The Importance of the Interdisciplinary Team in Running Palliative Care Services in the Community

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Concepts, Constitution, and Challenges of a Community-Based Palliative Care Team Approach

Nowadays, teamwork is thought to be the best way to manage various clinical disorders, trying to couple accuracy and scientific progress with a complete patient evaluation. A team's particular characteristics may either have beneficial effects or detrimental consequences on quality of care, team performance, and resource use [1, 2]. Teamwork has been inherent to palliative care philosophy since its origin. Admittedly, this "modus operandi" has been an example for other medical specialties [1].

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Models of Teamwork

There are three teamwork models, each distinguished from the other by the interaction among its members: (1) multidisciplinary, (2) interdisciplinary, and (3) transdisciplinary. These terms are often improperly used as synonyms [3].

In the multidisciplinary model, members have different professional backgrounds and specific responsibilities – instead of interacting with the other members, each professional provides an isolated care. The main limitation to this model is care fragmentation and consequent loss of a common aim [1, 2].

On the other hand, in the transdisciplinary model, roles and responsibilities are shared among members – they have the same duties in each shift. In this kind of approach, specific care needs can be neglected to the patient's detriment. Due to this major disadvantage, the transdisciplinary model is rarely used in healthcare services [3, 4].

Between these two models stands the interdisciplinary approach – members with different professional qualifications act together in a coordinated way. Some authors use the hand analogy: individual fingers with different abilities, function, and dexterity work together to achieve more than the sum of the individual fingers [1]. Jo Weis also said "an effective interdisciplinary team complements, expands, and enriches not only patient care but also the experience of providing that care" [5]. That is why the interdisciplinary team is generally the goal of specialized palliative care, especially in the community [3].

Interdisciplinary Model on the Community: Constitution, Advantages, and Challenges

A palliative care team should be built by adapting it to the patients' needs and, consequently, to the place where care is provided – community/home, hospice, or hospital. If the general practitioner with generalist palliative care knowledge plays a key role in the community setting, the hospice- and hospital-based care must have more qualified specialists [3], which includes not only doctors but also nurses, physiotherapists, social workers, and volunteers in the core team [6]. As the same patient (according to the disease trajectory) could benefit from any of these places of care, the collaboration among teams is crucial to ensure a continuity of adequate care [3].

The interdisciplinary palliative care team presents advantages and challenges for patients, families, and professionals, assuming that the final decision-maker is the patient. In order for a team to work effectively, the members must have a common purpose, an understanding of each other's role and an ability to integrate resources [3]. Role ambiguity and overload, interpersonal conflict, inadequate communication, and leadership management are some of the challenges faced by this kind of team. The teams should grow only when these problems are overcome, or when resolution techniques are implemented. As teams get larger, subgroups and alliances, lobby groups, and different agendas may distract the team from the main goal, creating a great pressure on the leadership [3].

Team Thinking: Interdisciplinarity and Leadership

Palliative care comprises, intrinsically, the construction of a care team. An interdisciplinary team is stronger, more robust, and more capable of dealing with complex interventions. Complementarity among all members guarantees the best capacity to respond to the needs of patients and families [7]. Care in the community should be reflected by the team that executes it, more than in any context, since it is this team who defines the image of community care at home [8].

Leaders have always been associated with a characteristic personality; considered as representatives of great acts and equipped with innate qualities, it is well known today that leadership can be learned and developed [9, 10]. Leadership is one of the team's pillars, which is supposed to be effective by managing the group in response to its needs, also assuming the role of

problem-solvers [11]. The aspects associated with the act of leading come from an ability to share common goals and future projects, while also influencing others to follow the same ideals [9]. Leadership comprises a set of skills, such as intelligence, organization, and dexterity. However, these skills must be acquired and enhanced with programs for better training of the designated leaders [9, 11].

Bringing out the best of each member, leaders empower their teams for interventions. Additionally, it is the team that determines the success of the interventions made [7]. A community-based interdisciplinary team is, based on evidence, the best response to the needs of patients, families, and the community [8]. Acknowledging the diversity of these groups, we can understand the need for leaders to be just as diverse. Nevertheless, it is the leader's responsibility to mold its team and create better conditions for its development [1, 10]. A direct relationship between team satisfaction and its leadership is assumed, and better leaders potentialize its members, thus leading to better care for patients and families [8, 10].

