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Interprofessional Practice and Voice: An Undergraduate Perspective

Introduction

The goal of Interprofessional Practice (IP) is to promote health care professional (HC) collaboration and patient centered care (Buring et al., 2009). Patient voice and respecting diverse narratives is a key component of IP and patient centered care. Patient-centered care is defined as practitioners respecting the patient's narrative, preferences and care concerns in all clinical decisions (Johnsson, et al., 2018). Interprofessional Practice promotes collaboration between different disciplines, encouraging the breakdown of preconceptions and barriers between health care groups (Guraya & Bar, 2018), the understanding of perspectives and voices from diverse specialties (Guraya and Bar, 2018), and the promotion of communication (Kwame and Petruka, 2021) and empathy (Perfecto et al., 2023) towards practitioners and patients. Interprofessional Practice promotes dialogue and collaboration between medical specialties (Perfetto et al., 2023) encouraging health professionals to appreciate each other's approaches and value diverse experiences and perspectives (Lobchuk, 2021). It also promotes stronger communication with patients and families (Kwame and Petruka, 2021) and improves health outcomes. Inequalities in social capital and varied knowledge/faith in medical spaces, family dynamics, and medical complexities/disabilities, make all patients and families unique (Gengler, 2020). Determinants of health capital, such as literacy and socioeconomic status, create barriers for families in interacting with the healthcare system (Gengler, 2020). Understanding how socioeconomic status and access to resources influences family coping skills helps physicians to provide individualized care (Gengler, 2020). My experience in service-learning suggests that utilizing an IP approach supports the amplification of patient voices and will lead to improved care and patient satisfaction.

Description of Learning and Reflecting on Interprofessional Practice

Some patients report experiencing medical trauma (Mundy et al., 2004) and PTSD during medical experiences. (Flaum and Hall, 2013). Additionally, physician-patient miscommunication (Kwame and Petruka, 2021) and miscommunication between medical professionals (Perfecto et al., 2023) can negatively impact patient trauma, satisfaction, and safety (Tiwary, 2019). I have experienced medical trauma connected to chronic illness and a vision impairment. My experiences of being misunderstood and misrepresented in the medical space has inspired personal and professional research centered on understanding these experiences and identifying opportunities for optimizing medical experiences. In this report, I share themes on interprofessional communication, reflections on a service-learning experience I designed, and my perspective on opportunities for optimizing the patient experience.

As an undergraduate student, I have cultivated several meaningful experiences for understanding and optimizing medical experiences including a review of the literature, creating an approved interdisciplinary second major in Disability and Health Studies, and engaging in service-learning in my community. Personal experience motivated me to participate in service-learning and create my own interdisciplinary second major, Disability and Health Studies, at my university. I carefully designed this second major and recruited a diverse Faculty Mentorship Committee to sit at the intersection of neuroscience, biology, sociology, and education. In line with this major, and exploring career paths that utilize an interdisciplinary approach, I began a shadowing program at a children's hospital in the south-central United States. The goal of this program was to observe interdisciplinary roles, functions, and models in practice. While I began this observation with the broad goal of understanding diverse experiences in hospitals and hopefully identifying a career path, I was surprised to discover an

interdisciplinary approach I had been previously unfamiliar with: interprofessional practice in the medical space.

For my observation, I completed fifty hours of shadowing with different pediatric health care professionals. In the end, I observed four pediatric psychologists, one child life specialist, one occupational therapist, one physical therapist, one hospitalist, and their respective teams of social workers, lab techs, physicians, nurse practitioners, speech pathologists and graduate students. I observed practitioners collaborating with others from different disciplines and engaging patients and families in joint partnership. After each day of observation, I recorded detailed ethnographic fieldnotes.

In reflecting on my experience, I recognized the multitude of roles and opportunities for interprofessional practice in spaces that utilize, support, and promote this approach. I want to share themes I observed and the understanding I gained of how an interprofessional approach informs decision making and improves the patient experience. Additionally, I reflect on IP themes observed and their discussion in existing literature.

