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CROSS-CUTTING EDGE

# The wolf you feed: Challenging intraprofessional workplace-based education norms

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## Abstract

**Context:** The trajectory towards becoming a medical professional is strongly situated within the clinical workplace. Through participatory engagement, medical trainees learn to address complex health care issues through collaboration with the interprofessional health care team. To help explain learning and teaching dynamics within the clinical workplace, many scholars have relied on socio-cultural learning theories. In the field of medical education, this research has largely adopted a limited interpretation of a crucial dimension within socio-cultural learning theory: the expert who guides the trainee into the community is almost exclusively from the same profession. We contend that this narrow interpretation is not necessary. This limited focus is one we choose to maintain—be that choice intentional or implicit. In this cross-cutting edge paper, we argue that choosing an interprofessional orientation towards workplace learning and guidance may better prepare medical trainees for their future role in health care practice.

**Methods:** By applying Communities of Practice and Landscapes of Practice , and supported by empirical examples, we demonstrate how medical trainees are not solely on a trajectory towards the Community of Physician Practice (CoPP) but also on a trajectory towards various Landscapes of Healthcare Practice (LoHCP). We discuss some of the barriers present within health care organisations and professions that have likely inhibited adoption of the broader LoHCP perspective. We suggest three perspectives that might help to deliberately and meaningfully incorporate the interprofessional learning and teaching dynamic within the medical education continuum.

**Conclusion:** Systematically incorporating Landscapes of Competence, Assessment, and Guidance in workplace-based education—in addition to our current intraprofessional approach—can better prepare medical trainees for their roles within the LoHCP. By advocating and researching this interprofessional perspective, we can embark on a journey towards fully harnessing and empowering the health care team within workplace-based education.

## 1 | INTRODUCTION

*Often attributed to the Cherokee nation of North America, the parable of the two wolves is related as a conversation between an elder and a boy.*

*Elder: There is a struggle taking place inside of me between two wolves. One is evil—he is rage, hate, greed, vengeance, regret, envy, arrogance, self-pity, guilt, lies, pride, and ego. The other is good—he is love, patience, generosity, forgiveness, empathy, peace, joy, humility, gratitude, truth, faith, and compassion.*

*Boy: Which one wins?*

*Elder: The one you feed.*

The wolves in this allegory represent the internal struggle between an individual's evil and good nature. The individual determines the victor by nurturing one wolf over the other. This parable is more broadly relevant since it highlights a timeless point: the perspectives and practices we nurture thrive; those we ignore wither.

As health professions education (HPE) researchers who study clinical care and workplace-based education, we have come to conceptualise these domains as spaces where some perspectives and practices are nourished, but others are starved. Specifically, we have identified two ways of conceiving and realising interprofessional collaboration and education—two wolves—that are vying for supremacy in order to shape clinical care and workplace-based education practices.

One wolf is older, enjoys deep-rooted traditions and oversees respected expectations. This wolf is the *intra*professional conceptualisation of health care training in clinical contexts. In this longstanding conceptualisation, the education of medical trainees falls solely under the purview of physician educators; nursing trainees are overseen strictly by nurse educators, pharmacy trainees by pharmacist educators and so on. This orientation has given rise to many of the education structures, policies and practices that underpin the accreditation of the professions, the competency expectations of each profession and the daily practices of clinical work. This wolf has produced important and valuable outcomes: it has clarified professional boundaries; it has built professional communities, each with eager legitimate peripheral participants who strive to join in the profession; it has enabled health care to successfully incorporate the ever-growing body of clinical, biomedical and psychosocial insights which have enabled many of today's health care successes.

