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Towards an evolution of interprofessional practice: Lessons learned from two jazz piano trios

Paul Haidet, Wendy S. Madigosky

1. Introduction

Over the last two decades, interprofessional collaborative practice has been increasingly embraced as an ideal model for the delivery of safe, high quality, and patient-centered healthcare. There has been concurrent interest in interprofessional education, with articulation of core competencies by several international groups. At its best, interprofessional practice entails seamless communication across disciplinary boundaries, broad participation in and shared responsibility for healthcare decision-making among multiple professions, and high quality team-based practice. While these are laudable goals and have been demonstrated to foster a variety of positive outcomes, healthcare practice on the ground has been slow to evolve toward an interprofessional ideal. Efforts to foster more rapid adoption have focused mainly on structurally-based barriers to interprofessional practice or educational deficiencies of practitioners. While both areas are important, we posit that additional issues lie at the heart of interprofessional practice, and will require significant cultural transformation before the ideal can be achieved. It turns out that the field of jazz music underwent a similar interprofessional transformation in the early 1960s. In this essay, we examine two of the era’s leading jazz groups as models of pre- and post-transformation practice, and identify lessons learned for today’s healthcare environment.
2. Background: the jazz piano trio

The jazz piano trio is one of the most fundamental and popular group formats, and consists of a piano, a bass, and drums. Piano trios can stand alone, or can serve as the backbone (called a "rhythm section") for larger groupings of instruments. One of the reasons that piano trios are ubiquitous is that the structure of the trio mirrors the structure of music itself. Music is generally regarded as being composed of three main elements: melody, harmony, and rhythm. Melody consists of the progression of notes that give a song its identity. For example, if someone hummed the song "happy birthday", most people would recognize it, even if the words weren't being sung, because the melody carries the essence of the song. Harmony consists of the notes played simultaneously with the melody. Harmony provides context, and can make a given melody sound happy, sad, contemplative, or a wide range of other moods and feelings. Rhythm is responsible for creating the timing of a song, not only setting the pace, but also how the song "moves". The way rhythm unfolds can make a song sound like it is dancing, skipping, stumbling, flowing, or others.

Given the three structural elements of melody, harmony, and rhythm, the piano trio is ideally positioned, because each of the trio's instruments can be responsible for one of the musical elements. Most commonly, the piano takes the melody, the bass plays harmony, and the drums handle rhythm. This pairing of one instrument with one structural element can set up hierarchies within the trio, because audiences tend to focus on melody, making the piano seem like the most important instrument. It is not an accident that most piano trios are named for the pianist, and that the pianist often functions, or is seen to function, as the leader of the band. Since the instrument one plays forms a core component of the professional identity of the musician (just as specialties form the core of identity for health professionals), the primacy of melody over harmony or rhythm has implications for the interprofessional interplay among pianist, bassist, and drummer during a jazz trio performance.

3. Different models of practice

We suggest that the reader pause to listen to two different jazz piano trios perform the song Waltz for Debby. Both trios were led by highly accomplished and well-known pianists, and they serve as representative models of pre- (Oscar Peterson) and post- (Bill Evans) transformation ideas about interprofessionalism. Of particular importance are the actions of the bassists and drummers, which had implications for interprofessional practice in jazz, and have similar implications for health care practice today.

The first version of Waltz for Debby appears on the 1962 Riverside Records album Affinity by the Oscar Peterson Trio, [13] and can be accessed at: https://www.youtube.com/watch?v=ObKhaRwJ9M. We invite the reader to focus on the bassist (Ray Brown) and drummer (Ed Thigpen), and their actions during the performance. Since jazz music is inherently improvisational, and since the musical score, as formally written, only provides a loose guide for jazz musicians when playing, they will depart from what is written during a performance, engaging in a form of musical conversation with each other. The conversation in the Oscar Peterson Trio version is dominated by Oscar himself on the piano. On the trio has played the song through the first time and starts to improvise (at approximately 1:33 on the track), the piano tears into a blitz of notes, going up and down, idea after idea, in a solo statement of speed and technique. Meanwhile, the drummer and bassist mostly stick to keeping time and harmony without much creative input. What is striking is how little input this bassist and drummer have, considering that Ray Brown and Ed Thigpen were two of jazz's great players on their respective instruments.

