Roles and responsibilities of family physicians on geriatric health care teams

Health care team members' perspectives

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ABSTRACT

OBJECTIVE To examine the beliefs and attitudes of FPs and health care professionals (HCPs) regarding FPs' roles and responsibilities on interdisciplinary geriatric health care teams.

DESIGN Qualitative study using focus groups.

SETTING Calgary Health Region.

PARTICIPANTS Seventeen FPs and 22 HCPs working on geriatric health care teams.

METHOD Four 90-minute focus groups were conducted with FPs, followed by 2 additional 90-minute focus groups with HCPs. The FP focus groups discussed 4 vignettes of typical teamwork scenarios. Discussions were transcribed and the 4 researchers analyzed and coded themes and subthemes and developed the HCP focus group questions. These questions asked about HCPs' expectations of FPs on teams, experiences with FPs on teams, and perspectives on optimal roles on teams. Several meetings were held to determine themes and subthemes.

MAIN FINDINGS Family physicians identified patient centredness, role delineation for team members, team dynamics, and team structure as critical to team success. Both FPs and HCPs had a continuum of beliefs about the role FPs should play on teams, including whether FPs should be autonomous or collaborative decision makers, the extent to which FPs should work within or outside teams, whether FPs should be leaders or simply members of teams, and the level of responsibility implied or explicit in their roles.

CONCLUSION Comments from FPs and HCPs identified intraprofessional and interprofessional tensions that could affect team practice and impede the development of high-functioning teams. It will be important, as primary care reform continues, to help FPs and HCPs learn how to work together effectively on teams so that patients receive the best possible care.

EDITOR'S KEY POINTS

- This study explored FPs' and health care professionals' beliefs about roles on interdisciplinary geriatric teams and attempted to identify the similarities and differences between the perspectives of these 2 groups of team members.
- Both FPs and health care professionals acknowledged that they had learned to be team members in practice.
- Four key themes emerged from focus group discussions: whether FPs should have autonomy or collaborate on decision making, whether FPs should be leaders or simply members of teams, whether FPs should be insiders or outsiders on teams, and whether FPs should take responsibility for patients or share that responsibility with team members.

This article has been peer reviewed.
Full text is available in English at **www.cfp.ca.**
Can Fam Physician 2007;53:1954-1955

Rôles et responsabilités du médecin de famille dans l'équipe de soins gériatriques

Points de vue des membres de l'équipe de soins

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RÉSUMÉ

OBJECTIF Examiner les croyances et attitudes des médecins de famille (MF) et des autres professionnels de la santé (APS) à propos des différents rôles et responsabilités dans les équipes interdisciplinaires de soins gériatriques.

TYPE D'ÉTUDE Étude qualitative à l'aide de groupes de discussion.

CONTEXTE Région sanitaire de Calgary.

PARTICIPANTS Dix-sept MF et 22 APS œuvrant au sein d'équipes de soins gériatriques.

MÉTHODE Il y a eu 6 groupes de discussion de 90 minutes, 4 avec les MF, suivis de 2 avec les APS. Chez les MF, 4 vignettes portant sur des scénarios typiques de travail en équipe ont été discutées. Après transcription des discussions, 4 chercheurs en ont codé les thèmes et sous-thèmes pour ensuite développer les questions pour les groupes de discussion avec les APS. Ces questions concernaient ce que les APS attendent des MF dans l'équipe, les expériences vécues avec les MF dans les équipes et les opinions concernant les rôles optimaux des membres de l'équipe. La détermination des thèmes et sous-thèmes a nécessité plusieurs réunions.

PRINCIPALES OBSERVATIONS Pour les MF, les facteurs critiques pour assurer le succès des équipes sont: travail centré sur le patient, délimitation des rôles entre les membres de l'équipe, dynamique et structure de l'équipe. Les MF et les APS avaient des vues semblables sur le rôle que devraient jouer les MF dans l'équipe, notamment: le MF devrait-il décider de façon autonome ou en collaboration; devrait-il travailler à l'intérieur ou à l'extérieur de l'équipe; devrait-il être chef ou simple membre de l'équipe; et le niveau de responsabilité qu'il assume est-il implicite ou explicite?

CONCLUSION Les commentaires des MF et des APS ont permis d'identifier des tensions intra- et interprofessionnelles susceptibles d'affecter le travail de l'équipe et de compromettre le développement d'équipes hautement performantes. Dans le cadre des réformes en cours et dans le meilleur intérêt des patients, importera de favoriser l'apprentissage par les MF et les APS d'un travail en équipe efficace.