Discussion

Three themes are evident in my service-learning observational study, aligning with a literature review highlighting components of IP important to understanding voice. First, IP promotes the invitation, amplification, and respect of all patient voices (Metersky, 2022). Child and disabled patients have the right to be treated with respect and involved in important decisions that affect their health. Their voices should be amplified instead of ignored in the medical space. Relying on family members discourages hospital settings from raising patient voices and engaging patients as partners and individuals (Ali, et al., 2022) Second, family voices need to be invited, amplified, and respected (Pettersson, et al., 2020) in the medical space

(Sigurdardottir, et al., 2017). Medical spaces have started considering patient and family determinants of health, such as social capital and literacy as means to promote patient centered care. Understanding the family's situation and experiences helps HP provide more individualized care to patients and prescribe the best treatment for the family's situation. Lastly, IP promotes professional voice and respect for diverse opinions and perspectives (Perfetto, et al., 2023). IP encourages the understanding of diverse backgrounds, opinions, and approaches as a means to achieve patient and practitioner satisfaction. Healthy relationships and communication between HC professionals improves practitioner wellbeing, patient safety, interprofessional trust, and empathy (Lobchuk, et al., 2021). Below, I report examples of these three themes from my service-learning, observational experience.

Invite, Amplify, and Respect Patient Voices

Almost immediately after beginning my observations, I noted how patient voices were valued by medical practitioners. Based on my experiences, I was expecting practitioners to favor parent voices, as children are often overlooked due to age, even in matters regarding their own bodies. This is especially true for children with disabilities, whose voices are entirely ignored due to practitioners being unable/unwilling to communicate at their developmental level (Ali, et al., 2022). However, this was not the dynamic I observed at this hospital. In utilizing an IP approach, this hospital invited and respected pediatric perspectives, implementing strategies that amplified all patient voices.

While observing with a child psychologist who specializes in patients with ear, nose, and throat disorders, I had the privilege of observing her interactions with a variety of patients. I noticed how she always worked to make the room comfortable and individualized for each patient. For example, remembering that a patient favored a specific pillow during sessions to

help mitigate their symptoms, she made sure the pillow was provided. Work was also done to ensure she could meet the communication needs of patients and families. I learned that this hospital provides in-person and virtual translators for all patients and families free of charge.

One day, I followed as the psychologist prepared for a session with a young cochlear implant candidate and his family. The patient, his four siblings, and parents had recently immigrated to the United States from Afghanistan. The patient was primarily deaf, and in the process of learning ASL, however he was also learning Pashto, which his parents spoke at home, and English. For the session, the patient, mother, and two siblings were in attendance, and the father was able to join over the phone. The hospital provided a Pashto translator for the mother and Father, and an ASL translator for the patient.

During the appointment, I noticed how the psychologist looked directly at the mother while explaining treatment options, instead of just conversing with the translator. She did the same when speaking to the patient. She inquired about family and patient fears with surgery, and noted how the patient was very unfamiliar with the surgery process. When she brought up the level of pain, his face immediately perked up. He knew he was getting a cochlear implant yet was unsure about the process. During the session, the psychologist took detailed notes about the patient and family to convey to the surgical team, such as their living situation, fears, and understanding of the procedure.

The psychologist suggested to the mother that she spend one or two sessions with the patient to help him prepare for the procedure and what to expect afterwards. The psychologist explained to me afterwards that pediatric and disabled patients are often overlooked in the medical process because of their age and their disability. However, she explained how she likes to provide an explanation at the patient's developmental level, allowing the patient to ask

questions and have agency in the process. One way that she can meet a patient at their developmental level is by showing them pictures of staying in the hospital and what the bandages look like.

Invite, Amplify, and Respect Family Voices

The practitioners at this hospital not only valued and amplified the patient voice, but also appreciated family voices and dynamics. Practitioners took time to understand patient and family experiences, fears, and social capital as a means to provide more individualized care.

With the autism diagnostic team, practitioners recognized that each family was unique. Practitioners did extensive dialog and provided thorough questionnaires to ensure they suggested a treatment plan that was both possible for the family. For example, when the team found that their recommended treatment for one patient might be too expensive for the family, they found a research program at a university that provided a more feasible option. The practitioners also provided emotional and physical support, viewing patients and families as individuals with unique and individualized narratives. When one mother began crying during the testing, the team provided tissues and soothing words. While staying professional, they were able to meet the mother where she was at.

