosch University in South Africa, where she is also a professor in family medicine and primary care. She is currently responsible for all curriculum development, educational innovation, program implementation, and quality assurance on undergraduate, postgraduate, and continuing education levels at the FHS. Dr. de Villiers is registered as a specialist family physician at the Health Professions Council of South Africa (HPCSA), holds a master's in family medicine, and completed a fellowship at the College of Family Physicians of South Africa. She was awarded a Ph.D. in 2004 on the maintenance of competence of rural practitioners. Dr. de Villiers is chairperson of the Stellenbosch University Rural Medical Education Partnership Advisory Committee and is actively involved in the implementation and evaluation of the Medical Education Partnership Initiative project. As chairperson of the Continuing Professional Development (CPD) Committee of the HPCSA, she was responsible for the national reconfiguration of the council's CPD system and implementation.

Charlotte Exner, Ph.D., M.S., has served as dean of the College of Health Professions at Towson University in Towson, Maryland, for 14 years and is a professor of occupational therapy and occupational science. Previously, she served as chair of the Department of Occupational Therapy at Towson University and as assistant director of occupational therapy at the Kennedy Krieger Institute in Baltimore, Maryland. She received her baccalaureate degree in occupational therapy from the Ohio State University, her master's degree in education of individuals with severe disabilities from

Johns Hopkins University, and her Ph.D. in human development from the University of Maryland, College Park. The College of Health Professions includes five academic departments and an Office of Collaborative Programs with undergraduate, master's, and doctoral programs. She has supported the development and implementation of several interdisciplinary academic programs and inter-institutional programs. In addition, she supported the development of the college's Institute for Well-Being, which includes five centers that provide outreach to the community, with substantial interprofessional activities inherent to their mission.

Jody S. Frost, P.T., D.P.T., Ph.D., is the lead academic affairs specialist and program director, Education Leadership Institute Fellowship, in the Department of Academic Services at the American Physical Therapy Association. Dr. Frost is responsible for facilitating physical therapist academic/clinical education, professionalism, interprofessional education, and higher education leadership initiatives. She has been involved in facilitating initiatives including the development of Normative Curricular Models of Physical Therapist (PT) and Physical Therapist Assistant (PTA) Education, Clinical Instructor Education and Credentialing Programs, Clinical Performance Instruments for PT and PTA students, Clinical Site Information Form Web, Professionalism in Physical Therapy: Core Values, online physical therapy professionalism module series, Interprofessional Professionalism Collaborative, and interprofessional education. She received her doctor of physical therapy degree from Marymount University, her Ph.D. from Temple University, her master's in counseling and personnel studies from Glassboro State College, and her bachelor's in physical therapy from Ithaca College. Dr. Frost was formerly an assistant chair/faculty member at Temple University and a clinical manager, teacher, and practitioner in pediatric and orthopedic/sports medicine facilities. She has presented at numerous conferences on academic and clinical education, professionalism and interprofessional professionalism, performance assessment, mentoring, strategic planning and facilitation, and interprofessional education. She also provides consultation as an expert facilitator for strategic planning and consensus building. Her published works focus on interprofessional professionalism, professionalism, and clinical education assessments, academic and clinical teaching, and mentoring.

Martha (Meg) Gaines, J.D., L.L.M., is the associate dean for academic affairs and experiential Learning at the University of Wisconsin Law School, where she has served as a clinical professor of law for 25 years. She is also founding director of the interdisciplinary Center for Patient Partnerships, which trains future professionals in medicine, nursing, law, health systems, industrial engineering, pharmacy, genetic counseling, and other disciplines

that provide advocacy services to patients with life-threatening and serious chronic illnesses. Ms. Gaines teaches courses related to consumer issues in health care advocacy to graduate students pursuing various health professions and law. Following her graduation from law school, she served as a law clerk to the late Honorable Thomas Tang, 9th Circuit Court of Appeals, and as a trial attorney for the Wisconsin State Public Defender.

Elizabeth (Liza) Goldblatt, Ph.D., M.P.A./H.A. (*Forum Member*), is the chair of the Academic Consortium for Complementary and Alternative Health Care. Dr. Goldblatt is a leading educator in the acupuncture and Oriental medicine profession. She served as vice president of the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) from 1990 to 1996 and as president from 1996 to 2002 and is currently on the CCAOM Executive Committee. Dr. Goldblatt also co-chaired the Education Committee of the North American Acupuncture and Oriental Medicine Council from 1993 to 2007. She served on the board of trustees for Pacific University for 10 years, from 1994 to 2004. Dr. Goldblatt was president of the Oregon College of Oriental Medicine (OCOM) from 1988 to 2003, was the vice president for academic affairs for the American College of Traditional Chinese Medicine (ACTCM) from 2003 to 2011, and currently serves as director of assessment and planning at ACTCM in San Francisco, California. Dr. Goldblatt also had the lead in creating two of the eight clinical doctoral programs in acupuncture and oriental medicine at OCOM and ACTCM. These programs focus on collaborative and integrated medicine, which she views as a major step for educational programs in this field. In 2008–2009, she served as a member of the planning committee for the Institute of Medicine's National Summit on Integrative Medicine and Public Health. Dr. Goldblatt is currently working with the University of California, San Francisco, Osher Center and the California Pacific Medical Center in acupuncture internship placements, cross-education projects, exploring collaborative research, and placing medical doctors from both institutions on ACTCM's faculty. Dr. Goldblatt has an M.P.A. in health administration from Portland State University. She earned her Ph.D. in ethnomusicology from the University of California, Los Angeles, which combined anthropology and ritual arts. Her emphasis was on Tibetan culture.

Catherine L. Grus, Ph.D., is the deputy executive director for education at the American Psychological Association (APA) and has been on the staff of the APA since 2005. Dr. Grus received her Ph.D. in clinical psychology from Nova University in 1993. She completed a doctoral internship at the University of Miami School of Medicine and a 2-year postdoctoral fellowship at the University of North Carolina at Chapel Hill. Dr. Grus works to advance policies and practices that promote high-quality education and

training at the doctoral, postdoctoral, and post-licensure levels. She serves as a liaison to numerous national, inter-organizational, and interprofessional education and training groups. Areas of focus for Dr. Grus include the development of models and tools for competency assessment in professional psychology, supervision, and primary care psychology practice.

