

The development of an identity and pattern of practice in the health care professions is based on a process of socialization into the roles and norms of a particular discipline and has important implications for clinical practice with elderly persons. Presented is a model for understanding the socialization process of physicians, nurses, and social workers as the development of professional meaning ("voice") based on the acquisition of value orientations or themes intrinsic to their education and training. The implications of these patterns for the abilities of different professions to work together collaboratively in the care of older persons are highlighted as a framework for developing new interdisciplinary curricular models in gerontological and geriatric education.

Key Words: Training, Clinical practice, Communication, Collaboration

Values in Health Care Professional Socialization: Implications for Geriatric Education in Interdisciplinary Teamwork¹

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Collaboration among different health professions will take on greater importance as geriatric care moves increasingly into the realm of quality of life and not simply life extension (Clark, 1995). Of necessity, quality of life deals with the qualitative dimensions of care, including values, meaning, attitudes, and preferences — all of which are created and shaped by life experience, professional training, and interaction between the individual and his or her broader social environment. In particular, the education and training of health care professionals shape their identities, values, and norms of practice in certain ways that may either enhance or inhibit effective communication and collaboration in clinical practice settings, where these skills are crucial to the effective care of elderly persons.

This article proposes that the process of acquiring a professional identity and norms of practice is an ongoing dialectic of professional socialization that is both reflective and dynamic, in that it involves interaction between the self and others in the environment. The development of personal and professional values as they relate to patient care is an essential element of this identity and the hallmark of the artistry of professional practice (Schön, 1987). The implications of this interpretation of professional socialization are important to an understanding of communication between providers, as well as between providers and consumers of care. Such

communication is especially important in the care of older persons because of their multifaceted health problems, which necessitate greater contact with the health care system and more attention to the maintenance of functional ability and quality of life.

Because of its highlighting of the differences among individual professions and disciplines, this analysis has important implications for understanding the need for interdisciplinary collaboration and teamwork in geriatric clinical practice where communication among professionals becomes increasingly essential and yet often remains problematic. Interdisciplinary health care teams have gained more credibility as the "fundamental unit of geriatric care" for frail elderly persons with multifaceted health problems (e.g., Tsukuda, 1990; Zeiss & Steffen, 1996). This development is set against the backdrop of major changes in health care management and delivery that portend increased emphasis on collaborative practice and are mirrored in governmental recommendations and guidelines (U.S. Bureau of Health Professions, 1995), conferences of health professions educators (Bobby, 1994), and position statements articulated by national professional associations (American Association of Colleges of Nursing, 1995). In response to these emerging trends, new interdisciplinary geriatric educational models will be needed to bridge communication gaps among the health professions and make effective care of the older adult possible. These methods must preserve the individual identities of the different disciplines, while simultaneously creating a common ground where differences are valued because of their unique contribution to quality of care.

To explore these questions and issues in more detail, this article is divided into five sections. The first develops a theoretical framework for thinking about professional socialization as an interactive

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process of acquiring a professional identity based on values and meanings — the development of a professional “voice.” The second, third, and fourth sections explore the research and literature in the fields of medicine, nursing, and social work, respectively, as they relate to this framework. This discussion highlights relevant aspects of professional socialization that expand and elaborate on the framework presented at the outset, and it directs attention to those aspects relevant to the care of elderly persons. The fifth and last section explores the educational implications of these different patterns for the abilities of different professions to work together in the interest of the welfare of the older patient. Indeed, it raises questions about our current modes of professional training and whether they are adequate in educating a new generation of health care providers to communicate effectively with each other as well as with elderly persons. New academic program curricula and continuing professional education models will be needed to address these needs. The components of a model of “dual socialization” into both a disciplinary identity and the norms of collaborative practice or teamwork will be examined as a possible structure to guide this process.

Professional Socialization: Acquiring Values, Meaning, and One’s “Story”

Professional socialization may be broadly defined as the acquisition of the knowledge, skills, values, roles, and attitudes associated with the practice of a particular profession. That there are different health-related professions suggests that each discipline is unique in the basic cognitive and normative framework into which its practitioners are inducted, trained, and credentialed. Indeed, we can compare different disciplines with cultures — unique ways of thinking and acting — founded on prevailing assumptions about appropriate epistemological, behavioral, and normative bases of action. Given this interpretation, it is not difficult to understand why new “inductees” in the health professions are protectively housed, trained, and socialized in separate schools or colleges, away from the “contaminating influences” of other professions. The acquisition of unique patterns of language, modes of dress and demeanor, and norms of behavior are all manifestations of what we call *professional socialization*.