Despite what has already been described, in a palliative context, leadership models are not specifically described in the literature. Leaders can be authoritarian, liberal, or democratic [9], and they may be more responsible for managing than leading, focusing mainly on aspects of system organization instead of the team itself [1]. It is known that smaller teams or teams with more experienced members can have a more democratic leadership. On the other hand, larger or younger teams might integrate more strict leadership. Some of the palliative care teams are led by members of greater seniority, considering hierarchical positions, and sometimes are coordinated externally. In these situations, there could be a lack of focus on palliative care. According to the literature, there is great diversity on this theme [9].

What can be expected from team leaders in palliative care, namely in the community? They should foster a high-performing team mentality, articulate with external resources, distribute tasks, and manage the information shared within the team. They should also enable retrospective moments and conflict resolution, promote trust, manage difficulties, and create opportunities for sharing and even moments of fun [1, 8–11]. This is understood as integrative leadership, that is, one in which individual competencies potentialize the group in the follow-up of patients and families. In the community, leadership assumes an even bigger responsibility, providing connected interventions, dealing with larger teams, and working in more complex social contexts [10].

Leaders should have the responsibility of creating moments of leisure and sharing moments of joy. In contrast, leaders should also manage moments of greater stress and provide space for mourning [11]. Enabling the team to share difficulties and successes helps them to manage emotions, which is something essential to the work done in palliative care [8].

Poor or unrecognized leadership and even an absence of it can create episodes of frustration and conflict among members, also risking failure to monitor patients and families [3].

An interdisciplinary team consists of the union of several health professionals, and this team should be built with a constructive leadership that recognizes the group's value. The team's strength should overcome that of the individuals and leaders should promote integrated actions among members. This is the recommended model in a specialized palliative care setting [1, 10].

The Patient, Family, and Society as Members of the Team in the Community

One of the main principles of person-centered care and the priority of palliative care professionals is the users' involvement. Patients and caregivers are people with unique identities, preferences, and characteristics, thus the need to recognize their potential contribution to the palliative care process and its outcomes [12].

Quality palliative care encourages users to be part of the assessment and intervention processes with professionals in the multidisciplinary team.

However, according to Iskander cited by Oliviere [12], this is not compatible with the reality of some settings. Despite a clear emphasis on patient autonomy, their empowerment, and respect for their opinion, there is actually a huge variety of operational philosophies [13].

Multiprofessional teams can also be very ambivalent about this issue. This is particularly true in palliative care, since it comprises dealing with a highly uncertain universe and having a great deal of pressure to be "the expert" in dying [12]. On the other hand, Iskander refers that a more informed population of patients and caregivers has recently emerged, questioning and requesting more complex care. This emphasizes the need for a partnership between a multidisciplinary team and its users, since they should be capable of orchestrating and ensuring care together.

For Tritter et al., as cited by Oliviere [12], user involvement represents "active and meaningful participation and consultation of users by the service to plan, execute, develop and evaluate this service. This should be done to a level the users feel comfortable with and considering their unique perspective. The level of involvement must be self-determined by users and cannot be expected to represent the user's community; it must be free to represent them." User involvement is a process composed of several elements and something that does not happen in a single event. Involvement can be experienced directly and indirectly at two levels: the individual and/or the collective. In order to establish a true partnership, there must be a commitment between health professionals and users at each level. Thus, for Tritter et al., the relationship between professionals and users is the core of this problem.

There is a series of prerequisites for the involvement of users in the multiprofessional team. Firstly, it stresses the need for a trustful relationship. Trust, empathy, and genuineness are fundamental elements in the relationship between patient/caregiver and professionals as team members [12]. The multiprofessional team must see the person as someone capable of understanding the treatment and care and offer explanations in a spirit of collaboration. Opinions must be taken seriously and users should feel safe to expose concerns, feelings, and thoughts. Additionally, the relationship between professionals allows users a space for refusal, expressing disappointment, and criticizing. The deliberation between professionals and patients/caregivers should allow them to express themselves from different points of view.

Payne cited by Oliviere [12] also refers to the systematic relationship between the elements, where the needs of the patient and the caregiver are considered as an ongoing process, emphasizing the bidirectional nature of the relationship between users and professionals. Contradiction, paradox, and ambiguity are commonly present in this relationship, given the constant changes in the disease trajectory, which is common in the palliative care setting. Moreover, the construction of a partnership between users and professionals where there is "an emphatic exploration of the issues in the hope that the final decision reached will be one where all parties can feel committed" should also be present [12].

Oliviere [12] states that the professional who respects the user as a unique and complete individual, even when very ill, recognizes the user as an "expert" and as better informed about their condition and body, allowing them to capture their individual voice in the process of involvement with the multiprofessional team. Patients and caregivers can contribute with their collective voice through their written testimonies, using creative art, and participating in consultations or even feedback groups.