The other wolf is younger, has new ways of thinking and wants to change the status quo. This wolf is the *inter*professional conceptualisation of health care training in clinical contexts. In this conceptualisation, the education of medical, nursing, pharmacy and all other health care professions' trainees is overseen by the entire interprofessional health care team. This wolf seeks to fundamentally alter current health professions education structures, policies and practices. This wolf challenges accreditation practices, professional competency expectations, and clinical practices to embrace and harness the power of the full interprofessional collaborative team. This wolf looks to produce new outcomes: it wants to destabilise professional boundaries; it wants to forge stronger connections across professional communities and has peripheral participants join one of, but be facile in engaging across, these communities; and it wants to capitalise on robust interprofessional collaborations to achieve new health care successes that, to date, have only been hinted at.

We do not conceive as either intra- or interprofessional conceptualisation options as evil. In fact, we acknowledge that both orientations have a role in health professions education and are currently present in clinical care contexts and workplace-based learning practices. For instance, the intraprofessional orientation enables residents to learn from attending physicians by watching them work with patients, listening to impromptu didactic sessions and engaging in guided novice level clinical activities like order entry into the patient record. The interprofessional orientation encourages other care providers to support the medical students' learning. It enables the medical student to learn from the entire health care team by watching occupational therapists work with patients, by listening to impromptu didactic sessions from the pharmacist and by having nurses guide them in completing order entry.

However, we note that each perspective is a product of specific ways of thinking about individual professions and about the boundaries impacting cross-profession engagement. We suggest that it is important to interrogate the ways of thinking that serve as the foundation of health professions education to ensure that our practices evolve as care contexts, research and power dynamics in health care advance.

The questions we posit are these:

> Which wolf can best support the future of health care practices?
>
> How can we feed that wolf?

In other words, we ask the following:

> Can the future of clinical education integrate intraprofessional and interprofessional education?
>
> How can we bring that future to fruition?

We contend that the future of HPE needs to embrace an interprofessional approach to education. In this manuscript, we share our reasoning and justifications for this position, and we suggest three ways in which medical education could begin transitioning to a more interprofessional orientation. We argue that the absence[1] of attention to the role of the entire health care team in medical trainees' education is fuelled and maintained by the insidious influence of professional autonomy and role boundaries,[2] the pervasive impact of power and hierarchy within the health care team,[3] and the insufficiently challenged

notion that physicians have the sole prerogative and ability to train other physicians. These considerations are likely limiting our ability to capitalise on the opportunities made available via interprofessional workplace learning.

We propose that socio-cultural learning theory could address this absence because it foregrounds the role of all health care team members in medical trainees' education. We discuss the barriers that have hindered the adoption of the breadth of socio-cultural theory and describe how adopting this perspective might be the means through which to appreciate and enact interprofessional education of medical trainees. To illustrate the value of this perspective as it applies specifically to medical education, we apply our argument to the learning trajectories of medical trainees within the clinical workplace. Through these medical examples, we situate our argument and demonstrate how it holds for health care trainees' workplace learning in general.

## 2 | CLINICAL CARE AND THE WORKPLACE-BASED EDUCATION CONTEXT

When it comes to clinical care, research[4] and policy statements[5-7] are aligned on one point: safe, effective and sustainable health care is supported by interprofessional collaboration. To achieve this requirement—to become a successful health care provider—therefore necessitates that trainees collaborate with the entire interprofessional team.[8] Learning to safely practice patient care is a complex process that largely occurs within day-to-day medical practice, supervision, teaching and assessment of health care's trainees during clinical activities; thus, predictably, workplace learning has received considerable research attention.[9-14] However, this attention has typically focused on intraprofessional learning interactions—for example, the attending physician-medical trainee dyad. This research, steeped in and developed from the intraprofessional tradition, has focused on issues such as professional competence and its assessment and assessors,[12,15] supervision and teaching,[16,17] and the intraprofessional workplace curriculum and its learning dynamics and opportunities.[18-20] These findings have informed practices that achieve intraprofessional oriented goals such as competency-based curricula for the medical professional,[6,7] entrustable professional activities,[21] faculty development for attendings and residents developing their clinical teaching skills of medical trainees,[22] and evaluation of the clinical teacher performance where medical trainees provide feedback to their more senior physician colleagues.[23-25] Clearly, the current state of research into workplace learning has developed important insights and contributed to the construction of valuable education and patient care practices. However, an intraprofessional perspective has moulded this work. This concentration has created a contradiction: whereas interprofessional collaboration is lauded for its foundational value in patient care, the research and practices underpinning clinical care and workplace-based learning are soundly intraprofessional in focus.

