The Turf and Baggage of Nursing and Medicine: Moving Forward to Achieve Success in Interprofessional Education

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ABSTRACT

Interprofessional education has been identified as a core competency in nursing, medicine, dentistry, pharmacy, and public health. Students and trainees who learn with, from, and about one another in an interdisciplinary learning environment develop the skills necessary for team-based care. Faculty and experienced clinician preceptors are integral to this process because they develop curricula, interact with learners, and role model behaviors, yet most faculty and clinical preceptors were educated in a uniprofessional manner and bring to the table years of history and lived experiences. These *turf and baggage* issues are often subtle but influence our learners and invariably affect the care of the patient.

Keywords: interprofessional collaboration, interprofessional education, medical resident training, nurse practitioner education

Interprofessional education (IPE) is an integral part of health professional learning, focusing on learning with, from, and about each other to improve teamwork and provide quality patient care.[1] Learners from diverse health professions are learning together and increasingly are caring for patients together in an interprofessional environment. This new model for health education is self-evident because it prepares learners to collaborate with other clinicians in our increasingly complex health system.

In order for IPE to succeed, it needs experienced faculty and preceptor clinicians with the knowledge, skills, and attitudes to teach and model interprofessional behaviors. This is the crux of the issue with IPE because current health professions faculty and experienced preceptors were trained in a pre-interprofessional era and may be unaware of the core IPE competencies.[2] In fact, most health care academicians have been trained in a uniprofessional manner and bring with them their own profession-specific expertise and preconceived ideas, referred to here as *turf and baggage*. Issues of turf and baggage are particularly notable in nursing and medicine.

The scope of practice legislation and regulatory language represent *turf issues* between organized medical groups and advanced practice nurses (APNs). Turf, in this context, is defined as noncooperation or conflict between organizations/professions with seemingly common goals; *turf issues* is language borrowed from street slang, as in gangs defend their turf from other gangs.[3,4] These battles over professional turf have often focused on APN competency, have been detrimental to collaboration, and have resulted in deep divisions between the professions. These battles have informed our perceptions of each profession, how we interact with each other, and how we interact with our student/trainee learners.

The vast majority of faculties from schools of medicine and nursing received their education and entered their academic lives at a time when the professions operated in silos and in a hierarchical health care structure. This is reflected in the current age of faculty; the average age of doctorally prepared nursing faculty ranges from 51 (assistant professor) to 60 years old (professor), whereas the average age of medical school faculty is 48.5.[5,6] Historically,

physicians were trained as *captains of the ship* and assumed the role of the ultimate decision maker. Perhaps more importantly, they were trained to work independently. At the same time, nursing was historically perceived as a profession whose responsibility was to carry out the orders of the physician; in fact, the word *orders* speaks to this historic hierarchical relationship between the professions. At the nexus of this education and training for both professions was the patient and an underlying assumption that the nurse advocated and cared for the patient while the physician focused on treatment and cure.

The development of the APN in the mid-1960s represented a challenge to this long-standing relationship. Because APNs have been recognized as independent care providers and have begun to practice within the full scope of their training, scope and practice issues between APNs and physicians continue to be an area of tension.[7] This has been reflected at the state and federal level with scope of practice legislation and regulatory language. Nursing faculty and their students are well aware of the American Medical Association's Scope of Practice Partnership, whose sole purpose is to "fund investigations into the educational preparation and licensure requirements of health care providers with the goal of opposing autonomous practice of all providers except physicians."[8,9] This tension seems to have been further exacerbated by the implementation of the Affordable Care Act of 2010 as nurse practitioners (NPs) and other APNs join their physician colleagues in providing primary care services to newly insured individuals.

It is in this context that one must consider the challenges associated with faculty implementation of the *Core Competencies for Interprofessional Collaborative Practice* (2011). This report, coauthored by 6 professional education associations (from nursing, osteopathic medicine, pharmacy, dentistry, allopathic medicine, and public health) focuses on 4 areas of interprofessional competencies: (1) values/ethics for interprofessional practice (IPP), (2) roles/responsibilities, (3) interprofessional communication, and (4) teams and teamwork.[2]

Faculty members responsible for integrating IPE core competencies into their curricula face challenges related to long-standing cultural *baggage*. For APN and medical faculty, the challenge is particularly significant. Years of history and lived experiences exist between the 2 disciplines. These experiences inform how we develop our curricula, interact with our learners, and role model behaviors. When done well, IPE provides a foundation for collaborative patient-centered care, enriches the discourse between professions, and improves student satisfaction in the learning environment.[1,2,10] However, when done poorly, it reinforces stereotypes, perpetuates power imbalances, and undermines team development and culture.[10]

As teachers and preceptor clinicians, we need to acknowledge and move past our turf and baggage issues in order for IPE and IPP to succeed. In our institution, we have led several new IPE initiatives aimed at graduate-level learners. In one experience, adult and family NP students and first-year resident physicians in internal medicine engaged in a longitudinal IPE experience. The program included classroom sessions identifying assumptions and attitudes about the 2 professions and then focused on small group problem-based learning activities. The activities incorporated elements of communication, conflict resolution, and team building. The learners then re-engaged and jointly completed home visits to community-dwelling elders.[11]

In the first curricular activity, participants were asked to privately and anonymously describe their personal beliefs and commonly held stereotypes about each respective profession. These assumptions were then posted on a white board, and an interprofessional faculty pair cofacilitated a reflective discussion about these assumptions. This exercise, adapted from Margalit et al,[12] had always been quite successful with a lively and respectful dialogue between the professions. However, in this instance, the NP students collectively began to engage in what could only be considered *doctor bashing*. Comments, along with strong nonverbal language, included, "I chose to be an NP because I wanted to spend more time with the patient," "As an NP I will take care of the whole patient, not just the disease," "The medical model is just diseased focused," and "I approach the patient holistically." The NP students chose to define their role in a manner that was oppositional to medicine.