Team working: palliative care as a model of interdisciplinary practice

Gregory B Crawford and Sharonne D Price

ABSTRACT

- Teamwork is an integral part of the philosophy of palliative care.
- Cross-functional, interdisciplinary teams offer benefits to patients, practitioners and specialist areas of care.
- Leadership of teams can be difficult.
- With shared responsibilities, more than the sum of the competencies of team members can be offered.
- In palliative care the final decision-maker is the patient.

MJA 2003; 179: S32–S34

WORKING IN TEAMS has been an integral part of the philosophy of palliative care since its early days, enshrined in its standards[1] and embedded in its practice. What, then, have we learned from this emphasis, and how transferable are the lessons to other areas of healthcare?

Palliative care embraces a number of different frameworks and approaches to meet the needs of the "whole" person. As soon as we speak about the many dimensions of dying, and aim to provide maximum comfort and support, we are engaged in broad endeavours. Moreover, the origins of palliative care lie in the areas of religious care and nursing, rather than medicine,[2] and palliative care draws heavily on a broad spectrum of disciplines, knowledge, skill, experience and creative thought.

Palliative care teams may include nurses, doctors, social workers, volunteers, chaplains, allied health practitioners and a multitude of other therapists. Medical science has come to new understandings about the interplay of the physical, functional, emotional, psychological, social and spiritual aspects of wellbeing and more lately has supported the development of multidisciplinary approaches.

Different models of teamwork: multidisciplinary, interdisciplinary or transdisciplinary?

The features of multidisciplinary teams are well understood in current clinical practice. Professional identities are clearly defined and team membership is secondary. Leadership is often hierarchical. Many practitioners in healthcare teams work as "wedges of a pie", each with their own clearly defined place in the overall care of the patient, contributing their expertise in relative isolation from one another. In many settings, this may be the practical limit of the teamwork concept.

Interdisciplinary function is generally the aim of specialist palliative care teams, with members contributing from their particular expertise. The team shares information and works interdependently. Leadership is task-dependent,[3] with tasks defined by the individual patient's situation. The analogy of the hand is appropriate: individual digits of differing ability, function and dexterity work together to achieve more than the sum of the individual fingers.[4]

Lyell McEwin Palliative Care Service, Elizabeth Vale, SA.
Gregory B Crawford, MPHC, FRACGP, FAChPM, Clinical Head of Palliative Care.
Adelaide Community Health Alliance, Memorial Hospital, North Adelaide, SA.
Sharonne D Price, BA, BSocAdmin, GCertHlth, Chaplain.
Reprints will not be available from the authors. Correspondence: Dr Gregory B Crawford, Lyell McEwin Palliative Care Service, Haydown Road, Elizabeth Vale, SA 5112. Greg.Crawford@nwahs.sa.gov.au

It needs to be acknowledged that team structures vary widely within palliative care. The sole practitioner is one extreme — hardly a "team", but nonetheless providing a very valuable service. This situation may exist because of geographical constraints, or patients may choose to align themselves with a sole practitioner, of whatever available discipline, with (hopefully) a silent, unseen team in support.

The other extreme of team composition is the transdisciplinary approach[4] — a team in which "role release" occurs. Roles and responsibilities are shared and there are few seams between the members' functions. This means that a team member's particular expertise is not transparent to the patient or the consumer. This is not a model used in healthcare.

In the business world, organisation theory has developed the concept of cross-functional teams,[4] assembled to create sets of skills for a particular purpose. They are comprised of experts ready to move quickly and flexibly together; to adapt to changing needs with a diversity of team players — in essence, an interdisciplinary team. The synergy that is created by these teams is beneficial to the patient, the family and the team members. Interdisciplinary teamwork requires the "interaction of the team to produce the final product". It should be able to achieve more than the sum of the individuals involved.[4] Successful teams may possess combinations of skills that no single individual demonstrates alone.

