Interprofessional Education: A Theoretical Orientation
Incorporating Profession-Centrism and Social Identity Theory

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Introduction
Most health professions recognize the need for interprofessional education and clinical training at both the national and international level. In fact, the World Health Organization crafted interprofessional education (IPE) standards as early as 1970 that supported the establishment of a number of associations dedicated to IPE, such as the Interdisciplinary Professional Education Collaborative (IPEC) (United States), the Centre for Advancement of Professional Education (CAIPE) (United Kingdom), and the Centre for Professional Education Advancement (CPEAP) (Australia).1 Within the United States, health professionals, legislators, and policymakers are beginning to recognize the need for collaboration between universities and health care providers2 as we prepare the next generation of health care professionals. In 2011, IPEC published an extensive list of IPE competencies that set forth the skills, knowledge, and attitudes that students across the health professions should master in order to practice effectively as a team.3 Although many health profession trainees have exposure to multidisciplinary practice within their field work, few residencies, fellowships and/or internships, or graduate educational programs incorporate interprofessional learning competencies as integrated components of both course work and field experiences.4

This paper emerges from comments I prepared for the October 25, 2013 roundtable on Building Global Health Team Excellence: Developing an Interprofessional Skills Competency Domain. The roundtable focused on the importance of incorporating concepts from IPE into global health education. Many of the issues around IPE from a domestic standpoint hold true when health care workers move beyond their country boundaries. In a sense, effective global health care delivery is predicated not only on preparing culturally competent practitioners but also preparing health care workers who can move beyond their professional centrisms. As a scholar in the area of IPE, the goal of this paper is to set forth some critical organizing principals of IPE that are salient within both the domestic and global community.

The passage of the Patient Protection and Affordable Care Act (ACA) and its direct impact on the evolution of medical home and transitional care models creates momentum for team-based care that incorporates collaboration, clear and effective communication, and cross-profession training.5 The ACA has the potential to eventually revolutionize health care service delivery within our country by moving our system of payment from a “fee for service” model to a population-based or “capitated service delivery” structure. In the present fee for service model, competition between professionals is fierce, professional boundaries are rigid, and there is a distinct preference for community-based clinics and patient waiting rooms to be full. In the new system, many health professionals will be paid a salary managed by a corporate entity and their income will not depend on fees for the number and type of procedures performed. Thus, a conceptual shift from quantity of services to quality of services is taking place. This shift should not only promote the accessibility of health care to all citizens, but will also reduce the competition between professionals around “turf” or scope of practice issues that has helped shape the silos and isolation that exists in our present health care envi-
The impending changes brought about by the ACA will, of course, be incremental and dependent on the law’s resistance to being rescinded or revised. Nonetheless, it has set into motion a need by our professional schools to elevate collaborative interprofessional education and training as a necessary component of curricula for the foreseeable future. Collaborative practice models that evolve from these university-based IPE initiatives will need to address the issue of professional culture and may be easily adapted to the global health care arena.

Interestingly, many of the curricula challenges posed by changes in our domestic health care environment will be informed by health care systems across the globe already employing a population-based or universal health care delivery model. We can learn much about IPE curriculum from health care systems in countries like Canada, Great Britain, and others. To the extent that we borrow IPE ideas and profit from lessons learned from other countries employing this approach, our global health programming will be sensitive to, and rooted in, international issues and concerns. However, among the various issues challenging IPE implementation, there remains one essential problem that is often overlooked that keeps our health care system from promoting the integration of IPE into the postgraduate work environment and ultimately the advancement of collaborative practice. This issue is what I consider to be one of most intractable barriers to IPE, namely the barrier of profession-centrism or professional culture. This problem must be addressed along with model of care and reimbursement changes if we hope to have IPE implemented in the postgraduate practice environment.

A Universal IPE Curriculum Implementation Challenge

Clearly, cost and coordination are realities that challenge the implementation of interprofessional training both at home and internationally. However, there is one nagging and unyielding barrier to postgraduate interprofessional collaboration that rises above the barriers of finance, models of care and coordination, and curriculum. This is the issue of professional culture. Each profession possesses its own culture. The profession specific “cultural frame” must be identified, understood, and addressed if there is any hope of having IPE accepted as a viable dimension of our educational curriculum and practice environment. It is my belief that the primary barrier to successful implementation of IPE is the diverse cultural structures that guide and moderate the various educational communities and training environments. It is clear that we can appropriate funds to build creative IPE programs, but if there is no true buy-in by the professions and the leaders in those professions, then it will become nothing more than a cursory course requirement or transitory educational fashion trend.

