Received: 25 July 2022 | Accepted: 28 July 2022

DOI: 10.1111/medu.14885

COMMENTARIES

Together or not together: Paving the way to boundary crossing

Titia S. van Duin[1,2] | Marco Antonio de Carvalho Filho[1]

[1]Lifelong Learning, Education and Assessment Research Network (LEARN), University of Groningen, University Medical Centre Groningen, Groningen, The Netherlands

[2]Department of Critical Care, University Medical Centre Groningen, Groningen, The Netherlands

Correspondence
Titia S. van Duin, Lifelong Learning, Education and Assessment Research Network (LEARN), University of Groningen, University Medical Centre Groningen, Groningen, The Netherlands.
Email: t.s.van.duin@umcg.nl

Interprofessional education (IPE) activities have gained ground in medical curricula as preparation for interprofessional collaboration, and the design and evaluation of IPE programmes have become an increasingly relevant and prevalent topic in health professions' education literature.[1,2] In the last 2 years, the COVID-19 pandemic has boosted the use of 'virtual' IPE training; however, its theoretical groundworks are still lacking.[3] In their paper 'Building a Theoretical Model for Virtual IPE,' Azim et al[4] explored the extension of two interprofessional and workplace learning frameworks into the virtual setting using simulation-based workshops in which both medical and nursing students participated. Without the context of the clinical workplace and professional labels, the authors found that students participated more freely. In the online environment, students experienced no hierarchy, power imbalance or role misunderstanding, which allowed them to focus on their interprofessional tasks. One quotation reflected this perfectly: 'We felt like we were all part of one group'.

In the online environment, students experienced no hierarchy, power imbalance or role misunderstanding, which allowed them to focus on their interprofessional tasks.

It makes you wonder: What would collaborative practice look like if you take away professional boundaries? Currently, the landscape of healthcare practice is made up of professional communities, separated by role boundaries, power and hierarchy and professional culture.[5,6] Here lies possibly the biggest challenge to interprofessional practice and education: These boundaries are inherent to the clinical workplace, but act as barriers to successful interprofessional learning and collaboration.[6,7] In this context, preparing students for *real-life* collaborative practice requires learning activities that take the sociocultural aspects of the clinical workplace—like professional boundaries—into account. In simulation training, fidelity refers to the degree to which the simulation reflects 'real' practice. Fidelity has several dimensions, including physical and psychological fidelity, but also *sociological fidelity*.[8,9] 'High-sociological fidelity' simulation learning accurately reproduces the sociocultural aspects of clinical practice, helping students to directly transfer their learning to the workplace.[9] Thus, simulation in IPE may benefit from increasing levels of sociological fidelity to prepare young healthcare professionals to deal with the complexity of real-life interprofessional collaboration.

In this context, preparing students for real-life collaborative practice requires learning activities that take the sociocultural aspects of the clinical workplace into account.

When junior healthcare professionals enter the workplace, they need to learn and eventually master their own professional roles, including dealing with new tasks and responsibilities, while navigating the professional roles, attitudes and expectations of others. In addition, they need to manage complex interprofessional relations and preferably learn from these experiences at the same time.[7] Doing so is a challenging endeavour that proves to be a highly emotional process. When neglected, emotions may even impair the learner's ability to reflect on and actually learn from interprofessional experiences.[7]

IPE is not expected to dissolve professional boundaries, but it may ease the transition into collaborative practice by laying the foundation for boundary crossing. IPE starts with educating students about the existence of professional cultures, creating sociocultural awareness through interprofessional team-based activities. Such activities should truly reflect aspects of interprofessional collaboration as role perceptions, misunderstood expectations and conflicts. Through these activities, students gain social knowledge concerning the values, attitudes and beliefs of other professions, which helps them to take on different 'professional views', and explore how different views could cause interprofessional tensions and disagreements. By focusing on role-understanding and acknowledging the diverse expertise within the team, the learning activities may show students how to find knowledge and guidance *inside* the interprofessional group. Interprofessional engagement can thus strengthen professional autonomy by allowing junior healthcare professionals' identity to develop across professional boundaries.[5,7] In this way, undergraduate IPE can prime students for boundary crossing activities in the clinical workplace.

IPE is not expected to dissolve professional boundaries, but it may ease the transition into collaborative practice by laying the foundation for boundary crossing.

In accordance to Paradis and Whitehead's *Fourth Wave of Education for Collaboration*,[1] IPE should also take place in the post-graduate practice setting. Learning with, from and about each other, starts with seeing the interprofessional team as a credible source of feedback. Interprofessional feedback, however, is hampered by biases between professional cultures and power imbalance within the team,[10] stressing the importance of undergraduate IPE in paving the way to stimulate feedback-seeking behaviour across professional boundaries. For interprofessional feedback to be successful, health professionals will need to bridge professional silos and see both professional and interprofessional learning as an integrative process that requires participation from each member of the interprofessional team.[5,7] We argue that this is only possible if senior healthcare professionals act as collaborative role models and deliberately invite the interprofessional team into the feedback-process.

For interprofessional feedback to be successful, health professionals will need to bridge professional silos and see both professional and interprofessional learning as an integrative process that requires participation from each member of the interprofessional team.

