Interdisciplinary Health-care Teams: What Should Doctors Be Aware Of?

There are barriers to refining interaction among health-care professionals; however, an interdisciplinary approach has a far-reaching potential to improve health care for patients and doctors alike.

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team approach. Since transition to this practice style has been gradual, physicians’ knowledge about it may be inconsistent. This paper aims to add to their understanding of interdisciplinary health-care team structure and function, with the objective of maximizing its potential.

Rationale for Health-care Teams

Changes to health-care systems, including greater financial accountability, evolving technologies, reduced hospitalization length of stay, managed care, patient care plans, community outreach and the progressive shift to more holistic and culturally sensitive health care are all obliging physicians to acquire new competencies. This has become necessary in order for physicians to survive professionally, while meeting specific population needs. The activities of a single type of health-care worker, therefore, may be insufficient to enable patients with increasingly complex medical and social problems to achieve optimal well-being. The collected efforts of an effective health-care team working with doctors in solo or group practices, polyclinics, emergency rooms, community health or social service centers, acute care hospitals, rehabilitation centers, and long-term care facilities would seem preferable.

Continuous quality improvement has been identified as a health-care priority, especially when promoted by well-functioning interdisciplinary teams. Such a focus occurs at a time when there are gradual shifts towards greater autonomy from within other professional groups, such as nursing, social work, physiotherapy, occupational therapy, and dietetics. The impact of these changes has been compounded by changes in allegiances and alliances among these groups.

Understanding Team Function

Physicians, and family doctors in particular, have practised for years in diverse clinical settings, using various working relationships. Some may, therefore, view team work as common or self-evident. However, the extent to which medical practitioners are familiar with different structures and functions of interdisciplinary teams and with ways to successfully work in them is unclear. This conclusion is derived from Medline computer searches we conducted for published materials in...
English between 1991 and the present time. The searches were identifiable from MeSH headings interdisciplinary, multidisciplinary, patient/health-care teams, collaborative care and health professional education. Despite our expectation that much would appear from the medical or physician perspective on factors influencing how clinical teams work, this information was generally lacking, or not easy to find in standard searches.

What does appear in searches generally focuses on outcomes of team activities. Examples include a look at the association between interdisciplinary collaboration and patient outcomes in a medical intensive care unit; a team approach to practice guidelines for the development of institutional policies; perceptions of physicians, nurses, social workers, and chaplains about the utility of ethics committees; analysis of efficacy of team decision-making from a health management perspective; and differing team approaches to solving aspects of geriatric care.

We found, however, in a nursing publication the opinion that physicians and nurses may have different views about decision-making pertaining to their collaborative activities. This suggests a need for identification and discussion of effective team-building processes and team dynamics that could be generalized for physicians in most prac-
Interdisciplinary Health Care

Working on the premise that team work is not necessarily intuitive, this paper discusses some characteristics of patients, clinical team members, and the structure and function of teams and institutions that may effect the outcome of team performance on patient care.

What is Interdisciplinary Care?

Multidisciplinary or pluridisciplinary work involves health professionals—from different but optimally complementary disciplines—working together, but often in a parallel fashion, with each discipline setting its own goals. By contrast, interdisciplinary work sees individuals involved in interdependent goal-setting, sharing responsibility, respecting and relying on each others’ competence and being involved in evaluation of the outcome. While no comprehensive evidence-based analysis of the value of interdisciplinary work has been reported, it seems to offer greater potential to address a broad range of patient and health professional needs.

Team Membership and Roles

Issues challenging health-care delivery include critical care and terminal illness; quality and quantity of care; degrees of patient competence, autonomy and self-determination; discharge and placement decisions; and issues of family wishes and support. Such complex topics may benefit from broad and encompassing teams that include doctors, nurses, social workers, dieticians, physiotherapists, orderlies, recreational therapists, occupational therapists, audiologists, speech pathologists, pastoral care workers and lay volunteers. Ethicists, hospital administrators, and lawyers would ideally be available as consultants for special situations.

As team composition becomes increasingly heterogeneous, its decision-making may correspondingly become more complex. There is need, therefore, to be aware of individual and group influence, as well as of the relative degree of influence each member has on the group. For example, the significance that each team member places on a particular patient’s age may impact positively or negatively on a specific treatment plan or follow-up. While each team member has specific responsibilities, it is often the collective input that influences a patient’s physical, mental, or spiritual outcomes.

Functional Characteristics of Team Members

Team members have a collective responsibility characterized by distinct supplementary and complementary professional skills, time allotments, and personal and professional accountability. Team members are required to be effectively interactive and mutually supportive of the decisions and actions of the entire group, and not just of the team’s individual members. However, health-care providers have usually learned professional skills independently of one another, and are generally accountable to different governing and disciplinary bodies for standards of care and ethics. These team members have individual responsibilities within a particular area of expertise congruent with their profession and area of specialization. In response to a patient’s unique multidimensional needs and characteristics, health-care professionals may encounter conflicting loyalties to their own associated institutions, to their own particular needs, and to their distinct profession-specific cultures. Negative consequences
for patient care or clinical outcomes may result when lack of mutual respect, interprofessional disputes, devaluation of others and defensiveness or rivalry occurs.