Frederic W. Hafferty, Ph.D., is professor of medical education and associate director of the Program for Professionalism & Ethics at the Mayo Clinic. Dr. Hafferty received his undergraduate degree in social relations from Harvard University in 1969 and his Ph.D. in medical sociology from Yale University in 1976. He is the author of *Into the Valley: Death and the Socialization of Medical Students* (Yale University Press); *The Changing Medical Profession: An International Perspective* (Oxford University Press, with John McKinlay); and *The Sociology of Complexity: A New Field of Study* with Brian Castellani. He is currently working on a volume tracing the hidden curriculum in medical education. He is past chair of the Medical Sociology Section of the American Sociological Association and associate editor of the *Journal of Health and Social Behavior*. He currently sits on the Association of American Medical College's Council of Academic Societies and the American Board of Medical Specialties Standing Committee on Ethics and Professionalism. His research focuses on the evolution of medicine's professionalism movement, mapping social networks within medical education, the application of complexity theory to medical training, issues of medical socialization, and disability studies.

Nancy Hanrahan, Ph.D., R.N., FAAN, received her bachelor's degree in nursing from the University of Kentucky, Lexington, and her master's and doctoral degrees from Boston College. Currently, Dr. Hanrahan has a faculty appointment as an associate professor at the Center for Health Outcomes and Policy Research at the University of Pennsylvania School of Nursing. In 2011, she was named the Champion of Games & Technology. She teaches an interdisciplinary course called *Innovation & Technology for Healthcare* that integrates students and faculty from schools of engineering, computer science, design, Wharton, education, medicine, and arts and sciences. Dr. Hanrahan is an advanced-practice psychiatric mental health nurse, teacher, and researcher. Her clinical expertise is with individuals who have serious and persistent mental illness including HIV and individuals with neuropsychiatric conditions secondary to brain trauma. Her program of research spans mental health policy, outcome measures, risk adjustment, and evaluation of the quality of the mental health delivery systems, specifically, general hospital psychiatric services. She teaches courses on the neuroscience of mental disorders and technology. In her current research, she is studying mobile technology and gamification of learning for novel

interventions, particularly for individuals who have expressed learning difficulties in neurological processing. Dr. Hanrahan is a member of the National Quality Behavioral Health Steering Committee.

Patrick W. Kelley, M.D., Dr.P.H. (*IOM Board on Global Health Director*), joined the Institute of Medicine (IOM) in 2003 as director of the Board on Global Health. He has also been appointed as director of the Board on African Science Academy Development. Dr. Kelley has overseen a portfolio of IOM expert consensus studies and convened activities on subjects as wide-ranging as the evaluation of the U.S. President's Emergency Plan for AIDS Relief, the U.S. commitment to global health, sustainable surveillance for zoonotic infections, cardiovascular disease prevention in low- and middle-income countries, interpersonal violence prevention in low- and middle-income countries, and microbial threats to health. He also directs a unique capacity-building effort, the African Science Academy Development Initiative, which over 10 years aims to strengthen the capacity of 8 African academies to provide independent, evidence-based advice to their governments on scientific matters. Prior to joining the National Academies, Dr. Kelley served in the U.S. Army for more than 23 years as a physician, residency director, epidemiologist, and program manager.

Sandeep Kishore, Ph.D., is a postdoctoral fellow at Harvard Medical School and co-chair of the Young Professionals Chronic Disease Network, a global network of 400 young professionals from 50 countries committed to the equitable prevention and treatment of noncommunicable diseases as a social justice issue. He seeks to leverage lateral thinking and transdisciplinary approaches at universities worldwide, with the goal of preparing and cultivating the next generation of young leaders to tackle health challenges of the 21st century. In this capacity, he served as a delegate to the United Nations General Assembly in 2011. He is a fellow at the Massachusetts Institute of Technology Dalai Lama Center for Ethics and Transformative Values and a recipient of the Paul and Daisy Soros Fellowship for New Americans. He completed his medical training at Cornell University's medical college in 2012.

Barbara L. Kornblau, J.D., OTR, FAOTA, CCM, CPE, currently serves as the executive director of the Society for Participatory Medicine. She is also the founder of the Coalition for Disability Health Equity, which brings together cross-disability advocates, researchers, health and rehabilitation providers, and disability advocacy groups. An occupational therapist, attorney, certified case manager, certified pain educator, e-patient, and parent of six children with disabilities and multiple chronic conditions, Ms. Kornblau is a former Robert Wood Johnson Foundation Health

Policy Fellow for Senators Harkin and Rockefeller and past president of the American Occupational Therapy Association. She was a dean and professor of nursing at the University of Michigan–Flint and a professor of occupational therapy, public health, and law at Nova Southeastern University. Ms. Kornblau served as a senior government relations consultant for the Special Olympics and the Health Reform Czar for the American Association of People with Disabilities. Her successful coalition building and advocacy for the cross-disability community and the Affordable Care Act provisions that cover health disparities, data collection, cultural competence, and antidiscrimination led Department of Health and Human Services Secretary Kathleen Sebelius to appoint Ms. Kornblau to represent the cross-disability community on the Health Resources and Services Administration's Negotiated Rulemaking Committee on medically underserved populations and health professional shortage areas, on which she served for 14 months. She is co-author of *Ethics in Rehabilitation: A Clinical Approach* and author of numerous book chapters and peer-reviewed papers. She is has an academic appointment in the School of Allied Health Sciences at Florida A&M University.