Virtual simulation might prove a 'low-sociological fidelity' activity, not suited to prepare for effective collaboration in the sense of sociological learning, but it could be a promising primer for students to explore their own role in a team, learn to communicate when performing different tasks and discover the benefits of interprofessional engagement.[4] Using the absence of professional silos, virtual IPE can bring learners together— perhaps in a way that current collaborative practice never could. The virtual space allows students to participate in conflict-free interprofessional learning activities from the comfort of their own homes—increasing psychological and sociological safety. As a consequence, the interprofessional activities are likely to carry less of an emotional burden and, without power imbalance or interprofessional tensions, open up the way to conversations that stimulate giving and receiving feedback. Using the safety of the online environment to show the benefits of gathering feedback—independent of students' primary professional identity, virtual IPE may be perfectly suited to nurture interprofessional feedback-seeking behaviour.

Using the absence of professional silos, virtual IPE can bring learners together— perhaps in a way that current collaborative practice never could.

ORCID

Titia S. van Duin https://orcid.org/0000-0002-1768-191X

Marco Antonio de Carvalho Filho https://orcid.org/0000-0001-7008-4092

REFERENCES

1. Paradis E, Whitehead CR. Beyond the lamppost: a proposal for a fourth wave of education for collaboration. *Acad Med J Assoc am Med Coll*. 2018;93(10):1457-1463. doi:10.1097/ACM.0000000000002233
2. Reeves S, Boet S, Zierler B, Kitto S. Interprofessional education and practice guide no. 3: evaluating interprofessional education. *J Interprof Care*. 2015;29(4):305-312. doi:10.3109/13561820.2014.1003637
3. Lackie K, Najjar G, El-Awaisi A, et al. Interprofessional education and collaborative practice research during the COVID-19 pandemic: considerations to advance the field. *J Interprof Care*. 2020;34(5):583-586. doi:10.1080/13561820.2020.1807481
4. Azim A, Kocaqi E, Wojkowski S, Uzelli-Yilmaz D, Foohey S, Sibbald M. Building a theoretical model for virtual interprofessional education. *Med Educ*. 2022;56(11):1105-1113. doi:10.1111/medu.14867
5. Stalmeijer RE, Varpio L. The wolf you feed: challenging intraprofessional workplace-based education norms. *Med Educ*. 2021;55(8):894-902. doi:10.1111/medu.14520
6. Hall P. Interprofessional teamwork: professional cultures as barriers. *J Interprof Care*. 2005;19(Suppl 1):188-196. doi:10.1080/13561820500081745
7. van Duin TS, de Carvalho Filho MA, Pype PF, et al. Junior doctors' experiences with interprofessional collaboration: wandering the landscape. *Med Educ*. 2022;56(4):418-431. doi:10.1111/medu.14711
8. Sharma S, Boet S, Kitto S, Reeves S. Interprofessional simulated learning: the need for "sociological fidelity". *J Interprof Care*. 2011;25(2):81-83. doi:10.3109/13561820.2011.556514
9. Thomas L, Reeves S. Sociological fidelity: keeping the patient at the heart of interprofessional learning. *J Interprof Care*. 2015;29(3):177-178. doi:10.3109/13561820.2015.1035179
10. Miles A, Ginsburg S, Sibbald M, Tavares W, Watling C, Stroud L. Feedback from health professionals in postgraduate medical education: influence of interprofessional relationship, identity and power. *Med Educ*. 2021;55(4):518-529. doi:10.1111/medu.14426

How to cite this article: van Duin TS, de Carvalho Filho MA. Together or not together: Paving the way to boundary crossing. *Med Educ*. 2022;56(11):1054-1056. doi:10.1111/medu.14885

DOI: 10.1111/medu.14886

How can medical educators be good ancestors?

Andrea McKivett[1] | **David Paul**[2]

[1]Flinders University College of Medicine and Public Health - Population Health, Adelaide, South Australia, Australia

[2]University of Notre Dame Australia School of Medicine Fremantle, Fremantle, West Australia, Australia

Correspondence
Andrea McKivett, Flinders University College of Medicine and Public Health - Population Health, Adelaide, SA, Australia.
Email: andrea.mckivett@flinders.edu.au

> Access relies on more than just opening the door![1]

A recent paper by Foreshew and Al-Jawad outlined the current role and responsibility for medical academies to take informed and committed action to achieve institutional decolonisation.[2] This work focused on the experiences and needs of medical students to consider how they might strengthen their capability to fit in and belong in their cohort and how schools can assist with this. Medical students from diverse, marginalised and oppressed populations are essential to a future healthcare workforce that can disrupt the status quo of health inequities through individual and collective action.[3] Building a foundation of diverse and inclusive student and graduate cohorts requires schools to own and drive the necessary change from within.[1,4,5] Students should not have to shoulder the burden of change, nor should they be responsible for continued action to raise and address systemic power imbalances inherent within the structure of medical academies. Foreshew and Al-Jawad note the important role of medical institutions in decolonisation and proposes that reflection and observation must urgently move to informed and committed action because:

> … the actions that students put forward may or may not be implemented by the medical school and this places the next observation and reflective stages in the hands of the institution and its staff or student members involved in decolonizing the curriculum.[2]