Although there may be considerable variation within each profession in the outcomes of this process, there is nevertheless substantial similarity — rather than simple stereotype — in the disciplinary outcomes or “products” of these processes. The purpose of this discussion is not to deny that other variables — such as personality — may account for wide variation in the outlook and practice of different professionals from the same discipline. Rather, it is to argue that there is substantial research that supports the development of striking and predictable patterns in professional practice that are linked to the training and educational socialization process.

Socialization as Identity, Voice, and Image Formation. — Socialization has generally been viewed as a developmental process, and one that is often conceptualized as a continual interaction between the person being socialized and the environment (Conway, 1983). As such, it is characterized by accord and discord between what is expected and what is actually experienced (Kiger, 1993), as well as by the active creation of professional meaning (Colucciello, 1990). Not surprisingly, socialization has been compared with theories of cognitive and moral development, which attempt to link the acquisition of both “ways of knowing” and “principles of behaving” within a unified framework (Eyres, Loustau, & Ersek, 1992). In this light, socialization is much more than the passive learning of appropriate social roles — it can be thought of more actively as self-concept or identity formation (Fagermoen, 1995).

Additionally, socialization can be conceptualized as the development of a unique voice, perspective, or personal and professional world-view. For example, Gilligan (1982) has argued that women have a unique moral voice of caring and connection, in contrast with the more “rule-bound” approach of men. Similarly, the voices of patient and provider may be characterized as unique because of the different life worlds of the individual and the professional (Clark, 1996). Within the health care field, various disciplines represent different voices of professional practice (Eyres et al., 1992; McClelland & Sands, 1993), which may be combined into a unified approach to dealing with clinically difficult decisions (Aumann & Cole, 1991).

Another interesting perspective has been suggested by the metaphor of the “carapace” of professional development (Kiger, 1993), in which student images of professional identity are not whole entities whose parts are inseparable. Rather, they are linked components that, although interrelated, are capable of behaving independently. Another feature of this suggestive metaphor is the “protective” aspect of professional identity, in which the provider’s self-image may serve to shield him or her from some of the more threatening aspects of clinical practice — such as patients’ pain and suffering. And finally, as the provider changes in response to experiences and problems encountered in practice, old identities may be shed and replaced with new ones that signal a significant growth in professional judgment, insight, and understanding.

If socialization is thought of as identity, voice, or image formation, then it follows that the acquisition of different values is a central element in this process. A key dimension of the theory of symbolic interactionism (Berger & Luckmann, 1966), values may be articulated as meanings and the basis for internalized norms and standards of the professional culture characteristic of the individual’s own behavior and self-concept (Fagermoen, 1995). Within the field of aging more generally, Kaufman (1986) has relied on the symbolic interactionist framework in the search for intelligibility in late life, which she explored as the development of personal life stories

and themes related to individual identity as it has been defined and evolved over an entire life course. She used personal life stories — self-presented accounts of an individual's life — to understand the interrelationships among old age, personal reflection, and identity. The use of a life story approach reveals subjective experience, the individual's view of how he or she understands his or her own life. In addition, "[T]hrough life stories, people 'account' for their lives, that is, they make them logical and coherent and imbue them with a sense of naturalness and rightness. They select, define, classify, and organize experience in order to express the reality of their lives and permeate that reality with meaning" (Kaufman, 1986, p. 24).

Key Elements of Socialization. — Interaction and reflection are essential ingredients in the process of professional socialization. As mentioned earlier, professional identity is constructed by reciprocal interaction between the self and the environment — whether institutions or other individuals. This dialectic is built into the professional education process. Interactions with faculty, other students, and patients all influence the emergent nature of the practitioner's identity. More importantly, as the professional moves beyond the period of formal education, socialization does not stop but continues with the advent of different work environments; new supervisors, colleagues, and patients; and unexpected challenges, problems, and dilemmas that confront the professional in any health care field.

The shaping effects of these new experiences and environments on the individual depend on the degree of self-reflection that he or she has attained. Just as professional identity is built upon a preexisting personal identity with unique values that give life meaning and direction, so too will successive professional identities emerge from grappling with the difficult moral conflicts and problems that Schön (1987) described as the artistry of professional practice. In his view, the emergent character of professional judgment in the "reflective practitioner" is dependent on the individual's ability to grapple consciously with those "gray areas" of practice in which the precise direction to be taken is not clear because the situation is shrouded in moral ambiguity, value conflicts, or ethical dilemmas. A practitioner can be on "auto pilot" with regard to the scientific knowledge and skills that his or her discipline commands, but to be truly reflective he or she must consciously acknowledge and come to grips with the uncertainties, ambiguities, and limitations of actual practice. As discussed later, these dilemmas are common in clinical practice with older persons, because of the complex interrelationships among their health, functional ability, and quality of life.