When there is some role overlap, resources are actually multiplied and patients can have access to a multiskilled practitioner who has learned from and been extended by different professions and yet may suit individual patients in terms of their primary need or personality "fit". Family members may need to relate to different members in the team in order to have their own needs met without a sense of compromising the patient's therapeutic relationship with the original team member.

Cross-functional or interdisciplinary teams provide a unique forum for creative problem-solving, especially if

every member's contribution is genuinely solicited and respected. Different frameworks — new ways of "seeing" — may be the keys to resolving not only clinical but also ethical dilemmas. These dilemmas abound in palliative care.

Cross-functional teams are flexible. People learn how to "cover" each other, not perhaps in the most specialised areas, but in terms of the general patient support role. There is a sense of team responsibility for the wellbeing of the patient. Members cover each other's weaknesses and maximise each other's strengths. Cross-functional teams are able to make speedier responses to patient need when a crisis arises.[4] Careful documentation of explicit details and skilled communication of the nuances of need and care contribute to excellent care, even when decisions need to be made quickly and at inconvenient times.

Practitioners of diverse disciplines may all play fundamental roles in complex assessment. Ideally, this is much broader than a traditional medico-nursing assessment. If there is a process for and expectation of collaboration, an understanding of how each discipline might approach "treatment" will avoid conflicting advice, timelines, and goals. Given the different ways health professionals are remunerated for their work, especially in private practice, the time required to achieve these synergies may go unrewarded.

This interdisciplinary team model works extremely well in contexts such as mental health, rehabilitation, and aged care, but less well in acute care, where timeframes are short, cost considerations are paramount, and lines of liability determine process. In contrast, referral processes between professionals who do not truly work together can be so slow, clumsy and burdensome that it may become easier to choose not to refer.

Leadership

Best models of service provision and leadership for palliative care have not yet been identified.[5] In most services, teams have evolved as funding and opportunity have allowed. Often leadership is provided by the professional who has been present the longest. Sometimes leadership is provided by the sponsoring agency, not necessarily with a palliative care focus. A recent study in the United Kingdom identified a wide variation in services across several dimensions, including location, management patterns and resource use. The study highlighted problems in how teamwork is conceptualised and delivered.[5] Some writers suggest that membership of the team extends beyond the clinical team to encompass administrative, operational and financial management staff.[6] It would seem that in the palliative care literature[7] the need for teamwork is a given, but what an optimum palliative care team looks like depends on many contextual factors.

What have we learned?

For a team to function effectively, the members must have a common purpose, an understanding of each other's role and an ability to pool resources.[8] As Vachon succinctly states, "dying patients are not the real problem".[9] This is not to negate in any way the dilemma and effort involved in establishing relationships with dying patients,[10] but emphasises that the dynamics of the workplace play a major role in a practitioner's sense of wellbeing.

Challenges

Team conflict issues, role ambiguity, role overload, interpersonal conflict, inadequate communication and leadership dilemmas are well recognised challenges to creating good teamwork in the delivery of palliative care.[3]

Team conflict and difficulties can develop because of internal or external stresses, individual issues or a corporate problem.[9] Communication, both formal and informal, within a team is a major factor.[11] A longstanding team may become self-sufficient, or resistant to new ideas. Underground communication (eg, rumour, gossip) may destroy the trust and openness required to function as a team. Conflict between two team members and problems such as a dominant member, an isolated member, team factions and team secrets[12] are all potent means of disrupting team equilibrium and function. Poor definition of authority and individual responsibilities and roles, poor performance feedback processes, and reluctance to cooperate, collaborate and compromise can all undermine a team's capacity to achieve its goals.

As teams grow larger, subgroups and alliances, lobby groups and other agendas may distract the team from the "main game". It becomes more difficult for the whole team to take responsibility for the quality of care offered to patients and families. Members have less of a sense of their participation in what a service delivers.

