

ETHICS CASE

Interprofessional Training: Not Optional in Good Medical Education

Commentary by Paul Burcher, MD, PhD

Abstract

Interprofessional education is a vital part of medical education, and students should not be permitted to exempt themselves from it. Physicians are part of a team, and the importance of teamwork will only increase as physician shortages continue and medical care becomes more complex. To learn to be good physicians in this emerging environment, students must appreciate the skills, strengths, and vocabularies of other professions. It is shortsighted to think that the best educators of future physicians can only be other physicians.

Case

As director of an obstetrics and gynecology rotation, one of Dr. Chan's goals is to emphasize interprofessional collaboration so that her students will be prepared for the cross-disciplinary practice environments into which they will be graduating. In particular, she wants students to learn from nurse midwives, whom she admires as experts in normal deliveries, as role models and leaders in patient-centered care, and as fellow professionals who offer safe labor and delivery options for women with low-risk pregnancies. To achieve these goals, Dr. Chan divides each student's time on this rotation into two parts, one with an ob-gyn physician and one with a nurse midwife.

After the student assignments have been distributed, Dr. Chan receives an email from a student that says, "I recognize that many women want midwives for their deliveries, but I came to medical school to learn what physicians do. I will soon have to make a decision about which residency to do, and I want as much time as possible to work with physicians. I would like my schedule to be changed so I can spend my time in medical school learning from physicians, not nurses or midwives."

Dr. Chan has received a few emails like this in the past. She is concerned that accommodating this student's request will send a message to other students that learning what nurse midwives do is optional and unimportant. How ought Dr. Chan to address students with the kinds of concerns raised in the email?

Commentary

Dr. Chan should refuse this student's request and use it as an opportunity to fulfill her obligation to educate this student about the value of interprofessional training. An expert panel on [interprofessional education](#) noted that "Being able to work effectively as members of clinical teams while students is a fundamental part of ... learning" [1]. The panel's conclusion is justified by the team-based nature of medical practice today and by the importance of respecting and understanding roles in clinical practice played by professionals other than physicians. Dr. Chan's refusal thus can be justified on multiple levels, but there are two reasons I would like to discuss in some depth. The first is the nature of medicine as a [team-oriented profession](#) and the need to train our physicians as team players. Obstetrics, like other medical specialties, faces physician shortages that will require interprofessional collaboration between obstetricians and midwives, and medical schools should introduce students to this model for present and future practice. Second, the pattern in all medical training is to begin with the normal and progress to the pathological, and, by beginning an obstetrics rotation by working with a midwife—a master of normal, uncomplicated pregnancy and labor—the student is receiving an ideal introduction to obstetrics and gynecology.

The student's enthusiasm for medical learning should be embraced, but it should be tempered with a caution about the pitfalls of thinking of medicine as exclusively best. This student seems to have a mistaken notion of medicine in general, and the role of physicians more specifically, which Dr. Chan has an obligation to address with this student. Physicians can do little without the contributions of other health professionals; we function as part of a team. There is no better way to express leadership than to demonstrate appreciation of the value of other team members' contributions; this requires spending time learning what they do and allowing them to teach us about the areas of expertise physicians don't have. Certified [nurse midwives](#) (CNM) have advanced degrees in nursing and are independently licensed for practice in many states. CNMs provide prenatal care, deliver babies, and offer routine well-woman gynecological care. CNMs are not obstetricians with less training—they are highly skilled professionals with skill sets that both overlap with, and differ from, those of an ob-gyn. Studies have shown higher levels of patient satisfaction and much lower rates of cesarean section among women with low-risk pregnancies who were attended in labor by CNMs [2, 3].

