Interprofessional communication: How do we do it?

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ABSTRACT

Interprofessional education in preparation for the skills to execute teams and teamwork through interprofessional collaboration has been publicized and mandated by several professional associations through accreditation standards. The prerequisite is emphasized by the National Academy of Medicine (formerly the Institute of Medicine) as a mantra for successful healthcare outcomes. In response, the Interprofessional Education Collaborative (known as IPEC) published core competencies in 2011 with an update in 2016. While these statements are not each independently expressed in measurable terms, they stand as a compendium to guide interprofessional collaboration. To date, the literature does not reflect a comprehensive approach to explicating or interpreting these to be embraced more readily. Further, the literature to enlighten student education outstrips the literature to illuminate faculty education, though we acknowledge the work of the National Center for Interprofessional Practice and Education to inspire faculty education through a variety of platforms. Though the IPEC publications represent seminal work in the US, built on earlier work from the UK and others, its translation for faculty education applying a straight-forward, orderly, and methodical approach has not been done. Our attempt was to take one of the four ("4") IPEC core competencies, Core Competency 3: Interprofessional Communication, and describe its underpinnings in a systematic way as another tool for faculty education. It may open the door to further expound on each competency statement to employ IPEC competencies within a healthcare community that includes students, faculty and post graduate professionals.

Key Words: Interprofessional education, Interprofessional collaboration, IPEC, Faculty Education

1. INTRODUCTION

To capture important tenets to aid the development and permit guidelines for interprofessional collaboration and teamwork to which many professionals across multiple disciplines subscribe, in 2011 the Interprofessional Education Collaborative, known as IPEC, published competencies within "4" domains.[1] The 4 domains at their inception were labeled: Values/Ethics for Interprofessional Practice, Roles/ Responsibilities, Interprofessional Communication and Teams and Teamwork. These domains and their associated competencies were published and distributed through several confer-

ence proceedings.[2] Though the work was supported by significant and multiple earlier works based in the United Kingdom and Canada, amongst others,[3–6] the IPEC publications in 2011 and 2016 have prevailed as the seminal resource for higher education institutions in the US seeking to provide interprofessional education.

In past and recent publications, the focus of interprofessional education remains directed at students.[7–10] At our university, we began our curricula development by devoting attention to faculty education. We initiated our discussions in 2014 and it has been a slow tedious process. In the meantime,

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train the trainer sessions, sponsored by the National Center for Interprofessional Practice and Education has begun several conference workshops for faculty through a handful of established university centers called Train-the-Trainer (T3) Faculty Development Training Programs.[11] Therefore, there has been a growing recognition that we must develop the skills of faculty members before we can adequately teach students. Given the stature of IPEC and its compendium of sub-competencies, we used it as the guide to structure educational sessions for faculty. While these sub-competencies may not stand alone as measurable statements in each case, but rather a compilation of principles, behaviors and competencies, they establish quasi-standards for how we might proceed to launch faculty education. Our motivation was to be more descriptive and explicate the sub-competencies by adding awareness and familiarity to each to support education. Only one core competency is tackled here, but the other three core competencies, Values/Ethics for Interprofessional Practice, Roles and Responsibilities, and Teams and Teamwork, were addressed elsewhere. There is also considerable overlap between the language, purpose and interpretation of the "4" cores and their associated sub-competencies. The interrelationship between many of them is inextricable.

When the IPEC Core Competencies were revised in 2016, the prior Collaboration domain became the overriding umbrella under which the other domains, now called core competencies, are considered as contributors to the collaboration process. As part of this revision, Core Competency 3: Interprofessional Communication was differentiated as one core competency, along with each of the others: Values and Ethics, Roles and Responsibilities and Teams and Teamwork. Since it is intuitive that you cannot have effective collaboration without effective communication, the communication competency is the vehicle by which collaborative efforts and its developmental processes co-exist. For instance, communication occurs within a myriad of contextual forces that operate within a collaborative milieu, but we are not generally good at defining the context that is shaping the communication. The right words and tone translate a vivid picture that creates a shared image of reality, a shared mental model.[12, 13] It helps minimize conflict, essential to our interactions and teamwork. The communication landscape is infinitely complex. The differences between what is labeled skills versus what is skillful or competent communication is fraught with multiple constructs that are hierarchically underpinned by cognitive and affective processes. These are intrinsically related to interpersonal skills.[14] The sub-competencies listed under the core of interprofessional communication may both oversimplify the criteria for skillful communication by an emphasis on actions without a focus on what underlies the

functional capacity of the interactors. These assume an inaccuracy that we are each equally motivated to engage in like-fashion. Yet their value contributes to standardize expectation.

