

“Walking the Walk”: Promoting Competencies for Interprofessional Learning through Team Meetings—A Case Study

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Abstract

Background: Interprofessional learning is a key aspect of improving team-based healthcare. Core competencies for interprofessional education (IPE) activities have recently been developed, but there is a lack of guidance as to practical application.

Methods and Findings: Cancer Forum is a weekly multi-professional meeting used as the case study for this report. Power was identified as a critical issue and six questions were identified as the basis for a structured reflection on the conduct of Cancer Forum. Results were then synthesised using Habermas’ delineation of learning as instrumental, normative, communicative, dramaturgical, and emancipatory. Power was a key issue in identified obstacles to interprofessional learning. Leadership emerged as a cross-cutting theme and was added as a seventh question. The emancipatory potential of interprofessional learning benefited from explicit consideration of the meeting agenda to promote competencies of sharing role knowledge, teamwork and communication. Modelling of required skills fulfils a dramaturgical and normative role.

Conclusions: The structured reflection tool highlighted the relationship between power and IPE competencies. It was essential to walk the walk as well as talk. The process followed provides a practical guide for using team meetings to promote interprofessional learning competencies and thereby improving patient care.

Keywords: Reflection; Teams; Interprofessional learning; Structured reflection

Background

Teamwork is seen as the foundation of modern healthcare, and team meetings are an almost universal feature of team-based care. Professional teaching has lagged behind these developments, with education still predominantly done in professional groups or silos. Meanwhile, theories of learning have moved from the philosophy of individual consciousness to theories of collaborative learning, such as Lave and Wenger’s communities of practice [1]. This has raised interest in the potential of interprofessional learning to promote the development of knowledge and skills required for both individual learning and team-based care [2,3].

Research on team meetings has tended to focus on understanding the dynamics of professional interaction [4,5,6,7] and documenting the effectiveness of interprofessional educational interventions [2,8]. The synthesis of these findings has led to the development of core competencies for interprofessional practice [9] and learning [10]. Mitchell et al. [11] have provided a conceptual framework for this, but there is very little research on how to continually improve team meetings to achieve these competencies. The cancer centre at my institution has run a weekly whole-team meeting since the inception of the unit in 1984. Over the last 10 years the function

of the meeting has evolved, and this has provided an opportunity to reflect on the changes and potential utility of this meeting.

Although interprofessional learning has potential to address issues of interprofessional care, the literature has identified major risks to seeing the benefits, or that harm (in the form of increased conflict and isolationism) can occur [11]. A review of the literature identifies that many of the issues relate to the role of “power” in determining the nature of the discourse that occurs within a team meeting [4,5,7]. The importance of this discourse is highlighted by the changing nature of work and what Iedema and Scheeres have referred to as the increasing “textualization of work”: the observation that there is an “imperative that we increasingly engage in consultative and participatory processes with co-workers who are immediately, as well as indirectly involved in what we do” [12]. This process is critical in the way that professional identity is constructed and maintained [7].

Reflection has a central role in learning, including organizational and team learning [13], but one important critique of reflective practice is that it is often overly individualistic, instrumental, and insufficiently critical, particularly of power relationships [14]. A methodology of team reflection that addressed these concerns and promoted open and free discussion would have the potential to increase interprofessional learning and thereby improve patient care.

This article describes the derivation and application of a guided team reflection tool to address the issues of power within a multidisciplinary team. The project fits within an action-research framework as there has been a continuous process of experimentation in practice, evaluation, and reflection during the process of the meeting’s evolution. This article both performs this function and records its outcomes. The approach taken is also that of an autobiographical case study, and a first-person viewpoint, as I have been a participant in this process and there is no pretence of objectivity. I am a medical oncologist and educator within the cancer centre of a teaching hospital, where I participate in providing education for junior medical staff and serve as director of specialist training in medical oncology. In this role I developed an online education program for medical staff which then expanded to host online learning for nursing staff as well [15] and eventually led me to a role as director of a state-wide multiprofessional learning program for the Cancer Institute of New South Wales [16]. This experience raised my interest in the issues of multiprofessional and interprofessional learning. My position in the power structure is somewhat ambiguous. The culture of the unit is very much one of distributed leadership, where formal authority is less important than initiative and interest. It is in this setting that I have pursued an interest in the functions of our multidisciplinary meetings.

