VIEWPOINT

Health Care Education Must Be More of a Team Sport

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I am a member of a team, and I rely on the team, I defer to it and sacrifice for it, because the team, not the individual, is the ultimate champion. –Mia Hamm¹

Much dialogue in pharmacy is associated with the things that serve to divide us worldwide. Academics discuss the differences in our disciplines (eg, biomedical sciences, clinical sciences, social/behavioral sciences). Practitioners discuss the differences in our practice sites (eg, community, health system, industry). Accreditors discuss the differences in our degree programs (eg, BPharm, MPharm, PharmD). Professional bodies discuss different perceptions of requirements for entry-level patient care (eg, licensure/registration, residency, board certification). Policy-makers discuss differences in the scope of the work we do (eg, advanced practice pharmacist/APP, clinical pharmacist practitioner/CPP, pharmacist/clinician/PhC). For a relatively small profession, we spend a great deal of time differentiating ourselves from one another in ways that don't provide optimal role modeling for our students and are likely confusing to those outside of pharmacy.

The “insider-outsider” patterns we use to classify the world are inherited from our culture as a sociological phenomenon described in *The Silo Effect: The Peril of Expertise and the Promise of Breaking Down Barriers*.² Author Gillian Tett writes that because these divisive patterns exist at the borders of our consciousness, they seem “natural” and we rarely even notice them. This may also suggest that our educational systems unintentionally reinforce such patterns. And just as these intraprofessional silos have contributed to tunnel vision, they also have led to normalization of interprofessional tribalism, which is complicated by the increasing use of technologies in health and education. Indeed, for a nightmare-inducing example of this, read “The Overdose” section in *The Digital Doctor: Hope, Hype, Harm at the Dawn of Medicine's Computer Age*, where a text message from a pharmacist in a disconnected system is described as “a lit match dropped onto the dry forest floor.”³ Moreover, relationships matter.

To help break this silo mentality, the International Pharmaceutical Federation (FIP) published a report on

interprofessional education (IPE), the intent of which was to focus on values and approaches that could not only unite us within our profession but also connect us to those in other professions.⁴ Indeed, all health professionals have a sustained, compelling need to work together in collaborative teams for the benefit of patients. Operationalizing this is one of the most important problems educators will face in the next decade.

Training health professionals to work together is not a new concept. In 1972, the Institute of Medicine (IOM) issued a report called *Educating for the Health Team* based on the first time that leaders of the five major health professions had come together at a national meeting to examine what was then called interdisciplinary education and practice.⁵ This report was followed by a steady stream of supporting work from IOM, Pew Health Commission, Institute for Healthcare Improvement, Josiah Macy, Jr. Foundation, Robert Wood Johnson Foundation, World Health Organization, The Lancet Commission, and others.⁴

Despite the window of opportunity afforded by the major changes in curricular format for pharmacy in key countries in the last two decades (eg, entry-level PharmD in US), many of the recommendations from the 1972 IOM report are still aspirational today. Although some advances have been made (eg, we now have a national clearinghouse), many would argue that there is still a significant gap between where we are today and the high functioning teams required for consistently delivering comprehensive, effective, and compassionate care.

This highlights an important perspective. Pharmacy appears to be entering another period of major curricular change, with programs that last made broad updates during their transition to the entry-level PharmD degree. This means we have another chance to prioritize IPE. Because of new guidance (eg, Accreditation Council for Pharmacy Education (ACPE) Standards 2016, Center for the Advancement of Pharmacy Education (CAPE) 2013 Outcomes, General Pharmaceutical Council Standards 2011) and new professional and accreditation collaborations (eg, Interprofessional Education

Collaborative, Health Professions Accreditors Collaborative), we now have a stronger foundation on which to build this priority.

The truth is that most of the “add-on” time in our curricular and cocurricular space is full. Further, our learners are savvy enough to see that when IPE activities are inserted into nooks and crannies, they don’t translate as “real” curriculum. To make interprofessional instruction convincing will mean profound changes in the classroom and clinical and organizational arenas. We must be willing to build the IPE skeleton first, and this may mean sacrificing some good things for the chance to build some great things. And although evidence regarding the impact of IPE on patient outcomes is still emerging, we have an ethical responsibility to contribute to this. It’s time to play smarter.

To be sure, the challenges of logistics, funding, cultures, and general reluctance for change are no less complicated today than they were in 1972. Perhaps these challenges can never truly be overcome, and yet creative educational leaders must find effective ways to work around them. In the US education system, proximity to other health professions students for authentic, patient-facing collaboration is a problem—yet innovations from new and flexible programs without colocation are becoming more visible.⁶ As the FIP report shows, there are promising innovations from programs all over the world.⁴

While much of the published IPE literature comes from Australia, Canada, the United Kingdom, and the United States, there has been progress in IPE throughout all of the WHO regions. In fact, in countries such as Lebanon, Namibia, and the Philippines, programs are taking bold approaches to IPE. In some cases, these activities have become so interwoven in the pharmacy curricula, they no longer have to be labeled as separate curricular entities. There is much we can learn from these collaborations.

To be able to contribute responsibly and accountably to team-based care, we not only need to model a different pharmacist practitioner, but we may also need to recruit a different kind of pharmacy student and develop a different kind of instructor. Schools are beginning to report including teamwork assessments as part of multiple mini-interview models,⁸ but we could find no published reports of admissions that include an interprofessional assessment. Students who come into pharmacy based on their individual performance must be intentionally taught to value team performance. And this team training must spiral through the curriculum to include classroom, experiential, and cocurricular activities.

Some have suggested that because most faculty members came up in a system that emphasized personal

autonomy and independence, we are part of both the problem and the solution.⁷ We must identify and encourage IPE innovators and early adopters in our programs. Endowed chairs, seed grants for IPE, and support to complete formal IPE teaching programs are a start. To encourage wider adoption of IPE, we will need to change the faculty incentive structure to prioritize collaboration, perhaps recognizing an IPE “extra credit” to motivate students and recognizing the importance of IPE in the faculty promotion and tenure process.

Finally, to advance this conversation we need to move beyond the days of participating primarily in single profession gatherings. Even more ironic than a lecture on active learning is a pharmacist telling other pharmacists how much other team members value their contributions. Although combined meetings such as Collaborating Across Borders and All Together Better Health have grown in popularity, and the IPEC sessions are almost always oversubscribed, it’s going to take rethinking the efficacy of single profession organizations—in the educator, practitioner, and student arenas—if we are to prioritize collaboration. A compelling piece in the *Journal of Interprofessional Education and Practice* suggests that it is indeed time for an interprofessional professional society.⁹ What an unselfish and flexible proposition!

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