There is, however, ample evidence that testifies to the presence and value of one profession's trainees being guided by the members of the interprofessional health care team. For instance, in a study of how residents found opportunities to practice technical skills on a paediatric emergency ward, Bannister et al[26] described how senior nurses use their judgement of residents' competence levels to provide or withhold learning opportunities. Similarly, the work of Olmos-Vega et al[27] showed that members of the interprofessional health care team judged residents' intentions of practicing within a certain field. If residents on rotation were judged to be "passing through" a department,[28] the health care team was far less interested in assisting a resident's transition into the department than if they were judged to be on a direct trajectory into the community.[27] As these and other studies[29,30] highlight, in assessing competence and fitness to practice, members of the interprofessional health care team act as gatekeepers who can facilitate or obstruct residents' learning trajectories and learning opportunities. Clearly, the interprofessional team has impact on medical trainees' educational development.

Interprofessional colleagues also add considerable value to medical trainees' progression. One study establishing this value investigated the roles of physician assistants (PAs) in residents' learning. Polansky et al[31] found that PAs fulfilled various roles within the residents' learning process—including the role of clinical teacher. PAs demonstrated clinical skills, modelled professional behaviour and demonstrated how to manage workflow within the department. This contribution to resident learning is not restricted to PAs. While looking at informal interprofessional workplace learning across professions, Rees et al[32] found various instances of interprofessional care team members directly teaching and giving feedback to trainees. Notably this feedback was sometimes direct and sometimes indirect, a finding also noted by Varpio et al[33] In a study on the development of junior doctors prescribing capabilities, Noble et al[34] found that pharmacists made an important contribution to this process through direct guidance and feedback. Similarly, regarding the uptake of interprofessional collaboration skills, Martimianakis et al[35] highlighted the direct teaching of subspecialty residents by allied health professionals in a paediatric rheumatology setting. These papers and others[11,36] also underscore the socialisation processes that the interprofessional team support for medical trainees, both by role modelling collaborative behaviour[11] and by shaping the learning climate.[36]

Together, these studies represent a small selection of the empirical evidence highlighting the essential role of the entire health care team in learning processes and trajectories of medical trainees. However, the overarching discourse on medical education still champions the intraprofessional perspective on assessment, learning and guidance. This perspective could change whether we attended more closely to the lessons from socio-cultural learning theories.

## 3 | NEW PERSPECTIVES FROM SOCIO-CULTURAL LEARNING THEORIES

Over the last two decades, socio-cultural learning theories have gained considerable traction in health professions education as

lenses through which to interpret and understand the complexities of learning and supervision in the clinical workplace.[37-40] These theories align with a *learning through participation* orientation[41] wherein learning is framed as a process of *becoming part of a community* and teaching requires the educator to take on the role of an expert community participant who guides the apprentice during learning processes. These theories were introduced in medical education as a welcome addition to the field's historically strong focus on the more individually focused and cognitive approach to *learning through acquisition*.[41-43] Interestingly, in its use of socio-cultural learning theories the vast majority of research in medical education has adopted a limited interpretation of a crucial dimension of these theories: the expert who guides the trainee into the community is always from the same profession. We contend that this narrow interpretation is not a necessity; instead, it is a focus we choose to maintain. Therefore, we can choose differently.

