

Managing an Interprofessional Health Team Working Interculturally

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Abstract

In this article, we analyze the efforts of an interprofessional² health team working in Gales Point, a remote village in eastern Belize, Central America. The health team was comprised of students and faculty from a variety of academic disciplines, including communication, dentistry, nursing, and medicine. The analysis addresses how these “academic cultures” combined to create a working team and how this team adapted to the intercultural opportunities and challenges of international health service.

SERVICE LEARNING IN HIGHER EDUCATION

For more than 30 years, an important movement in higher education has emphasized expanding the classroom beyond the walls of universities. Often referred to as experiential education, this educational philosophy and its coordinating practice encompasses several types of learning experiences, including service learning, internship, cooperative education, and study abroad programs (Katula & Threnhauser, 1999). A key goal of experiential education is ensuring concrete experiences, where students have opportunities to apply concepts, models, and theories learned in the academic environment to actual situations and problems. Evolving from the ideas of philosopher John Dewey (e.g., that people learn by doing, that abstract concepts in the absence of application are more difficult to both grasp and retain; see, for example, Dewey, 1938, 1941, 1974), experiential education programs stress the active engagement of students and are believed to enhance student learning through their pragmatic approaches (Katula & Threnhauser, 1999).

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² Because some professions have several disciplines, we have opted to use the term interprofessional, rather than interdisciplinary. Certainly, the health team was interdisciplinary as well.

Of the various types of experiential education programs, service learning is one of the most commonly utilized. In fact, many colleges and universities across the United States offer such opportunities to students, and this method of learning is common in several other countries as well (see Schine, 1997). For example, Sellnow and Oster (1997) indicated that at least 700 U.S. higher education institutions boast such service programs. In addition, a growing number of institutions of higher education are making performing community service mandatory for graduating (Rehling, 2000).

Service learning is defined by the National Society for Experiential Education (2003) as a “carefully monitored service experience in which a student has intentional learning goals and reflects actively on what he or she is learning throughout the experience” (para. 5). In short, service learning is premised on the notion that we learn by doing—through experience—and that due to the acquisition and application of knowledge linked to course concepts, academic credit is warranted. Successful service learning programs contain two critical components: structure that reinforces classroom concepts and reflection that integrates experience with existing knowledge (e.g., see Bringle & Hatcher, 1997, 1999; Cohen & Milone-Nuzzo, 2001; Crabtree, 1998; Eyler, Giles, & Schmiede, 1996; Weigert, 1998).

Service learning can be traced to the late 19th century. At that time, schools such as Johns Hopkins, Chicago, Columbia, and Pennsylvania promoted programs emphasizing service with the goals of creating both more educated students and a better society (Harkavay, 1996; Katula & Threnhauser, 1999). However, at the outbreak of the first World War, most of these programs were suspended (Harkavay, 1996). And according to Harkavay (1996), it was President John F. Kennedy’s 1961 call for citizens to determine what they could do to serve their country that led to the resurgence of service learning programs.

Today, service learning courses are common across many academic disciplines leading to considerable interest in their outcomes (e.g., Eyler & Giles, 1999). Extant literature shows several positive effects, including increased participation as citizens, increased learning through the melding of theory and praxis, increased employment opportunities, and increased awareness of society’s problems (see, for example, Nnakwe’s, 1999, work on homelessness and hunger and Schaffer, Mather, & Gustafson’s, 2000, project on assessing the health needs of the homeless). In addition, students perform better on course objectives when they participate in service learning (Hesser, 1995). Many studies substantiate that service learning has been found to contribute to the intellectual, moral, and civic development of participants. Students in service learning programs develop stronger beliefs that individuals can create social change and make a real difference (Giles & Eyler, 1994; Holland & Gelmon, 1998). According to Carver (1997), recognition of this potential alone can spark a sense of civic commitment that spans a lifetime and serves the vital function of showing students that what they study is pertinent in their own lives and those of others in their communities and the world.

Service Learning in Communication - Given the discipline’s traditional emphasis on civic engagement, service learning programs are a good fit with communication coursework. As a natural extension of the focus on social participation and democracy, service learning can play an important role in preparing students to engage in public life and dialogue (Morreale & Droge, 1998). Perhaps this logical coupling accounts for the large number of communication programs with service learning components. For example, Sellnow and Oster (1997) reported

that of 263 communication programs responding to a survey, 240 awarded students academic credit for performing service.