POINTS DE REPÈRE DU RÉDACTEUR

- Cette étude explorait l'opinion des MF et des autres professionnels de l'équipe de soins sur les rôles des membres des équipes gériatriques interdisciplinaires et tentait d'identifier les ressemblances et différences entre ces deux groupes.
- Les MF comme les autres intervenants reconnaissaient avoir appris à travailler en équipe au cours de leur pratique.
- Quatre thèmes clés sont ressortis des groupes de discussion: le MF devrait-il décider seul ou en collaboration, devrait-il être chef de l'équipe ou simple membre, devrait-il œuvrer à l'intérieur ou à l'extérieur de l'équipe et devrait-il assumer seul ou partager avec les autres membres de l'équipe la responsabilité des patients.

Cet article a fait l'object d'une révision par des pairs.
Le texte intégral est accessible en anglais à **www.cfp.ca.**
Can Fam Physician 2007;53:1954-1955

Interdisciplinary team care with high-functioning teams has been shown to have positive effects on patients' health and to lead to better clinical outcomes, higher patient satisfaction, and enhanced delivery of care.[1] As the evidence on effective patient management changes, particularly for chronic disease management, it is increasingly being shown that many patients benefit from the expertise provided when various disciplines work together.[2-4] The need for FPs to work in teams, participate in primary care networks, and explore newer models of health care delivery (eg, shared care) has become recognized as a priority in the health care system.[5]

While interprofessional education is thought to be a good idea,[4] it can be difficult to implement.[6] Attitudes and experiences with team care, regulatory requirements for the various professions, legal responsibility for care, variability in faculty support, and differing levels of training can all work against setting up interprofessional care teams. Creating an educational culture conducive to promoting interprofessional care is a hurdle that has yet to be successfully negotiated.[5,7,8] It is a complex proposition: attention needs to be paid to learners, educators, learning contexts, and factors at all levels (micro—individual level, meso—institutional or organizational level, and macro—sociocultural and political level) that can influence the success of interprofessional initiatives.[9,10]

It can be difficult to develop high-functioning teams and ensure that they maintain their effectiveness. We know that successful interdisciplinary care requires team members to work collaboratively; to have clear, measurable goals; to be supported by clinical and administrative systems; to have a clear division of labour; and to have received training in interdisciplinary care.[1,4] Attitudes, culture, and differences between professions sometimes prevent interdisciplinary teams from becoming cohesive.[6] Different perspectives on roles, turf competition, and the perception that FPs have a leadership role on teams leave other team members feeling that their roles are secondary.[7]

To start designing a curriculum to help FPs enhance their performance on interprofessional teams in general, and geriatric teams in particular, we set out to learn about their perceptions of teamwork and how they feel collectively about their role on teams. We also wanted to know how health care professionals (HCPs) perceived FPs in team settings. The purpose of this study was to explore FPs' beliefs about their roles on interdisciplinary geriatric teams and to identify similarities and differences between FPs' and HCPs' perspectives.

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METHOD

Family physicians known to provide long-term and home-care services in the Calgary Health Region in Alberta as part of their regular practice were invited to participate in 1 of 4, 2-hour focus groups. We specifically chose the geriatric setting as the context for this study, and all FPs approached to participate had had some experience working on geriatric interdisciplinary teams. Geriatric medicine in Calgary has a long history of functioning team-based care.

All focus groups were led by the same trained moderator (H.F.) and assistant moderator. Participants were asked to discuss 4 vignettes (**Table 1**) that reflected 4 issues FPs might face when considering or working on interdisciplinary teams. Vignettes were selected for focus group discussions, as they had been used successfully in previous studies on professional activities.[11] All focus group discussions were audiotaped and transcribed verbatim; identifying information was removed.

Following the FP focus groups, data were analyzed to identify common themes. We used a grounded-theory approach to data analysis. All 4 researchers read all the transcripts and independently identified key themes. The researchers met frequently to establish an open coding system. Data were then coded into this framework and reviewed again by the group. Data from the FP focus groups showed us that there was a lack of consensus among FPs about the roles they should play on teams. We thought that asking HCP team members to address specific questions on their perceptions of the roles FPs play would help clarify the issues and delineate the roles assumed by FPs on teams.