The views outlined in this article are therefore subjective, but have arisen as part of a process of “communicative action,” where discourse about validity occurs within the group during a weekly multidisciplinary meeting in a metropolitan teaching hospital in an ongoing and reflective process [17]. It fits well within the ambit of action research as defined by Carr and Kemmis as “a form of self-reflective inquiry undertaken by participants in social situations in order to improve the rationality and jus-

tice of their own practices, their understanding of these practices and the situations in which the practices are carried out” [18].

The theoretical approach taken is influenced by an integration of Jürgen Habermas’ theory of communicative action [17,19,20] and the concept of communities of practice [1,21]. This has been well summarized by Kemmis:

Practices can best be developed when they are understood as being shaped and reshaped in communities of practice, especially where these communities are constituted as public spheres as described by Jürgen Habermas; that is, in communicative spaces in which people can converse openly, freely, critically and self-critically about the nature, meaning and consequences of what they are doing. [22, p. 394]

Methods and Findings

This article consists of:

- a) A description of Cancer Forum
- b) Derivation of draft questions for a guided team reflection
- c) Personal application of guided reflection and optimization of tool
- d) Feedback to participants for validation and ongoing action
- e) Synthesis and evaluation according to a “Habermasian” framework

Case study: A description of Cancer Forum

Cancer Forum is a weekly multidisciplinary meeting and the major communal learning activity of the cancer centre in a metropolitan teaching hospital. Cancer Forum has run since the centre opened in 1994. The meeting has been multiprofessional (with involvement of nursing, allied health, and medicine) as well as multidisciplinary (with involvement of teams from medical oncology, radiation oncology and palliative care). The purpose of the meeting has changed over this time. At the outset, there were few multidisciplinary meetings, and the meeting functioned as a forum for presentation of problematic clinical decisions. With further sub-specialization there has been a growth of more specific multidisciplinary team meetings (MDTs), for example, lung MDT, breast MDT, including input from other disciplines (such as surgery) and other professionals. At one stage there was a lot of activity from one team, without an MDT, that led to a domination of the meeting agenda by problems from that particular team. With the establishment of a new and separate meeting to discuss these problems, the function of Cancer Forum again changed and the purpose of the meeting became open for other possibilities. The purpose of the meeting has therefore evolved to meet the residual need for a multidisciplinary and multiprofessional meeting that discusses more generic issues that affect the whole team, as well as presentation of cases thought to be of broad educational interest.

The attendance at the meeting has been consistent at around 30–40 people, with the audience fairly evenly spread between medical practitioners from either medical or radiation oncology; palliative care; and nursing, research, and allied health staff.

Education has been part of the activity of the meeting from the start, with a tradition of grilling of medical students, residents, registrars, and trainees in front of the

whole department (17). This would then be followed by a discussion of decision to be made by various senior clinicians. In recent years there has been a focus on getting trainees to identify cases for presentation and to present them. There has been feedback from trainees that they find this intimidating.

The agenda of the meeting is self-generated. Thus, whoever wishes to speak at the beginning puts up their hand and the chair allocates time. The chair rotates between the different specialities but is always a medical doctor.

I have had a personal interest in the role of this meeting and in maximizing its benefit to the cancer centre. Thus, over the last 12 years I have been reflecting on the meeting and trying different actions to increase its utility. I have also used the meeting to discuss as a group the issues of how the meeting runs and how the team functions. Thus, in this case report the function of the meeting is both the result of reflection in action and the subject of further reflection.