A survey of the communication literature reveals the diversity of courses in which service learning has been employed. The November 1998 issue of *Spectra*, the newsletter of the National Communication Association (NCA), described several recent service learning projects, including a public relations campaign for Habitat for Humanity and a project to teach English to immigrant factory workers (see Morreale & Droge, 1998). Another NCA sponsored project, in conjunction with the American Association for Higher Education, produced an edited volume examining concepts and models for service learning in the communication curriculum (see Droge & Murphy, 1999). And a 2001 special issue of the *Southern Communication Journal* chronicled a number of others—see, for example, Artz's (2001) stress on dialogue and social justice through service learning; Braun's (2001) and O'Hara's (2001) communication audits; Gibson, Kostecki, and Lucas's (2001) work on communication training and development; Keyton's (2001) projects in research methods; and Staton and Tomlinson's (2001) work on oral communication skill development with elementary school children. Although most of these projects are domestic, some have taken place outside the United States.

Service Learning in Medical Fields - Growing out of a recognition that today's health professionals benefit from training in dealing with cultural diversity, health education and disease prevention, and working in teams, service learning programs have been increasingly implemented in various types of medical education (e.g., Schamess, Wallis, David, & Eiche, 2000; Seifer, Hermanns, & Lewis, 2000; Sternas, O'Hare, Lehman, & Milligan, 1999; Wilwerding, 2003). Given that "the health care and human services professions have a long standing tradition of training students through practical experiences" (Quinn, Gamble, & Denham, 2001, p. 9), service learning programs seem to be a natural complement.

It has long been a standard requirement in medical, dental, and nursing programs that students participate in clinical care; however, much of this clinical work has typically been experienced inside the institution's training facilities. More recently, many programs are encouraging clinical experience in the community (Bailit, 1999; Quinn et al., 2001). For example, community-based clinical training is now permitted by 98% of medical schools, and a number require this type of training (Quinn et al., 2001).

Nursing has had community-based experiences in the curriculum for decades. For many years this factor distinguished between associate and baccalaureate degree nursing programs. However, the reflection involved in service learning and the immersion into the culture are key components that were otherwise lacking. In general, this type of service work and training is seen to forge an important link between universities and communities, often creating a successful partnership between a university and a community (Seifer, 1998).

In particular, forms of service learning, such as work in interprofessional teams involving medical and nursing students, assist in teaching and reinforcing the skills in collaboration and problem solving that are needed to effect real change in overall health and health practices (Levy & Lehna, 2002; Sternas et al., 1999). Further, such programs are believed to improve patient care, students' negotiation skills, and levels of trust and respect (Sternas et al., 1999). Additionally, enhancements in cultural awareness improve communication and subsequent health outcomes.

Increasing in popularity as an elective educational experience in medical programs, it is also becoming common for service learning experience to be international. Between 1990

and 1993, the number of medical schools offering training in international health increased 35% and the number of students completing these courses increased 58% (Heck & Wedemeyer, 1995). Further, during their coursework, approximately 2,500 of the 1992 graduates of medical schools participated in an international health elective experience.

Incorporation of international experience has been shown to increase both student knowledge (e.g., world view, resource utilization, public health awareness) and skills (e.g., clinical, communication), which are important for both domestic and international practice (Haq, Rothenberg, Gjerde, Bobula, Wilson, Bickley, Cardelle, & Joseph, 2000). Guidelines for success with international medical education include ensuring ample preparation, experience, teamwork, supervision, and feedback (Taylor, 1994).

International Service Learning Across the Disciplines - Although most university service learning programs take place locally or regionally, some schools support international service learning opportunities. Despite being a country populated by immigrants and increasing in multiculturalism, “Americans, in general, have a reputation for being ethnocentric, ignorant of other cultures, and often suspicious of foreigners” (Grusky, 2000, p. 866). Yet, simultaneously, geographical boundaries dissipate with the advent of global communication, the ease of international trade, and the increased use of new technologies. Based on their experiences, Cowan, Kagima, Torrie, Hausafus, and Machacha (2003) assert that “as the world becomes a global community, service-learning in a developing country can advance international understanding, foster heightened cultural sensitivity and sense-of-service, and improve human conditions while also developing the leadership skills of participants” (p. 55). “For all of these reasons, for the hope of a peaceful and stable future, it is crucial to offer young people the learning opportunities of an international and intercultural education” (Grusky, 2000, p. 866).

