Reflection on the Importance of Interprofessional Training

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Introduction

Traditionally, physicians have been perceived as working in isolation to take care of all a patient's problems. However, the American Association of Medical Colleges is focused on changing this siloed perception through required accreditation standards focused on interprofessional team training (LCMC, section 7.9). The evolving health care field, with an increasing number of specialties and referrals, has created the necessity for competent health care teams (Mitchell, 2012). A competent patient care team prevents disease, limits mistakes, and promotes health (Boult, 2009). "Yet, without explicit acknowledgment and purposeful cultivation of the team, systematic inefficiencies and errors cannot be addressed and prevented" (Mitchell, 2012, p. 2).

Moving away from the traditional view of physicians working in isolation, emphasis in healthcare practices has been on a multidisciplinary approach where several specialties work with a patient, but in parallel (Pecukonis, 2009). More recently, as the field evolves further, focus has shifted towards interprofessional teams, teams where different disciplines actively work together towards a common goal (Drinka, 2000). Interprofessional teams require efficient and competent team members with skills beyond individual medical knowledge. Teamwork requires understanding other team members' strengths and weaknesses in order to maximize the team's full potential. Traditionally, medical students' education is focused on pathology and pharmacology with little to no emphasis or experience on how to utilize other disciplines' skills, to collaborate with other professions, or even to fully understand the role of other health professionals with whom they work daily.

Pecukonis et al. argue the pneumonic "IDEA" creates a framework to help students learn to work competently across disciplines, ultimately creating interprofessional patient care teams. ""I" stands for interactions, "D" stands for data, "E" stands for expertise, and "A" stands for attention" (Pecukonis, 2009, p. 423). Interactions refer to working with students in other disciplines. Data represents collecting information about other professionals and their professions. Expertise illustrates the ability to communicate effectively. Attention is the ability to self-reflect on personal biases or assumptions. As a third-year medical student at Louisiana State University School of Medicine in New Orleans, I have had many opportunities to work in an interprofessional setting and utilize this framework to improve my interprofessional cultural competence.

Interprofessional Education Experience

Each month, I attend a class where I learn from, about, and with my peers from occupational therapy, nursing, physical therapy, public health, audiology, dental, and dental hygiene programs. We work through cases designed to promote conversation about each profession and increase our knowledge of the many health professions involved in the patient care team. Ultimately our

goal is focused on one of the Interprofessional Education Collaboration (IPEC) Roles/Responsibilities subcompetencies, specifically Roles/Responsibilities 3 - "engage diverse professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific health and healthcare needs of the patients and populations" (IPEC, 2016).

One such case focused on obesity. While many professions had similar attitudes regarding prevention of obesity, it was interesting to listen to each profession discuss why their specific profession cared about the topic, beyond general health. Since we are all members of the health care team, I initially assumed we all focused on obesity for the same reasons. After discussion, I realized every profession viewed the topic differently, through a different lens, and had interests in different outcome measurements (Table 1). Understanding other disciplines' assessments and trainings have helped me utilize the IPEC Roles/Responsibilities sub-competency 9 - "use unique and complementary abilities of all members of the team to optimize health and patient care" (IPEC, 2016). It also helped me self-reflect on personal biases I had surrounding the role of a physician on the patient care team. While the physician may be a leader at certain times, they must also depend on the knowledge and expertise of many other professions involved in the patient's care. The physician's role is an equal partnership with other disciplines.

Reflecting upon the IDEA framework illustrated by Pecukonis et al., I improved my interprofessional cultural competence through interacting with students from other programs (I), listening to my peers' professional focus during case discussions (D), expressing my professional opinion effectively in a group setting (E), and starting to become aware of professional biases I had developed throughout my life and training (A).

Having classroom-based interprofessional experiences has caused me to think critically about other experiences, such as my volunteer work in the student-run community clinic. While I have worked at the community clinic many times with dental students and faculty, I was not acutely aware of the intricacies of my interprofessional team until I viewed it through the lens of Pekukonis et al.'s IDEA framework.

The medical team sees all the patients that walk through the door at the community clinic. We screen patients and can immediately refer them to the dental team, as appropriate. Working in this setting, I realized both medical and dental professionals are interested in knowing various details about a patient (D) but for very different reasons (Table 2). How we present this information to each other (E) shapes our ability to build an interprofessional team.

While I had worked with the dental students in the community clinic before, I never paid attention to why the dental team cared about a patient's medical history, beyond tooth problems. Reflecting on my personal experience visiting the dentist, I realized every appointment started with "have any of your medications changed?" This question always seemed insignificant and essentially forgettable until I worked with dentists and under-

Profession	Focus of Reducing Obesity
Physician	-Reduce risk of comorbidities -Promote better overall health -Increase life expectancy
Occupational Therapist	-Promote mobility -Increase exercise ability -Decrease pain

Table 1. *Different professions' reasons for reducing obesity*

Information Obtained	Physicians' Interest	Dentists' Interest
Patient Medications	-Interactions with other medications -Review negative side effects -Snapshot of medical history	-Screen for medications causing increased bleeding times
Social History	-Screen for risk factors and need for follow-up testing -Complete understanding of patient's life	-Screen for illegal substance use that increases bleeding times -Screen for possible complications during procedures
Blood Pressure	-Screen for hypertension	-Hard cutoff to screen for eligibility for procedures

Table 2. *Comparison of physicians' and dentists' interest in patient data*

stood its significance to them, highlighting the need to understand other disciplines' areas of concern to maximize utilization of and understanding between everyone in the patient care team.

