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On interdisciplinarity and why it matters … A lesson from primary care

Catherine L. Gilliss, DNSc, RN, FAAN

Catherine L. Gilliss, DNSc, RN, FAAN, is the Dean at the Duke University School of Nursing, the Helene Fuld Health Trust Professor of Nursing, and the Vice Chancellor for Nursing Affairs for Duke University, Durham, NC.
Corresponding author: Dr. Catherine L. Gilliss, Duke University School of Nursing, DUMC 3322, Durham, NC 27710-3322.
E-mail: *Catherine.gilliss@duke.edu*

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While attending a national meeting of nurses earlier this year, I was surprised to hear an esteemed colleague question the need for interdisciplinarity. Perhaps my current work environment, which places a high value on interdisciplinary effort, has lulled me into making assumptions about its value, but I have become a believer and find myself wondering why others are not greater advocates. To me, the case is fairly straightforward.

Universities are organized into orderly divisions to promote the preparation of graduates who will advance the work of the academic discipline. Within the discipline of nursing, we educate our students to a body of knowledge that we believe represents our point of view and our discoveries. We provide a set of tools for discovery and frame the data elements systematically to promote problem solving. The approach builds depth within the discipline and advances solutions to the questions generated within our general paradigm. We prepare members of the discipline who are "disciples."

REAL WORLD PROBLEMS TEND TO NOT BE DISCIPLINE-SPECIFIC

The limitation to the disciplinary perspective lies in the tendency to bring the same basic set of information and solutions to novel problems. The problems we face are diverse and complex, and many require novel solutions. The content and problem-solving approaches used within the discipline of nursing will be enhanced through closer educational exchange with other disciplines, practice, and research partnerships that expand our point of view.

EACH DISCIPLINE FRAMES PROBLEMS IN DISCIPLINE-SPECIFIC WAYS, WHICH CAN LIMIT THE POSSIBILITIES FOR UNDERSTANDING

In response to the notion proposed by a television commentator that walking away from an "underwater" mortgage had moral implications, my husband exclaimed, "Nonsense. It's a legal issue!" Guess which professional tribe he belongs to?

Each discipline tends to frame relevant issues in specific ways and define problems with specific language. In nursing, we have learned to be fluent in several "languages." We are able to speak in medical diagnoses, but our mother tongue would have us describing symptom complexes. Why? Most simply, it is the symptom we plan to address with our professional intervention, as opposed to the root causes. (As with most generalizations, in some cases, this is not true.) Economists approach health reform looking at costs; humanists are drawn to significant issues of social justice. We frame the areas of concern to our discipline with language, a philosophical commitment, and the problem-solving methods needed to advance understanding.

THROUGH INTERDISCIPLINARY COLLABORATION AND PROBLEM SOLVING, WE LEARN

Each discipline brings knowledge to the conversation. Some of it is overlapping, but much of it is not. We grow in understanding when we discover what others have brought to the discussion, and it is important to remember what President Lyndon B. Johnson said: "You aren't learning

when you're talking." The key lies in spending time listening to others.

When we form interdisciplinary work groups, we assemble a set of individuals with "common knowledge", or information that is known to all. Within each group, there will also be "distributed knowledge," or information that is known within the discipline, but not necessarily across the disciplines. To expand its ability to understand and solve problems, interdisciplinary groups need to access the pockets of knowledge distributed across its membership. Listening helps, although we have all been with people who do not understand that sometimes they need to take a turn at listening. Too bad—that probably means they are not learning.

INTERDISCIPLINARITY KEEPS US HONEST

You cannot sit in a room with "the other" (fill in the blank here) and make wild assertions about how you are the "only one who cares/shows up/understands" (fill in that blank, too). Although it is naïve to think that we do not have true differences and disagreements within and across disciplines, when you are embroiled in a stalemate, it is important to remember the "Robert's Rule of Order," also known as Rule No. 1: Go talk with him/her. Screaming alone in a room does not advance the cause, though it may be self-soothing.

People of good will have different points of view. They are generally valid and relate to the way in which they are framing the problem at hand and the desired outcomes. A basic tenet of negotiation is finding common ground, and a second one is knowing your BATNA (best alternative to a negotiated agreement) or the bottom line on your own position. Sadly, no one has a lock on reality.