According to Grusky (2000), “university service-learning programs are being challenged to build longer term sustainable relationships with the communities and programs that serve as service-learning sites—relationships that build in reciprocity, respond to community-identified concerns, and concretely address inequities in resources and opportunities” (p. 860). One ongoing program that seeks to address such issues is the University of Louisville’s International Service Learning Program.

The International Service Learning Program (ISLP) - Since its inception in 1997, the University of Louisville’s ISLP has been committed to students and faculty pursuing service projects that combine student learning with a variety of service commitments. Beginning in 1998, these service efforts included work in Belize in Central America (International Service Learning Program, 2001). And since 2000, university representatives have worked with the government of Belize and other agencies to sponsor ongoing service activities. As part of these efforts, each year university students and faculty travel to various parts of Belize and carry out service efforts. The full interprofessional team is comprised of more than 50 persons from a variety of areas of study, including business, counseling psychology, education, justice administration, and sports studies. For example, students in marketing and urban planning are working to devise a tourism plan for the nation and education students have projects on increasing literacy (ISLP, 2001). Based on a needs assessment in 2002, an interprofessional health team was formed to provide free medical and dental clinics in Gales Point, a remote village. Faculty and student teams from communication, dentistry, nursing, and medicine combined to plan for, set up, and staff these clinics during the university’s spring break in

March of 2003. The clinic operated for four days, with all or portions of it open 8-10 hours a day. In the remainder of this analysis, we describe the conditions in Belize and the specifics of the project, the teams involved, and the opportunities and challenges presented in this type of service work.

BACKGROUND ON THE GALES POINT, BELIZE, PROJECT

Health care in Belize - Situated to the south of Mexico and east of Guatemala, Belize, formerly known as British Honduras, is a small, mainly English speaking, nation populated by individuals from a number of diverse cultures (e.g., Creole, Mayan, and Garifuna). Although private insurance and some government-supported care are available, the Belizean government does not sponsor a health care system for its working-class citizens (Wheeler, 2001). Despite this providership issue, some estimates suggest that three-fourths of Belizean citizens have access to quality health care, which includes mobile care units, rural clinics, and hospitals (Chanecka, 1998). However, individuals in remote areas have limited access to health care, and estimates suggest that one-half of them have restricted access due to geographical boundaries and the lack of rural nurses (Barry & Vernon, 1995; Chanecka, 1998).

Gales Point - Located on a peninsula, Gales Point, or Gales Point Manatee, is a remote coastal village in eastern Belize with approximately 400 residents. This figure counts persons in the village itself as well as the surrounding areas. Nearly 56% of the population is female, and over 98% of the residents are of Creole descent (Bent, 2000). Slightly more than 82% of the residents have completed elementary school, and an additional 12% have completed high school. The unemployment rate is over 47% (Bent, 2000).

Although there generally is a village nurse, who is assigned to the community and lives in the village clinic, which consists of one exam room and some supplies in a room adjacent to the nurse's sleeping area, typically the only health care available in Gales Point is basic first aid. Several residents, however, do practice herbal and other native forms of medicine. Access to and from Gales Point is somewhat difficult, involving travel over a dirt road, and the nearest traditional health services are approximately two hours by bus. Approximately 92% of residents rely on public transportation (Bent, 2000). Few residents have access to cars.

At the invitation of the Belizean Ministry of Health, our University of Louisville contingent was charged with developing a health care project that could continue over time. Given the scarcity of information on the current health of Gales Point residents, we elected for the first year of the project to provide basic medical and dental assessments and care and health information, an approach that will allow us to tailor service toward community needs in subsequent years. Thus, we formed an interprofessional health team committed to achieving these goals. Some authors suggest that interprofessional health teams are especially needed in rural communities (e.g., Amundson, 2001). In planning the project and while onsite, we worked closely with the mayor of Gales Point and other officials.