The "Interprofessional Communication Competency (Domain)" as described by IPEC in 2016 is the ability to, "Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease" (p. 13).[15] An important observation is that only one sub-competency, CC2, clearly addresses patient communication. All the others focus on communication within and between health care team members. To be consistent with the statements, we explored the literature by examining each sub-competency to identify the literature aligned with the language and the perceived intent of each sub-competency. Along with applicable literature in nursing, public health and medicine, we also researched journals specific to communication, leadership and healthcare communication. As guiding principles to Communication, the sub-competencies outlined by IPEC in 2016 are included in Table 1 and will be referred to in this article.

2. THE SUB-COMPETENCIES

2.1 CC8

To begin the discussion the last sub-competency listed, CC8, provides a framework for the others. It refers to the importance of communicating within a teamwork model in patient-centered care. But in the IPEC 2016 publication, the change from 2011 added the component of population health programs and policies to teamwork communication, consistent with extending the needed inclusion of community health. Commonly cited are the multiple publications of the Institute of Medicine (Now the National Academy of Medicine [NAM]), the Joint Commission and others, that testify to the growing recognition that improved communication leads to better delivery and access to care.[16–20] Yet the Affordable Care Act (ACA) of 2010 also renewed the thrust needed to motivate hospital and health care systems to understand what public health organizations have fully understood: know the communities you serve and what drives the health of populations. Section 9007 of the Act expanded federal community benefit requirements for nonprofit hospitals by establishing new standards to fulfill a tax status that require a community health needs assessment. At least every three years tax-exempt hospitals must conduct a community health needs assessment (CHNA) that includes and represents the input from and by broad interests of the community.[21] Though the fate of the ACA Act in its entirety is

undetermined, what remains is, our responsibility to promote the importance of teamwork in patient-centered settings and population health programs through interprofessional com-munication. The remaining sub-competencies numbered one to seven are presented in order of their appearance in the IPEC 2016 publication.[15]

Table 1. Core Competency 3: Interprofessional communication sub-competencies

	Communicate with patients, families, communities, **and professionals in health and other fields** in a responsive and responsible manner that supports a team approach to the **promotion and** maintenance of health and the **prevention and** treatment of disease. (Core statement: Interprofessional Communication)
CC1	Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.
CC2	**Communicate** information with patients, families, **community members,** and **health team** members in a form that is understandable, avoiding discipline-specific terminology when possible.
CC3	Express one's knowledge and opinions to team members involved in patient care **and population health improvement** with confidence, clarity, **and** respect, working to ensure common understanding of information, treatment, care decisions, **and population health programs and policies.**
CC4	Listen actively, and encourage ideas and opinions of other team members.
CC5	Give timely, sensitive, instructive feedback to others about their performance on the team, responding respectfully as a team member to feedback from others.
CC6	Use respectful language appropriate for a given difficult situation, crucial conversation, or conflict.
CC7	Recognize how one's uniqueness (experience level, expertise, culture, power, and hierarchy within the **health** team) contributes to effective communication, conflict resolution, and positive interprofessional working relationships (University of Toronto, 2008).
CC8	Communicate the importance of teamwork in patient-centered **care and population health programs and policies.**

Note. The 2016 updates to the competencies and sub-competencies appear in **bold.**

2.2 CC1

The look of today's interprofessional (IP) team includes the effective use of communication tools. These tools appear in all venues of patient care, and in most community settings providing services. CC1 sub-competency expects the team to "Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function" (p.13).[15] These technologies include smart-phones, electronic tablets, computers that come in various sizes, and human patient simulators. Studies of the use of various technologies conclude that their use with IP teams lead to improved quality of patient care and better team communication. One such study looked at the use of Smartphones at the bedside.[22] Both nurses and doctors were dissatisfied with the "old" communication styles because of the time wasted waiting to actually have a conversation related to a patient's care. Whitlow et al. cited an example of nurses who waited from 20 minutes to more than an hour to converse with other healthcare members. Implementing Smartphones improved the quality of communication and workflow efficiency. Although this study utilized nurses and doctors, it is highly likely that all healthcare professionals would have a similar experience.[22] More important is implementing technologies during the preparation of a professional in a collegiate education setting.