Derivation of draft questions from the literature for a guided team reflection

There is a vast literature on teamwork, reflection, and interprofessional learning, and many potential questions could be asked in a reflection on interprofessional learning. This literature supports the effectiveness of interprofessional education (IPE) in some circumstances [2], but a critical review has concluded that “evidence is still lacking on the key approaches and elements to an effective IPE” [8].

Table 1:

Questions used for a structured reflection on the team meeting “Cancer Forum”

1. What time is available to think about practice?
2. What context?
3. What is spoken about?
4. Who speaks?
5. Is there critical thinking?
6. How is discussion linked to action?
7. What do the leaders do?*

*The Seventh question was added after the first iteration.

Key competencies identified from the article by Tashiro et al. [10] are listed in Table 1. Issues relevant to a team educational meeting in particular are sharing of knowledge, modelling of working as a team, and desirable attitudes and behaviours [10]. One issue that is critical to all these competencies and the relationship to practice is the influence of power, as has been powerfully highlighted by social theorists such as Foucault and Bourdieu (18). Given that the aim of this guided reflection is to increase the effectiveness of interprofessional learning, the literature review focused on two key questions:

What are the practical issues?

There is precedent in the patient communication literature for the practical issues required to optimize communication [25]. The key enablers are to set aside appropriate time in an appropriate context. One critique of reflection is that it is just talk and needs to be connected to action. An examination of how reflection connects to improvements in practice is therefore critical.

What is the existing literature on discourse and reflection within multidisciplinary teams?

An initial literature search revealed two major reviews from different perspectives. The first was a review of social and cognitive factors in effective interprofessional collaboration by Mitchell et al. [11]. The second was a set of core competencies for interprofessional healthcare based on a process of extensive literature review and expert consultation [10]. These existing reviews were supplemented by 1) a (non-systematic) review of the literature focusing on the evidence in the medical (PubMed) and grey (Google) literature on communication within multidisciplinary teams and 2) a process of forward and backward snowballing [26] to identify and explore themes in other related literature, such as reflection, professionalism, teamwork, and communication. The following themes were identified by the author as being particularly relevant to the context of interest.

The existing literature on discourse in multidisciplinary teams supports the contention that there is a heavy medical bias within the discussions and that the perceived power of the medical staff relative to other staff limits contributions (19). Free interchange of ideas is critical to the development of trust [28].

The literature, however, does identify significant limitations to reflection in practice, particularly: lack of critical thinking, and how to guide, support, and scaffold reflection without turning the process into an unthinking application of the guide for reflection being used [14,29,30,31].

An important principle is that the agenda for reflection is examined critically. The concept of single-loop and double-loop learning is useful here [32], where the agenda for single-loop learning is an instrumental solving of the problem under discussion, and where double-loop learning asks questions of systems and processes as to how this instrumental problem occurred. This study could be considered an example of triple-loop learning, where there is reflection on the process of single- and double-loop learning in an organization and how these are promoted.

Development of a guided reflection

Development of a guided reflection was chosen as a method to promote interprofessional learning. This decision was based on the excellent review conducted by Mitchell et al. [11]. The literature on team performance suggests that communication and reflective practice are key to improving team performance in critical situations; interprofessional learning should therefore aim to promote these competencies. The process of individual reflection (developing the draft by the author) and team reflection (review and revision of the draft), as well as the process of implementing any

changes in practice, constitute a process of reflective inquiry and quality improvement aimed at improving communication and reflection skills.

The key step is to identify what reflective questions meet this goal. The selection of questions was informed by the identified literature, the specific context, and inevitably the perspective adopted. The questions identified were particularly influenced by issues identified during previous informal cycles of reflection and action during Cancer Forum as to how the meeting was run. The perspective that I selected as best addressing these concerns was to consider Cancer Forum as a socially constructed “speech act.” Other participants, other perspectives, and other concerns would lead to different questions.

I then drew upon the above mentioned work to identify 6 key questions for a structured reflection on the Cancer Forum team meeting (Table 2). A seventh question was added after application of these questions to Cancer Forum (see below) based on feedback received.