Such issues put great pressure on the leadership of a service. Leadership may be provided more from a base of clinical expertise than leadership skill. Some leaders are better managers than they are leaders, and some palliative care teams are comprised of several "leaders" who find it difficult to follow. While there is much written about leadership issues generally, research in the area of palliative care team leadership would be useful. One is reminded that leadership is always dependent on the relationship between the leader and others and the context in which the task and the process take place. Those contexts are as numerous as they are confounding.

Benefits for the patient

The opportunity for genuine consultation and collaboration offers great benefit for the patient. These benefits have been an integral part of the practice of medicine for a long time, but the concept of who has the final say when there is conflict may still present difficulties. In palliative care, the final decision-maker is the patient, and the patient uses many pieces of information, many sources of support, and their own values as a guide.

Benefits for practitioners

Practitioners who engage in teamwork benefit from the support and wisdom of diverse colleagues, but also need to be prepared to be challenged and, at times, to practise courage and humility. A challenge for specialist teams is to support primary carers, such as general practitioners and generalist community nurses, in caring for their patients. Primary carers may need encouragement to work in a team. In the early stages of working closely with others, the time and effort required for good communication seems costly. The dynamics of mutual inclusion are not always easy. Communication is a core requirement to establish roles and responsibilities. A well constructed formal summary of assessment is a valuable basis for collaborative care. Teams should try to develop some continuity in who interfaces with a specific primary carer, to allow relationships and secure referral pathways to develop.[13]

Benefits to specialists in other areas of care

Models incorporating shared roles and responsibilities offer more than the sum of the competencies of the individual team members. A true benefit of these models is that each team member can support and further the therapeutic goals of other team members. Opportunities for research and investigation may multiply. The result is that the healthcare system as a whole remains responsive to the changing needs of the community it serves. It may be that, just as palliative care has evolved over a number of decades, the challenges of multi- and interdisciplinary teamwork will help with the evolution of new approaches to patient care in broader contexts.

Competing interests

None identified.

References

1. Palliative Care Australia. Standards for palliative care provision. 3rd ed. Canberra: PCA, 1999.
2. Kellehear A. The changing face of dying in Australia. *Med J Aust* 2001; 175: 508-510.
3. Cummings I. The interdisciplinary team. In: Doyle D, Hanks GW, MacDonald N, editors. Oxford textbook of palliative medicine. Oxford: Oxford University Press, 1998.
4. Parker GM. Cross-functional teams; working with allies, enemies and other strangers. San Francisco: Jossey-Bass Publishers, 1994: 7, 31-40.
5. Clark D, Seymour J, Douglas H, et al. Clinical nurse specialists in palliative care. Part 2. Explaining diversity in the organization and costs of Macmillan nursing services. *Palliat Med* 2002; 16: 375-385.
6. Norlander L, Grimmer T. The ballet of baseball: lessons of the game for hospice. *Am J Hospice Palliat Care* 2000; 16: 415-418.
7. Woodruff R. Cancer pain. Melbourne: Asperula, 1999: 72.
8. Gilmore M, Bruce N, Hunt M. The work of the nursing team in general practice. London: Council for the Education and Training of Health Visitors, 1974.
9. Vachon M. Occupational stress in the care of the critically ill. New York: Hemisphere Publishing Company, 1987: 51-73.
10. Carson M, Williams T, Everett A, Barker S. The nurse's role in the multidisciplinary team. *Eur J Palliat Care* 1997; 4: 96-98.
11. Jones A, May J. Working in human service organizations. Melbourne: Longman Cheshire, 1992: 184-227.
12. Larson D. The helper's journey — working with people facing grief, loss and life-threatening illness. Champaign, Ill: Research Press, 1993: 199-227.
13. Crawford G. Continuity of care: palliative care in the community. *Cancer Forum* 2002; 26: 11-13.

(Received 6 Jun 2003, accepted 1 Aug 2003) ❑