One method of introducing students to developing the skill of communicating interprofessionally is the use of standardized patients. Solomon & Salfi define the standardized patient as a person who is specially trained to follow a scenario of someone in need of care by an interprofessional team.[23] This is a simulated experience, in which actors are the pa-tients in need of care, and the caregivers are members of an actual interprofessional team. However, an unfortunate burden of using actors as standardized patients is that it takes time to educate them on their role, and they can be expen-sive; not all education programs have access to this resource. The researchers conducted a mixed-methods study program evaluation of an IP communication skills initiative that led to the development of an interprofessional patient care plan. Student participants included medical, nursing, physiother-apy, occupational therapy, midwifery, physician assistant and pharmacy programs. The experience was a team of five to eight interprofessional students interviewing a standardized patient, then coming together to establish an IP plan of care. Following each experience, students received feedback from a faculty member from their profession. One particularly important finding of the study was that students felt that they learned about others' scopes of practice, which led to improved confidence in their communication skills.[23]

Another technology used to teach IP communication skills is high-fidelity human patient simulation (HFHPS). There have been several studies supporting the effectiveness of using scenarios with an interprofessional team and HFHPS. In a one-year quasi-experimental study, researchers found the use of HFHPS to be an effective pedagogy for teaching IP communication skills to students from undergraduate nursing, nurse anesthesia, medicine, and respiratory therapy.[24] The students who participated engaged in a simulated emergency situation in each of the fall and spring semesters. The results showed improved communication and team-work skills.[24] Once again supporting the value of the HFHPS use in education.

The consensus is to develop IP communication skills at the beginning of the education process which prepares our next generation of IP practitioners.[23] The use of technologies to improve communication skills facilitates discussions and interactions in a timely manner, which leads to improved quality and safety of patient care and enhances the function of the IP team.

2.3 CC2

The second sub-competency encourages us to "Communicate information with patients, families, community members, and health team members in a form that is understandable, avoiding discipline-specific terminology when possible" (p.13).[15] During a healthcare professional's tenure, the topic of understanding terminology during dialogue is imperative, whether it is with patients, families, community members, or between IP team members. Use of understandable terms with common meanings that are transferrable is an important communication skill. Throughout the years, literature has mostly reflected patients' understanding during conversations with physicians. However, there are times when IP team members do not understand their colleagues. Each of us involved with healthcare can cite examples when we were not understood, or we did not understand or interpret the message accurately from someone else on the IP team. This sub-competency guides us to convey information by an awareness of language that is discipline-specific and may need to be translated or stated differently amongst our healthcare encounters to be understood.

Though the use of discipline-specific terminology is a barrier to IP communication, other factors compromise communication that are less apparent. For instance, a small pilot study conducted by University of Michigan researchers looked at nurse-physician interactions. The team video-recorded interactions between physicians and nurses; they then had the study participants critique the footage separately and together.[25] The researchers noted several common causes of poor communication during the critique. One cause was the power disadvantage for nurses fostered by hospital hierarchies. For fear of speaking the truth to physicians, nurses do not directly request or express their needs leading to confusion for physicians, who then often ignore the nurses' requests and move on to the next task instead of seeking clarification, thus potentially putting patient safety at risk.[25]

Another finding of the study is that achieving an understanding is often difficult due to the vastly different perspectives of physicians versus nurses used in approaching patient care.[25] In one example of poor communication, the physician realized that he had not heeded the nurse's comments related to the patient's pain that needed treatment along with the illness. By treating both the illness and the pain the patient was more comfortable and the outcome was better. Conversely, in good communication scenarios the body language of both parties was synchronized with each other. Study participants and researchers realized that by watching their interactions they were able to discover both desirable and undesirable practices, paving the way to creating good communication habits.[25]