Accordingly, the HCP focus groups addressed the following questions. What do you expect of FPs on interdisciplinary geriatric teams? What do you see as barriers to FPs participating effectively on interdisciplinary teams? What have been your positive and negative experiences with FPs on teams? What is the optimal role for FPs on interdisciplinary teams?

Health care professionals on 2 different geriatric teams at a local hospital were invited to participate in 1 of 2 focus groups. One team was an inpatient geriatric assessment and rehabilitation team that included FPs. The other was an outpatient multidisciplinary team in an ambulatory clinic attached to an acute care hospital; it

Table 1. Vignettes

Vignette 1

You are approached by your clinical head to join a new interdisciplinary team that takes care of geriatric transition beds at an acute care hospital. You are happy with the money and hours offered and definitely have an interest in the work.

- What would you like to know about the job?
- What concerns would you have about taking such a job?
- What would indicate that the team dynamic is functioning?

Vignette 2

As a family physician, when would you consider interdisciplinary team care to be

- an optimal approach?
- a suboptimal approach?

Vignette 3

You have a man coming from the lodge. He is happy there, but he has had a stroke and cannot stay dry at night. The nurse on the team says the man can go back to the lodge. The team social worker says the support available at the lodge is insufficient to manage his incontinence. How would you resolve this situation if you were

- the patient's physician in the community?
- a member of the team in the assessment unit?

Vignette 4

You are a member of a geriatric assessment team. One member of the team, the pharmacist, is having problems working with the team. When questioned, some members of the team admit they do not like the pharmacist and others complain she appears unhappy with her role. They say she questions out loud whether others are as "thorough" as they should be. Every time the team works together, there is palpable tension. What is your experience in resolving difficult interpersonal situations on a team?

included both FPs and geriatricians. Both teams received referrals from community-based FPs. These 2 focus groups were led by the same 2 moderators who conducted the FP focus groups with assistance from a doctoral student (M.H.). Following the HCP focus groups, data were discussed and themes were re-examined in an iterative way with all members of the research team discussing and agreeing upon the themes and their implications. The study was approved by the Conjoint Health Research Ethics Board of the University of Calgary and the Calgary Health Region.

RESULTS

A total of 17 physicians participated in the study. Three focus groups involving 16 physicians were held, and 1 physician was interviewed separately, as others did not arrive for the fourth focus group. There were 8 women and 9 men. Eight physicians had graduated between 1960 and 1980, and 9 had graduated between 1981 and 2000. Ten physicians were Canadian graduates, and 7 were international graduates. Most of the physicians (14) practised in Calgary; 2 practised in smaller centres near Calgary. Twenty-two HCPs representing pharmacy, nursing, social work, physiotherapy, and occupational therapy participated in the 2 HCP focus groups. The discussions yielded 165 pages of transcript data.

Physicians who addressed the questions posed by each of the vignettes talked about the information they required in order to join a team.

> What's the role of the physician in the team because I've—there's different kinds of teams. There's teams where the physician is kind of the centre of all the decision making. There's other teams where someone has a case manager. (FP #1)

> I would like to know [the] goals or the targets of the team. How are those goals going to be measured? As part of the team, who do I answer to? (FP #2)

> I'd like to know what are the dynamics at a team meeting. So is it taken over by 1 individual, is it equally shared, are all comments valid. (FP #2)

> Does [the team] include a pharmacist, physiotherapist, occupational therapist, RN, LPN .... How often are we meeting to discuss patients and in what contexts do we meet .... Is this the family, is it just the whole team, is it once a week, is it, you know, a couple of times a week. (FP #3)

They described their perceptions of optimal team organization and how they measured team success. When they talked about team organization, they particularly noted the importance of having team goals, chains of command, and approaches to decision making both for conflict resolution and for general decision making.

> You need to agree on the philosophy of the team ... so that it's all patient-focused and it's for the benefit of the patient. (FP # 4)

> There has to be a main person. (FP # 2)

> Each of these team meetings has to move along, has to start on time, has to end on time. (FP #2)

They focused on some of the phenomena that made teams successful, namely, having agendas for meetings, having a clear delineation of roles, and taking time for team building.