The second version of Waltz for Debby appears on the 1962 Riverside Records album Waltz for Debby by the Bill Evans Trio, [14] and can be accessed at: https://www.youtube.com/watch?v=P0FisfD9MXU. At the time this was recorded, Bill Evans had been asking questions that challenged prevailing notions about piano trios. Why did the three functions of melody, harmony, and rhythm have to be siloed among the three instruments? What if the flow of ideas could come from multiple members of the band, instead of just the piano? How could two or more instruments co-construct a melody line, in essence changing the standard jazz solo from a soliloquy into a co-constructed, narrative dialogue? In this version, when the improvisational section begins around 1:15, the piano is not playing nearly as fast or as much as the previous version. However, many listeners perceive that more things are going on musically in this version. Scott LaFaro, the bassist, is all over his instrument, going high and low, playing snippets of melody, plunking occasional low harmony notes, and generally engaging in a back and forth exchange with the pianist. Meanwhile, the drummer Paul Motian is keeping a steady beat, but varying his accents to provide a kind of musical punctuation for the dialogue between the bassist and pianist. In this version, all three musicians seem to be attending to all three components of the music. The result is a more modern and complex sounding version, that, while less accessible at first, retains interest with repeated listening, because three sets of ideas, as played by three individuals, are unfolding in real time and having to be reconciled with each other. This stands in opposition to the Oscar Peterson Trio, with its one main set of ideas, voiced by the piano, and supported in predictable fashion by the bass and drums.

4. Two paradoxes at the heart of differences in practice

In order to achieve their new interprofessional model of jazz, Bill Evans, Scott LaFaro, and Paul Motian had to contend with two paradoxes. We call them “paradoxes” because they challenge cultural norms. Such norms exist in today's health care, and are strengthened by the two factors of uncertainty and risk. These risk and uncertainty factors act as barriers to realizing the potential inherent in the paradoxes, and they play out on three different levels (relational, individual, and systemic). These three levels can provide both context and potential targets for intervention aimed at promoting better interprofessional practice.

4.1. Power is not a zero sum-game

The first paradox is about power. Since audiences typically pay attention to melody, this positions the piano front and center and affords it a significant amount of power and control. By sharing the melody with LaFaro and Motian, Bill Evans was, in effect, sharing power with them. While the cultural norm would suggest that power is finite and that Bill Evans would therefore have less power, this flattening of the power differential had the paradoxical effect of increasing the total amount of power in the system. While it might be frightening for a pianist to consider giving up some of their power by sharing with the bassist and drummer, what the Trio discovered was that, rather than the piano losing power to the bassist and drummer, instead the piano retained its power, even as the bass and drums gained it. All three instruments were now empowered, and all three were responsible for the integrity of the melody. This increased the stakes, but also the level of commitment of the drums and bass, because now, rather than creating music indirectly by supporting the piano player, LaFaro and Motian could take part in creating it directly.

In health care settings, there have been some success stories about empowering members of the team. One example is the elevation of physician assistants and nurse practitioners in primary
care practices. Traditionally, such providers have functioned in a subservient role to the physician, for instance, having to “sign out” patients to the physician before they could be discharged from the clinic, or having to get prescriptions countersigned by the physician. In contrast, many modern primary care practices address patient care needs indistinguishably by physicians, physician assistants, and nurse practitioners. [15,16] All engage meaningfully in the task of caring for a population of patients, analogous to all members of the Bill Evans Trio engaging meaningfully in the task of caring for the melody. Another example is the participation of physician assistants on surgical services, taking a lead role in the postoperative medical management of patients [17]. While such examples provide a beacon of hope for interprofessionalism, we note that structural changes in the sharing of tasks is only the beginning. Reducing power differentials entails changing the ways we communicate with each other, and the ways we view each other.

The flattening of power differentials in health care can be difficult, because cultural norms about power relate to the factor of uncertainty. Medical culture values reducing uncertainty through clear lines of control and hierarchical decision making. While a leader sharing power may render the path of decision making less clear, he/she/they also increase the amount and diversity of input into decisions, potentially drawing upon a broader base of evidence and perspectives. [18] The difficulty comes from the stress resulting from a perception of greater uncertainty. This uncertainty can be managed on three levels. First, on a relational level, the trust developed by personal relationships can result in deeper listening, better comprehension of meaning, and more open back and forth conversation around important decisions. For example, a common factor that empowers nurses to speak up the hierarchy to prevent a potential error is the existence of an informal relationship with the doctor making the decision [19]. The trust garnered by such informal relationships reduces fear of retribution, and also enables the person in a position of power to take advice more seriously. Second, on an individual level, persons who are more comfortable with uncertainty will be more able to engage in back and forth deliberation that does not fall prey to premature closure, thus enabling higher quality decisions. Finally, on a systemic level, organizational factors such as availability of resources, examples set by senior leadership, fairness of processes, and cultural norms can either foster or inhibit the ability of teams to deal with uncertainty. Systems that inhibit teams’ ability to embrace and work with uncertainty will be less likely to foster flattened power differentials, and less likely to realize the full benefits of the first paradox of interprofessionalism.