2.4 CC3

The importance of communication is based on not only what we say, but also how we say it. The sub-competency states: "Express one's knowledge and opinions to team members involved in patient care and population health improvement with confidence, clarity, and respect, working to ensure common understanding of information, treatment, care decisions, and population health programs and policies" (p.13).[15] This sub-competency builds on the previous one by adding that communication should be done with confidence, clarity, and respect. This sub-competency is also a function of the others elaborated more fully in those sections (See CC4, CC5 and CC7.). Developing confidence can begin during the collegiate education, by participating in experiential exercises. An example of this is an interprofessional team interviewing a standardized patient then developing an interprofessional plan of care.[23] The more practice students can experience, the more expeditiously their confidence can be enhanced. Students participating in this study stated that although they felt stress when making decisions among other unknown students, the experience allowed them to make mistakes and learn communication techniques in a safe environment where the patient was not harmed in any way. This encounter facilitated building confidence in communication in their professional roles.[23] While building confidence, the students also learned about the roles and scope of practice for the other professions involved in the simulation providing the opportunity to dispel misconceptions about other pro-

fessions' duties and responsibilities, thus creating a more efficient communication environment.

2.5 CC4

Through decades the best practice communication skill prolific in the literature is that we listen actively to others (without preoccupation or bias) and encourage ideas and opinions from others, an almost verbatim language of sub-competency four (CC4). Yet, what interferes with that action is its execution. Why? There are multiple influences. One may be intra-professional communication may hamper inter-professional communication. Each profession has its language, symbols and values through which a situation is evaluated. Individual disciplines create a "virtual world", a conceptual world by which events get translated and the professional group decides what is significant and worth the effort (p. 1800).[26] Multi-dimensional problems are sometimes entrusted to one individual (despite team assignment). The assignment is often based on the perception of what the most acute dimension of the problem is. Engineers, lawyers, nurses, pharmacists, physicians and public health officers each are likely to convert a problem into a "kind of formulation" based upon their root competencies. Therefore, the problem may get translated within the scope of the respective profession. The notion may help us exercise the advantage of cognitive diversity by actively listening and appreciating the opinions of others. For instance, in a situation, a physician, nurse or pharmacist may conceive an event differently than a public health officer assessing the social, political, legal and neighborhood implications of an event to a public health program.[26]

Another barrier to CC4 is that each of us operates within a different active listening scale. Despite the sub-competency of listening and its significance as a core communication skill, we still do not know precisely how it is done well, though the literature has moved away from a linear model of the communication process.[27] Bodie studied listening in a systematic way. He proposed that active-empathetic listening or AEL is the active emotional involvement of a listener during an interaction. He asserts that one suspends their own judgment to attend to another. Though he developed a scale (AELS) to gauge the level of AEL amongst individuals, it did not address the frequent claims that AEL can improve emotional status with better medical care and patient satisfaction.

The AEL scale differentiates behavioral and cognitive aspects of listening. Bodie breaks down listening into three different stages: (a) sensing, recognizing relational content and being sensitive to emotional needs, (b) processing, recalling points made and integrating speaker's words into an integrated whole, and, (c) responding, clarifying with questions and paraphrasing, using body language, such as eye contact and head nodding.[27] He also incorporated the elements of conversational sensitivity developed by Daly, Vangelisti and Daughton which points to the awareness by individuals of underlying meanings in conversations.[28] Higher level-sensitivity individuals are able to make inferences, and also seem to have a deeper understanding of the exchange. However, Bodie's findings suggest that sensing and responding each have greater implications for emotional congruency than processing. Interestingly, though the AEL scale tested indicates it provides a guide for good and bad listeners, an important finding was that non-verbal cues or what was termed "non-verbal" immediacy was not an important determinant (p.291).[27] As a practical comment, during interprofessional communication the focus is generally on the patient or client. Though it is an obvious observation in patient-centered care, we may need to be aware that this essential focus may distract us as we are immersed in the patient's needs and its distracting influence away from listening to other disciplines as we contemplate the patient's or client's priorities from our separate disciplines.

Salmon and Young argue that teaching communication skills as a behavioral coding scheme may blunt the inherent and needed creativity of clinical communication targeted for the complexity of patient/client encounters.[29] Because patient-centered care ultimately means including the patient physically and within team dialogue, a brief discussion from this perspective is justified. They posit checklists or terms such as 'appropriate or proper' in communication exchange and the advancement of a number of psychometric tools to measure a skill, implies a constant meaning to elements. These rules omit the context-dependent and subjectivity characteristics required from both the practitioner and patient's perspectives. They contend that acquisition of skills is often evidence enough of successful training when every clinical situation is different and there needs to be a reconciliation between pedagogy and practice (p. 220).[29] Instead, they propose learners should be assessed on their ability to judge, not technically, "but aesthetically, whether the communication 'worked'" (p. 222).[29] Effectiveness is based upon recognizing the contextual variability, uncertainty and ambiguity in communication.