> The roles have to be understood, the nurses have to be proud of their contribution, the social worker has

Table 2. Comments of physicians and other team members on various issues

ISSUES	PHYSICIANS' COMMENTS	OTHER TEAM MEMBERS' COMMENTS
Decision making		
• Physician as autonomous decision maker	I'd be trying to get information from everybody ... and then I would be making the final decision. (FP #3)	Sometimes you are working in an environment where they [physicians] need to take more of a leadership role, but sometimes on a collaborative team like we're on now, it can be more of a collaborative effort … But I can also identify certain areas of practice or a consultative role where that decision making I think has to be more immediate. (HCP #2)
• Physician as collaborative decision maker	You want to rely on as many people's opinions as you can. You know they're spending more time with them [the patients] and often can give you insight. (FP #4)	The inpatient … unit physicians … respected their team members and they were very clear in being able to articulate that they understood they did not hold all the pieces and that different players needed to feed information to them so it was a 2-way street, so that we could all do our jobs more effectively. (HCP #1)
Role on the team		
• Physician as leader of the team	There has to be a captain, and ... I would like [to] think that, that the physician should be the captain of the team. (FP #3)	But in terms of expectations, the expectation is that when there is a time when the buck has to stop somewhere I want a physician who is clear, definitive, and can really make a definite statement at the end about a recommendation based on the information he's got from the team, and you don't always get that, and that is an expectation that I have in the care sector. (HCP #2)
• Physician as a member of the team	The other multidisciplinary team I work on has ... a nurse who is the program head and then ... there's a kind of a case management approach where I [the physician] am only a member of the team. (FP #1)	I would like them to be an integrated player. Not the parental, patriarchal figure that directs the team. But that we all have input into creating what's best from a client-centred perspective. (HCP #1)
Insider or outsider on the team		
• Physician who is *in*	You know, I'll have to sit down with the nurse and the pharmacist and go through [the information]. Is there another choice of medication? (FP #3)	I expect them to be very involved—visiting the patients regularly, attending our conferences, family committees as well as patient conferences. (HCP #2)
• Physician who is *out*	The physician, as part of the team meetings, should have an agenda that's fairly tight, that runs on time, and in addition, would allow for the physician to have their input, but at an appropriate time the physician could then leave. (FP #3)	They schedule hours to be here when the majority of the team is not here. We can always leave notes or what have you, but there's nothing like a face-to-face communication, but coming here at 7:00 AM they are not likely to run into many team members. (HCP #2)
Responsibility		
• Physician has responsibility	It all goes back to the physician ... (FP #3)	But nobody ends up having to be [responsible] because I think right now our model is the physician signs the report and they indeed do have the accountability and responsibility of that report. (HCP #1)
• Physician shares responsibility	My experience would be a more positive one because I find it very educational to, to be a member of the team. I always find it quite breathtaking, the knowledge that the pharmacist can bring to the team in the meeting ... they're gently educating me into how to treat this patient better. (FP #2)	When you look at the incident following an error and who's responsible, the top of the line is the pharmacist, then it will be the nurse because she gave it, and then the bottom of the line the physician because he ordered it. You're supposed to check it, and you're supposed to check it again. We were taught as a nurse, you handed the pill so you bear the responsibility of was the order correct. (HCP #2)

> to be proud of their contribution, but if people stay within the boundaries of their task with ... flexibility in difficult situations, it really runs a lot better. (FP #3)

> On any team, we should always be able to refer back to the role definitions that are outlined for each member of the team. (FP #3)

> We have a good facilitator and a good leader ... who knows everybody and everyone's capabilities there. Everyone has the chance to contribute. (FP # 4)

Family physicians thought that team success hinged on patient outcomes and well-being and that success should be "centred on patient outcome, and there's positive feedback coming from the patients with some specific parameters showing increased level of function." (FP #2)