Mary Jo Kreitzer, Ph.D., R.N., FAAN, is the director of the interdisciplinary Center for Spirituality & Healing and a professor in the School of Nursing at the University of Minnesota, where she also serves as the co–faculty lead of the doctorate of nursing practice program specialty in integrative health and healing. Dr. Kreitzer was the principal investigator (PI) on recently completed studies funded by the Medical Research Institute on the outcomes of health coaching, the co-PI of a clinical trial funded by BlueCross/Blue Shield Minnesota on the impact of an integrated residential treatment program on women with eating disorders, and the co-PI of a National Institutes of Health (NIH) National Center for Complementary and Alternative Medicine (NCCAM) R21 grant on mindfulness-based stress reduction for caregivers of Alzheimer's patients. She is also the co-PI of a NIH NCCAM R25 grant focused on integrating research in a complementary and alternative medicine educational institution. From 2004 to 2007, she served as the vice chair of the Consortium of Academic Health Centers for Integrative Medicine. In 2009, she testified at a U.S. Senate hearing titled Integrative Health: Pathway to Health Reform as well as at the Institute of Medicine Summit titled Integrative Medicine and the Health of the Public. Dr. Kreitzer earned a doctoral degree in health services research and master's and bachelor's degrees in nursing.

Lucinda L. Maine, Ph.D., B.Pharm. (*Forum Member*), serves as executive vice president and chief executive officer of the American Association of Colleges of Pharmacy (AACP). As the leading advocate for high-quality

pharmacy education, AACP's vision is that academic pharmacy will work to transform the future of health care to create a world of healthy people. Dr. Maine previously served as senior vice president for policy, planning, and communications with the American Pharmacists Association (APhA). She served on the faculty at the University of Minnesota, where she practiced in the field of geriatrics, and she was an associate dean at the Samford University School of Pharmacy. Dr. Maine is a pharmacy graduate of Auburn University and received her doctorate at the University of Minnesota. Her research includes projects on aging, pharmacy manpower, and pharmacy-based immunizations. Dr. Maine has been active in leadership roles in the profession. Prior to joining the APhA staff, she served as speaker of the APhA house of delegates and as an APhA trustee. She currently serves as president of the Pharmacy Manpower Project and as a board member for Research!America.

Susan H. McDaniel, Ph.D., is the Dr. Laurie Sands Distinguished Professor of Families & Health. She is director of the Institute for the Family in the Department of Psychiatry, and associate chair of the Department of Family Medicine at the University of Rochester Medical Center (URMC). She is also the director of the Patient- and Family-Centered Care Physician Coaching Program for URMC. Her special areas of interest are behavioral health and family-oriented primary care and physician–patient communication. Dr. McDaniel is the author of many journal articles, including an upcoming paper in the *Journal of General Internal Medicine*, "Physicians Criticizing Physicians to Patients." She is an associate editor of the *American Psychologist* and has co-authored or co-edited 13 books. Her latest book, with William Doherty and Jeri Hepworth, titled *Medical Family Therapy and Integrated Care, 2nd edition*, was published by the American Psychological Association Publications in July 2013. Dr. McDaniel is on the board of directors of the American Psychological Association and the board of the Collaborative Family Healthcare Association. She has received many awards, including the American Psychological Foundation/Cummings PSYCHE Prize in 2007, the Donald Bloch MD Award for Outstanding Contributions to Collaborative Care in 2009, the Society of Teachers of Family Medicine Recognition Award in 2011, and the Elizabeth Hurlock Beckman Award for Mentoring in 2012.

Himanshu Negandhi, M.D., M.M., is currently contributing to academic activities and research in his position as an assistant professor at the Indian Institute of Public Health–Delhi. He is a community medicine postgraduate from a premiere national institute engaged in service, research, and training in medical disciplines. Dr. Negandhi has also acquired a master's degree in clinical epidemiology from the University of Sydney–Australia. He has served

as a doctor in an urban metropolitan hospital with experience teaching public health to postgraduate medical students, paramedics, and in-service public health professionals over his career. He has actively contributed toward the curriculum design of a postgraduate diploma program in public health management offered by Public Health Foundation of India, in collaboration with multiple stakeholders from the government and teaching institutions. This included identifying the core competencies, framing the learning objectives, creating a draft course curriculum, and creating a plan for the course delivery. He has also assisted in developing an evaluation framework for the program. His research interests include human resources in health, education for health professionals, and program evaluation. He has worked on creation of a competency framework for public health professionals in India as part of a World Health Organization–India–supported activity. He was a core team member in a cross-country comparison of master's- and doctoral-level public health programs with a focus on competency-driven curricula across select countries. He is currently involved in a five-country network study that is undertaking a situation analysis of health professional education across five Asian countries. He is also the academic coordinator for the postgraduate program in public health management at the State Institute for Health Management and Communication–Gwalior. He coordinates the epidemiology module across various academic programs at the institute and substantially contributes in modules pertaining to health systems, economic evaluation, and systematic reviews.

Sally Okun, R.N., MMHS, is the vice president for Advocacy, Policy & Patient Safety at PatientsLikeMe, an online patient-powered research network. Ms. Okun joined the company in 2008 as manager of health data integrity, overseeing the site's medical ontology, patient-reported health data, drug safety/pharmacovigilance platform, and the site's ever-evolving patient voice vocabulary. Ms. Okun participates in numerous collaboratives of the Institute of Medicine's Roundtable on Value & Science-Driven Health Care; she is a member of the Office of the National Coordinator for Health Information Technology Standards Committee Consumer Technology Workgroup and the Program Advisory Board for the Schwartz Center for Compassionate Care in Boston. Ms. Okun practiced patient-centered palliative and end-of-life care for more than three decades in community- and home-based settings engaging with patients and families living with the challenges of illness, caregiving, and complicated aging. Ms. Okun completed her nursing education at the Hospital of St. Raphael School of Nursing and Southern Connecticut State University and her master's degree at the Heller School for Social Policy & Management at Brandeis University and was a fellow at the National Library of Medicine Program in Biomedical Informatics.

Nelson K. Sewankambo, M.B.Ch.B., M.Sc., M.M.Ed., FRCP Doctor of Laws (HC) (*Forum Member*), trained in general medicine and internal medicine at Makerere University (MU) in Uganda and later graduated with a degree in clinical epidemiology from McMaster University, Canada. He is a fellow of the Royal College of Physicians, United Kingdom, a professor of medicine at MU, and is the principal (head) of MU College of Health Sciences. He was dean of MU Medical School for 11 years (until 2007). He contributed to the seminal work of the Sub-Saharan African Medical Schools Study (2008–2010). As co-chair of the education/production subcommittee of the Joint Learning Initiative, he contributed to the landmark report titled *Human Resources for Health; Overcoming the Crisis*, which had a major influence on the World Health Organization's 2006 report *Together for Health*, which focused on the global crisis of health workers and the need for urgent action to enhance health of populations.