Building a Team in the Community

Palliative care should be provided in teams. When there is no team, well-intentioned health professionals are caring for their patients, but they are not providing palliative care. Although there is a paucity of research relating to interdisciplinary palliative care teams, the available data demonstrates positive effects [14, 15].

Palliative care teams should be organized and respected. Nowadays, as shown in the literature, the development of interdisciplinary palliative care teams is primarily focused on delegating tasks and attributing roles to each member [16].

For these teams to work well, there should be a horizontal hierarchy where blended expertise creates a therapeutic synergy. Additionally, they should be led by a member of the team who can better influence a positive outcome.

Although there are a number of models for interdisciplinary teams in palliative care and this diversity should be encouraged, it is a complex specialty and requires compassionate expertise that cannot be delivered by one professional alone. These teams need resources such as adequate time, staff, communication, and a physical space to work in a community-based palliative care setting. Being able to maximize the quality of life for people challenged by serious illness requires many things, such as adequate training, high-level knowledge and skills, emotional maturity, and commitment [11]. Nevertheless, interdisciplinary teams are effective because they can rapidly adapt to different contexts.

Choosing staff is the most important part of developing a successful team. Jim Collins [17] says that the "who" should come before the "what." Picking the right people is much more important than defining the roles of each member. Members should support each other and effectively communicate difficulties to the leaders, such as insufficient staff. Members should also try to bring out the best in each other, maintaining a healthy equilibrium between mind and body. These individuals should be responsible for helping patients and families finding hope in challenging situations along the disease trajectory [11], and this requires several skills.

The community-based palliative care team also needs to learn how to address conflict within the group. Team members play a role in constructing and sustaining a high-functioning group, and each one must commit to the work's success. By this, we mean the whole is greater than the sum of the individual parts. Members should also commit to learn from new as well as senior members of the team. Moreover, individuals should know how to be a mentor and complement each other's knowledge. Table 1 lists outcomes of palliative care team functioning. Conflict should be expected but never avoided; it should be used as a vehicle for self-reflection, learning, and team growth [11]. Table 2 lists vulnerabilities and challenges that may result in conflict.

Table 1 Outcomes of palliative care team function

With colleagues – Builds trusting relationships with referring physician, nurses, and healthcare team through ongoing work together
Respect for their expertise
Comfort with what value the service has to offer
Rounding
Referrals
Ongoing communication
Verbally and in writing
Role-modeling effective management of conflict inherent in high-stress situations
For patient and families – Provides state-of-the-art clinical services
Open and honest communication
Symptom management

Table 2 Vulnerabilities/challenges of interdisciplinary team

Time consuming
More up-front costs and resources
Personality conflicts
Power struggles
Communication
Competitiveness
Splitting
Role confusion
Managing unrealistic expectations
Workload
Sharing of duties

Communication is the essential tool used to inform patient and family. It is the way the team can understand and address patients' needs and concerns [11]. If communication between health professionals and patients is to be improved, we need to understand why professionals use distancing strategies so frequently and find other approaches [14]. Learning communication strategies can reduce the risk of burnout, which has been linked to health professionals who feel they have insufficient skills in this area [18].

Ethical Issues

A palliative care team is not just a group of people gathered for a simple task. It is so much more than that. It encompasses joining people with dif-

ferent personalities and from different professional backgrounds to work based on deontological, legal, and ethical aspects.

When working in palliative care, the ethical issues are not just present in research and direct patient care but also within the team. The approach of these issues is not common [19]. However, if the team wants to achieve the best outcomes, it must work "all for one and one for all," similar to the Three Musketeers of Alexandre Dumas.

All team members, including the patient and their family, are unique individuals. Therefore, they have their own personal preferences, beliefs, and feelings. Their cultural background, projects, goals, and values should also be known and valued. If these characteristics are not adequately integrated, it can lead to internal conflicts.

Of the several ethical issues already reviewed in the literature [19], the autonomy principle, free expression, working together, and thinking outside of the box will be discussed here.

One of the most critical issues is autonomy and it is probably the most important one in a healthcare setting. The general concept of autonomy is self-government, a self-regulation that relies on both individual sovereignty and liberty, focused on the individual. It comprises an independence of others. In a healthcare setting, all individuals' autonomies must be taken into account and respected, from patient to family and healthcare professionals. When working as a team, there is a relational autonomy. In other words, the team must assume that the interdependence among members is vital and their own autonomy should be put aside and relational autonomy prioritized. In this model, choices should be made considering loyalty and friendship, which are essential in teamwork, and it is the only way to put the teams' interests above that of individuals.