Salmon and Young's perspectives are worthy of expounding upon, given their patient focus. The deployment of communication demands considerable ingenuity, according to the authors, as they cited a survey of cancer patients wherein "100% of respondents wanted practitioners to be honest, but 91% also wanted them to be optimistic" (p. 218).[29] Through several resources they assert more research is needed to examine communication inductively to identify clinical know-how

and navigate the dilemmas of clinical practice to be passed on to future practitioners and to regain the art as well as the science of medicine. Often communication research and patient surveys regards patients as consumers, and the outcome, is patient satisfaction. But, according to Salmon and Young: "...the aim of health care is not to entertain or even just to satisfy consumers. Health care is a moral enterprise with obligations to patients and the population that transcend consumer satisfaction" (p, 223).[29]

2.6 CC5

The literature is replete with guidance about timely, sensitive and instructive feedback about performance, and conversely, how to receive feedback, the components of subcompetency CC5. However, the focus tends to be applied to faculty/teacher/mentor to student and to a lesser degree feedback amongst colleagues within a team. Yet, this section is approached with the perspective that the principles represented in the literature are easily transferrable to varied scenarios, including the encounters we each have within dyads and groups amongst faculty. Additionally, because the aim here is to support faculty in their quest to develop curricula within IPEC's competency framework, the teacher to student relationship is not overlooked. Faculty as students may be selective and weave through the information provided and pluck and integrate ideas to be useful. The overriding theme is to better facilitate conversations about performance between interactors to be constructive and promote a collaborative environment.

Definitions of feedback include whether it fulfills formative or summative purposes. Summative assessments are exemplified by evidence such as traditional end of the course examinations, post-mortems and/or a display of expected outcomes, essentially it is measuring achievement.[30, 31] In contrast, formative refers to a goal that takes steps in feedback for planned delivery so it is built upon an end educational goal. It is sequential and not a grouping of unrelated events. It takes place several times and focuses on the cognitive, social, and affective aspects of learning.[32] Formal peer assessments may align with team function, but may be overly structured to practically apply to behaviors amongst team members. Instead, in a work environment their use lies within the objectives to include reflection, shared responsibility and collaboration as an interactive communicative process.[32]

Though between colleagues the opportunity to build a "scaffold" for learning (teacher to student) as described by Archer (p. 103) is less achievable between colleagues, the end goal is easily conceptualized, to motivate collaboration in this case.[30] Teams evolve over time and so do the relationships

within those teams. Each of us is investing in one another. However, the goal of improving team function must be clear at the outset to shape the collaborative expectation. Whether the feedback is deemed formative or summative, the point is, an opportunity should not be missed to make encounters productive and consider each of us as learners.

In almost all the literature reviewed, the reiteration noted is that the individual is at the center of feedback intent with a need to consider the message within a performance, psychosocial, and goal-directed context. Feedback comes in from a variety of sources, teacher to student and vice versa, between colleagues and through multi-source feedback (sometimes referred to as 360-degree feedback: peers, subordinates and superiors), a systematic approach.[33] To this end, the recipient's frame of reference, self-awareness assessments, culture and the individual's goals, have a profound influence on how feedback is received, the credibility or influence it has and to the degree it affects self-esteem.[30, 33] And, it is often not a shared reality.[30, 34, 35] Intrinsic to each of us is self-preservation, whether generated by physical or emotional status. In response, there can be 'fundamental attribution error'—"the tendency of individuals to attribute negative outcomes of their behaviors to factors external to themselves and positive outcomes to personal attributes, whilst other raters are more likely to do the opposite." (p.38)[34]

The following reflects a summary of best practices synthesized by the literature review to encourage feedback that is assessed by and between all the interactors as a positive exchange. Though it is not based on a systematic review, it represents a reasonable saturation of the literature for the purposes of enhancing our understanding of how to apply CC5.

A. Nurture a culture within which feedback is expected and fostered so the recipient is nourished to self-monitor and the messenger is equally motivated to provide it.[30, 31, 36] The feedback is reciprocal. Opportunities are not ignored but seized to perpetuate the culture.