Table 2

Key competency domains for interprofessional education from Tashiro et al., 2011

- | |
|--|
| <ol style="list-style-type: none"> 1 Problem solving 2. Decision making 3. Respect 4. Communications 5. Shared knowledge 6. Patient-centred care 7. Working as a team |
|--|

Application and results of the guided reflection

The next step in the process was for me to apply the guided reflection as a form of self-directed reflection on the practice of Cancer Forum.

What time is available to think about practice?

The nature of Cancer Forum makes it an opportunity for interprofessional reflection. There is a tension related to its undefined role, and two related roles have evolved in practice. The meeting has an instrumental role—where members of the department bring difficult decisions (some of which require urgent attention) and input is provided from other team members. It also has a potential role as a more reflective space where there are no urgent decisions to be made. There has always been a tension between these two roles. In recent times, the move to specific MDTs for particular tumours has meant that the instrumental role has been taken over by the MDT meetings, and this has created space for the reflective role to grow. However, it does raise the question of where the reflective space is for those individual multidisciplinary teams. Quarantining some time for reflection in those meetings could be an advantage.

Interestingly, teaching is potentially a competing instrumental role. To the extent that the transfer of technical knowledge is discussed, this can be an issue. If teaching is reflective and encouraging of a broader agenda, then teaching may be a vehicle for reflection. In this way, teaching can function as a barrier or enabler of reflection.

What context?

The venue for the meeting is close to but separated from clinical areas, thus allowing some “distance” from the immediate demands of patient care. Cancer Forum is squeezed between morning and afternoon clinical duties, so there is a constant pressure to finish clinical tasks in time to attend, and absences are frequent. This example represents the constant tension between clinical duties and time for education. How senior individuals prioritize between these represents a powerful “hidden curriculum” [33]. The meeting is frequently interrupted by pagers and phones. Food is provided and funded by a roster of pharmaceutical companies. Overall the context does seem to enable participation and reflection.

Other contexts for reflection within the unit are not so well structured. The wards are busy and crowded, and spoken reflection on the run raises concerns over privacy. Reflection in clinics is limited by appointments running late and the need to move on to the next task. The allocation of specific time and an appropriate venue is a noticeable aid.

What is spoken about?

The tendency to focus on instrumental issues and adopt a medical perspective was obvious on reflection about the meeting. A variety of methods were therefore tried to broaden the agenda. The main method was modelling. The self-generated nature of the agenda leads to potentially actively promoting broadening of the topics spoken about. An example of a topic used to promote discussion on a broader curriculum was discussing ethical issues raised by patient care. Support was enlisted from other clinicians with similar interests, and the group as a whole was encouraged to raise questions regarding broader aspects of patient care. One particular strategy was to identify my own emotional responses to patients and to use this as a springboard to seek input from others regarding their own responses and coping strategies. This approach was modelled and explicitly taught to junior presenters.

The initiatives supported by the centre to broaden the agenda (to include humanistic values and issues of professionalism) have changed the nature of Cancer Forum substantively. However, it remains difficult to challenge “technical rationality” as a dominant discourse. Providing a structure to discussions that facilitates broadening of the discussion is one potential method. The use of questioning with an agenda to raise particular issues (such as communication) is another. We could also take an instrumental technical approach to undermining technical rationality and make a checklist! It has become obvious that broadening the curriculum of Cancer Forum also involves a consideration of the formal curriculum provided and the agenda of related meetings. In this sense, reflection on the agenda of Cancer Forum has led to a questioning of our overall curriculum and a move to re-emphasize humanistic and professional values.

Who speaks?

The almost complete domination of senior medical voices was another obvious point when reflecting on the conduct of the meeting. There has been a long-standing difficulty in getting junior medical staff to present. When they do present, the norm has been to prepare a standard medical case presentation with computer slides and address only instrumental issues of technical expertise. Despite encouragement to speak to the group regarding issues such as their emotional responses, the default has always been to fall back to the “safe” areas of medical expertise. The focus on the need to prepare facts and demonstrate knowledge has been inhibitory of more spontaneous presentations that relate to emotional responses.