The Phenomenology of Professional Practice. — Recent research into the phenomenology of geriatric medical practice (Kaufman, 1995) suggests the importance of clinical stories in uncovering the def-

initions and meanings of patient-care dilemmas as described by health care providers — thereby revealing the underlying values and value conflicts encountered in professional practice with older persons and providing insight into the nature of work as a reflective practitioner. Such stories illustrate how authority and responsibility are conceptualized in the provider/care recipient relationship, and they show that individual interpretations of health and illness cannot be separated from moral and social contexts. Dilemmas in assessing risk, recommending the extent of behavior change, and making decisions about placement are examples of gray areas in geriatric practice in which it is impossible to find easy, "scientific" solutions to complex, multifaceted problems. Importantly, the use of stories in revealing and studying these complex questions and their answers — the domain of the reflective practitioner — illustrates the power of biographical and autobiographical methods not only in understanding the aging process as experienced by the individual, but also in exploring the complicated aspects of geriatric practice for an array of health care professionals. An understanding of the socialization processes of these professionals must include an analysis of their education and training as it shapes their approach to both themselves and their elderly patients.

Medicine: Forces of Depersonalization or a New Humanism?

The physician, as gatekeeper to the health care system, is a key provider for older persons. Yet the traditional basis of medical practice and the unfortunate ageism of many physicians together create a dissonance between the "voice" of the doctor and that of the older patient. Indeed, medical education — and its attendant processes of socialization — can be seen as locked in an unequal struggle between two different value systems: one more reductionistic and scientific, the other more social-ecological and humanistic (Bloom, 1979, 1989). The former entails faith in the rational solution of medical problems, disinterested concern for patient and society, and dedication to competency in practice and the community of science. As a result of these values, this orientation discounts the social, behavioral, and personal dimensions of illness; relegates familial and social dimensions of practice to the periphery; and dismisses ethical issues as simply "matters of opinion" not subject to rational discourse. In contrast, the more humanistic perspective on the practice of medicine considers the social and behavioral approaches to be as relevant as the biological; selects students for training on the basis of their social concerns and interest in people; emphasizes caring as much as curing; and considers the community — and not just the hospital — as the proper place for medical education. This latter, more holistic perspective is clearly more consistent with the need to consider all the biopsychosocial facets of aging so essential to caring for the "complete" elderly person.

In spite of numerous official reports and studies calling for the revamping of medical education along lines that would more effectively balance these two approaches, little change has occurred — which is accounted for by some observers as due to the research base of most medical schools (Bloom, 1989). Indeed, the recent history of medicine can be read as largely based on an expanding foundation of scientific and objective practice, at the expense of its more “artistic” and humanistic aspects. Scientific methods have had growing centrality in medical care — for example, the use of large amounts of objective laboratory data — with a resultant erosion in direct, patient contact (Davidson, 1991; Reiser, 1993; Risse, 1982; Roter & Hall, 1992). Although this scientific basis for medicine enhances its professional legitimacy, it also widens the distance separating provider and older patient. The development of elaborate classification systems for diseases and illnesses has multiple related impacts: downplaying the variability among patients, objectifying medical practice, and reducing its need to know the patient in order to understand the unique meanings patients give to their conditions. Such effects significantly undermine the physician’s ability to appreciate the multiple impacts that chronic illnesses may have on the lives of elderly persons.

The Moral Landscape of Medical Socialization. — Medical education as a socialization process can be characterized as one filled with conflict: tension between basic biomedical science versus clinical exposure to “real patients,” the medical school experience versus the actual internship and residency period that follows it, and detachment and objectivity versus attachment and concern. These thematic polarities characterize different phases of the medical socialization process, and they serve to shape it in ways that I would argue dehumanize and desensitize its physician “products” — rendering them less attuned to the unique and complex clinical needs of older persons with multifaceted health problems.

Selection biases. Some research suggests that medical students are preselected for certain traits that affect their abilities to be empathic and sensitive to the needs and concerns of others. For example, Furnham (1988) found that first-year medical students rated certain values very differently than nursing and psychology students: An “exciting life” and “logical” were rated more highly by the medical students than by the other two groups, while “a world at peace” and “polite” were rated as less important than by members of the other two disciplines. This reveals a more self-centered and rational perspective on the part of medical students, in contrast to the more other-oriented values seen as important by nursing and psychology students.

Similarly, research by Geller, Faden, and Levine (1990) suggests that the selection of medical students may be more important than their training in influencing their ability to tolerate ambiguity in pro-

fessional practice. Insofar as modern technological medicine has created many situations that are ambiguous and problematic, tolerance of ambiguity would seem to be desirable in creating reflective practitioners comfortable with the gray, morally conflict-filled areas of medical practice.