THE INTERPROFESSIONAL HEALTH TEAM

The University of Louisville interprofessional health team consisted of four medical students and two physicians, six nurse practitioner students and two nurse practitioners, three dental students and a dentist, four communication students and two communication professors, and a pharmacist. The Director of the university's ISLP as well as the Associate Director, who

is a Belizean citizen, also facilitated the team's activities. Prior to the travel, we met as a large group at least monthly, and several subgroups met much more frequently. Students were briefed in the cultural, political, economic, and geographic traditions of the country. Below we describe the role and goals of each of these subgroups.

Communication - The communication students and faculty had three primary responsibilities. First, they coordinated publicity of the clinics prior to and during their operation. This function included contacting media outlets with press releases and other information, sending flyers for the mayor to distribute at community gatherings, and going door-to-door onsite and inviting residents to the clinic. Second, they compiled health information packets to distribute to clinic patients. These packets contained information on a variety of health conditions and problems common in Belize. Third, they interviewed patients to determine common health beliefs and practices in the area, so that future health education efforts and campaigns could be based on existing views and practices (i.e., common beliefs and behaviors in the community).

Dentistry - The activities of the dental students and faculty member centered in reparative work. Dental care in Gales Point is quite limited. Although some residents reported previous access to dental work, the primary method of dealing with problems had involved extraction of teeth. This dental team was the first to visit the village that provided restorations, such as "fillings" and "partials" or "flippers." Numerous residents were missing teeth; thus, tooth replacement was a highly sought after service.

Nursing and Medicine - The nurse practitioner students and the two nurse practitioners and the medical students and two physicians combined efforts in screening, prevention, diagnosis, and treatment. Referrals also were made to Belize City when necessary care or evaluation was out of the scope of the university team. The students alternated tasks and were supervised by the faculty. Standard health histories and vital signs were taken and physical exams were performed. Some basic immunizations were administered, height and weight were recorded, and serum glucose screening was performed. Medication was dispensed by our pharmacist according to the treatment plan. We provided most of the care in a community building that we converted into a clinic, but we made a few house calls to examine patients with limited mobility or travel difficulties.

OPPORTUNITIES AND CHALLENGES

We were buoyed by the exciting opportunities for participating in this international service learning project, but we also had to confront and manage some expected and many unexpected challenges. Beyond providing useful service in an area where it was needed, many of us were interested in this project because it allowed us to combine areas of expertise and thus potentially achieve even greater goals. In other words, we looked forward to the process of becoming a fully functioning, integrated health care team—and we believed that we would learn a considerable amount from the experience. However, not surprisingly, achieving this goal—an integrated team—was also one of our primary challenges. As Hinojosa, Bedell, Buchholz, Charles, Shigaki, and Bicchieri (2001) point out, team development can be difficult, professional programs do not necessarily educate us in working with those from other areas, and "teamwork is not magic" (p. 210). However, recognition of the potential value of interdisciplinary teams has led to such efforts becoming increasingly common (e.g., Alexander

et al., 1996; Barr, Hammick, Koppel, & Reeves, 1999; Coopman, 2001; Westbrook & Schultz, 2000; Whorley, 1996). And with the stress on collaboration, health care professionals who can work comfortably in team settings are highly sought after (e.g., Patterson, 2001).

Extant literature discusses several benefits of interprofessional health care teams, both in terms of benefits to patients (e.g., improved care) and to health care providers. For example, Schofield and Amodeo (1999) examine benefits to team members based on increased understanding of one's own profession as well as other professions, development of respect for those working in other professions, and increased skill in and orientation to working collaboratively. And according to Akhavain, Amaral, Murphy, and Uehlinger (1999) these benefits include both personal and professional growth. "There is also a greater sense of unity because team members leave the narrow confines of separate disciplines, let go of territorial attitudes, and share expertise, insights, and knowledge" (Akhavain et al., 1999, p. 10).

Despite these benefits, however, several factors play a part in the process of and challenges in becoming a team. One is that despite the many possible benefits of teamwork, considerable time investment and work are required to combine efforts. For example, an area of conflict not completely anticipated was the overlap in the nurse practitioner role and medicine's role. Generally, medical students have had little exposure to nurse practitioners; rather, their predominant experience is with the bedside Registered Nurse. The scope of practice of the advanced practice nurse is different from that of the generalist. These misunderstandings led to a few 'turf wars' but with faculty eager to succeed in an interprofessional model, disagreements were generally minimized. Further, although the nurses were nurse practitioner students at the graduate level, most had many years of experience clinically as RNs. They viewed the medical students as novices and themselves as experienced, not altogether an accurate perception as their role in diagnosis and treatment was new at the advanced practice level.