Explicit calls to draw attention to this imbalance and encourage the voices of a broader range of contributors were therefore made. This has had limited success. Senior nursing staff were a particular target to initiate discussions, and a very small number of excellent presentations resulted. These presentations have provided opportunity for modelling the value placed on multiprofessional input. The feedback from groups traditionally considered less powerful (such as nursing) was that the practice of grilling students and letting people be humiliated by not knowing answers to questions were major inhibitory factors.

More success has been obtained with using the position of the chair to draw out contributions from a broader range of staff. Asking questions is a way of acknowledging expertise and experience. Involving the psychosocial oncology team or the nursing staff is also a way of broadening the range of items discussed. This has also provided opportunities to reinforce the value of their contributions.

There has therefore been some success in broadening the range of voices heard, but the barriers remain substantial. The slow progress demonstrates that more than just permission to speak is required. It is notable that the chairing of the meeting still resides with medical staff. One further action would therefore be to redistribute the roster of chairs to explicitly include nursing, psycho-oncology, and other staff. Within individual multidisciplinary departments, the efforts to make staff present remains assumed to be a medical duty. A further action would be to allocate talks to staff from other disciplines. This is difficult as the formal lines of responsibility within the department run along professional lines. I have no authority to require a non-medical staff member to present, whereas medical staff under my direct supervision involves a different power relationship.

The potential role of humiliation as a barrier to presentation is challenging, as public examination of knowledge is a very traditional part of medical education [4]. In clinical practice knowledge needs to be declared publically, and much of the authority of the consultant doctor or nurse depends on their ability to proclaim their expertise. Should such declarations of knowledge be performed publically to mimic practice or privately to minimize distress? Dealing with feedback in a sensitive way is an obvious requirement, and I would believe that this is what happens. Understandably, individuals who have a lack of knowledge exposed don't always feel that way.

Dealing with a demonstrated lack of knowledge is problematic, particularly in the medical profession. I remember being told by a senior professor, as a young consult-

ant, that I wasn't allowed to not know the best treatment of a rare tumour for which there was no real data! Yet acknowledging what we don't know is seen as a key skill. Perhaps the best way to deal with humiliation is to make explicit the tasks of admitting the limits of our knowledge and the paths we would take to find out. It does highlight that the emotional responses to public and team reflection are a very major issue and that dealing sensitively with the emotional response to reflections is necessary, but not sufficient to prevent it being a barrier to participation.

We have taken the approach of naming humiliation as an issue, discussing as part of the meeting how we can minimize it, and then translating this into action within the meeting. The actions agreed to were: to balance critical comments with positive ones; to monitor each other for examples of insensitive questioning; and to "rescue" distressed trainees through moderating statements, for example, "most trainees at your stage wouldn't know this." The effect of these interventions is difficult to assess quantitatively, but ongoing discussion is a demonstration of the cyclical nature of the reflective process.

It should also be acknowledged that although an effort has been made to challenge the assumption of medical domination, it is a large department, and it is expected that there would be a variety of views as to how desirable it is to broaden the contribution. The leadership of the unit, however, is supportive and inclusive. There is of course a substantive interaction between the issues of who speaks and what is spoken about; broadening the participation is a key aspect to broadening the agenda of the conversation.

Is there critical thinking?

The culture of medicine is highly dependent upon critical thinking in the sense of scientific critical thinking. The discourse is therefore often "critical" in the sense of critiquing the evidence behind particular decisions and quoting and applying evidence as a key part of medical discourse. It is harder to determine critical thinking in the sense of a critical exploration of the assumptions behind decisions. An example may be a speaker challenging the assumption of patient's consent in making treatment decisions and querying what the patient's wishes are. This sort of critical examination of agendas and power in the clinical encounter is sometimes incorporated into practice. There is some structure to promote critical thinking by the pitting of different perspectives against each other. Thus, the opinion of a surgeon may balance an assumption by a radiation oncologist that radiation is the preferred treatment, or vice-versa. Thus, in some ways multidisciplinary discussion promotes critical thinking. This again highlights that it is the plurality of the voices heard that is essential.