Moral development. Other research has shown that as students progress through medical school, they tend to develop preferences for healthy over sick patients (Fasano, Muskin, & Sloan, 1993). In addition, research on moral development in medical students (Self, Schrader, Baldwin, & Wolinsky, 1991) indicates that their training inhibits, rather than enhances, the development of moral reasoning. Andre (1992) suggested that although medical students may be drawn to the practice of medicine because of their care and concern for the patient, their “moral landscape” is re-formed during the process of training. This reconstruction may be due both to the students’ need to protect themselves from intense emotional responses to pain and suffering (the process of developing “detached concern”), and to the burden of cognitive processing of a massive amount of material (such as physiological data). Whatever the causes, however, the end result of this process is that it becomes more difficult “to see, in a morally effective way, the patient as person” (p. 149).

Within a similar framework of moral development, Gilligan and Pollak (1988) suggested that women medical students may, “like the canaries taken into the mines to reveal the presence of unseen dangers” (p. 262), point to areas in medical training and practice in which detachment and isolation threaten the connection between provider and patient because of their greater sensitivity to issues of connectedness and caring in relationships. The authors’ conclusion is that the development of these “moral emotions” should be an integral part of a medical curriculum that has grown increasingly separated from the world of the patient.

Forces Shaping Physician Attitudes Toward Patients. — Perhaps the most important desensitizing and dehumanizing period in medical education is the time of residency. Flynn and Hekelman (1993), for example, talked about the transition from medical school — where there is idealism in caring for the whole patient, to residency, where time limitations and practice demands set severe restrictions on clinical practice — as one of “reality shock” and values dissonance. Nowhere is this discontinuity, and its long-term impacts, seen more clearly than in the participant-observer research of Mizrahi (1986) on the internship and residency training period. She outlined the process whereby physicians-in-training develop coping mechanisms to “get rid of patients (GROP)” in order for them to survive in the frustrating environment of the acute care hospital. By physically and psychologically distancing themselves from patients and their families, interns and residents are able to cope with the stresses and

strains of an environment that largely destroys the idealism and motivation that may have originally drawn them into medicine.

Some GROPIng methods entail passing the patient "down the hierarchy" to the least experienced, junior members of the "team" — interns and medical students. These responsibilities are typically those associated with patient education or care functions. Additionally, some patient-care functions were passed horizontally to social workers, whose formal role was perceived as GROPIng — discharging patients from the acute care setting as soon as possible. Another mechanism for distancing was narrowing the focus of interaction, particularly limiting the taking of a patient history with an emphasis on efficient data collection. The ability to progressively narrow and condense the amount of information "needed" for an adequate history was learned as part of the socialization process as the physician-in-training proceeded through the residency period.

The significance of this history-taking method has been explored by researchers, including Roter and Hall (1992), who have noted that the nature of the language and discourse — or "talk" — between doctor and patient is important as the main ingredient in medical care and the very foundation upon which medical goals are built. Mishler (1984) has used methods of language analysis to study the medical interview, revealing a great cultural gap between the life world of the patient and the scientific-technological domain of the physician. The two distinct voices of medicine and the patient represent different "provinces of meaning" or "modes of consciousness" that limit the physician's ability to understand and appreciate the patient's real world concerns and life goals. When, in the medical history, the patient's life and its reality are redefined into the cognitive structures of medicine, this reformulation can change the meaning of the patient's condition and depersonalize him or her. Objectifying the patient's story may obscure or mask the fundamental values at stake for both the physician and the patient (Poirier & Brauner, 1988). This tendency is reinforced by the ageist tendencies of many physicians to objectify and devalue elderly patients by the use of such terms as "gomer" ("get out of my emergency room") for them.

Is Change Possible? — Calls for changing the medical curriculum and, by implication, the socialization process for physicians-in-training have been heard for many years (Bloom, 1989). Most recently, emerging from within medicine itself have been suggestions for breaking down the technological-personal barrier separating physician from patient. For example, Matthews, Suchman, and Branch (1993) suggested that a stronger "connexion" — the powerful and mutual experience of a shared understanding — between physician and patient is an essential part of the therapeutic relationship. Similarly, Delbanco (1992) underscored the importance of "inviting the patient's perspective" by instituting

a patient review that specifically addresses the preferences, values, and needs of each patient. Finally, goal-oriented medical practice incorporates both these perspectives by developing a new, more positive clinical model to replace the old one based on problems perceived by the provider — one emphasizing deficits, diseases, and disorders (Mold, 1995; Mold, Blake, & Becker, 1991). These new clinical models hold great potential to improve the care of older persons who, in spite of chronic health problems, have specific goals in maintaining their independence and quality of life.