Each health discipline possesses a professional culture that shapes the reality of educational experience of its members; determines the salience of curriculum content, core values, customs, dress, professional sym-
bols; the meaning, attribution, and etiology of symptoms; what constitutes health, wellness, approach to care; and what constitutes treatment success. Most importantly, professional culture defines the means for distributing power within the work environment, how decisions are made, how conflict is resolved, how reality is constructed, power allocated, the level and nature of inter-profession communication, and the resolution of conflicts and management of relationships between team members and constituents. This perspective, a person judges the worth, value, and utility of their environment. Sumner argues that human interaction is organized within social groups that go to great length to differentiate between legitimized participants (members of the group) and outsiders (persons who are not members of the group). In addition, his notion of ethnocentrism suggests that strong group affiliation is positively associated with negative attitudes towards outside members. In this way, ethnocentrism typically results in mostly negative stereotypic images of the out-group. Those enrolled or affiliated with the social group readily proclaim their view of the world as enlightened and preferred when compared to other cultural groups. Profession-centrism is similar, but the “narrowed view of the world” is now applied to the cultures of health professions. From the first day of a student’s professional training, they are continuously inoculated with a preferred set of perceptions that define aspects of health, well-being, and the appropriate methods for achieving this status. These interactions are intimately tied to both a student’s developing sense of professionalism and their constructed view of the world. It will influence their perceptions, attitudes, and behaviors.

Even the word “professionalism” is socially constructed and denotes difference, being special and possessing knowledge or skills unknown and unavailable to others. In addition, professional training across the health professions takes place with mentors, teachers, and role models who help to establish this constructed reality and define the boundaries and scope of practice of a particular health profession. This effort to protect professional identity paradoxically also promotes isolation, elitism, and territorialism. Thus, if our goal is to accomplish IPE and the ability to effectively collaborate across disciplines, then we need to reduce the role of profession-centrism. To achieve this goal, Pecukonis et al. suggest that students and faculty must develop interprofessional cultural competence. Consistent with the concept of cultural competence, interprofessional cultural competence (ICC) suggests that health care professionals develop skills and comfort as a member of a health care team.

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discipline-centric perspective is not unique to the United States health care delivery system, but it is rooted in the histories and interprofessional relationships of most global health care systems. These historical legacies cannot be denied and must be understood as a first step in ameliorating the schisms and tensions between professions.

**Profession-Centrism**

Similar to ethnocentrism, profession-centrism (professional centric thinking) is a constructed and preferred view of the world held by a particular professional group developed and reinforced through their training, educational, and work experiences. The concept of profession-centrism is parallel to the concept of ethnocentrism as defined by sociologist William Graham Sumner. Ethnocentrism reflects a person’s preference to look at the world through the perceptual frame work or lens of their own culture. Sumner states, “Each group nourishes its own pride and vanity, boasts itself superior, exalts its own divinities and looks with contempt on outsiders.” A person makes meaning of their lives by inferring or attributing causes to everyday events through this cultural lens. Through their cultural perspective, a person judges the worth, value, and utility of their environment. Sumner argues that human interaction is organized within social groups that go to great length to differentiate between legitimized participants (members of the group) and outsiders (persons who are not members of the group). In addition, his notion of ethnocentrism suggests that strong group affiliation is positively associated with negative attitudes towards outside members. In this way, ethnocentrism typically results in mostly negative stereotypic images of the out-group. Those enrolled or affiliated with the social group readily proclaim their view of the world as enlightened and preferred when compared to other cultural groups. Profession-centrism is similar, but the “narrowed view of the world” is now applied to the cultures of health professions. From the first day of a student’s professional training, they are continuously inoculated with a preferred set of perceptions that define aspects of health, well-being, and the appropriate methods for achieving this status. These interactions are intimately tied to both a student’s developing sense of professionalism and their constructed view of the world. It will influence their perceptions, attitudes, and behaviors.

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Effective collaboration with other health professions requires a set of congruent behaviors, attitudes, and health policies that minimize profession-centrism. Unfortunately, most professional schools have limited training experiences that prepare students for working collaboratively across professions. However, upon graduation and entrance into the workforce, the
health care system (including patients and their families) expect this type of cooperation and collaboration. A student who waits until after graduation to learn interprofessional cultural competence requires significant and enlightened continuing educational support systems that rarely exist in a busy health care environment. In addition, it is better to prevent profession-centric thinking and promote ICC during training rather than asking a trainee to disregard values they believe to be true following their graduation and dealing with the anxiety inherent with their first job. If effective ICC is not in place upon graduation, it is only established with significant difficulty as most professionals become avoidant, confused, or defensive when asked to work collaboratively without preexisting competence in this area. The values they have acquired through their “siloeed” training will discourage and perhaps devalue the importance of interprofessional health care practice, limit communication, and ultimately positively reinforce their discipline-centric perceptions.