There is, however, a lack of truly alternative perspectives, as all the voices come from within the medical-scientific paradigm. There have been a few occasions where alternative practitioners have been invited to speak, resulting in quite difficult and irreconcilable clashes of opinion, perhaps demonstrating that the inclusion of truly critical voices remains problematic.

Consumer representation is one aspect that remains to be explored. The direct representation of patients involved in particular decisions has always been seen to

inhibit free and open discussion, but consumer presentation through official representation is a possibility for promoting a different perspective.

Is there a connection with actions, and do actions get enacted?

The connection of reflection with actions is difficult to assess. There is no clear mechanism within the meeting to ensure that actions are carried out. The managerial accompaniments to an action-orientated approach are missing. There are no minutes, no agenda, no specific allocation of tasks. Occasionally a learning need of a trainee will be identified and a task given to a trainee to come back to the meeting next week, to answer a question on notice.

On a broader view, issues discussed in the meeting do inform subsequent departmental meetings and actions. This interaction goes both ways. Patient histories that address issues under discussion in the department get presented at the Cancer Forum as a way of raising awareness and seeking consultation, while issues raised as case presentations can be followed up in departmental meetings. The person with a major role in promoting this articulation between discussion and action is the chair.

Cross-cutting issues: Leadership?

Examination of the issues in the structured reflection revealed some issues that cut across multiple domains. The first one of these is the role of the chair. Once the context is set, the actions of the chair are a major determinant of each of the areas considered. The advantage of sharing the chairing of the meeting is that it meets one of the requirements for broadening the voices heard, but it does dilute the agenda. The chair has a critical role in determining who speaks, what is spoken about, and the types of critical thinking heard. The chair sets the agenda, either explicitly or not, and the chairs also have a critical role in modelling behaviour in the meeting. Members other than the chair also model behaviours, such as valuing input from other disciplines from the floor, but the chair retains a pivotal role. Leadership has been identified as a critical component of interprofessional interaction previously, with the note that it was often missing [27].

Feedback to participants for validation and ongoing action

The next step in the reflective process was feeding back the results of the reflection to the group for discussion and actions. This was done by circulating the manuscript to opinion leaders for written feedback as well as presentation of the paper to the Forum itself over two consecutive meetings with feedback collated through written notes taken. This formalized a process of reflection by the team. The results of this process revealed that there were quite divergent views within the group regarding the purpose of the Forum. Although no one would challenge the importance of interprofessional learning, there were few willing to advocate for it. The most support came from non-medical staff—interestingly, not expressed in the meeting but quietly afterward. Some comments were that the paper was an “interesting idea” or that “I hadn’t thought of this before.” The idea that generated most interest was the concept of intimidation, and there was a general agreement that presenting could be

“intimidating.” There were contrary views that this was part of learning to be a consultant. There has been no immediate uptake of the idea of sharing the chairing of the meeting beyond medical practitioners. Actions agreed to as part of this process included trialling an arrangement of co-chairing (between a medical and nursing representative), Forum for one month and instituting an annual review of the agenda, participation, and communication practices within Forum.

Synthesis according to a Habermasian framework

The types of learning observed can be viewed through a framework based on Jürgen Habermas’ theory of communicative action [19]. The theory of communicative action derives from the linguistic concept that a speech act can perform multiple functions: it can say something, but it also can do work (such as making a decision, establishing social relationships, building a team, enhancing confidence). For this to work, communicative action requires a common understanding of the terms involved. It is one of the major functions of a team meeting to do the work of establishing a common understanding of who we are, what we do, and why we are here. It is a characteristic of an ideal speech situation that imbalances of power are neutralized so that decisions are made on the basis of rational argument, not force. In this situation, the biases of individuals can be overcome by the wisdom of the group.