Jacquelyn Slomka, Ph.D., M.A., R.N., has a perspective on public health that has been informed by training and practice as a registered nurse, doctoral education in cultural anthropology, a professional work history in nursing and clinical bioethics, and academic experience in public health and community health nursing. As a nurse, she was able to view health care as an "insider." Training in cultural anthropology provided the perspective of an "outsider" and a view of health and health care in a broad, "holistic" sense. Through dissertation research in Morocco, she was exposed to a different cultural model in which the relative scarcity and expense of clinical biomedicine necessitated reliance on a public health system to provide universal care and disease prevention, and where modern biomedicine existed alongside a traditional medical system. Dr. Slomka's professional career has focused on health care ethics in both the clinical and public health arenas. She has extensive experience in clinical ethics consultation and ethics education. She has taught health care ethics to physicians, medical students, nurses, allied health professionals, and public health graduate students. Her research interests are the social and cultural factors influencing health care decision making, with a particular focus on health care and health research as social and cultural processes. Her current research involves an academic–community partnership to enhance quality of life for persons living with HIV and other chronic conditions through the provision of early palliative care services.

Richard (Rick) Talbott, Ph.D., FASAHP, FASHA, FAAA (*Forum Member*), is currently the dean of the College of Allied Health Professions at the University of South Alabama and the president of the Association of Schools of Allied Health Professions. He also serves on the American Speech and Hearing Association (ASHA) Foundation Board and the ASHA Committee on

Honors and is a founding past board member of the American Academy of Audiology. He has previously served as president of the Council of Academic Programs in Communication Sciences and Disorders, president of the Speech and Hearing associations of Oklahoma and Georgia; head of the Division for Exceptional Children at the University of Georgia; and chair of the Communication Sciences and Disorders programs at the University of Virginia and Oklahoma Health Sciences Center. Dr. Talbott received his doctoral degree in audiology with an emphasis in auditory neurophysiology from the University of Oklahoma Health Sciences Center in 1973. He has published and/or presented more than 100 scientific papers on topics ranging from the role of the Rasmussen's bundle in audition, efficacy of otoacoustic emissions in newborn hearing screening, and controlling variables affecting hearing-aid performance.

Maria Tassone, M.Sc., B.Sc.P.T., is the inaugural director of the Centre for Interprofessional Education, a strategic partnership between the University of Toronto and the University Health Network (UHN). She is also the senior director of health professions and interprofessional care and integration at the UHN in Toronto, a network of four hospitals comprising Toronto General, Toronto Western, Toronto Rehab, and Princess Margaret. Ms. Tassone holds a B.S. in physical therapy from McGill University and an M.Sc. from the University of Western Ontario, and she is an assistant professor in the department of physical therapy, Faculty of Medicine, University of Toronto. Ms. Tassone was the UHN project lead for the coaching arm of the Catalyzing and Sustaining Communities of Collaboration around Interprofessional Care, which was recently awarded the Ontario Hospital Association international Ted Freedman Award for Education Innovation.

Richard W. Valachovic, D.M.D., M.P.H. (*Forum Member*), is the executive director of the American Dental Education Association (ADEA) and president of the ADEAGies Foundation. Dr. Valachovic joined ADEA in 1997 after more than 20 years in research, practice, and teaching of pediatric dentistry and oral medicine/radiology. He is a diplomat of the American Board of Oral and Maxillofacial Radiology and completed postdoctoral training in pediatric dentistry and dental public health. He previously served on the faculty and administration of the Harvard School of Dental Medicine and the University of Connecticut School of Dental Medicine. Dr. Valachovic has served as president of the Federation of Associations of Schools of the Health Professions and as executive director of the International Federation of Dental Educators and Associations. He is a member of the Washington Higher Education Secretariat. Dr. Valachovic earned his B.S. degree in 1973 from St. Lawrence University;

his D.M.D. in 1977 from the University of Connecticut School of Dental Medicine; and an M.P.H. (1981) and an M.S. in health policy and management (1982) from the Harvard School of Public Health. He completed a residency in pediatric dentistry at the Children's Hospital Medical Center in Boston in 1979.

Sarita Verma, L.L.B., M.B., CCFP (*Forum Member*), is a professor in the Department of Family and Community Medicine, deputy dean of the Faculty of Medicine, and associate vice provost for health professions education at the University of Toronto (U of T). She has been a diplomat in Canada's foreign service and worked with the Office of the United Nations High Commissioner for Refugees in Sudan and Ethiopia for several years. Dr. Verma is the 2006 recipient of the Donald Richards Wilson Award in medical education from the Royal College of Physicians and Surgeons of Canada and the 2009 co-recipient of the May Cohen Gender Equity Award from the Association of Faculties of Medicine in Canada. Along with colleagues at McGill University, the University of British Columbia, and U of T, she has been the lead consultant for the Future of Medical Education in Canada–Postgraduate Project on the Liaison and Engagement Strategy and the Environmental Scan Scientific Study. As deputy dean, Dr. Verma leads strategic planning and implementation as well as communications and external relations. In addition, she is responsible for integrated education across the health sciences and liaison with affiliated partners.

Patricia Werhane, Ph.D., is the Wicklander Chair of Business Ethics and Director, Institute for Business and Professional Ethics, at DePaul University and professor emerita at the Darden School of Business. She received her B.A. from Wellesley College and M.A. and Ph.D. from Northwestern University. Dr. Werhane is a founding member and past president of the Society of Business Ethics. She has been a Rockefeller Fellow at Dartmouth and visiting professor at the University of Cambridge. She is the author or editor of more than 25 books, including *Ethical Issues in Business*, edited with Tom Donaldson (eighth edition); *Adam Smith and His Legacy for Modern Capitalism*; *Moral Imagination and Managerial Decision-Making*; and *Organization Ethics for Health Care*, published by Oxford University Press. Her latest book, with Laura Hartman, Crina Archer, Elaine Englehardt, and Michael Pritchard, published by Cambridge University Press, is titled *Obstacles to Ethical Decision-Making*.