B. Performance criteria is explicit. If learners are conceived as all team members, then developing performance criteria for team members makes sense, just as learners should have an understanding of what good performance looks like.[31] Both the giver and receiver need to understand the appropriate criteria for performance.[37] Ground rules at the time of team inception, and charters that outline behavior or prepare the team for mutual feedback is consistent with establishing each of us as learners. The objectives of the feedback are clear and communicated.[36]

C. Be specific about performance, not comments such as: "wonderful job". It may "warm the heart", according to

Cantillon and Sargeant, but does not guide future performance. Rather, "you waited for the patient to explain what she was afraid of before reassuring her" (p. 1292).[31] Align it with the objective of the feedback. In team settings, an example may be: "I was intrigued about the point you discussed, but I don't understand how it correlates. What am I missing?" In most cases the messenger is fearful of eroding self-esteem, particularly, when directing feedback to novice learners.[31] But, Archer warns unconditional praise may be ineffective.[30] Within faculty, it has been observed rapport maintenance, or the deconstructing of it, is fraught with extremes from exaggerated praise to disparaging, critical and disrespectful outbursts towards one another. Addressing specific content and thoughtful and respectful insights may cause the desired reflection presumed to motivate the feedback. Albeit, setting a framework takes time and deliberation, but as rapport builds, so does trust. Trust-invoked rapport mitigates emotional, content and task conflict.

D. Base feedback on what was directly observed—the behaviors, not the person.[31,36,38] Be precise, descriptive and relevant with a neutral tone.[39] This supports credibility and permits the receiver to rely on the feedback.

E. Offer feedback time-proximal to an event.[31] Our ability to reconstruct conversations and actions accurately, diminish with time. Recall flaws exist for all participants, particularly recalling the details or the nuances of the context.

F. Time feedback well. Though in team interplay the moment may be lost and is difficult to re-create, feedback 'in the moment' in a group setting may not be ideal. In teacher to student, immediate feedback may be desirable for procedural skills, yet high-achieving recipients undertaking complex tasks may benefit from delayed feedback and avoiding interruptions during complex tasks (Archer 2010).[30] According to some authors, consultations for feedback that were scheduled routinely at the beginning of a training that followed observations were a first step to organizing feedback.[40]

G. Prepare the receiver. Receiver readiness may be supported through a comprehensive orientation, a workshop or other deliberate presentations, but are designed to garner a mutual expectation before feedback.[31,34,41] The intensity of the feedback, the preparation of the receiver to listen and the emotional charge of the message contribute to the impact and whether feedback can be used to generate learning and behavior change.[14] The congruency of the feedback with self-perceptions is also a significant factor for if and how the feedback is used for performance.[39,42]

H. Generate reflection.[27,31,36,39] There are several models, but according to Sargeant, et al. all the models have the common elements of an iterative process that allows an experience "to be revisited, analyzed and integrated into an existing base of knowledge and understanding, as a basis for future experience" (p. 400).[39] Ramani and Krackov further add that the feedback giver reflects on the session as well.[36]

I. Conclude with an action plan.[36,38] Though this may be an explicit expectation conceived between teacher and student and between supervisor and subordinate, it can be made implicit in the rationale for feedback between team members.

2.7 CC6

Knowing what to say and how to say it can be difficult. Communicating during a critical time can be even more difficult. The IPEC sub-competency CC6 states: "Use respectful language appropriate for a given, difficult situation, crucial conversation, or conflict" (p13.).[15] Using respectful language is of the utmost importance among all healthcare providers, as disrespect is one of the elements that leads to job dissatisfaction.[43] Disrespectful behaviors include acting in a condescending manner, using insulting or rude language, as well as name-calling, yelling and swearing. However, many healthcare providers are uncomfortable intervening when these situations arise. Confronting people is difficult, but the most powerful force over human behavior is social influence. In healthcare, the whole idea of confronting someone is that the abusive behavior can negatively affect patient outcomes.[43]

A study by Brown et al. examined the effect of conflict on interprofessional (IP) healthcare teams.[44] The authors of this phenomenological study discovered three main themes: source of team conflict, barriers to conflict resolution, and strategies for conflict resolution. The sources of team conflict include role boundary issues, scope of practice, and accountability, likely contributions resulting from discipline-specific education.[44] Role boundary conflict surfaces when the member of one profession does not understand another profession's role(s). Likewise, not understanding or knowing the scope of practice of other team members can lead to conflict. This particularly occurs when new members are introduced onto the team; each member needs to know and understand the scopes of practices.[44] Accountability issues can also lead to conflict. Expectations of accountability need to be delineated by each professional on the team to avoid any one person feeling ultimately responsible.[44]