More specific suggestions for curricular reform, such as the development of problem-based learning (PBL) methods for medical education, have also been implemented, but only at a few sites. PBL emphasizes the development of skills in clinical judgment and problem-solving, relying on active, self-directed learning by the student/practitioner (Neufeld & Barrows, 1974; Norman, 1988; Pallie & Carr, 1987). By combining the learning of basic science with the acquisition of clinical skills, based on small group or collaborative processes, the goal is to empower students with the ability to continue to refine the problem-solving, cognitive processes at the heart of clinical judgment and diagnostic reasoning ("Problem-Based Learning," 1981). Unfortunately, few such models have actually been implemented at major medical schools, and the prevailing approach remains the traditional one (Bloom, 1989) — which does not bode well for educational changes supporting a more appropriate approach to the health care needs of elderly persons.

Beyond medical education, the integration of PBL and case study methods into geriatric and primary care training has been more widely practiced, in part within such settings as the Veterans Administration's Interdisciplinary Team Training Programs (Heinemann, 1994), the U.S. Bureau of Health Professions' Geriatric Education Center (GEC) network, and the recently initiated Geriatric Interdisciplinary Team Training (GITT) Program of the Hartford Foundation. The implications of these instructional methods and models for interdisciplinary education will be explored more fully in the final section of this article.

Nursing Education and Practice: Values of Patient to Person

That there is no shortage of studies on the socialization of nurses has been noted in reviews of the literature in this area (e.g., Conway, 1983). Some of the same issues as those recognized in medical education — such as reality shock between initial educational preparation and the real world of actual clinical practice — are discussed in nursing studies as well. Some research suggests contrasting socialization patterns between physicians and nurses — with medical students developing more cynicism and less humanitarianism and empathy, and nursing students stronger needs for autonomy and nurturance and a reduced trait anxiety (Larsson & Hall-Lord, 1993).

Similarly, self-selection biases for nursing students have been noted to include a high need to analyze the motives and behaviors of others, interest in feelings, and understanding of others in an empathic way (Wright & Smith, 1993). These differences have potential implications for nurses to be sensitive to the broader health-related needs of older persons.

Values and Value Conflicts. — The issue of values and value conflicts is frequently mentioned in the nursing socialization literature (e.g., Colucciello, 1990; Fagermoen, 1995; Kelly, 1991; Kiger, 1993; Saarmann, Freitas, Rapps, & Riegel, 1992; Wilson & Startup, 1991). This topic is conceptualized in three ways: (a) as conflicts between what “is” and what “should be” in nursing practice — such as seeing elderly patients treated with disrespect, (b) as a clash between professional standards and organizational constraints, and (c) as the acquisition of professional identity and associated practice values. Overall, dealing with value conflicts is seen as an integral part of the nursing socialization process and, indeed, as central to the ability of nurses to become empathic and sensitive to the dilemmas at the core of nursing practice. Saarmann et al. (1992), for example, clearly distinguished between the acquisition of critical thinking and problem-solving skills, and the internalization of certain values essential to professional nursing identity — mirroring the distinction previously discussed that Schön (1987) made between the science (facts) and the artistry (values) of professional practice.

In particular, the relationship between the development of nursing identity and the acquisition of specific values has been studied by Fagermoen (1995). Based on her qualitative research with nurses, she concluded that human dignity was the core value that constituted nurses’ identity and guided their practice with patients. Other values — such as security, integrity, personhood, being a fellow human, autonomy, privacy, reciprocal trust, hope, and general humanity — all either arose from it or were aimed at its preservation. These are similar to values discussed by other researchers as being constitutive of the nursing profession (e.g., Kelly, 1991; Murphy, 1986; Wilson-Barnett, 1988).

A different approach to understanding the values transformation occurring as part of the nurse socialization process has been characterized by Seed (1994) as the changing perceptions by nursing students of those for whom they were caring. Coming to understand patients as people — people who were being cared *about* and not simply cared *for* — is seen as an integral part of the maturity of the students as both nurses and adults. Importantly, it is an outgrowth of the recognition of their own personhood. This shift in thinking is dependent on a set of transformational experiences growing out of nursing training, in which students increasingly identify with their patients as people. This identification is linked to the ability to reflect on the meaning of experience and to develop into a more sensitive and

empathic person. Again, the theme of reflection is critical to the development of this insight, which has been shown by Kolb (1984) to be an essential skill in the overall experiential learning process. In this light, change in the personal conception of “what it means to be a nurse” depends on the development of abilities that will alter the outcomes of the educational process, leading to the development of insight into the very nature of the patient-nurse relationship. The patient is no longer “just a patient,” but a whole person.

Summarizing this discussion of values in nursing practice, it seems evident that the training of nurses leads them to develop a more holistic approach to the patient — one less reductionistic and more humanistic in its orientation than the medical model previously discussed. This perspective is more conducive to the development of the holistic sensitivities needed for caring for elderly persons.

New Models of Holistic Nursing. — The development of the ability to see the whole person as an essential outcome of the nursing educational process is clearly different from that described for medical socialization — in which depersonalization, objectification, and distancing seem to be the norm. Similar to some of the new models for medical practice already discussed (e.g., Delbanco, 1992; Matthews et al., 1993; Mold, 1995), models of nursing practice linked to an understanding of the unique value priorities, meanings, hopes, and dreams of the patient are beginning to emerge.

