

Families, Systems & Health

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EDITORIAL

Training for Collaborative Family Healthcare

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EACH WEEK we read about some exciting clinical innovation to provide collaborative family healthcare. There is no question that systems thinkers (and other colleagues) are being forced to respond to the financial crisis in healthcare with new, more efficient approaches to patient care. Collaboration offers the possibility of being efficient, effective *and* respectful. These are the innovations that inspire. But who *trains* current and future practitioners to work in these new ways? And how much are we training our students to work in a traditional system that will be obsolete by the time they

graduate? What are the critical elements missing from most training today?

At the Wingspread planning meeting for the Collaborative Family HealthCare Coalition in January of 1994, a subgroup on training met to articulate the core competencies of training for collaboration.¹ These beginning ideas included generic core competencies for all professionals (see Appendix I), core competencies for healthcare providers (see Appendix II), and core competencies for mental healthcare providers (see Appendix III). The brainstorming done by this group offer us a place to start in developing core competencies and planning for the healthcare team of the future.

What is the current state of training for collaboration, here in 1996? Let us first consider *interdisciplinary training*. Because so many graduate programs spend

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¹This subgroup was facilitated by Susan McDaniel and Jeri Hepworth. Participants were Kit Chesla, Kathy Cole-Kelly, James Griffith, Robert Like, Larry Mauksch, Sherri Muchnick, Ruth Newman, John Rolland, Joseph Scherger, and Penny Williamson.

huge amounts of time socializing students into their professional ethnicities, their unique marketplace identities, few truly teach interprofessional collaboration. This is best accomplished through interdisciplinary teaching and training, working side-by-side in a seminar or in a practicum situation. We know of one program at Wright State where medical, nursing, and psychology students train for collaboration together; another at University of California at San Diego where family medicine residents and family therapy trainees are housed together to promote collaborative learning. Students in both these programs are learning what is unique about each profession and what is similar, when to work together, and when to work alone. We suspect other innovative programs exist out there.

As for *intradisciplinary training*, working side-by-side with those who will eventually be our colleagues or team members can help break down stereotypes or, better yet, prevent them from developing in the first place. There's no question that what is taught within disciplines either predisposes people for collaboration with families and other professionals, or it doesn't. It seems a lot like politics in the new world order—we're only going to succeed if we all work together.

Family Medicine and Family Nursing are two disciplines that have been out front, for at least the last 20 years, in promoting training consistent with collaboration. Since Family Medicine legislated the inclusion of behavioral scientists in all residency training programs, trainees have long been exposed to an interdisciplinary faculty. Family Medicine has also put the patient and family at the center of care. Nursing, and especially Family Nursing, has taught the importance of teamwork and collaboration with patients and other professionals as central to its mission.

Other disciplines have provided important ingredients for the collaborative pie. General Internal Medicine has an impressive literature on patient-centered care

that helps to elucidate what it means to collaborate with patients in their treatment. Behavioral and Developmental Pediatrics have interdisciplinary faculty and teach about families (not necessarily family systems, but children and parents). Family therapy has been out front in the application of a systems approach to collaboration with patients and families. Like all disciplines, it has been variable in its willingness to enter the collaborative arena and become part of the healthcare team.

Many Continuing Education opportunities exist, from the Society for Teachers of Family Medicine: Family in Family Medicine meeting at Amelia Island, Florida, in March, to the Medical Family Therapy Institute in Rochester, in June, to the Collaborative Family HealthCare Conference in Washington DC, in January.² Many disciplines offer collaborative training at their annual meetings (family therapy and psychology, to name a few). We all have to be retrained.

How does it work where you are? What is needed? We hope that *Families, Systems & Health* will provide an outlet to dispense information about training in Collaborative Family HealthCare, beginning with an article in this issue by George Saba. We invite your response. If you are training for collaboration, consider writing an article or an essay that describes your program. What works? What doesn't? What is innovative? In our rapidly evolving system, we all need to benefit from each other's trials and successes. We don't have time to re-invent the wheel.

² For information on the Family in Family Medicine meeting, contact the Society of Teachers of Family Medicine (800-274-2237). For information on the Medical Family Therapy Institute, contact the University of Rochester Family Therapy Training Program (716-275-2532). For information on The Collaborative Family HealthCare Conference, contact the Collaborative Family HealthCare Coalition (212-675-2477).