Theoretical Model of Profession-Centrism
The relational aspects of “team” reflect how professional identity is established and ultimately inform our understanding of the challenges of IPE curricula and are nicely explained in micro-sociologists Tajfel and Turner’s Social Identity Theory. The theory suggests that one part of our self-concept and social identity emanates from, and in turn reflects, our unique social (group) affiliations. People’s sense of who they are and their worth or value in life is at least partially determined by their group memberships. In this sense, being a member of a health profession helps to coalesce an aspect of our identity and provides rules for understanding and behaving appropriately within our social world. Tajfel suggests that social identity is constructed interpersonally from experiences nested within the various groups salient to the individual, including their professional affiliations. As Miller and Prentice suggest, “Social Identity Theory is interested in how the group is expressed within the individual rather than how a person acts within the group.” Thus, a person’s self-concept is shaped by, and intimately tied to, group interaction. These interactions create a context for vetting and affirming ways of thinking, feeling, and behaving that reflect the culture of the group which is ultimately passed along to subsequent generations. According to Abrams and Hogg, integrated members will attempt to maintain aspects of their self-concept (self-esteem) by defending and preserving the ascribed group values. The quest for positive social identity establishes the need to create and maintain perceptions and attributions that promote group affiliations in a preferred positive light. This interactive frame work is used to preserve the integrity and boundaries of the group by providing members with a cultural lens to interpret and evaluate information while becoming the rationale for constructing activities that preserve the status quo. This interaction manages group culture by constructing reality consistent with perceptions of self-concept.

Although efficient in some simplistic forms, and indeed reflective of the typical way we attempt to organize and make sense of the world’s complexities, the quest for social identity also leads to the creation of stereotypes that can be limited, involve bias judgment and action, and must be managed to achieve effective interprofessional team work. Paradoxically, these “pre-judgments” can never be fully eliminated as they are required to identify and maintain some semblance of boundaries between professions or groups. This notion is often confusing to many professionals since a significant source of anxiety about entering into interprofessional education is the loss of their professional self. This anxiety is not dissimilar to the experience of entering into any important relationship and begs the question of “how can I maintain autonomy and the integrity of my personal values and beliefs etc. while fully joining with another to accomplish some goal?” Is it possible?

Theoretical Underpinnings of IPE to Help Promote Interprofessional Cultural Competence
Successful curricula that promotes ICC must focus on eliminating profession-centric thinking by addressing the relational or interactive components across professions. In general, efforts to reduce relational bias need to address issues of power (how decisions are made and who gives direction to the health care delivery team), hierarchy (how is labor divided in the health care setting and between professionals and how are these decisions around role or scope of practice generated), professional culture (how socialization in our professional groups is inherent in our training experiences including language, perceptions of health and illness, selection of interventions to ameliorate illness, and views of etiology of malaise), professional roles (determining our professions tasks, clinical responsibilities and scope of practice), and team interaction (communication, problem solving, conflict management and cohesion that emanate from present day interactions but is also rooted in historical relationships between various professions).

The relational issues of “power and hierarchy” are particularly important, as they directly challenge physician hegemony rooted historically in many health care delivery systems. This dominant cultural view of
how health care should be delivered includes beliefs, attributions, and values that require challenge and should not be perceived as teleology and inevitable by team members. Leadership in successful interprofessional teams must be fluid and flexible and not vested in tradition where the physician has ultimate power and responsibility. Members need to be on equal footing when it comes to deciding a course of action for patient and family care. At the same time, those with the needed expertise at the moment must not only step forward, but be allowed and encouraged to do so by the team. Relinquishing this ultimate control will not be simple or easy for the medical profession based on long-honored tradition, as well as many current system structures. Likewise, stepping forward and assuming charge of a situation will not always be comfortable for health care providers socialized to defer to the physician as the ultimate arbiter. Effective implementation of a team cannot be a dictatorship by any one member of this group. It is shared and rooted in process and discussion rather than unquestioned action. Of course, this type of process is both time consuming and costly but will enrich the care of a patient and their family if employed judiciously. That said, not every patient will require this level of intervention or care.

Conclusion
It is clear that in order to improve health for our citizens, our health workforce must be team-focused and collaboration-ready at the time of their graduation. Shortages of adequately trained health care workers must be addressed if we are to reduce the global disease burden for HIV/AIDS and other infectious diseases, infant mortality, childhood preventable disease, among other global health woes. Adequately trained and collaborative health care workers must be willing and able to work hand-in-hand with other health care professionals, paraprofessionals, local community health workers, and lay health providers who reflect community need and cultural tradition. Preparing health care providers to work effectively across professions will help craft coordinated policies and strategies that accommodate local need.

The achievement of these goals is contingent on reducing profession-centrism. Reducing profession-centrism will promote cooperation between health providers as they design both curriculum for their trainees and health interventions for their patients, families, and communities. These models of practice and training will need to be flexible as collaboration may need to extend past the typical physician/nurse relationship to include professionals relevant to developing economies such as engineers, veterinarians, nutritionists, and agricultural experts. Health care delivery from both the macro- and micro-levels will promote disease prevention and health promotion and reduce the hegemony of physician-directed health care delivery.

References
7. Id.
8. Id.
10. Id.
11. Id.
13. See supra note 7.