Habermas’ (1981) classification of learning (quoted in Mezirow [34]) views learning as instrumental, dramaturgical, normative, communicatory, and emancipatory, and it provides a way of synthesizing the recommendations arising from the case study.

Reflection can be *instrumental*, that is, directed toward achieving a particular goal, for example, improving team communication. This agenda of reflection may be quite open, but it can also be hidden under the surface, conscious or subconscious. This has been called the hidden curriculum. Explicit attention to making reflection part of the agenda of the meeting and ongoing explicit reflection around what is spoken about is one key step to promoting interprofessional learning. This can put key domains of teamwork, interprofessional communication, roles and responsibilities, and values/ethics onto the agenda.

There is also a *dramaturgical* (or impressionistic) aspect of reflection in public. Team meetings are a type of performance where values are not only stated, they are acted out. Reflection in this context is modelling: how to reflect, and what suitable subjects for reflection might be. It is also potentially a modelling of openness to criticism and input from others. Cancer Forum has become a powerful way for modelling attitudes of mutual respect, willingness to collaborate, and openness to trust. The dramaturgical aspect of public reflection also creates a risk around authenticity. Is the behaviour modelled a pose? Do comments reflect what people think, or are they acting a role they are expected to play? This highlights the need to “walk the walk.”

The public use of reflection, particularly by authority figures, creates a *normative* aspect of learning. Public reflection sends powerful messages on what one is entitled to respect and how one might act. These normative messages are a key aspect of creating an organizational culture.

Reflecting in public is also *communicative* learning. Public discussion of these potentially normative positions subjects them to scrutiny and provides the opportunity for reaching a consensus view. This highlights the importance of “talking the talk.” In an ideal speech situation, this type of communication does work to help establish common understandings.

The *emancipatory* potential of public reflection comes from its potential to challenge power relations. A critical discourse on who speaks and what is spoken about is required in order to acknowledge or change existing distortions of free speech created by power imbalances. In Cancer Forum this is seen in the relation between medical and non-medical staff and in attempts to address the imbalances seen. The issue of power was seen to be entrenched in the patterns of speaking and not speaking that were observed. This issue of power differentials in a group reflective process contrasts with that of an individual reflection where conflict around decisions is internal rather than external.

All of these aspects of public reflection can work in the opposite fashion, to enforce power structures, to give normative power to unhelpful behaviours, and to enact messages counter to espoused values. It is the work of critically reflecting on the patterns of team reflection that can identify or challenge these forces.

Conclusions

There is agreement that there is a need for promoting core competencies for interprofessional learning, such as communication, teamwork, definition of roles and responsibilities, and values, but there is a shortage of guidance on how to put these ideals into practice. This case study is an attempt to do that through the development and application of a guided reflection. The reflection is derived from the literature and from a theoretical perspective that sees team meetings, ideally, as a form of participatory democracy in which the freedom of any agent to speak and question assertions is central to the validity of the outcomes determined. This perspective derives from Jürgen Habermas’ theory of communicative action.

This case study deals with reflective practice at multiple levels. At one level it is an individual reflection on Cancer Forum and its functions. At another level it describes Cancer Forum as a communal space for reflection. At a third level it is an intervention in the culture of the organization to reflect upon its own practices and to challenge and potentially change attitudes and practices.

The methods used were deliberately ones that can be undertaken in a practice setting, without research support. It is acknowledged that there are formal methods to obtain feedback, such as thematic analysis of feedback obtained or formal interviews via focus groups. The intention of the case study is, however, to provide a model of interprofessional learning that can be applied in practice and a set of questions that can aid this process as a guided reflection. This process can support the implementation of strategies with support in the literature to improve team outcomes and to reinforce consensus competencies.

There is a wide variety of questions that can be asked, so it is helpful to have a philosophical framework to support the questions selected from the literature. A

Habermasian framework for both learning and communication is put forward as a potentially useful lens through which to address this problem.