4.2. Transcending traditional roles

The second paradox has to do with supporting roles. In a jazz piano trio, bassists traditionally have to play the harmony and provide secondary rhythmic backup to the drummer. Ray Brown did this exceedingly well in the Oscar Peterson Trio. Scott LaFaro, though, playing with Bill Evans, faced a challenge. If he was going to go up into the high registers of the bass and share melody with the piano, what would happen to the harmony? In the past, whenever a bassist would take a melody solo, someone else in the band would drop down to attend to the harmony. With Bill Evans, however, Scott LaFaro would not be taking a solo; rather, he would be sharing the melody with the piano, and the problem of harmony needed to be addressed. LaFaro’s solution realized a second paradox, and would revolutionize jazz bass playing. Scott LaFaro found a way to transcend his traditional role, even as he was fulfilling it. In Waltz For Debby, one hears the bass going up and down, playing snippets of melody in the high registers, and in between, dropping down and hitting harmony notes. LaFaro’s example showed bassists that they did not have to abandon the traditional role of the bass. In fact, they could take on additional roles at the same time.

In health care settings, during the early days of the Patient Centered Medical Home movement, a core expectation was that medical assistants, nurses, and physicians would “function at the top of their license” [20,21], implying that they could safely and meaningfully take on additional tasks that would promote optimal patient outcomes. For example, medical assistants in some practices now gather core historical information from patients, pend orders relevant to the chief complaint, document subjective and objective data, and provide patient education. Using protocols, nurses manage anticoagulation levels. Pharmacists manage diabetes medications and recommend adjustments based upon patient-generated data. Patients themselves gather data and adjust medication dosages for conditions like diabetes and asthma, based upon care team guidance. All of these are tasks that were previously considered only in the purview of physicians, nurse practitioners, and physician assistants. Such new tasks exist in concert with the traditional tasks of these roles, and, when embraced, have resulted not only in improved medical outcomes, but also better patient and provider satisfaction. [22–24]

Like the flattening of power, role transcendence can be difficult in health care, because of the factor of risk. By taking on additional roles, such as participating in decision making, a supporting player on a health care team is also taking on some of the responsibility for those decisions, and therefore incurring risk that comes with such responsibility. For example, a number of studies have identified the fear of malpractice litigation as a barrier to non-physician personnel assuming roles traditionally defined as residing in the purview of the physician. [25,26] As with uncertainty, risk can be managed on relational, individual, and systems levels. On a relational level, the positive effects of trust between the leader and other members of the team can help to mitigate risk, because the team members will feel that the leader has their back and is sharing in the responsibility for their behaviors, acting to help them succeed. On an individual level, those who are more comfortable with risk will be more able to transcend their traditional roles. Finally, on a systems level, those organizations that rigidly define job descriptions and foster a culture that incentivizes individuals to stay within their own boundaries and avoid approaching problems creatively will have very low rates of role transcendence on their interprofessional teams.

5. Discussion and conclusion

5.1. Discussion

In the 1960s, the reaction of other pianists, bassists, and drummers to the Bill Evans Trio was mixed. Some saw an exciting development heralding new directions for jazz. Others saw the trio as a threat. These conversations in the jazz community were sometimes heated, and some pianists asserted that the Bill Evans Trio model would destroy jazz. The main argument was that the trio was creating chaotic music that would be less accessible to listeners. [27] However, what such arguments failed to acknowledge was that, while more complex, the music produced by the Bill Evans Trio was deeper, richer, and ultimately more rewarding for listeners, because they could witness the whole interprofessional process unfolding in real time on the bandstand. The Trio ultimately became one of the most influential bands in jazz history, inspiring generations of musicians to come.

Today’s health care culture celebrates strong leaders who have power, make important decisions, are immediately decisive, and lead teams to victory. Such a narrative is organized, clear,
straightforward, and predictable. Much of the hero worship in the news during the COVID-19 pandemic follows this narrative. Unfortunately, the world works in messy, unpredictable, and chaotic ways, and team science over the past few decades has demonstrated that the most successful teams have leadership that is distributed, relational, and not necessarily always done by the physician. [28–30] In other words, on any given day in any given situation, any of a team’s members can help it find success. The best teams, whether in jazz or medicine, organize their business and communication to maximize this potential by drawing upon the full complement of perspectives and strengths of their members. This requires embracing the paradoxes of power and role transcendence. Rather than creating chaos, embracing the paradoxes represents an alternate, more complex and nuanced way of responding to chaos already inherent in health care settings, and better draws upon the strengths that teams bring to medical care [31].

