How would an egalitarian health care system operate? Power and conflict in interprofessional education

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Recently, I initiated a study into interprofessional education (IPE) that involved the qualitative evaluation of an interdisciplinary team simulation. Recruitment of allied health and nursing students was straightforward; we approached teaching staff about advertising the study on their unit websites and in lectures. Recruitment of medical students was more difficult. Although I had secured ethics approval from the University, the School of Medicine required additional approval by an internal committee. For the team competition, we successfully included students from a range of health professions, such as nursing, physiotherapy, podiatry, Chinese medicine, medicine and psychology. However, no medical students volunteered for the qualitative portion of the study.

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This experience is not unique; others have encountered reluctance from medicine to participate in IPE.[1] These experiences illustrate a point emphasised in Paradis and Whitehead's review[2] of the IPE literature in this issue: there is a hierarchy in health care that IPE seeks to address. Well-known to readers of *Medical Education* are the steep entry requirements for medicine, crowded curriculum, and leadership responsibilities imposed upon graduation. Medical authority is widely recognised, historically symbolised through stethoscopes, white lab coats, titles (e.g. 'Doctor') and letters (e.g. 'MBBS').

There is a hierarchy in health care that IPE seeks to address

Paradis and Whitehead[2] bravely spotlight what medical authority means to IPE: power and conflict. Interprofessional education can be perceived as associated with an agenda to redistribute medical power, leading, at times, to opposition.[3] Despite the breadth of sociological literature on the uneven health care landscape,[4,5] Paradis and Whitehead[2] found only six articles within the IPE literature that explicitly address power. This omission, they conclude, 'speaks louder than words'.[2]

It is time, argue Paradis and Whitehead[2], to address the centrality of hierarchies, power and conflict to IPE. For too long IPE researchers have worked on the assumption that changes leading to improved collaboration will occur once the 'correct' approach to IPE is discovered, without acknowledging the contextual and tiered nature of health care systems. To this end, they call for engagement with sociological concepts of power and for the accommodation of complexity through the use of relevant research methods.

I unreservedly agree with Paradis and Whitehead,[2] but suggest that we should go further. To better understand how IPE (potentially) works to improve collaboration and why outcomes vary, we need to change our language and scope of inquiry. We also need to give serious consideration to questions about hierarchy and collaboration in the health care system we are attempting to (re) create.

It is time to address the centrality of hierarchies, power and conflict to IPE

Firstly, we can reconsider the *language* we use. Rather than viewing IPE as a knowledge transfer, skill acquisition or behaviour change intervention,[1,6] IPE researchers should define IPE as a pedagogical process. 'Pedagogy' acknowledges the transfer of values involved in education.[7] Furthermore, we should reconceive IPE as representing merely one of many mechanisms involved in social change. 'Social change' is the modification of cultural patterns and social structures.[8] Culture encompasses shared forms of 'living and thinking' comprising 'symbols and language... knowledge... values... norms... and techniques.'[8] Social structure is the 'persistent network of social relationships'[8] that (re) produce ongoing roles, groups, organisations and communities. Reconceptualising IPE in this language allows us to view it as an attempted revolution in health care culture and to be more realistic about expected IPE outcomes. Structures may also need to change before collaboration

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replaces power struggles in medical systems.

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Next, we might look at the *scope* of IPE. New scopes of inquiry are required to accommodate this reconceptualisation of IPE as a pedagogical value transfer process aimed at social change. As others have pointed out, snapshot evaluations of IPE underpinned by epistemologies familiar to scientists may be 'inappropriate' in IPE and medical education.[6,9] Each paradigm excludes different data.[9] Including complexity and context necessitates the use of a range of additional paradigms: interpretivist, phenomenological, post-structuralist and critical.[9] Positivist epistemologies, for example, exclude emotions and subjectivity, but emotions, as Paradis and Whitehead's[2] content analysis implies, may be central to IPE. Additionally, revaluing IPE as a social change endeavour requires research at different levels. Studies of social change are concerned with how it takes place (at individual and structural levels), how it is initiated (from inside or outside, by those in power or through grassroots initiatives), and at what pace.[8] To appreciate the pedagogical, contextual and social change elements of IPE, a range of approaches, scopes and paradigms is required.

Structures may also need to change before collaboration replaces power struggles

Finally, there is a need to ask serious *questions* about the future we are reimagining for health care. As we reconceptualise IPE as revolutionary cultural change, redressing issues of power and conflict in health care collaboration, we need to solidify our image of the changes we are working towards. Is flattening the hierarchy within the medical system what we want? Do we need hierarchies in health care? How would an egalitarian health care system operate? Answers to these questions should be prioritised as we judge the effectiveness of IPE programmes at driving cultural change towards them.

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