This type of reflection that not only reflects on events but critically examines assumptions and predisposing factors for how events have happened fits with what Argyris has called “double-loop reflection” [32]. When the event in question is itself the activity of reflecting, this can legitimately be considered triple-loop reflection. This case study is an example in practice of how triple-loop reflection can inform the function of teams.

The autobiographical case study method used in this example has significant limitations. Some of the limitations of subjectivity and perspective can be partially addressed by feeding back these reflections to the team. An individual’s reflections on the team’s function can be evaluated by the group and then becomes part of the group reflection. Provided issues of power are addressed, the group can serve as a corrective to individual perspectives.

The subjectivity of an autobiographical case study can be addressed in the application, as it is offered as a learning arising in practice, which the readers have to apply to their own situations. Application could be by borrowing the guided reflection and applying it in the readers’ contexts, or it could be borrowing the method of deriving the questions by: literature review, selection of a critical perspective, and derivation of a different set of questions that apply to their own contexts. In either case, it is the readers’ understanding of their own contexts as well as the literature which is crucial.

The use of structured reflection also creates a paradox. By providing structure, are we encouraging a “checkbox” mentality that undermines the creative potential and thoughtfulness required of reflective practice? The relevance of this issue will really be determined by how it is applied. The structured reflection is offered as a model to enable reflection, not as a recipe.

The feedback from the meeting about the reflective process revealed that there are substantial barriers to promoting interprofessional learning. The changing of culture and challenging of power structures are long-term goals, and there is a need for strong leadership in this field if practices are to change.

The final observation arising from this case study is that it highlights the iterative, cyclical, and embedded nature of reflection, learning, change, and practice. It is impossible to separate the activity of conducting Cancer Forum from the reflection, learning, and change that various actors have performed to make it what it is. Reflection permeates its design, conduct, and improvement, as it does for any practice.

The structured reflection provided is a potential tool for structuring reflection on how teams reflect together. It encourages an examination of context, power, leadership, hidden and overt agendas, and effective linking of reflection to practice change.

The process of team reflection has significant differences from individual reflection. As well as an instrumental function, team reflection fulfills important additional functions that can be dramaturgical, normative, emancipatory, and communicative. Habermas’ imagining of an ideal speech situation gives a guide for the conditions required to maximize communicative functions. Purposeful “triple-loop reflection”

on the conditions enacted to enable effective reflection is a key step to ensure team reflection promotes team values, rather than frustrates them.

This case study provides a worked example of reflection on improving interprofessional learning through the purposeful development of multiprofessional team meetings. The meeting provides an opportunity to promote core competencies related to interprofessional learning, such as knowledge of other health professionals roles; skills in communicating with others; and attitudes of mutual respect, trust, and willingness to collaborate. Achieving this requires a reflective process that addresses key questions around the critical influence of power within the team. Questions identified as structured reflection for more general application were: What are the opportunities for learning? In what context does the meetings occur? Who speaks? What is spoken about? Is there critical thinking? Do discussions get enacted? And what leadership occurs?

Application of these questions to Cancer Forum provided a structure for promoting team discussion and identified that promotion of interprofessional learning remains difficult. There is a strong default setting that only medical senior voices are heard and that the agenda focuses on instrumental rationality, and there is no consensus that this should change. Allocating time, attention to context, and dealing with competing agendas of instrumental problem solving and teaching instrumental problem solving were identified as major issues.

Changing requires us to talk about the way the meeting runs and to explicitly deal with the issues of promoting competencies associated with IPE. But more importantly than this, it requires us to “walk the walk.” The meeting needs to become an exemplar of interprofessional learning, where reflection occurs and the voices of all team members are heard.

This case study and associated guided reflection tool are offered as a worked example of how to support competencies for interprofessional learning through a process of guided reflection that can be applied to other teams and contexts. A process of reflection that encourages thinking about processes (double-loop learning), and on the way that learning occurs within the meeting (triple-loop learning), is critical to maximizing the potential of team meetings to promote interprofessional learning.

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