Parse (1987, 1992), for example, has put forward a model of nursing that is holistic, emphasizing the essential unity of the individual. The focus here is on the lived experience and personal history of the elderly individual patient — embodying his or her own personal values and life goals — as the centerpiece for the model of caring. Old frameworks based on the problem-centered methodologies of assessment and care plan development controlled by the professional must be replaced by approaches based on communication about the goals and concerns of the individual. In this view, an integral part of nursing practice is the incorporation of an ethic of caring that places the patient at the very center of what nursing is all about: The lived world, the life story, and the goals of the patient become the essence of caring for and about the patient. Nursing practice should be driven by this ethic, not a professional standard that places the origin and perspective of nursing with the nurse. This view coincides with a historical and recently renewed theme within social work of empowerment and advocacy — essential themes emerging within the literature on geriatric health care (e.g., Clark, 1989).

Socialization for Social Work: Advocacy and Empowerment

The process of socialization in education for social work is filled with questions that have plagued social work practice from its very inception (Kane,

1983). What precisely is the role of social workers? Is their primary concern for social welfare, even though they are housed in health care settings? Is health per se their major focus? How is health defined? The answers to these questions are important, because they directly relate to the roles, values, and identity of the social work profession. Importantly, role overlap and conflict with other health professions seem to be an issue of particular importance to social workers, who frequently work in collaborative or teamwork contexts (Lister, 1980).

Contrast with Medical Socialization. — The socialization of social workers has sometimes been contrasted with that of physicians (e.g., Mizrahi & Abramson, 1985). For example, social workers are taught the importance of dealing with feelings and relationships, and mentors in the education process emphasize the development of self-awareness and conscious use of the self in transactions with others. Similarly, the more stable, long-term contact and interrelationships between social work students and their supervisors — as well as between social workers and their clients — are in contrast with the rapid rotational changes that sever growing bonds of connection for medical students. Additionally, social workers are trained to broaden the basis for clinical discussion to “rule in” dimensions of problems that may be initially overlooked in assessments — such as the psychosocial and economic dimensions of illness — rather than the more traditional “ruling out” of information in the medical diagnostic process. This has major implications for teamwork in geriatric care settings (Qualls & Czirr, 1988).

In addition to representing the major influences of psychosocial factors in shaping health and assessing health problems, social workers have traditionally emphasized the rights of their clients to self-determination and have worked to increase their self-help skills (Kane, 1975). The avoidance of labeling and “blaming the victim” have also been major themes in social work practice and the development of interventions. More recently, a renewed emphasis in social work practice has underscored the principle of client self-determination and empowerment (Tower, 1994). This trend is consistent with the goal-oriented health care practice themes already discussed within medicine and nursing that support the development of a more positive perspective on the health problems of older persons. It entails a shift away from professionally determined problem definitions and solutions, toward consumer-defined needs and personal processes of discovering or creating ways of meeting them (DeJong, 1984). Again, many authors cite growing conflict between this approach to gathering knowledge from the patient and the more traditional medical model, outlined earlier (Mizrahi & Abramson, 1985).

Teamwork and Values. — Unlike other health professions, social work has a well-developed literature on the role and socialization of social workers in

the collaborative or teamwork setting. For example, Sands (1989) has studied how social workers become socialized into a clinical team through a process of successive role changes mediated by coaching from the instructor, the development of unique language for the team, and the growth in assertiveness skills. Indeed, it is interesting to note that social workers have seemingly been plagued by problems in team practice — in spite of their skills in group work — because of the very nature of their socialization into values of patient advocacy that may put them into conflict with other members of the team (Kane, 1975). These issues are important because of the growing emphasis on collaborative teamwork practice in geriatric clinical contexts (Tsukuda, 1990; Zeiss & Steffen, 1996).

In addition to the acquisition of the values of client autonomy and empowerment, social workers grapple with the value conflicts implicit in collaborative practice. For example, when interprofessional collaboration and client advocacy — both important social work values — conflict, which should take precedence (Mailick & Ashley, 1981)? Similarly, most codes of professional ethics have been developed for individual disciplines — but what happens when these come into conflict on the interprofessional team (Abramson, 1984)? This dilemma is perhaps particularly compelling for the social worker, because he or she has traditionally been the professional most associated with client responsibility and self-determination. The importance of the practice setting (Mailick & Jordon, 1977) and differential status (Wikler, 1980) to this issue of decision making has also been underscored in the social work literature.