Practitioners at this hospital also took the time to help families understand the best way to emotionally support their children through trauma. For example, the child life specialist I observed explained how she likes to explain to families that saying “your fine” to patients may not be comforting because it invalidates their pain. Also, dialog with families helps practitioners to better understand the patient so their team can provide more personalized care. For example, when a child life specialist in the PICU learned that a patient might have autism, she recommended strategies and tools that would help make his environment more calm.

Medical Professional Voice and Interprofessional Practice

While shadowing an autism diagnostic team, I learned that families travel from all over the state to this hospital for testing. This testing center is coveted and unique in that an interprofessional team of practitioners work together to run tests, determine a diagnosis, and outline a treatment plan in the span of one visit. Most are unable to get a diagnosis within a day because a thorough diagnosis requires an interdisciplinary specialist team. The team I observed included a pediatric physician, clinical psychologist, nurse practitioner, psychologist tech, social worker, and speech pathologist. I originally assumed that such a big team might lose sight of the patient's voice, especially since patients were quite young, yet I observed quite the opposite. Having a diverse team promotes patient individuality because each team member provides a different perspective on the patient's narrative.

Before each appointment, I observed the team discuss the patient's questionnaire, often filled out by a family member due to patients being under four years old. Then half of the team would proceed into the testing room, while the others observed on the opposite side of a two-way mirror. After the practitioners observed the patient and ran their different tests, they would meet all together and discuss their results and observations. Their little office was crowded, but everyone was included and could weigh in on the discussion. I found it very significant how the team took particular note of the family's access to treatment, such as location and insurance plan. I learned that the team did this to ensure the best treatment recommendation not only for the patient, but for the entire family.

During the diagnostic process and discussion afterwards, there was constant dialog and open communication between practitioners. While observing on the opposite side of the mirror, I was even asked for my opinion on a certain patient's behaviors. As an undergraduate student

observer, I was shocked and humbled to be included. Additionally, practitioners patiently took the time to explain to me how their tests worked and point out interesting behaviors. For example, when we observed a little boy hit his head and run to a tech for comfort, the social worker explained how this behavior was unusual. Young children usually seek comfort from their mothers and primary care providers, however because this child had been abused, he did not have healthy attachment and was open to comfort from strangers.

The literature suggests that while IP is meant to reduce misconceptions and interpersonal conflict over territory, there still can be severe distrust between practitioners (Perfecto, et al., 2023). However, this is not what I observed at this hospital. One psychologist on this team told me how she chose to stay at this hospital after grad school because she loved its unique structure of multidisciplinary collaboration and focus on patient centered care. Additionally, IP promotes healthy relationships among coworkers, thus improving practitioners' well-being. In the healthcare field, due to severe emotional stress, practitioners often rely on one other for emotional support (Jordan, 2023). While at this hospital, I observed that IP not only improved patient well-being, but also promoted healthy relationships among practitioners and emotional support.

Conclusion

I observed many beneficial practices suggested in the IP literature, such as increasing patient and practitioner well-being. However, every institution has room for improvement. For example, one child life specialist explained the frustration she faces when physicians do not take her role seriously. Often, physicians do not call for child life specialists during procedures thinking their role is insignificant. This is an example where IP has not completely taken down

the barriers of professional misconception and territorial distrust. I believe that further implementations of the IP model can help achieve this goal.

The IP approach in this hospital bridges the gap between social and medical models of disability (Ladau, 2021), something unseen in the literature before. And, from my reflections, I believe it can be highly successful. When I observed patients and families interacting with medical professionals, I observed partnerships built on empathy, care, and understanding. When I observed the practitioners interacting with each other, I observed an efficient and healthy dynamic built on mutual trust and respect for diverse opinions and perspectives. Overall, I observed respect for patient, family, and practitioner voice as a model to improve patient safety, experience, and well-being. While I am still exploring different practitioner and specialty roles as possible careers, this observation has inspired me to pursue roles that support and advocate for voice in the medical space and in public health policy.

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