### 3.1 | Practicing and learning in communities and landscapes

There are several different theories and orientations on the social aspect of learning residing under the socio-cultural learning theory umbrella including, for example situated learning,[44] Cultural Historical Activity Theory[45] and Practices of Communities.[46,47] These socio-cultural learning theories emphasise the *social* and *interactional* nature of health professionals' education. To date, the *intra*professional interpretation of the *social* and *interactional* nature of that learning has tended to dominate medical education's discourse. Learning trajectories have been constructed for and targeted at the discipline-specific community of physicians. Guidance for medical trainees has been authorised for and provided primarily by more senior physicians. As shifting from this intraprofessional orientation to a more interprofessional orientation could be informed by many of a number of socio-cultural theories, we have selected the theories of Communities & Landscapes of Practice[44,48,49] to foreground the importance of embracing interprofessional guidance of trainees. We elected to use the theory of Communities of Practice (CoP) to ground our argument because it has been widely adopted in the research and practices informing medical education.[50] It resonates with both theorists and practitioners as a way to typify the trajectory of a medical trainee as a legitimate peripheral participant to the centre of the community.[44,49,51]

Despite several critiques on the theory from various fields,[46,52-54] the use of CoP is still prominent in medical education[50] and the theory has been evolving. Recently, Wenger-Trayner et al introduced the theory of Landscapes of Practice (LoP) to describe learning through participation in the workplace. LoP widens the focus from single communities organised around an individual profession, to the landscape of communities brought together by a shared purpose. LoP acknowledges that trainees need to participate in and interact with various communities throughout their learning trajectories en route to becoming a competent professional. The potential of LoP for the field of medical education has been described by Hodson[55] who specifically pointed to the learning opportunities residing in boundary crossing and boundary activities. The LoP evolution broadens the CoP theory's focus, moving away from an *intra*professional orientation of clinical work and health professions education, to a broader *inter*professional emphasis that acknowledges how multiple professions collaborate to support patient care and trainee development.

Conceiving of clinical practice as both a physicians' community of practice *and* as part of many professions' landscapes of practice has significant ramifications for the education of the health professions. First, when considering the role of clinicians in the education of medical trainees in the clinical workplace, the LoP orientation encourages us to discuss *which* communities medical trainees need to be legitimate, peripheral participants within and, eventually, to become a part of. The use of CoP theory in medical education has predominantly focused on medical trainees' trajectory into the community of physician practice, reflecting an intraprofessional definition of the community the trainee is entering. This highlights how the final goal of residency training has been to earn belonging in the Community of *Physician* Practice (CoPP), graduation from residency signals that the trainee has become an equal to the masters of the profession's trade. However, LoP theory posits that learning to become a doctor simultaneously entails learning to be a part of the interprofessional health care teams and their practices.[56] We therefore argue that, in addition to becoming a member of the CoPP, medical trainees are also becoming members of the *Landscapes of Healthcare* Practice (LoHCP). In the LoHCP, medical trainees are members of the interprofessional health care community of practitioners who share the goal of providing safe and effective patient care. To this end, medical trainees must develop a shared understanding of the goals, repertoire of skills, common language and resources within the CoPP; moreover, medical trainees need to develop *knowledgeability* about the practices of the other CoPs represented within the LoHCP. Residents' level of knowledgeability will determine to what extent they are considered a *reliable source of information* within the LoHCP and a legitimate peripheral participant of the LoHCP.

Wenger-Trayner et al make an important distinction between development of competence and development of knowledgeability. Development of competence would be what the field of medical education is typically studying and what competency frameworks[6,7] describe: characteristics of a competent physician. However, from the perspective of the LoHCP, what medical trainees equally need to develop is an understanding of what is required to be an effective physician member of health care teams.[11,32,57,58] Developing the knowledgeability to be successful collaborators in LoHCP requires that medical trainees not only have the sanctioned opportunity to engage in these teams, but also have the formally sanctioned opportunity to engage in interprofessional education. There are important considerations that emerge from the formal approval of interprofessional education of medical trainees—not the least of which being a broader appreciation for the skills required of a competent medical trainee.