In my last practice, a group of six obstetricians worked with five CNMs to provide care for thousands of women. The patients could choose either a physician or a midwife. The midwives had physician back-up should complications arise, and the physicians were able to spend more time treating patients with medical complications and doing surgery, activities that align more closely with our specific clinical training and interest. This is more than just "[triaging](#)" medically complex patients to physicians; the patients who received midwife care arguably got better low-risk care than a physician could provide. For example, they were scheduled for longer visits focused on normal aspects of

pregnancy rather than shorter, problem-focused physician visits. Physicians appropriately spend more time with more medically complex patients, but this can lead to healthy women feeling “shortchanged” in terms of time spent during prenatal care. Everyone benefitted from the team approach, and we served far more patients than a physician group of six could have otherwise accommodated. This model is in no way unique to obstetrics—physicians working in teams with nurse practitioners, physician assistants, clinical pharmacists, physical therapists, and other allied health professionals is now the norm, not the exception.

A recent article in *Obstetrical & Gynecological Survey* by William F. Rayburn, chair of obstetrics and gynecology at University of New Mexico, and Erin E. Tracy underscores the implications of the looming [physician shortage](#) for collaborative practice: “Perhaps the most important means to address the increasing women’s health care demand is to develop collaborative practice models. Reshaping delivery of care with nonphysician clinicians into more integrated office and hospital settings will ... bring about more comprehensive, team-based quality of care” [4]. It is unrealistic to expect that physicians who trained only with other physicians and medical students can be competent team members in collaborative care once they are in practice. If medical education is to be “real world” and forward looking, then medical students need to both participate in team-based medical care and learn from each of the team members. There is no justification for having the clinical clerkship set apart from the rest of the health care delivery environment where many professions share patient responsibility and teaching.

Of course, it is somewhat presumptuous for this medical student to believe that she knows what the best curriculum is for her own education. I would remind her of a maxim repeated throughout medical school: the best person to teach an individual subject is the expert in that subject. In the basic sciences, many of the student’s professors were not medical doctors; they were basic scientists and experts in the area in which they taught. My professors of anatomy were not physicians, and they knew anatomy better than any surgeon. Even physicians who are generalists, such as those in family medicine and pediatrics, still have a particular expertise in that specialty not matched by others. As I have stated above, midwives are masters of normal pregnancy and birth, with excellent results surpassing those of ob-gyn clinicians in some areas [3].

To place the third-year student with a midwife is not a compromise; it is the ideal setting for learning the specialty with a progression from the normal to the abnormal that is typical in medical education. In my experience, integration of basic science teaching with clinical teaching is a frequent topic of discussion in the halls of medical schools around the country. Starting an obstetrics rotation with an emphasis on the normal is an optimal way to achieve this integration without taking a physician away from her role treating medically complex patients. The student is learning from an expert and beginning with

the physiologically normal rather than the pathological, while also learning the skill set of another professional who might one day be her colleague.

But the knowledge and skills that the midwife can impart are only one aspect of what the student would gain from this experience. Imagine for a moment that the student got what she wished and all of her medical school training came solely from interacting with other physicians. She would graduate without learning the skills and vocabularies of other critical health professionals. As a resident she would not understand that it is other people who make her orders, prescriptions, and recommendations come to fruition. She would have an unrealistic view of medicine in which the physician decides and, somehow, the universe provides. Just as it is important to complete all the required rotations prior to graduation, so it is also critical that students experience how medicine is actually practiced today—interprofessionally, as a team, with each member understanding the roles of the other team members.

[Interprofessional communication](#) is also a learned skill. Midwives and obstetricians have different perspectives on childbirth and use different descriptors and vocabularies to describe the same phenomena. In my experience, this is true across other interprofessional exchanges as well, and the more familiar students become with the vocabularies and perspectives of other professionals on the care team, the more fluent they will become in interprofessional dialogues. I remember working one night with a CNM who wore a button that read, “Trust in Birth.” That night we took care of several very sick obstetrics patients together, and at one point the nurse midwife attended a birth of one of my patients who was healthy so that I could continue to manage a patient of hers whose condition had become quite complicated. At the end of the night I pointed to her button and asked her what she thought. “Trust in birth,” she said, smiling, “except when you should not.” We were of the same mind at that moment, and moments like these only come when we do not isolate ourselves in our respective professions but take advantage of opportunities to see health care from the eyes of another. The student in our case scenario is being given an opportunity to expand her perspective and should be helped to understand that twenty-first century health care relies on multiskilled team players, not the solo practitioner of the past.

The student can and should work with the midwife.

References

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