Bringing Specialties Together: The Power of *Intra*-Professional Teams

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“**Y**ou don’t *know* when the patient last ate?” Exasperated by another sloppy consult, my chief resident reminded me that, “they call because they need help. Remember, the *patient* really needs us.” Who said this? A chief on internal medicine? Or surgery? Can you tell? In truth, we have all felt this same sense of frustration with a late-night, seemingly incompetent consult.

As residents, the intensity of training—and the pressure to complete ever-accumulating work—causes us to dread the shrill page portending another consult. Can’t they figure out this question? Did they even look at the patient before calling? The frustration from poor consults, and the need for consult courtesy, has been well documented.¹ As communication and teamwork break down, we take on tribal identities: the belief that *they* are different from *us*. And by different, we mean inferior. Other services don’t work as hard or understand the patient the way we do. This lack of partnership and respect can lead to delays in providing care, an inefficient system, and more concerning, suboptimal patient care.²

Academic medicine is in the thick of a national dialogue on team-based approaches, with a focus on “interprofessionalism,” which examines the interactions between medicine, nursing, pharmacy, and other health professions.³ We suggest that something is missing in medical education—that it also must foster *intra*-professionalism. This concept is not new. More than 2 decades ago, surgeons began to discuss the need for modification of their own “ethic of rugged individualism,” realizing that the evolving health care system required “that we play as a team.”⁴ Residents should be learning not only to know when and how to

consult other physicians and medical teams, but also to trust, depend on, and work in concert with other specialties. Currently, there is no formal graduate medical curriculum related to *intra*-professional teamwork.

As residents from different specialties, we have common backgrounds in our dedication to quality and access to care, and 1 of us (M.D.S.) is a program director who enthusiastically supports intra-professional training. Despite that alignment, the pressures of residency training encourage us to silo ourselves into specialty-specific subcultures. Through our graduate medical training, we learn not only the intricacies of the human body, but also the culture of our new “in-crowd.” Through this, we have allowed ourselves to see specialties we interact with as the “other.”

Whether or not the rationale is valid, all too often consulting specialties are not on the same page. Here, a crucial opportunity emerges: We must train intra-professional teams to examine, design, and deliver the medical care we all envision. Our inability as a house of medicine to optimally work alongside one another poses considerable risk—for our profession and for our patients.

Teamwork training as a strategy for improving quality has been associated with substantially improved outcomes.^{5,6} For example, when the Veterans Health Administration implemented a formalized medical team training program for personnel in the surgical operating room, the result was an impressive 18% reduction in annual mortality among patients who were treated by teams that had undergone this training.⁷ Where team-based care and coordination among different services have been encouraged, there have been great strides in improving patient outcomes, and even evidence of sustained collaboration between different specialties.^{8–10}

The promise of these findings is seen in emerging intra-professional models (TABLE). An example is the University of California, San Francisco’s hospital-neurosurgery team-based approach. This combined service has led to decreased costs and increased physician perception of quality.¹¹ For residents, there has been another benefit: learning from other services. As Dr Robert Wachter highlights in his online blog,⁸ the hospitalist who runs this service won a departmental teaching award last year from the Department of Neurosurgery. The lesson is clear: embracing intra-professional teams helps hospitals, patients, residents, and learning.

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TABLE	EXAMPLES OF INTRA-PROFESSIONAL TEAMS
Institution	Intra-Professional Team
University of California, San Francisco	Hospitalist-neurosurgery team-based approach ⁸
University of Chicago Medicine	Comanagement model of chronic liver disease by hospitalists and hepatologists ⁹
Mayo Clinic, Rochester, Minnesota	Medical and surgical comanagement after elective hip and knee arthroplasty ¹⁰
Veterans Health Administration	Medical team training including surgeons and anesthesiologists ⁷

Teams aren't just made; they require skills that can be taught. Team-based science teaches us that experienced teams are able to develop psychologically safe environments where team members can make better use of each other's knowledge, skills, and abilities.¹² Residency programs should embrace this, and begin to teach with this approach. These team science lessons include the cultivation of psychological safety, enabling the development of *transactive* memory—a group-level memory system, and the recognition that the leader's behavior matters.¹²

Structured programming engaging intra-professional teams in health care and health care delivery improvement should happen through purposeful reorganization of teams into shared intern rotations, or collective research opportunities. Having met beyond the wards through a mutual interest in health policy, the authors have repeatedly found that high-quality care emerges from cross-specialty efforts around a common goal. To that end, the collective impact amassed will not be additive—it will be exponential. In an era where the medical education community, including the Accreditation Council for Graduate Medical Education, strives to meaningfully engage trainees to lead change in quality and safety,¹³ substantive intra-professional training may provide a compelling solution.

As our health care delivery system shifts toward new collaborative payment models, such as bundled payment models and Accountable Care Organizations, specialties will no longer be stand-alone silos. We will need to work together to enhance and support high-quality care, and to continue to innovate in medicine. By being part of these types of teams during training, residents will be less likely to hide in the shelter of their own tribal identity. They will be

better prepared to work together through mutual respect and understanding, which will lead to improved patient outcomes and efficiency of the health care system as a whole.

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