When any of these situations arise, it is necessary to resolve the problem to avoid having the patient experience untoward effects. Conflict resolution is one method of dealing with intra-team problems. However, there may be barriers to successfully resolving the conflict. One of these barriers is that workload issues of the IP team members lead to lack of time to deal with the conflict. It is best to deal with seemingly simple concerns before they become a source of

conflict.[44] If the power of a team member's position is perceived as "less than", it can become a barrier to conflict resolution. Members in a less powerful position may feel intimidated, resentful, and often silenced when offering an insight. Failure to recognize conflict or lack of motivation to resolve a conflict can also act as a barrier. This barrier can be further influenced by the different personalities of the team members.[44]

In the study by Brown, et al., strategies for conflict resolution fell into both team strategies and individual strategies.[44] Regarding team conflict, Brown, et al. found resolution included developing conflict resolution protocols, along with relying on leadership of the organization to be involved. However, someone must take the lead in the resolution process. The participants of the study by Brown, et al. identified actions and attributes of a good leader as having an open-door policy; be accessible; be non-judgmental; be able to listen to all parties involved; and exhibit a certain humbleness in their involvement. When dealing with individuals during conflict resolution, open and direct communication requires a willingness to find solutions, showing respect, and a practice of humility by everyone involved. When applied, humility was found to be a facilitator of conflict resolution, and brought improved listening to all parties.[44]

Difficult situations, crucial conversations and conflicts are inevitable with teams. It is important to address issues as soon as they arise. Learning to resolve conflict, guide a difficult situation or crucial conversation takes time and practice, as it is an art.[45] In an effort to expose nursing students to an experience of lateral violence and practice conflict resolution skills, the online virtual reality tool Second Life was used to study students' perceptions of this experience.[45] As with other simulation experiences, students reported this experience as an opportunity to explore and implement responses to a complex situation in a more comfortable environment than had it been face-to-face. Both faculty and students found this process to foster both collaboration and communication.[45]

2.8 CC7

The sub-competency of CC7 is broad and inclusive and not only addresses how individual characteristics of power, culture, and expertise define our communication impact and style, but contributes to how effectively we communicate and form working relationships. This diversity extends to gender too, according to Gardner.[46] While stereotyping is not ideal, viewed from a lens to help us understand how characteristics might be explained can be useful. As Gardner cites, men tend to communicate based on the task at hand and women tend to put more value on the relationship, which affirms

the ideas and efforts contributed. Though the demographics of our separate disciplines is changing rapidly, particularly in medicine and nursing, understanding the communication priorities of stakeholders is a precursor to communication approaches.

Cognitive diversity is critical to good decision making without which the quality of the decision is often compromised.[47] However, it often takes both awareness and facilitation to optimize the expertise of team members through actively seeking input and a belief in multiple realities.[46] One approach offered and worthy of consideration was posited as early as 1961 by Frank: each professional might give a brief orientation about how s/he perceives a given situation, an exposition that is often based on unformulated assumptions. It helps the audience understand the professional conceptual frames of reference, but it also might make the speaker aware of unrecognized assumptions due to ones' professional uniqueness.[26]

Professional role has a separate influence on culture diversity. Power gradients are established by the scope of a profession, legal attributions and how an organization has established the importance of each discipline's contribution to the organization. Yet, a mitigating technique may be to apply systems' thinking to a problem, so the framework of a conversation encourages connections and strategies based upon how the contextual situation applies to an entire system.[46] It depersonalizes professional boundaries for a collective dialogue and can minimize the power gradient due to reputation, title, and inherent responsibilities. Above all, systems thinking places the patient and/or the community above individual team members, and keeps the goals of the communication clear.[48]

Another influence on the performance of CC7 is how well team members have been educated to appreciate interprofessional communication. In a health care communication study conducted with students, not surprising, the feedback indicated that select students were more expressive in less intimidating environments.[49] In addition, one medical student observed: "...going through the ranks, ...we are always trying to emulate those above us...the attending physician or resident. It's great that we're all getting this experience now, but it seems like residents and the attendings... should be getting this training" (p. 257).[49] It is likely that training for some, particularly students, without the complementary training of post licensees can exacerbate a communication problem due to the disequilibrium it creates in live settings with urgent problems to resolve. In these circumstances, rank is likely to prevail that compromises CC7.