COALITIONS ARE BUILT THROUGH COLLABORATION AND COALITIONS HELP US GET THINGS DONE

A recent meeting convened and sponsored by the Josiah Macy Foundation shows the power of addressing an important topic across disciplines. *Who Will Provide Primary Care and How Will They Be Trained?*[1] brought together almost 50 physicians (MDs and DOs), nurses, physician assistants (PAs), journalists, health services researchers, payers, policy leaders, patient advocates, and foundation executives. The meeting focus was clearly outlined in the meeting title and resulted from a well-established national need to create policies that promote the development of a primary care work force. Concerns about the future work force have grown in the face of declines in physician selection of primary care as an area of specialization, but the degree of concern is a function of how much commitment one has to the belief that the physician must lead the primary care delivery team. Nurse practitioners (NPs) and PAs have been identified by many as the work force willing and able to address primary care delivery in a health care system reformed to address current obstacles in payment and design. But how to break through the first deadlock of question: *Who shall deliver primary care?*

The assembled group initially met over dinner and then spent 3 full days in dialogue. Substantive background papers reviewed the issues at hand, including a variety that would not have been known to all, thereby converting distributed knowledge to common knowledge. Participants were heard to say, "I never knew that," which is a small sign of success. Differences and commonalities were identified in the ways that NPs, PAs, and physicians are prepared and the subtle and not-so-subtle ways in which they are influenced by what they see during their educational programs.

In the privacy of our 50-person meeting, tough discussions followed on the barriers to our progress and our shared goal of designing a system that works to serve the public and those who pay for care, in both the public and private sectors.

Two of the most contentious issues with which advanced practice nursing has grappled are: state laws on scope of practice for NPs and payment for services. The issues are economic and political; and talking to ourselves about the barriers informs one another, but does not necessarily eliminate the barriers. Nor have we been successful when we take on organized medicine, head to head. That polemic is purely political.

Through discussion, give and take, and the pressure to be honest in a group of peers across disciplines, the group produced a series of recommendations that were released in early March 2010 and appear on the Josiah Macy Foundation website (http://www.macyfoundation.org). I want to quote from the *Co-Chairs' Summary of the Conference* to report the first conclusion and related recommendation coming from this group:

> CONCLUSION 1
> In order to meet the societal needs for primary care and train the right primary care professionals in the right numbers with the right competencies for the most appropriate roles, health care systems need incentives to dramatically change the way primary care is valued, delivered, and integrated in evolving health care systems. We will not attract and retain sufficient numbers nor achieve the needed geographic distribution of primary care providers unless there is a greater proportional investment in primary care. Our students and trainees must be educated throughout their clinical training in practices that deliver first-contact, comprehensive, integrated, coordinated, high-quality, and affordable care. These practices require teams of professionals who give care that elicits patient and provider satisfaction under conditions of clearly defined roles, effective teamwork,

patient engagement, and transparency of outcomes.

RECOMMENDATION 1
(omitted)

RECOMMENDATION 2
Coupled with efforts to increase the number of physicians, nurse practitioners, and physician assistants in primary care, state and national legal, regulatory, and reimbursement policies should be changed to remove barriers that make it difficult for nurse practitioners and physician assistants to serve as primary care providers and leaders of patient-centered medical homes or other models of primary care delivery. All primary care providers should be held accountable for the quality and efficiency of care as measured by patient outcomes.[1]

In one relatively brief meeting of the relevant disciplines, the issues of medical home leadership, reimbursement, accountability, and regulation were all addressed, and the need for reform was endorsed. This is too important to go unnoticed, both for how it happened and that it happened. This meeting and its outcomes matter.

Given the Academy's commitment to advancing policy reforms, how can we take these recommendations to the next step? And what are the coalitions we need to build across professional organizations and across the disciplines to bring about these and other related reforms? I welcome your thoughts.

I am particularly grateful to my colleagues, including a number of AAN Fellows, for their candid and sensitive participation in the JMF meeting on Primary Care. Your participation made the difference described above.

REFERENCE

1. Cronenwett L, Dzau V. Co-Chairs' Summary of the Conference: Who Will Provide Primary Care and How Will They Be Trained? New York: Josiah Macy, Jr Foundation; 2010.