Another example centered in differing perceptions involved in performing an arthrocentesis. With several students around, one of the physicians asked who wanted to do the procedure. A medical student was the first to volunteer. A nurse practitioner student felt slighted, believing that the physician did not recognize that this procedure was within the nurse practitioner scope of practice. The physician was concentrating on what the patient needed and the best procedural approach, not on making sure any given student was offered training experiences. The result was a misunderstanding between the professions.

These experiences are not uncommon ones according to the research literature. For example, Alexander, Lichtenstein, Jinnat, D'Aunno, and Ullman (1996) assert that "team-based health care rests on the assumption that groups of care providers, representing multiple disciplines, can work together to fashion and implement a care plan that is both comprehensive and integrated. It also assumes that professionals, who traditionally have worked independently and autonomously, can function effectively in an interdependent relationship with members of other occupational groups" (p. 38). Echoing these sentiments, Drinka and Streim (1994) posit that "team members from different disciplines are trained to practice autonomously using diverse values, languages, methods for problem-solving, and professional behaviors. When independent health practitioners are thrust into working together with professionals from different disciplines, communication difficulties, conflicting values, and interpersonal disagreements are likely" (p. 542). In a similar vein, Cooke (1997) notes that although interdisciplinary teams can improve care, they can also result in strained interpersonal relationships and turf tending. In addition, Vinokur-Kaplan (1995) cautions us to remember

that teams are fragile entities, often with “thin skins.” Thus, proactive behavior is needed reinforcing cooperation; otherwise, the risk is great that other forces will pull the group apart. As Curtin (1998) noted, successful team functioning requires that team members must recognize and acknowledge both the qualifications and contributions of others. Beyond the above problematic areas, other difficulties include: problems resulting from different status being afforded to different practitioners, varying benefits to team members (e.g., based on career stage), challenges in merging different disciplinary methods of administration, unequal levels of commitment to the team and to collaborative work, and confusion over roles (Schofield & Amodeo, 1999). Despite recognizing these risks and potential downfalls, we chose to emphasize possible problems as learning opportunities, both for ourselves and our students. As Patterson (2001) noted, through observation, students may learn to model faculty collaboration, another benefit of training in teams. Our focus on learning as well as the short, though intense, nature of the cultural immersion and hands-on training minimized the likelihood of some of the potential pitfalls for our group. Plus, as we were all fairly new to this type of process, commitment to working together and seeing the project through was high.

Coordinating team efforts also involves challenges in scheduling and logistics (Sternas et al., 1999). And though we planned diligently, we had to recognize that due to many unknowns (e.g., projections of patient turnout, best hours to operate clinic) flexibility was paramount. Thus, we created an operational plan leaving as much room for modification as possible (and we discovered the real need for such flexibility). Another area of challenge was communicating different professional needs (e.g., privacy, running water, electricity, instruments, information) to other team members. We were also challenged by differing understandings and the fact that information changed over time. In addition, a number of environmental challenges presented themselves (e.g., heat, bugs, space). For example, we confronted extreme heat—105 degrees Fahrenheit. Most of our students and faculty were used to working in air conditioned comfort and the temperature became an added stressor. One dental student was near heat exhaustion after working in a tiny room with one window and a door. Emergency first aid was utilized to reduce his core temperature and prevent collapse.

Hesser (1995) stresses that positive outcomes from service learning do not simply “happen.” The courses in which the best results are achieved are well planned and structured by faculty. In addition, Gibson et al. (2001) discuss the importance of encouraging students to participate in the planning phases. This planning helps develop students’ skills at real-world planning as well as “increases the authenticity of the experience” (p. 192). Clearly, our students learned a considerable amount from the planning phases—just as they observed the importance of being flexible as much shifted in process. Considerable thought underlies successful execution, and careful attention to how the field experience is tied to course concepts is essential. One strategy we used to facilitate learning was “debriefing” sessions. Periodically, throughout the service learning, we scheduled meetings where students and faculty shared their views (e.g., key observations, suggestions for improvement). During the days of clinic operation, the challenge was in finding time for these sessions. However, the sessions themselves contained valuable and reinforcing information (i.e., many observations and opinions validated the teamwork concept).