Matthew Wynia, M.D., M.P.H., FACP, has medical training in internal medicine, infectious diseases, public health, and health services research. He cares for patients at the University of Chicago. Dr. Wynia's work at the American Medical Association (AMA) has included developing a

research institute focusing on bioethics, professionalism, and policy issues; he founded the AMA's Center for Patient Safety; and he has led a variety of projects on understanding and measuring the ethical climate of health care organizations and systems, communication and team-based care, defining physician professionalism, ethics and epidemics, medicine and the Holocaust, and inequities in health and health care. He is the author of more than 130 published articles and a book on fairness in health care benefit design.

Sanjay Zodpey, M.D., Ph.D. (*Forum Member*), presently works as director of public health education at the Public Health Foundation of India (PHFI), New Delhi, and holds a leadership role as director at Indian Institutes of Public Health (IIPH), Delhi. Dr. Zodpey also served as director of Indian Institute of Public Health, Gandhinagar and Bhubaneswar. He earlier worked as professor of preventive and social medicine and vice dean at Government Medical College, Nagpur. By training, he is a physician, public health specialist, and epidemiologist. Dr. Zodpey completed his medical education—MBBS, M.D., and Ph.D. (preventive and social medicine)—from Government Medical College, Nagpur, India. He has also acquired postgraduate qualifications in sociology, public administration, and economics. He has been awarded a fellowship of the Indian Public Health Association and the Indian Association of Preventive and Social Medicine. Dr. Zodpey is involved in designing several capacity development initiatives, including long-term academic programs at PHFI. He is currently leading the project supported by the U.S. Agency for International Development for designing human resources for health policy for the Government of Jharkhand (India). He is also providing leadership to Technical Assistance Project of Madhya Pradesh (India) for creating a public health cadre in the state. He has recently authored two monographs related to education of health professionals in India. He also leads the Cluster for Health Workforce (with focus on education of health professionals) established at PHFI (IIPH, Delhi) in 2010.

Appendix C

Summary Updates from the Innovation Collaboratives

The Institute of Medicine's (IOM's) Global Forum on Innovation in Health Professional Education is complemented by the work of four university- or foundation-based collaborations in Canada, India, South Africa, and Uganda. Known as innovation collaboratives (ICs), these country-based collaborations characterize innovators in health professional education through their demonstration projects on how schools of nursing, public health, and medicine can work together toward a common goal. The four ICs were selected by IOM leadership through a competitive application process that provides for certain benefits on the forum. These benefits include

- the appointment of one innovation collaborative representative to the IOM Global Forum;
- time on each workshop agenda to showcase and discuss the IC's project with leading health interprofessional educators and funding organizations;
- written documentation of each collaborative's progress summarized in the Global Forum workshop summaries published by the National Academies Press; and
- remote participation in Global Forum workshops through a video feed to the collaborative's home site.

Each collaborative is undertaking a different 2-year program of innovative curricular and institutional development that specifically responds to one of the recommendations in the Lancet Commission report or the 2011 IOM *The Future of Nursing* report—reports that inspired the estab-

lishment of the Global Forum. These on-the-ground innovations involve a substantial and coordinated effort among at least three partnered schools (a medical school, a nursing school, and a public health school). As ad hoc activities of the Global Forum, the ICs are amplifying the process of reevaluating health professional education globally so that it can be done more efficiently and effectively and so that it will create increased capacity for task sharing, teamwork, and health systems leadership. The work of each of the collaboratives is detailed below.

CANADA

Maria Tassone, M.Sc., B.Sc.PT
Sarita Verma, L.L.B., M.D., CCFP
University of Toronto

The Canadian Interprofessional Health Leadership Collaborative

The Canadian Interprofessional Health Leadership Collaborative (CIHLC) is a multi-institutional and interprofessional partnership whose goal is to develop, implement, evaluate, and disseminate an evidence-based program in collaborative leadership (CL) that builds capacity for health systems transformation. The CIHLC's work is grounded in the principles of social accountability and community engagement and is embedded in a context of interprofessional and relationship-centered care. The program will be targeted at emerging health care leaders who are in positions that enable them to create sustainable change with their communities.

The CIHLC lead organization is the University of Toronto, partnered with the University of British Columbia, the Northern Ontario School of Medicine, Queen's University, and Université Laval. The project is supported by the five universities as well as the Ontario Ministry of Health and Long-Term Care.

In the past year, CIHLC investigators completed foundational research to understand the concept of CL and design an educational program to develop collaborative leaders. The research involved

- a review of scientific and gray literature on the concept of CL for health systems change;
- a review of educational programs for the development of collaborative leaders in health care;
- an environmental scan of existing programs for the development of collaborative leaders; and

- the completion of key informant interviews with thought leaders in the health and education fields.

Across these four streams of research, the unique elements of CL (e.g., transformational leadership, social accountability, collaborative decision making) were identified. In addition, there was found to be broad consensus that CL is needed to support transformational system change within the health system to better meet the needs of patients, care providers, communities, and health system sustainability.

During the past 6 months (May through October 2013), the CIHLC

- has designed the CIHLC education program;
- has begun to develop modules for in-class and online learning;
- has been developing the framework for a capstone project;
- is establishing the organization of online content for program delivery;
- has developed a communication strategy for the program and launched a website; and
- has conducted a process evaluation to ensure that next steps are conducted efficiently and effectively.

The CIHLC is in the process of creating

- a community engagement toolkit,
- an evaluation framework to measure program quality and impact, and
- a searchable repository of existing leadership programs.

Key Developments: May–October 2013

Design of the CIHLC Education Program

Through an iterative process, the CIHLC has designed the Collaborative Leadership pilot program. The program targets emerging leaders who have completed general leadership courses and are looking for advanced specialized training in collaborate leadership grounded in community engagement and interprofessional practice. The program combines both face-to-face and online learning, including a capstone project in which the learners engage communities to develop, implement, and evaluate a community-centered project that meets the needs of an underserved community.