My skills as a physician were unchanged, but my attitude, perspective, and understanding of how the medical and dental teams worked together changed after participating in our multidisciplinary class. Understanding my dental colleagues' training and patient goals through previous interactions allowed me to tailor my data collection and patient presentation (E) to work collaboratively with my dental colleagues, instead of in parallel.

Using Reinders et al.'s meta-model of interprofessional development, my interprofessional class discussions gave me knowledge: it provided "content and competencies on desired outcomes and added value of different professions" (Reinders, 2018), pushing me to phase two of my interprofessional development. However, applying my knowledge of interprofessional training to my experience in the community clinic pushed me to phase three of the meta-model. I integrated content and learned to "integrate different professional goals" (Reinders, 2018).

My experience in the community clinic highlights the basic difference between multidisciplinary practice and interprofessional practice (Steffen, 2014). In multidisci-

plinary practices, each member of the healthcare team uses individual assessments and creates discipline-specific treatment plans (Steffen, 2014). Interprofessional practice requires team discussion to create one team-based treatment plan where all members of the patient care team work together to create a better overall outcome for the patient (Steffen, 2014). In the community clinic, before becoming acutely aware of the dental students' training and assessment measures, I was practicing multidisciplinary medicine. I assessed my patient for things that are important to a physician. I presented the information through a physician's lens without regard for the dental students' assessments or treatment plan. Our assessment of the patient was individualized and divided based on what our training and professions taught us were important. We were working in parallel. Ideally, after working with the dental students and understanding what information they needed and why, my assessment and presentation of the patient is coded with the dental student's training in mind, a step closer towards working together in a true interprofessional practice.

Understanding what other professions in the patient care team are looking for and why they are interested in certain measures is important in building a true interprofessional team that promotes patient health, a value illustrated by the interprofessional core competency "explain the roles and responsibilities of other provid-

ers and how the team works together to provide care, promote health, and prevent disease" (IPEC sub competency Roles/Responsibilities 4, 2016).

Conclusion

My training and experiences with other members of the patient care team changes how I view my profession, the other professions I will work with daily, and my understanding of the patient care team. Improving my interprofessional cultural competence through the IDEA framework allows me to create a better patient-centered care team and maximize the potential of all members of the team. My patients will benefit from my knowledge of and effective communication with other healthcare professionals. Understanding differences in assessment tools, measurements of outcomes, and focus on details allows me, as a future physician, to break the professional centric thinking mold (Pecukonis, 2009) and strive to practice true interprofessional medicine.

The continued exposure throughout my education to other professions allows for self-exploration and critical analysis of my professional training, allowing me not only to recognize assumptions I inadvertently make and inherent biases I have but to increase my awareness of prejudicesinadvertently woven into the curriculum, completing the IDEA paradigm. Ultimately, learning from, with, and about other professions allows me to build a true interprofessional team in my future practice. A team without a hierarchy, centered around the patient, with participants understanding other's roles, strengths, weaknesses, and needs.

Acknowledgements

References

Boult, C., Frank Green, A., Boult, L., Pacala, J., Synder, C., & Leff , B. (2009). Successful Models of Comprehensive Care for Older Adults with Chronic Conditions: Evidence for the Institute of Medicine's "Retooling for an Aging America" Report. *Journal of the American Geriatrics Society*, *57*(12), 2348–2349. https://doi.org/10.1111/j.1532-5415.2009.02571.x

Drinka, T. & Clark, P. (2000). *Health care teamwork: Interdisciplinary practice and teaching*. AuburnHouse.

Interprofessional Education Collaborative. (2016). *Core competencies for interprofessional collaborativepractice: 2016 update.* Washington, DC: Interprofessional Education Collaborative. https://www.ipecollaborative.org/ipec-core-competencies

LCMC. *Functions and Structure of a Medical School: Standards for Accreditation of Medical EducationPrograms Leading to the MD Degree.* March 2020. https://lcme.org/publications/

Mitchell, P., Wynia, M., Golden, R., McNellis, B., Okun, S., Webb, C. E., Valerie, R., & Von Kohorn, I. (2012). Core Principles & Values of Effective Team-Based Health Care. *NAM Perspectives. DiscussionPaper, National Academy of Medicine*. https://doi.org/10.31478/201210c

Pecukonis, E., Doyle, O., & Bliss, D. (2009). Reducing barriers to interprofessional training: Promotinginterprofessional cultural competence. *Journal of Interprofessional Care*, *22*(4), 417–428. https://doi.org/10.1080/13561820802190442

Reinders, J. J., Pesut, D. J., Brocklehurst, P., Paans, W., & van der Schans, C. P. (2018, Nov. 12). *Meta- Model of Interprofessional Development: A roadmap to guide interprofessional practice, education andresearch*. [unpublished poster presentation]

Steffen, A. M., Zeiss, A., & Karel, M. (2014). Interprofessional Geriatric Healthcare: Competencies andResources for Teamwork. In N. Pachana and K. Laidlaw (Eds.), *Oxford Handbook of Clinical Geropsychology* (pp. 733–752). Oxford University Press.

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