One of our biggest opportunities—becoming a fully functioning integrated team—was simultaneously one of our biggest challenges. The opportunity was ripe with expectations, but the execution would determine if our planning and hopes would come to fruition. Several models exist for examining goal achievement, and many of these include different types or

categories of goals. For example, several typologies include individual, group (or team or relational), and task goals (e.g., Hackman, 1990). In general, initial evidence suggests that team members believe that their goals were met. For example, evidence of task goal achievement includes operating the clinic for the planned number of days and examining approximately 400 persons. Evidence of individual goal achievement includes positive comments from the students and faculty. In addition, students and faculty learned much individually outside the clinic work hours. Some of us took drum lessons. Some attended evening gatherings and danced around campfires. Some played ball with children. And overwhelmingly, all commented that they had learned a great deal from the Gales Point residents. And as group, despite some moments of tension or misunderstanding, we came to understand much more about other professions, what each has to offer, and how to work in ways that maximize the potential for contributions from all. The team experience was not flawless, but it certainly helped all participants make progress in functioning as a unit with integrated skills. And it gave us a baseline for how to improve the program in subsequent semesters.

WORKING INTERNATIONALLY AND THE EDUCATIONAL BENEFITS OF CROSS-CULTURAL EXPERIENCE

It is widely reported that U.S. citizens lack interest and information regarding global issues as well as specific issues in particular countries (Patterson, 2000). Increasingly, health care providers need to work in global contexts to learn about differing health services and policies and, even more importantly, to learn to successfully interact with patients from various cultures (e.g., Peabody & Feachem, 2001).

Through this project, we learned a number of lessons not only about adapting to other disciplines and professions, but also about learning from and adapting to other cultures. And we confronted “cultures” we had not expected. Upon arrival, we learned that the U.S. Army had a medical task force in the region, and they were scheduled to operate a clinic in Gales Point two of the days that we were. We decided to partner with the military and set up clinic operations with them in the school, rather than at the community center where we had originally mapped out our plans. Combining resources provided the ability to see more patients in a shorter time and offer more services (such as treatment for worms, ophthalmology screening). However, the military “culture” presented other challenges (e.g., the ranking officer, not understanding the role of some subteams, refused to allow nurse practitioners to function except as nurses and prohibited most of the communication team from working in conjunction with the rest of the unit), which had to be managed.

From the people of Gales Point and their culture, our students learned a great deal. Similar to Patterson’s (2000) assessment, we see one of the main benefits of this project as students coming to deeply appreciate other people and cultures and gaining confidence as world citizens and people who can make a difference. Few of our students had been outside the United States before, and they ranged in age from the late teens to early sixties. Overwhelmingly, the students remarked on the kindness, friendliness, and openness of the people of Gales Point. And the students repeatedly stressed that this experience had changed their lives and their outlooks and that they would always remember their time in the village.

We, as faculty, learned much too—and were reinvigorated about teaching and working with students. It is hoped that the relationship between the University of Louisville

and the village of Gales Point is longstanding and fruitful. Faculty are committed to seeing through intervention projects based on data collection during the screening process.

CONCLUSION

The decline in citizen participation in the United States over the last several years is a serious concern, and considerable calls have been made for increased engagement. Many writers discuss the disconnected nature of social and civic relations in the United States (see, for example, Lisman, 1998; Putnam, 1995, 2000). Perhaps education, through projects such as service learning, can help us to reconnect. At the conclusion of our project, we saw some evidence of such connection. Several students remarked that the experience had changed their lives and that they wanted to go again the next year—and a few have signed on for the upcoming visit. Others insisted that they want to come and speak to our classes and orientation groups next year to help other students prepare for the experience. And many remarked that they planned to become regular participants in volunteer activities and take other service learning courses. Thus, “as service learning projects and coursework become more and more a part of our academic landscapes, [we] ... can be in the vanguard, providing our own service: to our students, to our programs, and to our communities” (Rehling, 2000, p. 90).

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