Overall, the centrality of values and value conflicts seems to characterize the literature on socialization into social work. Reflection on value conflicts between social work and medicine, for example, is a constant theme, as are moral dilemmas in collaborative practice in general. The traditional knowledge, skills, and values emphasis in professional development is interpreted in the reverse order for social work, where it is recognized that values take precedence over knowledge (Mizrahi & Abramson, 1985). Values are put at the very center of social work practice, whether with regard to professional–professional interaction or professional–patient relationships. In this regard, social work is unique in placing reflection on this aspect of clinical practice at the core of what it means to be a professional — an emphasis consistent with the type of geriatric health care provider being advocated for in this discussion.

Implications of Values and Voices for Interdisciplinary Education

To reach relevant geriatric and gerontological educational conclusions from this exploration of the role of values and the socialization experience in the development of professional identity, we must now return to the theme of “voice” presented throughout this discussion. Here, the emphasis has been on developing an understanding of how pro-

professional socialization shapes the experience of health professionals-in-training and those in current practice to take on unique identities, reflecting the acquisition of personal values that shape how they think and act — in short, what kinds of people they are. Although much of the socialization literature focuses on the mastery of specific roles by trainees, the symbolic interactionist approach outlined in this discussion draws our attention rather to the complex interaction between the environment and the individual student or clinician, in which the individual and his or her values are shaped by the forces at work in the process of *becoming* a physician, nurse, or social worker. Each profession comes to have its own voice, or unique perspective on being-in-the-world, that affects its relationship with other voices, whether professional or patient. In particular, these voices either enhance or inhibit effective collaboration, both with other professionals and with the patient in geriatric clinical settings.

In particular, it is the value dimension of this voice that concerns us the most in this discussion. The traditional voice of medical practice, for example, is a powerful one that typically drowns out the voice of the older person's life-world — virtually constructing the reality of his or her condition through powerful medical imperatives to select only the "most important" information; to distance the practitioner from the patient; and otherwise to dehumanize, depersonalize, and decontextualize the patient in the interest of "objective" clinical judgment. Although new forces have brought this perspective under scrutiny and attack, change has been resisted, and at this time it appears unlikely that a revolution will occur in how physicians are trained to see the world and to "be physicians."

Nursing and social work, on the other hand, have countervailing pressures to take on a real understanding of the "patient as person," to participate in the older person's world as a way of both understanding it and revealing their own humanity and, even, vulnerability. The voices of nursing and social work — more holistic and inclusive — are less strident than that of medicine. New models of practice in these professions have underscored the importance of listening "with the inner ear" to the voice of the patient, and even amplifying this voice as it is heard in the decision-making processes in health care.

Conflict, Communication, and Collaboration. — The significance of these differences in communication styles and voices for collaboration among professionals over such issues as quality of life for older persons (Clark, 1995) and between professionals and elderly patients in clinical decision making (Clark, 1996) has been examined, with important implications for professional teamwork in geriatric health care settings. Insofar as collaborative practice models promise to become increasingly important in the delivery of geriatric health care services in the future (Tsukuda, 1990; Zeiss & Steffen, 1996),

it is essential that health care professionals acquire new appreciation for both the knowledge and skills needed in teamwork and, perhaps more importantly, for the values represented by interprofessional collaboration (Clark, 1994). Interprofessional conflicts have been described for nurse-physician interactions (e.g., Stein, 1967; Stein, Watts, & Howell, 1990; Watts, McCaulley, & Preifer, 1990), social worker-physician relationships (Mizrahi & Abramson, 1985), and nurse-social worker collaboration (Lowe & Herranen, 1978, 1981). Although these have traditionally been couched in terms of role conflict — based on the conceptualization of professional socialization as the acquisition of specific roles — another, more useful way would be as value conflict or "voice dissonance."

From this perspective, the question becomes one of how geriatric and gerontological educators can promote the development of greater appreciation for the sounds of different voices in interprofessional practice in geriatric care (Aumann & Cole, 1991) and increased recognition of the fact that absent voices really do make a difference in the quality of care of older persons (McClelland & Sands, 1993). Far from being rigid roles into which professionals have been socialized and trained, these voices represent unique views of the self and the patient, as well as other professionals, that are the products of a complex interaction between themselves and their colleagues, the larger institutional environment, and their elderly patients. In this process, the distinction between themselves as professionals and as persons may become blurred, because they have internalized the very values essential to their modes of practice.

Thus, it is essential that professionals learn to recognize and appreciate that each has a different voice — a perspective or way of "being in the clinical world" — that is equally valid and valued. Perhaps most importantly, it is the voice of the older person that is the most critical and that must increasingly be seen as the core essence guiding professional practice. The metaphor of the reflective practitioner has been proposed for one who develops an appreciation for those gray areas of clinical practice where value conflicts and moral dilemmas are encountered and where the true artistry of professional practice is evident. Perhaps we need to develop an auditory metaphor in addition to this cognitive one: The reflective practitioner is also the "hearing practitioner," who is a good listener and whose own voice does not drown out the voices of other professionals or the patient.

