Commentary

Interprofessional health care education and the accreditation process: Good for students, programs and patient care

For decades, we have known that health care is a team sport. The best care draws on the perspectives and expertise of physicians, nurses, pharmacists, respiratory therapists, physical therapists and many other clinicians who each bring a particular expertise and way of interacting with patients to the health care team.

While we have known this work is a team activity, we haven't always treated it this way. The longtime paradigm of physician as "captain of the ship" contributed to behaviors that suggested only the physician's observations, opinions and plans regarding the patient mattered. Under this model, the perspectives of nurses, who spend far more time with hospitalized patients than do physicians, have often been undervalued and even gone unheard. Similarly, pharmacists who have voiced questions or concerns about prescriptions have been unappreciated and sometimes treated with outright hostility. This lack of cross-professional respect and collaboration has resulted in failures to speak up even with a concern about a patient's well-being.

A foundational problem underlying these behaviors is that our health care system was not built to foster, and insist upon, team care and team collaboration. Failure to acknowledge the role of varying health professionals led to problems with patient care. Medication errors, wrong-side surgeries and patient death were just a few of the results. In addition to the alarming toll on patients, clinicians of all types, including physicians themselves, suffered professionally and personally under this model.

In recent decades, these issues have gained attention, and momentum for change has grown.

The Institute of Medicine (now the National Academy of Medicine) cast a bright spotlight on health care quality deficiencies in 2000 with its seminal report To Err is Human, which outlined the devastating toll of medical errors: tens of thousands of lives lost each year, diminished confidence in the health care system, professional dissatisfaction, billions in wasted spending. Among the solutions outlined in the IoM report was a recommendation that patient safety programs "establish interdisciplinary team training programs for providers." The subsequent IOM report, Bridge to Quality, published in 2003, built upon this foundation, calling for institutions to foster interdisciplinary work by bringing down the silos in health professions education.

Health professions educators rightly saw a role for their teams to advance this work. One can hardly expect physicians, nurses, pharmacists and other health care professionals to function effectively in teams when they have never done so during their training and may not even fully understand one another's work. The Interprofessional Educational Collaborative core competencies – published in 2011 and updated again several years ago – provided a framework for applying this thinking in higher education.

As medical and other health professions schools began paying attention to the idea of interprofessional training in the late 1990s and early 2000s, so did accreditation agencies. At this time, much of the

movement toward interprofessional education was in its infancy, but the implementation of accreditation standards both encouraged and insisted upon this work. The subsequent body of work, including interprofessional experiences, curricula and collaboratives, has been stimulated by the presence of accreditation standards on the topic.

The Accreditation Council for Pharmacy Education (ACPE) was an early adopter in this space, and the ACPE standard was significantly strengthened in 2016. Other accreditation bodies have also addressed interprofessional education in their standards, including the Liaison Committee on Medical Education (LCME).

In the current LCME standards, Standard 7.9 calls for core curricula to "prepare medical students to function collaboratively on health care teams that include health professionals from other disciplines as they provide coordinated services to patients. These curricular experiences include practitioners and/or students from the other health professions."

What accrediting bodies are looking for in health care professional education programs is evidence that students are truly learning what they need to function effectively in a team-based environment. Examples that might demonstrate that a school is delivering in this area include:

- Medical education program objectives (MEPO) that speak to the importance of learning to work in an interprofessional environment and clear linkage of these MEPOs to course and clerkship learning objectives and experiences that relate to these competencies.
- Interprofessional education activities that go beyond joint participation in lectures. While having medical and other health professions students taking joint courses can be a part of meeting an IPE standard, this alone won't be enough. Small-group discussions, problem-based learning sessions, joint rounding on clerkships and joint simulation exercises are more likely to foster cross-professional understanding, provide students the opportunity to work together and send a clear message that the institution values and practices effective interprofessional education.
- Community-service and service-learning activities that engage students from multiple disciplines. These activities can be helpful elements of an interprofessional learning system. For example, work in student-run health clinics and exercises developing community-based solutions to local problems can allow health professions students of various types to make a meaningful contribution to their community while learning from and with each other.
- Meaningful evaluation of individual learning sessions and the overall program goals for interprofessional education.

The National Center for Interprofessional Practice and Education and the Health Professions Accreditors Collaborative recently released a consensus document that further underscores the importance of interprofessional education to accreditation bodies, with endorsement from 24 health care accreditation boards and commissions, including the LCME. This work sends a powerful message that medical schools should continue their work in this area. It also sends a pointed message that accreditors are looking for this work as they evaluate programs.

The document establishes common terminology to facilitate consistent program development around interprofessional education, encourages institutions to foster interprofessional education and

collaborate with other institutions as appropriate, and provides a framework for implementing these efforts. Of particular interest to accreditation teams, the document seeks to "provide(s) opportunities for HPAC member accreditation boards/commissions to utilize the guidance to assess their IPE standards and to train site visit teams regarding essential elements of quality IPE."

What this tells us is that interprofessional education is likely to become more, not less, important to accreditation standards and compliance moving forward. A true commitment to interprofessional learning and collaborative practice of medicine is good for clinicians; it's good for patients; and it will also be good for medical education programs as they work through the accreditation process.

We welcome your feedback about this commentary, including questions, comments and ideas for future discussion. Please send thoughts to info@msagroup1.com.

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