The curriculum includes change leadership, strengths-based leadership, and transformational leadership. Skills for community engagement will be embedded throughout the course to enable the learners to co-create a

shared vision with their communities and implement a project to achieve that shared vision. Feedback from learners participating in the pilot will ensure that the modules continue to evolve to maximize quality and impact.

Learning Management System (LMS) for Program Delivery

Taking into account the various modalities of course delivery and learner needs, the CIHLC has organized the course structure through the Blackboard LMS. This multilingual, internationally available platform will allow the CIHLC to provide distance education through online tools such as webinars, act as a depository for multimedia and interactive resources for the learners, and provide online assessment tools for educators. It will also facilitate the availability of the program internationally.

Communication Strategy

The project has developed a comprehensive communications strategy and has established a wide online and offline presence through various social media outlets and print. Currently, information about the CIHLC and the Education Program under development can be obtained through press releases (http://cihlc.ca/news), Facebook (www.facebook.com/cihlc), Twitter (https://twitter.com/cihlc), LinkedIn (http://www.linkedin.com/company/3200229), and pamphlets. The official CIHLC project website (http://cihlc.ca) provides information on project activities and collaborative members. It is also being used to recruit, register, and direct learners to the CIHLC program; provide information on instructors and learning resources; and facilitate ongoing engagement of alumni in the years following the pilot program.

Evaluation

The CIHLC is using a developmental evaluation approach to guide the development of the program and assess its quality and impact. Learners participating in the pilot test will be asked to provide ongoing feedback that will be used to improve the program to better meet the needs of the learners and support system transformation. As part of its own reflective processes, the CIHLC recently conducted a process evaluation to provide greater insight on the CIHLC team functioning. Results showed that supporting the development of relationships and fostering innovation leads to a valued collaborative.

Next Steps

During the next 6 months, the collaborative will complete the development of the program and launch the pilot cohort. Feedback from participants and continual scanning of the literature will be used to refine and enhance the program, while additional funding is being sought for the marketing and knowledge dissemination phase of the project.

INDIA

Sanjay Zodpey, M.D., Ph.D.
Public Health Institute of India

Building Interdisciplinary Leadership Skills Among Health Professionals in the 21st Century: An Innovative Training Model Progress Report (April 2012–July 2013)

Background

The Lancet Commission report on *Education of Health Professionals for the 21st Century* discusses three generations of global educational reforms. It elaborates on transformative learning, focusing on development of leadership skills and interdependence in health education, as the best and most contemporary of the three generations (Frenk et al., 2010). The purpose of this form of education reform is to produce progressive change agents in the field of health care. *The Future of Nursing* report also strongly focuses on transformative leadership, stating that strong leadership is critical for realizing the vision of a transformed health care system (IOM, 2011). The report recommends a strong and committed partnership of nursing professionals with physicians and other health professionals in building leadership competencies to develop and implement the changes required to increase quality, access and value and deliver patient-centric care.

Leadership is a complex multidimensional concept and has been defined in many different ways. In the field of health care, leadership serves as an asset to face challenges and is an important skill to possess. In order to reach this goal, common leadership skills must be looked for among students applying for health professional education, including medical, nursing, and public health professionals (Chadi, 2009). The Lancet Commission report's recommendations are targeted at a multidisciplinary and systemic approach toward health professional education. In India, the lack of and need for professional health care providers has been discussed for the past many decades. The education system for health professionals in India is

strictly compartmentalized and there are strong professional boundaries and demarcations among the various health professions (medical, nursing, and public health); there is recognized need for integrating these three streams. Moreover, the current health professional education system in India focuses minimally on the development of leadership competencies to address public health needs of the population.

Rationale for the Initiative

Health professionals have made enormous contributions globally to health and development over the past century. The demand of 21st-century health professional education is mainly transformational, aiming to help the professionals strategically identify emerging health challenges and innovatively address the needs of the population. The need of the hour in India is to amalgamate the skills and knowledge of the medical, nursing, and public health professionals and to develop robust leadership competencies among them. This initiative proposed to identify interdisciplinary leadership competencies among doctors, nurses, and public health experts necessary to bring about a positive change in the health care system of the country.

Objectives of the Initiative

1. Identification of interdisciplinary health care leadership competencies relevant to the medical, nursing, and public health professional education in India.
2. Conceptualization of and piloting an interprofessional training model to develop physician, nursing, and public health leadership skills relevant for the 21st-century health system in India.

Partners of the Innovation Collaborative

The Innovation Collaborative is a partnership between the following three schools:

- Public Health Foundation of India, New Delhi—public health institute
- Datta Meghe Institute of Medical Sciences, Sawangi, Wardha—medical school
- Symbiosis College of Nursing, Pune—nursing school

These schools teamed up to further the objective of the Innovation Collaborative. Table C-1 provides basic information of the three schools.

TABLE C-1 Innovation Collaborative Partners

Name of School	Address	Administrative Point of Contact	Members of Working Group
Public Health Foundation of India	Public Health Foundation of India, ISID, 4 Institutional Area, Vasant Kunj, New Delhi 110070, India	Prof. Sanjay Zodpey	• Dr. Preeti Negandhi • Ms. Kavya Sharma • Dr. Himanshu Negandhi • Ms. Ritika Tiwari
Jawaharlal Nehru Medical College—constituent college under Datta Meghe Institute of Medical Sciences (Deemed University)	Paloti Road, Sawangi Meghe, 442004, Wardha District, Maharashtra State, India	Pro-chancellor Dr. Vedprakash Mishra	• Dr. Abhay Gaidhane • Dr. Zahir Quazi
Symbiosis College of Nursing—constituent of Symbiosis International University	Symbiosis College of Nursing (SCON) Senapati Bapat Road, Pune, 411 004, Maharashtra (India)	Col. Jayalakshmi N.	• Dr. Rajiv Yeravdekar • Mrs. Meenakshi P. Gijare

Innovation Collaborative Activities—Update

The three partner institutes collaborated to address the major objectives of this initiative. A formal approval of the proposal was obtained by the IOM, following which the team members conducted various outlined activities.

