

## Form versus Function: What does and does not constitute an interprofessional team

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## Commentary

# Form Versus Function: What Does and Does Not Constitute an Interprofessional Team

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The World Health Organization's definitions of interprofessional education and collaborative practice posit that it is the professional identity of students and health workers which is the essential element that makes teams interprofessional. Specifically, "interprofessional education occurs when students from two or more professions learn about, from and with each other..." and "collaborative practice happens when multiple health workers from different professional backgrounds work together..." (WHO, 2010) This essay argues that it is not the professional identity or the form of a student or health worker which is the essential element, rather it is the function that these students and health workers carry out. Viewed from this perspective not all allopathic physician and physician assistant teams are interprofessional in nature, because much of the work performed by these professions has significant areas of overlap in function. It is only when the allopathic physician is practicing medicine beyond the scope of practice of their physician assistant colleague that we can call this an interprofessional team. It is, therefore, the function in which the students and health care workers are engaged that should frame our conceptualization of what constitutes an interprofessional team.

The proximate locality in which multiple health workers converge is a type of ecological niche which is defined by its unique functionality. For instance we go to the preoperative anesthesia clinic for a specific

function to be performed: an assessment of our relative health and readiness to receive anesthesia and undergo a surgical procedure. The ecological niche of the preoperative clinic may include different forms of health workers such as physician anesthesiologist and certified registered nurse anesthetist, but similar to the example above when an anesthesiologist and a nurse anesthetist are practicing anesthesia, despite their different educational backgrounds, professional identities and the historic and philosophic differences between practicing medicine versus practicing nursing, virtually all of the time the functions these professionals engage in, that of providing anesthesia care, are the same. Viewed from this functional perspective, as is the case above, the anesthesiologists and the nurse anesthetist are not an interprofessional team, except in those rare cases when the anesthesiologist is providing anesthesia care which is beyond the scope of practice of the nurse anesthetist.

Allopathic and osteopathic physicians are another example of different forms performing the same function. Both can complete allopathic residency programs, despite their different forms and for a majority of the medical specialties, there is no difference in the functions performed by allopathic physicians and their osteopathic physician colleagues. Here again, despite historic and philosophic differences between allopathic and osteopathic medicine the two

professions do not constitute an interprofessional team, with the exception of when the osteopathic physician practices osteopathic manipulations which are outside of the scope of practice of the allopathic physician.

There has been a trend of ever-increasing diversity in forms of health workers; witness the anesthesia assistant, another health worker with some functional overlap with their anesthesiologist and nurse anesthetist colleagues. This trend has far outpaced the relative diversity and growth of the functional ecological niches which exist in health care. As in the natural world an increase in forms or species diversity within a local ecological niche, all vying for the same limited resources spawn's competition. Here, conceptualizing health workers based on their function may help mitigate inter-profession competition, and true interprofessional teams may emerge. Teams of health workers, who are practicing at the upper limits of their scope of practice, which, once their functional capacity is reached, then engage colleagues in true interprofessional collaboration.

This trend of ever-increasing diversity in forms of health workers is driven in part by a natural tendency for taxonomic classification; that is the desire to distinguish one health worker from another based on their academic preparation and their clinical training, in short based on their forms. This type of taxonomic classification is becoming ever more difficult to do as the clear features once used to parse one health worker from another are becoming increasingly blurred. The nurse anesthetist profession is transitioning to having a clinical doctoral degree be the entry level degree, and now the doctor of nurse anesthesia practice stands alongside the medical or osteopathic doctor anesthesiologist. These three distinct forms are now all 'doctors' and all practicing anesthetists. Vestiges of past taxonomic classifications are now being strained and are starting to fail in their attempts to distinguish one health worker from another.

This failure is because functionally there is no justification for taxonomic classification; functionally these three anesthetists are just that, three anesthetists. In nature competition arises when there is functional overlap, the result of which is that one form usually dominates over other forms in their niche; the parallels

to health care here should not go unnoticed. The natural origins of form diversity may be found in evolution by means of natural selection, where certain individuals of a species are a better fit for their ecological niche and, as the theory goes, are more likely to reproduce and pass on the characteristics which made them more fit. Over time, the fit population grows to dominate their ecological niche. There is no corollary to natural selection in health care, where the trend of ever-increasing diversity of forms of health workers is artificial and forced. Is there a natural need for three different professionals to do essentially the same work?

A reconceptualization of what does and does not constitute an interprofessional team to favor function over form may help advance the dialog about interprofessional education and collaborative practice.

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