The central paradoxes of power flattening and role transcendence, and the barriers of uncertainty and risk, can provide an important frame to guide the development of interventions that function on relational, individual, and systems-based levels. For example, a number of existing interventions that aim to flatten power hierarchies through reducing uncertainty and risk are designed to work by targeting one or more of these levels. These include TeamSTEPPS, the Medical Team Training Program communication processes (both relational interventions), [32,33] checklists to verify important facts rather than assuming authoritative accuracy (a systems intervention), and critical language that enables all team members to speak up (an individual intervention), like the CUS mnemonic (CUS = I Concerned, I’m Uncomfortable, this is a Safety issue). [34] Concepts such as psychological safety [35] help support the development and evaluation of such interventions [36,37]. It is our hope that a focus on the power and role transcendence paradoxes, their respective barriers of uncertainty and risk, and the relational, individual, and systems levels will empower new ideas and interventions that significantly enhance the quality of interprofessional practice across health care settings.

For health care to achieve the ideals of interprofessional collaborative practice, we believe it must work toward a shared culture regarding interprofessionalism. [38] Work by multiple authors has demonstrated fundamental differences in how health care providers view interprofessional collaboration itself. For example, a discourse analysis of the interprofessional collaboration literature demonstrated not one, but two distinct conversations [39]. One conversation focuses on the utility of interprofessional collaboration to achieve improved outcomes, so that the ends justify the means, and is typically embraced by physicians and those in authority. Another conversation positions interprofessional collaboration as valuable in and of itself due to its emancipatory nature, affording all professionals with the respect, authority, and voice that they deserve. This second conversation most readily occurs among those traditionally in supportive roles (nurses, pharmacists, etc.). This difference is not just confined to the literature. A large survey of doctors and nurses demonstrated that not only did the two groups evaluate the quality of interprofessional collaboration differently, they defined the concept itself in different ways. [40] For health care culture to shift toward sharing power and responsibility, there needs to be not only tools and concepts, but also an acceptance of the need to promote the voices that have not been heard and to elevate those who have been made low by tradition. In other words, there needs to be a single integrated conversation.

In this essay, we have focused on the practitioners, whether they be the jazz musicians on the bandstand or health care personnel working in hospitals and clinics. However, there are additional important actors in both settings. Most musicians will acknowledge that the quality of a performance is dependent on the audience, and most health care personnel would agree that the chances for a positive outcome are strongly influenced by the patient and their community. While a discussion of the details of including patient voices in health care team decision making is beyond the scope of this article, we would just observe that modern articulations of patient-centered care, [41,42] community engagement [43], co-production of care [44], as well as the processes of community-based participatory health research [45], align well with the realization of the paradoxes of power and role-transcendence that Bill Evans, Scott Lafaro, and Paul Motian grappled with nearly sixty years ago.

5.2. Conclusion

In conclusion, the lessons learned by examining differences between the Oscar Peterson and Bill Evans Trios have relevance for today’s health care. In order to realize the potential of interprofessional practice, health care personnel need to grapple with the paradoxes of power and role transcendence. There are barriers to this endeavor in the form of uncertainty and risk. However, creative solutions exist on one or a combination of relational, individual, or systems levels. The lessons of the Bill Evans Trio can provide a useful framework for thinking about and devising interventions to promote higher quality interprofessional collaboration.

5.3. Practice implications

Health care is not a one-size-fits-all endeavor. The tasks across varied environments, such as the hospital ward, clinic, operating theater, and elsewhere, are extremely different, and approaches to flatten power hierarchies and create role transcendence will necessarily differ. While discussions about power and roles in an interprofessional context are not new, [38,46,47] the idea that power and roles set up paradoxes that need to be grappled with, in the setting of cultural norms that preserve the status quo, gives a clearer picture of the nature of the problem. Fostering interprofessional practice is not an instrumental task that can be “fixed” with a simple solution. Rather, it is a complex, improvisational challenge, and the framework of paradoxes, uncertainty, risk, and relational, individual, and systems levels can help leaders and team members alike to organize efforts that rise to the challenge.

CRediT authorship contribution statement

Paul Haidet: Conceptualization, Formal analysis, Investigation, Writing – original draft. Wendy S. Madigosky: Conceptualization, Formal analysis, Investigation, Writing – review & editing.

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