# Team work

*By Mary G. Turco, Ed.D.*

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Among the many changes taking place in medicine is an ever-increasing emphasis on patient-centered care. Teaching patient-centered care has become an important goal within medical education. To reach this goal, we need to encourage patient-centered learning as well.

What makes a physician patient-centered? One answer was suggested to me by Michael Zubkoff, Ph.D., chair of community and family medicine at DMS. He believes patient-centered doctors are self-reflective about two things: how effectively they engage each patient as a partner when developing a treatment plan and how well they communicate that plan to everyone involved in the patient's care, including nurses, social workers, pharmacists, and others. This sort of engagement requires changes to the traditional medical hierarchy and recognition that medicine is a team sport, not an individual, heroic endeavor by each clinician.

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It also requires rethinking how we educate doctors. Medical education researchers Alan Bleakley, Ph.D., and John Bligh, M.D., believe physician behavior has not received enough attention from medical educators. They argue that physicians today need to learn a narrative-based approach to patient care that situates the patient within his or her personal and social context and complements the traditional scientific, evidence-based approach.

**Narrative:** Taking a narrative-based approach to working with patients is one part of becoming a patient-centered learner and one part of creating ideal patient visits. In an ideal patient visit, everyone on the health-care team would employ a narrative-based approach to the patient's care. They would also know current evidence-based best practices, use the tools of the evaluative clinical sciences, and commit to continuous, patient-specific learning to improve constantly, both as an individual and as a team member.

Several factors would go into making such visits standard practice. First, the patient's narrative would be the central component of the visit. Second, each clinician would know and appropriately employ best practices. Third, each clinician would use outcomes data to determine if there is a gap in the knowledge, skills, or competencies needed by the medical team to give this particular patient ideal care. If a gap exists, the clinician would know where to obtain the required information or training. Fourth, rather than focusing only on individual learning to improve performance, each clinician would also engage in group learning related directly to the patient. That learning might take place in any of several ways: with the patient and the care team at the site of care; via a collaborative, online team discussion; in a team-based simulation exercise; or in an interdisciplinary, interprofessional case conference. Fifth, each clinician would know how to explain the various treatment options, how to elicit the patient's treatment preferences, and how to match those preferences to the right treatment decision. Finally, each clinician would be able to discuss with patients the cost of various treatment options. Ultimately, clinicians would democratize their relationships with patients and other team members, resulting not only in ideal patient visits but also in an ideal study, work, and learning environment.

**Train:** Examples of the transition to patient-centered learning are already appearing across the health sciences curricula at Dartmouth. DMS Dean Chip Souba, M.D., Sc.D., is leading a redesign of the curriculum for medical students to train physicians to be both dynamic leaders and strong team players. At DHMC, Marc Bertrand, M.D., director of graduate medical education, is working with residency directors to train residents in self-assessment as well as in teamwork in DHMC's world-class simulation facility, the Patient Safety Training Center. Richard Rothstein, M.D., associate dean of continuing medical education (CME), and I are studying education outcomes with the goal of ultimately reinventing CME here at Dartmouth. In the future, Rich and I will offer fewer didactic conferences and more learning collaborations, as well as a variety of targeted "learning campaigns" designed to result in improved patient outcomes and better population health. We will prioritize pedagogies that measurably change behavior and improve care (such as interactive, interdisciplinary small groups) and that use data from DHMC's electronic health record.

Many exciting initiatives are already under way. Jonathan Ross, M.D., and Carolyn Kerrigan, M.D., are leading efforts to strengthen morbidity and mortality rounds by aligning quality and systems improvements with specific patient cases. Louise Davies, M.D., is collaborating with the University of Vermont and Boston University to develop new teaching tools for tumor boards. The Association of American Medical Colleges (AAMC) chose Dartmouth as one of its 2012 Aligning and Educating for Quality sites, and I'm serving on the AAMC's Integrating Quality Initiative Steering Committee.

**Measure:** Profound changes today in the delivery of health care are challenging physicians to behave democratically, measure effectively, and learn differently. As Paul Batalden, M.D., a DMS professor emeritus of community and family medicine and an expert in clinical microsystems, has written, "Everyone in health care really has two jobs when they come to work every day: to do their work and to improve it." Reaching the goal of patient-centered care, realized in ideal patient visits, will require medical educators and clinical teams to dedicate themselves to patient-centered learning as well. ■

*The Grand Rounds essay offers insight or opinion from a member of the Dartmouth medical faculty. Mary Turco is the director of the DHMC Center for Continuing Education in the Health Sciences and an assistant professor of medicine at DMS.*