Two important activities may have a positive influence on health professionals’ discussions. The first of these involves ensuring, by circulating relevant information, that team members have common patient data prior to group decision-making. This concept may seem intuitive, but likely requires discipline by team members to guarantee that it takes place. The second process involves team members becoming aware of their colleagues’ knowledge, talents and styles—information called “meta-knowledge.” 25 The remainder of this article will examine such aspects of team members, and the impact of the organizations in which they are found.

Factors Affecting Team Performance

A broad range of the health-care professionals’ social, cultural, personal, psychological and professional characteristics may affect team performance (Table 1). Concurrently, there are unique patient factors that may influence team members’ reactions and decisions in ways that call for patient-specific approaches (Table 2). For example, it may be impor-
tant to share the cumulative knowledge about a patient gathered by a community family physician, nurse, or social worker (e.g., the patient’s life history, family, cultural and religious background, lifestyle before illness, institutionalization and personal directives) with a hospital treating team in order to ensure that a patient’s desires or preferences are met. Efficacious use of patient and/or family information may decrease hospital length of stay, increase patient satisfaction with care, and provide a more efficient discharge process. The treating team, therefore, can view the patients’ families and friends not as threats to its function and decision-making, but rather as adjuncts, providing supplementary information and acting as potential patient advocates and a support system.

Team outcomes may be influenced by how individuals come together as a collective (Table 3). While members need to articulate and defend their own professional views and values, they also must have the capacity to listen to those of others. Role playing difficult discussions or decision-making activities by individual team members may later facilitate more orderly team behavior in the face of urgent or emotionally laden situations (e.g., in deliberations about end-of-life issues). Respect for colleagues, openness to their ideas and general positive regard may facilitate work in conflictual situations.

Team success also may be promoted by complementary integration of functions; by validation of insights or observations of others; by acknowledgement of individual limitations; and by the use of team-building skills. Power differentials among team members may be minimized through discussion of what might be effective behaviors and communication styles, by reviewing options for conflict resolution.

Table 4
Characteristics of Organizational Structure and Function

- Degree/nature of institutional support.
- Role of Board and administration.
- Institutional impediments to team decision-making.
- Impact of policies (e.g., admission, discharge, DNR orders, transfers between services, post-discharge transfers, role of families).
- Opportunities to influence policies/procedures.
- Impact on health-care system.
- Role of ethics committees.
- Size/mission of institution (affecting willingness/ability to deal with problems).
- Working language of institution (on language of choice for patients and staff).
- Institutional readiness to evaluate decision, to change and to teach/train in teamwork.

DNR=do not resuscitate

Adapted from Kosberg JI, Yaffe MJ, Keyserlingk EW: Decision-making as an expression of collective moral responsibility in geriatric health care teams: Constructing an ethical framework accommodating contextual influences on individual and team values. Forty-sixth Annual Scientific Meeting; 1993 November 18-21; New Orleans: Gerontological Society of America.
resolution and by developing strategies for co-operation within the context of interdisciplinary education and training.\textsuperscript{14}

Characteristics of organizational structure and function that may support or impede team performance are summarized in Table 4. Health-care institutions (e.g., hospitals, group practice, private or community clinics) have specific roles to play in creating an atmosphere where equitable decision-making powers are encouraged and accommodated. Organizations can help professionals become more sensitive to colleagues’ roles, values and beliefs by sponsoring interdisciplinary courses on effective communication. Such an approach might encourage the view that the position of others is not wrong or better, but different.\textsuperscript{19} It should be part of institutional policy that teams have the best human resources available for a particular case or problem when needed.\textsuperscript{20} Obstacles to team decision-making can be decreased by promoting “ownership” in a fashion that is conducive to the best use of specific staff skills. Institutions also may wish to ensure stability of team function by examining ways to promote permanence and stability of professional staff. This may involve a review of hiring and operational policies that might adversely affect team function (e.g., acquired rights, seniority, staff rotations, and shift work).\textsuperscript{32}

Failure to effectively deal with dysfunctional team issues may result in job dissatisfaction, low morale, animosity, disagreements and professional rivalries among team members. It also may cause undesired staff turnover and failure to share patient-related information. Consequently, there is risk of disregard for patient/family input, of inconsistent or inequitable patient care, or of incongruent ideas among family, the patient and the health-care team. Inefficient team functioning may breed conflict between administrators and health-care professionals. Disputes also may occur between teams on separate units or services as differences between team approaches and institutional policies become evident. Potential negative consequences include patient/family dissatisfaction with care, and, secondarily, possible public statements adversely impacting the reputation of an institution or a professional.\textsuperscript{3}

**Conclusion**

Barriers exist to refining team member interaction skills. These include some disparity of teaching content and styles found within the various health-care disciplines, research agendas of educators that may influence what is taught, variable levels of teacher training and comfort with new approaches to collegiality, and other important commitments that compete for time.\textsuperscript{33} Nonetheless, the interdisciplinary approach would seem to have far-reaching potential for patients and doctors alike.\textsuperscript{CME}

**References**

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