1. **Constitution of the collaborative:** A team was formed including members from all three partner institutes. Prof. Sanjay Zodpey, Director-PHE, PHFI represents the Collaborative as the National Program Lead along with Col. Jayalakshmi N., Principal, Symbiosis College of Nursing and Dr. Vedprakash Mishra, Pro-chancellor, Datta Meghe Institute of Medical Sciences as Regional Program Leads. The team also included other member representatives from each partner institute.

2. **Constitution of a Technical Advisory Group (TAG):** The TAG was formed, comprising of renowned experts in the field of health professions education. All these members were contacted for seeking

their consent to be a TAG member to oversee and provide guidance to the activities of the Collaborative. Regular meetings were held with the TAG members and their guidance was sought on various aspects of the project.

3. **Identification of interdisciplinary health care leadership competencies:** The initial activity undertaken by the Collaborative was an exhaustive literature search by the working group under the guidance of the Program Leads to understand need for and genesis of leadership competencies as a part of education of health professionals. Published evidence, both global and Indian, was included in the literature search to look for key interdisciplinary leadership competencies, the need for an interdisciplinary training of health professionals and the current scenarios in interprofessional health education. The literature search strategies included journal articles from electronic databases, medical journals, grey literature, newspaper articles, and papers presented in conferences. The search was not restricted by the period of publication or language. The electronic search was complemented by hand searching for relevant publications/documents in their bibliographies. A process of snowballing was used until no new articles were located.

4. **Expert group meetings:** Once the literature search was complete, the working group summarized the findings of the search and prepared a formal report. This report was reviewed by all senior members and finalized. This was followed by a consultation with experts from various disciplines of health professional education, where the findings of the literature search were presented.

5. **Development of training model:** The next activity of the project was the development of the training model for the pilot. The training model was conceptualized based on the findings of the literature search and the recommendations of the expert group at the consultation. A training manual was developed for use in the trainings by the working group along with the team leaders.

   The trainings are aimed at health professionals across the country from the medical, nursing and public health fields. The long-term objective of this training model is its integration into the regular curriculum of the medical, nursing and public health students, with an aim to develop interdisciplinary leadership skills among them.

   To align with the objectives of the Innovation Collaborative, the training model was pilot-tested on some in-service professionals

and students across the three streams. For this, a detailed agenda and the training material were prepared based on the content of the training manual.

6. **Piloting the training model:** The pilot trainings commenced in April 2013 and were completed in the first week of May 2013. These trainings were conducted in batches at three different sites:

   - State Institute of Health Management and Communication, Gwalior (SIHMC)
   - Indian Institute of Public Health, Bhubaneswar (IIPHB)
   - Datta Meghe Institute of Medical Sciences, Sawangi (DMIMS)

   The duration of each training batch was 3 days. Resource faculty from the three partner institutes actively trained the participants. IIPHB had 25 participants for the training, while SIHMC and DMIMS had 16 and 25 participants, respectively. The average age of the participants across all the three batches was 32 years. The total number of males in the three batches was 40, while there were 26 females.

   The group for each batch of the training workshop was mixed, with participants from different disciplines. The training was aimed at bringing the three disciplines (medical, nursing, and public health) together to build interdisciplinary leadership skills. Details of participants are mentioned in Table C-2.

   The pilot training workshops included didactic sessions as well as group discussions. The didactic sessions were aimed at giving the trainees an understanding of leadership skills and their importance in health care. The aim of the group discussions was to train them to innovatively apply interdisciplinary leadership competencies in their local health care settings.

   At the end of the pilot trainings, the trainees were asked to fill out a feedback form about various aspects of the training. Positive responses from the participants were many, ranging from good coordination of the training, suitable content, good pedagogy to friendly atmosphere. A few negative points, such as short duration of the training, more theoretical, less group discussions/practicum were also emphasized.

   Following the pilot trainings, a formal report was prepared by the working group and shared with the Global Forum at the IOM.

7. **Preparation and dissemination of findings:** The Innovation Collaborative is currently in the process of revising the training model

TABLE C-2 Participants at Training Workshop

Name of Institute	Participants from Medical, Nursing, and Public Health	Total Participants
Indian Institute of Public Health, Bhubaneswar (IIPHB)	14-medical, 2-nursing, 9-public health	25
State Institute of Health Management and Communication, Gwalior (SIHMC)	11-medical, 4-nursing, 1-public health	16
Datta Meghe Institute of Medical Sciences, Sawangi, Wardha (DMIMS)	14-medical, 8-nursing, 3-public health	25

based on the feedback of the trainees of the pilot tests. This revised model will be shared with members of the Technical Advisory Group for their inputs and accordingly finalized.

The findings of the initiative will be published as a monograph as well as in peer-reviewed journal. The Collaborative will also present the findings of the initiative to the Global Forum on Innovation in Health Professional Education.

Table C-3 summarizes the activities mentioned above.

TABLE C-3 Innovation Collaborative Activities—Update Summary

Activity	Current Status	Remarks
Constitution of the Collaborative	Completed	Team formed comprising of members from three partner institutes
Constitution of the Technical Advisory Group (TAG)	Completed	Regular meetings held and advice sought from members regarding project
Conducting a literature review	Completed	Report has been shared with the Institute of Medicine (IOM) earlier
Expert group meetings and consultation	Completed	Inputs taken from experts from the field
Developing training model	Completed	Training manual has been shared with IOM earlier
Piloting the training model	Completed	Trainings were completed in May 2013
Preparation of report based on pilot findings	Completed	A formal report was prepared and shared with IOM

continued

TABLE C-3 Continued

Activity	Current Status	Remarks
Finalization of training model	Ongoing	The training model is being revised to incorporate the changes suggested by the participants of the pilot trainings
Report preparation and dissemination	To be done	Will be done after finalization of training model. Inputs will be sought from TAG for the final report

SOUTH AFRICA

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South African Partnership on Innovation in Health Professional Education Update from the Leadership Team

The South African collaborative involves Stellenbosch University, the University of the Western Cape, and the University of the Free State collaborating on two overlapping yet distinct projects in innovation in health professional education.