### 3.2 | Professional competence: requirements to be constructed by CoPP or by CoPP and LoHCP?

Several studies have reported that a competent medical trainee is perceived differently by different members of the health care team, and yet, the senior physicians' perspectives often overshadow the perspectives of other stakeholders.[59] For example, Graham et al[60] found how, when trying to define the competence of system-based practice for the ACGME framework, system-based practice and what it entails was interpreted differently by attending physicians as compared to members of other health professions. During nominal group processes aimed at defining the characteristics of the system-based practice competency, the dimension "resident as team collaborator" (p. 197)[60] was exclusively endorsed by health personnel *other* than attending physicians. Similarly, Fiordelli et al[61] described how expected and enacted roles of medical residents were perceived differently by head nurses versus senior doctors: nurses felt the residents should enact an apprentice role foregrounding their position as trainee, but senior doctors stressed the need for residents to take their responsibilities as a physician. These studies highlight that, when it comes to defining what can be considered characteristics of a competent physician, if the perspectives of all health care team members were incorporated, the expectations of physician competence would need to be broadened. In fact, if we take the lessons of LoHCP seriously, the definition of professional competence within the LoHCP might require co-creation. This is not to say that the medical profession should be prohibited from defining the competencies of their profession within their CoPP; instead, *in addition to those intraprofession informed definitions*, the competencies of a health professional should *also* be informed by input from other professions so that *all clinicians* are helping each profession—including physicians—to understand, appreciate and train to become a competent member of the CoPP *and* the LoHCP. In this light, including all members of the health care team in the discussion of an individual profession's competency criteria is not just beneficial, it is foundational for the effective functioning of clinical teams.

## 4 | FEEDING OF THE INTERPROFESSIONAL WOLF

Considerable empirical studies highlight the value of interprofessionally informed definitions of competence for medical trainees.[59-61] Data abound testifying to the role of the interprofessional health care team in medical trainees' workplace learning.[26,27,32] And yet, a formal recognition of the interprofessional health care team's role within medical education and health care more generally is noticeably absent. This absence is likely maintained by several barriers which are part of the fabric of medical training and the clinical workplace: professional autonomy and role boundaries[2]; power and hierarchy within health care teams [3]; and problems with mutual credibility.[62] These barriers, already described as forces inhibiting successful interprofessional collaboration and education, are likely also inhibiting the acceptance interprofessional workplace learning dynamics.

Each profession's autonomy—and the principles that underpin that self-governance—has shaped the clinical training landscape: we teach our own. The historical and ingrained nature of this orientation has long hindered acceptance or even exploration of the notion that members of other professionals could be valuable teachers to medical trainees. Strengthened by the notion of role boundaries, education and training silos have persisted. Furthermore, epistemic and organisational boundaries have obstructed successful interprofessional collaboration.[63,64] Although *boundary work* and *boundary crossing* have been described as excellent learning opportunities,[65] to date those opportunities are rarely harnessed. Why is that? Why do we rarely explicitly support the crossing of professional boundaries for interprofessional education in clinical contexts despite knowing that it can benefit trainees?

Within-professional autonomy and boundaries lie power. Power is inseparably linked to conceiving of learning as a social process. As stated by Wenger-Trayner, "learning as a social process always involves issues of power" (p15)—nothing could be more true for the health care contexts in which professionals from diverse fields aim to collaborate and learn together.[3,66] The knowledge, skills and attitudes embedded in a profession's educational processes, expectations and policies—that is the profession's educational discourse—are products of power relations. As Foucault explained, power is productive through such discourses: "it [power] has the capacity to produce the cultural forms and social stratifications we have come to recognise as features of our society." (p. 82).[67] The dominance of the intraprofessional orientation to medical education is at least partially thanks to the effects of the power wielded by the medical profession via their educational discourse and the forms and social stratifications embedded therein. When power is conceived of in these ways, we can understand why efforts to change the medical education discourse to embrace and act on an interprofessional orientation have met with limited success. This partial and slow change is surely linked to power dynamics between the health care professions. This is not to suggest that such power is consistently wielded intentionally towards specific ends, such as maintaining an intraprofessional orientation to education. Power is more insidious than that. And yet, as Wenger-Trayner et al, explained, the dominance of a discourse within a landscape will be determined by its most powerful participants. In health care, physicians stand at the top of the professions' hierarchical pyramid. Physicians hold much of the power to change the intraprofessional discourse to a interprofessional one.