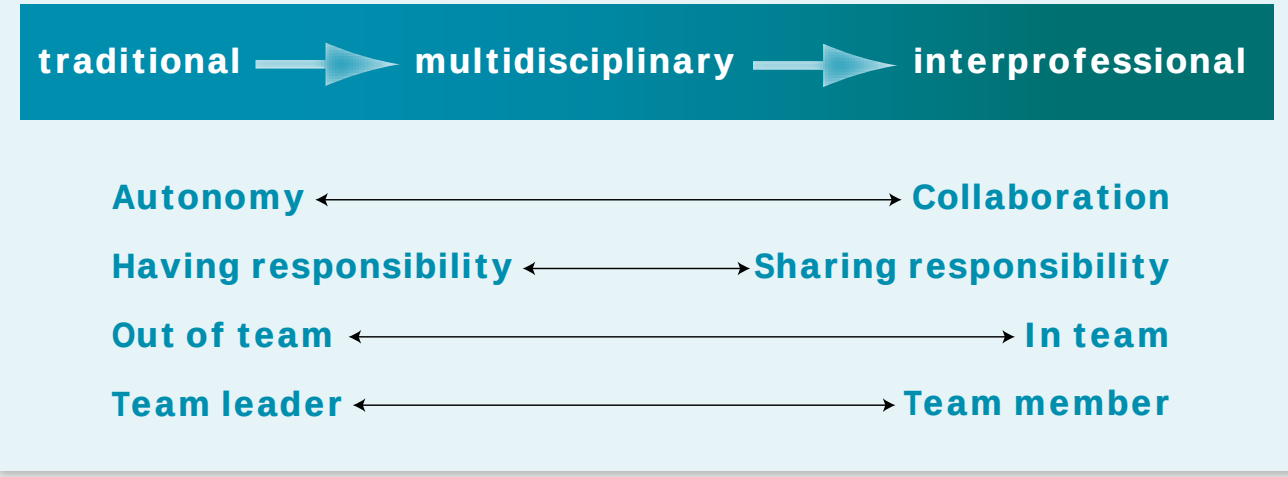
As the research team discussed the open coding, they identified tension over team members' roles as the main issue raised. Four issues emerged from the axial coding: the degree to which physicians' decision making was autonomous or collaborative, whether FPs were leaders or members of teams, whether FPs were insiders or outsiders on teams, and whether FPs were responsible for patient management or shared that responsibility with other team members (**Table 2**).

Our focus groups with HCPs, which were designed to gain perspectives on FPs' roles on teams, gave us an opportunity to explore 4 roles FPs have on teams. As we examined the transcripts, it was apparent that perceptions of roles ranged along a continuum shared by both FP and HCP team members. We did not find a well-defined dichotomy of ideas between FPs and HCPs, but rather different subgroups within each group shared the same perceptions along a continuum (**Figure 1**).

Autonomous or collaborative decision making. Whether physicians should be autonomous or collaborative decision makers arose during the discussion in all our focus groups. Some FPs were adept at working collaboratively and saw it as an important component of ensuring good patient outcomes. Other FPs were reluctant to relinquish the final decision. Health care professional team members were able to see both types of involvement for FPs. In some cases, teams worked around the physician; in other cases, they worked to advocate to the physician on patients' behalf. One team member talked about "how much energy gets put into working around a person that's perceived as having that power and ... how much we had to do to make sure that physician finally came around to an idea we had had probably almost a year ago, but certainly months and months ago." (HCP #1)

Leader or member of the team. Whether a physician was the leader or a member of the team was an important consideration for both FPs and HCPs. While some FPs felt their rightful place was as leaders, others were content to have the leadership rest with other team members. Similarly, HCPs were divided in their perceptions of whether physicians should be leaders or equal members. This affected decision making and HCPs' expectations of FPs. In some cases, FPs appeared willing to accept and support team decision making; in other cases, FPs appeared to be indifferent to good team functioning.

Figure 1. Continuum of perspectives on the role of the family physician on health care teams: *Physicians' and health care professionals' views on physicians' roles covered a continuum on all main themes.*



Insider or outsider. Whether FPs were insiders or outsiders on teams was a function of their availability to the team, the way the partnership worked with the team, the respect and respectfulness shown to other team members, and how FPs communicated with the team. As the quotations demonstrated, physicians' availability was an ongoing problem. The FPs described frustration at not knowing what was happening, but were unwilling to be present to discuss issues they did not believe to be within their domain. The HCPs noted the disruption caused when physicians' schedules changed and the team had to compensate and the advantage of having all members available to discuss patients on a regular basis. Physicians' ability to communicate and participate in team functioning was often compromised when FPs came and went from the team or appeared at irregular and often unpredictable times. Certainly, being based outside the institution also created problems for FPs as their patients were located in various care settings.

Having responsibility or sharing responsibility. There was also a continuum of perspectives on whether FPs should be responsible for patient care or should share that responsibility with the team. This is a tangibly different concept from whether FPs should be leaders or not. While medicolegal concerns were a component of this, both FPs and HCPs recognized they were all liable, but that FPs still perceived that they carried greater liability. Some FPs and HCPs, by historical default, felt an obligation to take the most responsibility. The medicolegal liability issue affected how they saw their roles in patient management and information sharing.

