Interdisciplinary Family Medicine

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For much of my career, authors from medicine, nursing, pharmacy, and the mental health disciplines have championed the notion of interdisciplinary education.\(^1,2\) With remarkable consistency, they complain that health professionals are trained in discipline-specific silos and socialized to practice in a disconnected health care system characterized by poor teamwork and poor communication. As we work toward a new primary care system based on the patient-centered medical home (PCMH), it has become clear that traditional educational models do not consistently produce graduates who know how to work as teams. But a myriad of barriers have thus far limited progress in building interdisciplinary health professions education. Such models are expensive to develop. Professional turf issues restrict options. Logistical barriers, such as differences in course schedules, thwart well-intentioned efforts. So, in spite of sustained success in fields like geriatrics and palliative care, interdisciplinary primary care education remains sporadic. Perhaps it is time to reconsider our approach.

Family medicine residencies have included interdisciplinary faculty members from our earliest days. Over 30 years ago, my own residency included required teaching from surgeons, pediatricians, obstetricians, and internists. I learned about doctor-patient communication and counseling skills from psychologists and social workers. My earliest experiences with faculty development included teaching from nonphysician educators and business management professionals. Built on the model of the rotating internship, our residencies were designed to incorporate diverse perspectives about the role of the family doctor. Residents in other medical specialties spend nearly all of their time learning from teachers in their own fields; this has never been the case in family medicine. Today, about three-quarters of STFM’s 4,596 members are physicians, but we also have members from nursing, pharmacy, social work, education, psychology, nutrition, statistics, and epidemiology.

Even though family medicine was born as an interdisciplinary effort, we have been focused narrowly on the education of family physicians. Our training has been a one-way street; our residents learn from others, but family medicine faculty play a limited role in the education of non-family physicians. No other medical specialty requires their residents to have educational experiences in family medicine. Our role in educating physician assistants, pharmacists, or nurses varies widely from one location to the next. With the Future of Family Medicine Project a decade ago, we began to embrace a broader perspective, but we are still struggling to make strong primary care teams a reality.\(^4\)

We know from the past decade of work that the PCMH requires teams of professionals that can bring together the traditional functions of primary care, mental health, and public health to form a new foundation for American health care. We suspect that the various disciplines required for such teams should be trained together. We do not yet know how to do this, nor do we know how to measure the effectiveness of such teams. As educators we always try to solve problems by devising new curricula, but how can we create a curriculum when we know so little about the outcomes we seek to achieve? Exposing our learners to dysfunctional teams teaches the wrong lessons, but do
we really know an effective team when we see one? In reality, there is a step we need to take before building educational models—we need to learn how successful primary care teams work in real community practices. Clinical innovation must precede educational innovation. New models of clinical care require rigorous study using methods that are not commonly used in medical research. In the past we have incorporated nonphysician faculty members as teachers. We now need to incorporate them more broadly as scholars. When we collaborate with scholars from diverse disciplines, we learn a lot, but we also encounter some interesting problems. Physician faculty members, even those from specialties other than family medicine, have been socialized into the culture of medical education during their own medical school and residency training. This is not true for faculty from disciplines outside of medicine. Traditionally, our faculty development efforts have been unbalanced. We focus on teaching nonphysicians about how family physicians do things but place less emphasis on teaching physician faculty members about other scholarly and pedagogic cultures. Effective teams require a shared culture that blends the best traditions from each component part.

Many medical school family medicine departments have faculty from multiple disciplines, but this is less often the case in community-based residencies. Our traditional residency model involves teaching from several medical specialties and from teachers in the behavioral sciences. More recently, many of our programs have added professionals from fields like pharmacy and nutrition science. But few community residency programs have faculty in epidemiology, statistics, medical sociology, anthropology, or communications, and these are examples of fields with rich scholarly traditions that bring new ideas about how to study team-based care. Since it is impractical for every residency to have faculty from every field, our residencies and departments must learn to work together in organized networks characterized by closer collaboration than we have had in the past. We can also use our national organizations and national meetings to facilitate such networking.

It seems clear that we cannot wait for interdisciplinary primary care scholarship and teaching to arise spontaneously; family medicine is in an ideal position to break the stalemate once and for all. STFM aspires to be the “indispensable academic home for all teachers of family medicine.” This is not the same thing as being the indispensable academic home for people who teach family physicians. Family medicine needs a larger vision than simply teaching family doctors. Our old mission was to train family physicians. Our new mission is to invent and study new models of primary care and teach learners from multiple disciplines to care for populations of people in community settings as teams. Patient-centered care is not about what physicians do; it is about how individuals and communities receive the care they need. We are fond of saying that family physicians should be leaders in the new health care system. This is the path to take if we are serious.

References

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