Legitimacy of a discourse, a perspective, a profession or even an individual's voice has been explored in relation to the credibility of interprofessional feedback sources. Empirical studies demonstrate how the legitimacy of a discourse shapes the work and attitudes of both a health care team and a medical trainee. For instance, while studying informal intra- and interprofessional learning in the workplace, Varpio et al[33] noted how nurses would use

discursive practices (eg modality) as a means of genuflecting to the power difference separating them from residents when giving advice. Highlighting the residents' perspective, Van Schaik et al[68] show how the source of the feedback (ie physician vs nurse) influenced the residents' perception of the feedback's credibility and acceptance thereof. As these examples illustrate, the power that medicine—as a profession—wields over the other health professions maintains the intraprofessional status quo. The discourses that currently hold sway give evidence to that power. But that power can be redistributed.

If we acknowledge the ways in which interprofessional engagement enhances medical trainees' development; if we embrace physicians' participation in a CoPP *and* a LoHCP; if we adopt an approach to self-regulation that sees professional autonomy as enhanced—and not threatened—by interprofessional engagement in the development of competency markers and in the education and training of medical trainees; if we can change the discourse of power then opportunities for innovative professional growth, expanded educational designs and perhaps even improved patient outcomes become the new horizon of interprofessional possibilities.

## 5 | USING A LANDSCAPE LENS TO CREATE OPPORTUNITIES

Perhaps the most daunting challenge is the number of "if" statements that need to be addressed. We do not pretend to harbour solutions for them all. They are deeply ingrained within the fabric of health care, and some—like role boundaries, profession-specific training programmes and regulatory bodies—have clear and valuable purposes within the system. Medical education as a field does, however, needs to attend more purposefully to questions like: How do we create productive intersections between the professional boundaries? And how do we capitalise on the qualities and values of both the CoPP and the LoHCP to create productive dynamics between them? In line with the suggestions made by Hodson[55] and by Akkerman & Bakker,[65] we would like to encourage deliberate, intentional and guided boundary crossing. We would like to embolden those who engage in activities within the LoHCP to move beyond, what Freeth and colleagues have described as "serendipitous interprofessional learning."[69,70] Training to become a health professional is a collective, interprofessional effort and should be recognised, supported and formalised as such. This adjustment would require simultaneous attention to further improving the qualities of the CoPP while also investing in and nurturing the LoHCP. From the perspective of medical education, creating space for interprofessional health care training within the clinical workplace will require a more integrative focus on educating future health care professionals and a broadening of the CoPP to the LoHCP. We suggest this might be achieved by creating a LoHCP discourse within the current medical education discourse that includes the landscapes of competence, assessment and guidance.

### 5.1 | Landscape of competence: a competent physician has knowledgeability and bridges gaps

Although the collaborator role is acknowledged in both the CanMEDS and ACGME competence frameworks, the description of what residents should be able to do when interacting with the interprofessional health care team remains relatively broad and abstract. As elaborated upon earlier, becoming an effective member of the LoHCP requires knowledgeability about the landscapes, the communities therein and its practitioners. A LoHCP contains a vast body of social knowledge. One end goal of undergraduate and postgraduate medical training should be to possess an acceptable level of knowledgeability about this body of knowledge. Schot et al[71] suggest that effective interprofessional collaboration requires health care professionals to bridge gaps across professional, social and communicational divides. The requirements of knowledgeability and gap bridging within the landscape of competence will need further specification and definition of what is expected from medical trainees as physicians within health care teams. This could have implications for our definition of competences like communicator, collaborator and leader both in undergraduate and postgraduate curricula.[6,7]