Both FPs and HCPs recognized and acknowledged that they had learned to be team members in practice. The skills were minimally or not taught in medical school or residency. One physician noted: "You're never taught this in, in medical school. You learn some of it in residency ... and when you're young, new, you sort of sat back and looked and listened and then you realized after a while you're, you're the one that's the main input with the patient." (FP #3) Another HCP said: "I just think that when you take a look at the package and how physicians kind of get spit out the other end, what they're taught and told is that they're ultimately responsible and nobody else is." (HCP #1)

DISCUSSION

This study was designed to explore FPs' and HCPs' perceptions of FPs' role on interdisciplinary geriatric teams. We sought information from 4 groups of FPs and 2 groups of HCPs. Both FPs and HCPs commented that FPs learned about teamwork after medical school and residency. Their formal training in the knowledge and skills necessary for effective interprofessional care, namely knowing about one another's disciplines, roles, and skill sets; knowing what information to share and when, and when to ask for assistance; and even knowing one another's legal obligations, are not taught well in medical school or residency programs.

The training and work experiences FPs and HCPs had had appeared to affect the way they perceived the roles that they saw physicians playing. We were surprised to find that both FPs and HCPs could hold very traditional views on the role of physicians. At the same time, both could have egalitarian perspectives on the appropriate role for FPs. Given this diversity, it was not surprising that we heard several anecdotes about the tensions that arose when the beliefs of the teams and the physicians were incompatible and when each group's perceptions were at different points on the continuum.

Our results have implications for educating FPs who contemplate joining teams, who wish to be more successful in their interactions within teams, or who want to mitigate problems they are currently experiencing. We suggest that physicians assess their own perceptions of the ideal role of physicians on teams. They need to consider such aspects as how they make decisions, how they assume responsibility for patients, how available they are prepared to be, how committed they are to the team and its functioning, and how important leadership is to them. Physicians also need to think about the key people on the team and locate the latter's perspectives on the continuum. Once these perspectives are understood, it becomes possible, through appropriate directed education, to move FPs and HCPs along the continuum in either direction—toward each other, as it were—to eliminate tension. Family physicians also need to be aware that perceptions evolve over time and that effective teamwork requires checking with others about care given and decisions reached with the goal of optimizing patient care.

For those designing educational programs to help FPs participate more effectively in team-based care, attention needs to be paid to the settings in which FPs are or will be working and the challenges they are likely to face. Ensuring that physicians understand the micro, meso, and macro factors that affect interprofessional care is important.[10,11] Research in continuing medical education reminds us that needs assessments, interaction between facilitators and learners and among learners, opportunities to practise new knowledge and skills, and sequenced and multifaceted educational programs will all be critical factors in facilitating this type of education.[12]

Limitations

This study focused on practitioners working in 1 city who had some involvement in team-based geriatric care. Those participating in the focus groups of HCPs were

from a single institution. Nonetheless, as we read and reread the transcripts, it appeared that concerns about leadership, communication, team function, and roles played arose frequently in each FP focus group discussion. These themes arose again in the HCP focus groups and reflect very real issues affecting care. We do not know how generalizable these concerns are to other care settings, such as obstetrics or care of patients with diabetes or asthma, or to other cities.

Conclusion

Family physicians should have clear ideas about what they need to know about team functioning before they assume formal (ie, paid) roles on teams. Both patient centredness and team cohesiveness are central concepts in optimal team functioning. The roles FPs should play on a team were much less clear than were the roles HCP team members should play. Those who participated in our focus groups had a continuum of perspectives on 4 main issues: the degree to which a physician's decision making should be autonomous or collaborative, whether a physician is the leader or a member of the team, whether a physician is an insider or outsider on the team, and whether a physician is responsible for patient management or should share that responsibility with the team.

Acknowledgment

This project was funded by Health Canada's Primary Health Care Transition Fund under the auspices of the Association of Faculties of Medicine of Canada within the project Issues of Quality and Professional Development Maintenance of Competence (grant 6799-15-20030002). The views expressed in this article do not necessarily reflect the views of Health Canada.

Contributors

Dr Wright *contributed to study design, analysis and interpretation of data, and writing up the study.* **Dr Lockyer** *contributed to study design and analysis and interpretation of data, and had a major role in writing all drafts of the article.* **Ms Fiedler** *was involved in acquisition of data, interpretation and analysis of results, and critically reviewing all drafts of the paper.* **Ms Hofmeister** *was involved in analysis and interpretation of data and critically reviewing all drafts of the paper. All the authors gave final approval to article submitted for publication.*

Competing interests

None declared

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