The South African Collaborative's work focuses on leadership through transformative learning and interdependence, and the purpose of the project is to determine the relevant competencies that are required for transformational and shared leadership in the context of health teams.

For that purpose, the IC has approached its work in a qualitative way, interviewing leadership across the faculties from the level of residents to faculty management.

In the process, they have generated 1,000 pages of transcriptions and have just completed an analysis. In brief, they have identified an understanding of leadership that has emerged from the interviewed, but is still being complied. However, two quotes that highlight the definition of leadership from the interviews are "I see the diversity, opportunities, doing things differently, which creates much more vibrant teaching environments where we develop leadership that interacts with communities and interacts with people," and "We should have a strong philosophy for change and leading beyond this but we are not doing that, and that leadership is not a positional appointment but that anybody can be a leader." Also, there was a strong feeling that there should be training, and the purpose of the

training is for people to understand leadership, to understand teamwork, and to become better leaders.

A set of attributes that were identified or related to enabling the environment are a strong value system, building relationships, the ability to create meaning, being strategic thinkers, and being able to communicate. In a review of the literature about leadership, all of these attributes were present in the data.

Several leadership strategies emerged and are shown in Figure C-1. The strategies that were most commonly expressed were the use of role models and mentors and inclusive, collaborative, and interdependent strategies.

As always, there are many challenges. And one of the challenges is the challenge of interdependence, to be collaborative and inclusive. Also, there is resistance to change, which we always experience. Then there are always challenges in capacity, environment, and context. And again, role models are important.

As far as training needs, there was need for formal programs, but much more important is the need for role models and, specifically, for a structured mentorship program.

FIGURE C-1 Stellenbosch University leadership strategies.
SOURCE: Stellenbosch University.

UGANDA

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Defining competencies, developing and implementing an interprofessional training model to develop competencies and skills in the realm of health professions ethics and professionalism

Innovation and Motivation for Selection of Innovation

This project is a major innovation aimed at contributing to improvement in the quality of health service. Although there is a lot of discussion about the need to improve professional ethics and professionalism in low- and middle-income countries, there has been very little attempt to develop competency-based interprofessional education programs to address the challenges. Professionalism is defined in several different ways (Wilkinson et al., 2009). The Royal College of Physicians (2005) has defined professionalism as "a set of values, behaviors, and relationships that underpin the trust the public has in doctors." This definition can be extended to embrace all types of health workers.

Overall aim: To prepare a future workforce committed to practicing to a high degree of ethics and professionalism and performing effectively as part of an interprofessional health team with leadership skills.

Specific Objectives

1. To define competencies and develop a curriculum for interprofessional education of health professional students (nursing, medicine, public health, dentistry, pharmacy, and radiography) in order to develop their skills in the realm of ethics and professionalism.
2. To pilot a curriculum for interprofessional education of health professional students (nursing, medicine, public health, dentistry, pharmacy, and radiography) to develop their skills in the realm of ethics and professionalism.
3. To develop curriculum for interprofessional education for health workers and tutors in ethics and professionalism and pilot its implementation in partnership with the regulatory professional councils.

Approach to Implementation of the Project

Instructional Reforms

A critical element of this project will be the engagement of major stakeholders, including the Ministry of Health, patients, hospitals and health centers, private practitioners, professional councils, educators, students, alumni, and consumer rights groups nationally. This engagement will ensure the participation of stakeholders in the implementation and the commitment of local resources to support this effort. Through this engagement, the collaborative will define the extent of the problem (unethical and unprofessional practices among nurses, doctors, public health workers, and other health professionals) and identify the necessary interventions, including the required competencies and interprofessional training approaches that will address the gaps as well as the necessary post-training support to ensure the institutionalization of ethics and professionalism among health professionals in Uganda. Stakeholders will participate in the implementation of training and mentoring trainees at their respective places of work. Of particular importance are the students who have initiated the formation of a student ethics and professionalism club. They are advanced in the planning process and will be supported through this project and contribute to the whole process of this project. Right from the beginning, the collaborative plans to align this educational project with the needs of Uganda's population. Concerns have been raised about ethics and professionalism among health professionals in Uganda, largely by the media. There are, however, only limited, brief reports in publications in the recent past in peer-reviewed literature on the issue of ethics and professionalism among health workers in Uganda (Hagopian et al., 2009; Kiguli et al., 2011; Kizza et al., 2011).

Some national reports highlight the challenges in this area, but few formal studies have been conducted to document the extent of the problem, the contextual factors, and possible interventions (UNHCO, 2003, 2010). Because of the lack of comprehensive evaluations and evidence, the collaborative plans to initiate this project with a systematic needs assessment. The needs assessment will involve the participation of representatives from several key partners mentioned previously. Data will be collected through an analysis of key documents from the professional councils, which are statutory units charged with the responsibility of investigating reports and cases of professional indiscipline among doctors, dentists, nurses, pharmacists, and others. The collaborative will undertake limited surveys and key informant interviews among the above-named groups.

Development and Implementation of the Curriculum

Results from the needs assessments will be used to inform the curriculum development process, which will employ a six-step approach (Kern et al., 2009). Prior to curriculum development, interprofessional competencies will be defined through stakeholder engagement and suggestions, building on the five competencies defined by the 2003 IOM report *A Bridge to Quality*. Trainees will learn not only competencies related to ethical practices and professionalism but also competencies of interprofessional collaboration and leadership (IPEC Expert Panel, 2011). Stakeholder discussions will be held to get a clearer understanding of society's needs and the challenges of ensuring high standards of ethics and professionalism. This will be followed by a consensus process to arrive at an agreed-on set of competencies to be acquired during an interdisciplinary course for the students who are the next generation of leaders.

A curriculum will be developed for students and for teachers based on the needs assessment results and the defined competencies.

Institutional Reforms

A number of institutional reforms will be needed as the instructional reforms are implemented. These include a careful review of the linkages and collaboration between the university and the aforementioned stakeholders, and the recognition and the reward system for excellence in demonstrating the desired high standards of ethics and professionalism among both students and staff.

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