### 5.2 | Landscape of assessment: an interprofessional perspective on performance

What is expected of a (junior) physician within a health care team differs depending on the perspective of the professional engaging in the assessment.[59-61] Consequently, assessing whether an acceptable level of knowledgeability is attained should be constructed intraprofessionally and interprofessionally. McMultry and colleagues[72] provide several suggestions of what such specification could entail. For example, these specifications could include assessing the extent to which residents are able to contribute to interprofessional collaboration, to engage in constructive interprofessional social interactions and to support the synthesis of a patient's health care plan. Furthermore, given the current demand on medical staff to complete assessments of Entrustable Professional Activities (EPAs) within the workplace,[73] the landscape of assessment perspective opens up the possibility of engaging multiple professionals to realise the assessment of medical trainees.[74] Not only could this alleviate some of the burden on medical assessors, but it would also create a multi-faceted report of a trainee's performance. This change would require formalising of the interprofessional health care team's role within the workplace curriculum and acknowledging the breadth of team's assessment capabilities in multisource feedback[75] to include specific EPAs.

### 5.3 | Landscape of Guidance: supporting medical trainees is a collective effort

Although the role of the interprofessional health care team in providing feedback to medical trainees has received research

attention, we contend that the scope of this work has been too limited. If we acknowledge that residents are on a trajectory to become part of the CoPP *and* the LoHCP, then we must also recognise the role of the interprofessional health care team in providing guidance to medical trainees. When describing the role of a senior member of a community in the learning process of a medical trainee, several concepts have been used: supervisor,[17] teacher,[16] preceptor,[76] guide.[77] Each of these concepts has a slightly different meaning and highlights different aspects of the role. We would like to propose that the role of all members in the interprofessional health care team, in relation to medical trainees' learning, is as *guides of the learning process*. This concept aligns with the description of learning as participation[41] and of workplace pedagogy.[77] It allows for "guidance" to be defined with different levels and types of deliberateness ingrained within it. Supported by empirical evidence, the health care team deliberately guides medical trainees for purposes of patient safety[26] and workflow.[31] Furthermore, given their unique perspectives on medical trainees' knowledgeability within the LoHCP, members of the health care team should be deliberately invited to share their perspectives and to create learning opportunities for individual trainees.

## 6 | CONCLUSION: MAKING ROOM FOR TWO WOLVES IN MEDICAL EDUCATION

Although there is a general agreement that interprofessional collaboration is the future of sustainable health care,[5] the field of medical education has been deeply informed by an intraprofessional perspective that upholds a uni-professional orientation vis-à-vis the education, assessment and guidance of medical trainees. In other words, medical education has been nurturing an intraprofessional position. By perpetuating this perspective, we obstruct our trainees' perspectives on the role and potential of other health care professionals in their learning and in their practice. There is another orientation that could be nourished: an interprofessional position. Here, power would be distributed more evenly across the health professions, enabling deep and meaningful intraprofessional *and* interprofessional collaborations. We contend that, as a field, we need to proactively contribute to foregrounding the role of the health care team in the learning trajectories of medical trainees. By truly capitalising on socio-cultural learning theories, we suggest that the *from* aspect of the IPE mantra of *learning with, from and about other health care professionals* can be better developed. By reframing our orientations with concepts such as Landscapes of Healthcare Practice, Competence, Assessment and Guidance, we could create stronger roles for the interprofessional health care team in medical trainee learning.

In the spaces of clinical care and workplace-based learning, two wolves are present: one offers an intraprofessional orientation, the other brings an interprofessional orientation. We ask the following: "would it not be to the benefit of patient care to feed both these wolves?".

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### CONFLICT OF INTEREST

None.

### AUTHOR CONTRIBUTIONS

Both authors contributed to the conception of the work, drafting and critically revising the content of the manuscript, approved the final version of the manuscript and are accountable for all aspects of the work.

### DISCLAIMER

The views expressed in this manuscript are solely those of the authors and do not necessarily reflect those of the Uniformed Services University or the United States Department of Defense.

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