Lessons for Clinical Practice Education. — Geriatric health educators need to provide both strong disciplinary instruction and interdisciplinary teamwork opportunities for health sciences students and current professionals to learn the joys and challenges of working together. This must be done in a parallel and dialectical way that shapes and enhances skills in both these areas. As students gain greater mastery of their own, unique professional

identity and voice, they need to be introduced to opportunities for their combined voices to be put together in clinical practice settings. Some proficiency in the basic knowledge and skill of each discipline is necessary for the students at least to know what part they have, but waiting until they have graduated before giving them the opportunity to collaborate is a mistake. Rather, gradual and graduated opportunities — and time for reflection on the process of working and learning together — are essential ingredients of effective instruction.

Experiential learning opportunities at clinical sites where multiple professions work together collaboratively would be ideal settings for this type of instruction, provided they are supported by a course or seminar structure that affords students the time and opportunity to reflect on their experiences in working together. Various models of actual courses developed along these lines are described in the gerontological and geriatric educational literature (e.g., Allen, Koch, & Williams, 1984; Bennett & Miller, 1987; Kappelman, Bartnick, Cahn, & Rapoport, 1981; Morrissey, Moore, Cox, Queiro-Tajalli, & Martz, 1989). Additionally, the development of service-learning model courses, in which students participate in community-based (rather than clinical) programs, provides a new opportunity to develop collaborative skills in settings that will be increasingly important as health interventions for older persons move out of traditional institutional contexts into this broader arena (e.g., Clark, Spence, & Sheehan, 1986). The emerging national movement combining service-learning programs and community-academic partnerships is a recognition of the importance of these basic concepts.

In addition, the development of structured case studies (as used in problem-based learning methods) gives students the opportunity to identify and address the multifaceted health problems of elderly persons. If carefully constructed to embody the need for many disciplines to be involved in geriatric care, such cases would be an excellent opportunity for participants with different backgrounds to work together. As indicated earlier, such methods have been developed within the Veterans Administration Interdisciplinary Team Training Programs (ITTPs), by some Geriatric Education Centers sponsored by the U.S. Bureau of Health Professions, and by the recently launched Geriatric Interdisciplinary Team Training Program supported by the Hartford Foundation. Importantly, however, these instructional methods need to be carefully developed to require truly interdisciplinary collaboration — with intersecting patterns of disciplinary communication — rather than the more parallel lines that typify multidisciplinary training (Clark, 1993).

This educational process may be thought of as one of dual socialization, in which students develop identities of both individual professional and team player. These two processes complement each other, as students only really learn who they are when they have to define themselves and their professional focus in the context of others — who may

overlap with them in some areas and share a common identity, or be complementary to them in other important dimensions of clinical practice. Indeed, theories of identity formation during the period of adolescence and young adulthood emphasize the importance of a moratorium period when the individual can “try on” different identities before determining the “right one” for him or her. Similarly, in the process of coming to know “who I am” as a physician, nurse, or social worker, exposure to a range of different identities may ultimately lead to more reflective and confident professionals — ones who have chosen their professional identity in a way that recognizes both the importance of their own profession and the necessity of valuing the diversity of others in the delivery of clinical care.

Beyond a greater understanding of their own discipline, students can gain additional instructional outcomes from interdisciplinary experiences, based on growth in the knowledge and skills relevant to collaboration. First, students can be expected to develop a greater appreciation of the need for different health disciplines to collaborate in geriatric care, including better knowledge of how different professions differ from, yet complement, each other. A second and related outcome is that participants will acquire an understanding of the cognitive and value maps — the conceptual and ethical frameworks — that characterize different health professions, so that they will really understand the mental and normative patterns of professional practice in other disciplines (Clark, 1993). Third, students in teamwork settings must learn how to communicate more effectively across disciplinary boundaries and, in a related outcome, to deal with the conflicts that inevitably arise when different professions — with different styles and modes of practice — are put into a collaborative context of care for elderly persons (Qualls & Czirr, 1988).

In summary, we need to train geriatric health care professionals to both reflect on, and listen to, the values and voices of others. “Listening with the inner ear” to what is being said in professional-professional and professional-patient communication becomes the basis for acquiring professional judgment in collaborative practice settings. This goal can be accomplished if we first recognize the limitations of the ways in which we currently train health care providers by isolating them from the worlds of each other and the older patient. Then, we need to develop opportunities for practicing the essential skills in listening to oneself and to others. We now have the theoretical foundation for how to do this, and some specific suggestions to follow. The challenge lies in implementing this new vision in the educational and clinical contexts in which we train both health sciences students and practicing health care professionals to work with elderly persons.

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