3. DISCUSSION

There are several ways in which the literature and health care communities have addressed the almost desperate need to improve our interprofessional communication. One way is the use of tools and mnemonics. And, while these may not reflect the complexities of communication elaborated upon in this article, they create a structure that can be used to simplify and guide interprofessional communication. Just two examples are described here.

The first example was undertaken by the Agency of Health-care Research and Quality (AHRQ) in partnership with the American Hospital Association to establish a widespread, nationally-based educational movement for institutionally-based health care teams. The goal is to standardize components of clinical communication to mitigate omissions and vagaries in communication and improve patient safety. It is called TeamSTEPPS® and uses the symbols SBAR.[20, 50–52] Each letter represents a short narrative of the desired information in a clinical scenario: what is the current situation of the patient (S); what is the background (B); what is your assessment (A); and what is your recommendation (R).

The second example by Conigliaro et al. constructed a communication model intended for students and post-licensees, which is highlighted here because it includes patients and caregivers, called the PEEER© Model.[53] The approach incorporates the patient and their caregivers along with multiple clinical team members as equal participants in communication. It was grounded through a literature review with the following elements as essential skills: (a) use of Plain Language; (b) Engagement of all team members; (c) Empathy to convey an awareness of the experience of all team members; (d) Empowerment of each team member; and (e) Respect for the experiences contributed by each member.

Both examples might be considered a technical approach according to Salmon and Young.[29] Although in each case educational content is explicated and delivered by varied methods, neither example reflects the deeper wisdom, enlightened by experience, by which we must function, a tacit knowledge described by Salmon and Young. Yet, there is also an irreversible quality about communication, not that it cannot be rectified.[14] But to rectify, the second communication may complicate the first, and not in the timeframe required of clinical encounters. Maybe we must be clearer about what we are trying to accomplish in our communication. For instance, a goal of patient safety may require a short, direct, and a less emotionally thoughtful expression than delivering an unfavorable diagnosis or message. Mnemonics fulfill what Spitzberg and Cupach might call fidelity and efficiency—the respective characteristics of clear communication that is parsimonious.[14]

Student and peer feedback represent yet another and different venue, dimension and purpose for which there are multiple guidelines to account for setting, relationship and goal. The degree of emotional intelligence informed by education, training and experience required in a communication exchange may be what we must assess before we begin any dialogue.

It's impractical to execute all the elements of "effective" communication in every encounter. The use of "appropriateness" criteria may also be dangerous, if not defined well. Appropriateness can glorify a collective assessment at the expense of individual intent and perhaps to Salmon and Young's point, bias to a conformist standard rather than by one informed by experience.[14, 29] We all have had the disappointing experience of walking away from a conversation with the impression that we did not reach the emotional goal, nor did we deliver a clear message, nor did we assert a stance that was clear. The question of: what makes the communication effective might be first considered by properly identifying the primary goal of the communication in a particular circumstance.

The sub-competencies in their totality focus on team communication; yet, inevitably and appropriately these apply to communication between patient and team members. However, a weakness in the sub-competency set may be the lack of differentiating communication between patient, family and team members. In order to effectively deliver a message to patients and or families we often must communicate the message differently with a sensitivity towards language, culture, affect and interpretation. This also extends to how health care teams communicate messages to the community. It may mean a relook at the IPEC compendium to align and address statements to reflect dissimilarities by which each audience may require distinct considerations for effective communication.

4. CONCLUSION

The IPEC 2016 interprofessional sub-competencies help us monitor how we communicate to create sustained, respectful and effective team cohesion. Though it does not attempt to navigate the streams of multiple theoretical constructs, it accomplishes a set of guidelines that most of us have received in our education and training, albeit in fragments. Further, it puts these guidelines into a published, integrated and abbreviated whole to guide communication conduct within and between disciplines with a common goal of patient-centered care and population health.[15] We posit that IPEC's 2016 publication stands as a vital approach to faculty education in

the absence of other organized compendiums developed by a cadre of professionals assembled to provide us a guide. The work ahead requires vesting in studies to demonstrate what learning is effective, but we must first figure out what we are trying to learn.

CONFLICTS OF INTEREST DISCLOSURE
The authors declare there is no conflict(s) of interest.

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