Another ethical barrier is free expression. In modern society, people have the right to express their opinions freely. The team's goals and beliefs should be shared among members, always considering each individual as one of the team. Everyone should feel free to speak openly and discuss issues with other members. It is only by free expression that members can feel genuinely a part of the team and work together toward common goals, which should focus on improving the quality of life of patients and their families. When teams are able to accommodate different points of view, they are capable of achieving success.

Working together, another ethical challenge [19], implies accepting team rules when caring for the patient and family. Eventually, conflicts can arise between the individual's own beliefs and values and that of the team. This should be approached carefully, since the ultimate responsibility is of the professional, and it should be respected by others. The leader should work in order to promote the acceptance of different points of views and recognize that in some situations one individual's decisions and views prevail [19–21]. Put simply, expressing one's own views should be done freely and safely, providing acceptance within the team [22].

To promote and improve the quality of palliative care provided, it is necessary to achieve and respect the quality indicators developed within the team, usually based on national programs, and to provide evidence-based care. Therefore, it is essential to innovate and find new ways and strategies of caring to help patients have the best quality of life possible [23]. Ultimately, research is usually the standard action, which implies thinking outside of the box.

Teamwork in Palliative Care at Home: Challenges

Palliative care recognizes the value of working in interdisciplinary teams, where the outcomes are greater than the sum of the individual results. However, teamwork is difficult and challenging, and one must be aware of the internal and external threats so that they can be faced and overcome [24].

Informal and formal communication plays a central role in a team. It is one of the most important aspects when talking about challenges. Communication is supposed to be clear and easy. It is also expected that members develop trust and mutual respect, facilitating team growth [25–27].

As mentioned above, conflicts between team members are a potential challenge for an interdisciplinary team, but they can usually be solved by effective communication [1].

Formal communication must flow in a team so that every member shares and gets access to updated information about patients [25, 26], guaranteeing confidentiality. This is a challenge, especially with regard to healthcare in the community. As it is likely that different professionals are not at the patient's home at the same time, information must be shared, ideally electronically, and accessible to the whole team. However, electronic devices are not frequently available outside health institutions, and this requires professionals to leave information in writing for the other caregivers, potentially losing some of it.

In order to avoid losing information that would impact on the team's work, a systematic review stresses the importance of using electronic medical records and standardized patient assessments, communicating via secure e-messaging and having interdisciplinary team meetings [28]. The importance of these meetings is outlined in other studies [29, 30] not only for the process of delivering care but also for building and maintaining trust in a team. Finally, another challenge related to communication is the language used across different professional groups in an interdisciplinary team [24, 31].

It is known that limited resources impact negatively on professionals and this is also true in palliative care. Particularly, limited human resources may cause role conflicts and overload in an interdisciplinary team. In addition to that, working as a team consumes time and the absence of this resource results in frustration and a fragile team [24, 27]. Delivering care in the community has the feature of wasting time in commute, including dealing with traffic, driving long distances, and parking. This consumes resources, but it can also be an opportunity for team building and a chance for effective, frequent, and reciprocal informal communication [32].

The team's age may also present a challenge as, while it is being formed, there must be a supportive environment and time must be allocated. A relationship should be constructed; members should grow together, define their roles, and learn to communicate effectively with one another [27, 29]. On the other hand, in older teams the challenges may be due to self-sufficiency, stagnation, and the tendency for rejecting different opinions [1].

Additionally, team size is an important issue as it can be large enough to have separate alliances or subgroups, resulting in less contact among members and a lesser sense of responsibility for the quality of care being delivered by the whole team [1, 30]. This may also be present in teams that care for a dispersed community, such as in rural areas, where it may be necessary for professionals to be geographically distant from one another, resulting in less frequent contact and causing further challenges for successful teamwork [25, 26, 30].

Team organization is also a major problem. Roles and interprofessional boundaries must be clear, since role ambiguity may lead to conflicts and competitivity [1, 21, 24]. There ought to be interprofessional collaboration, responsibility, and compromise [1, 32], and this cannot occur without effort [24]. Moreover, leadership can also bring potential difficulties, and it is recognized that having a clearly defined leader can contribute to the success of an interdisciplinary team [1, 8].

Each member should contribute with their individual expertise and knowledge. They should not always rely on consensus of opinion or groupthinking, striving to promote creativity in solving problems [24, 33]. In contrast, they must be aware that this may potentially delay making decisions as there may be too many different inputs.

Supporting each other in a palliative care team, beyond patients and families, is not only an expected role but it is also a challenge. Members must be caring and provide mutual emotional support, especially in an emotionally charged environment, in order to prevent burnout syndrome [24, 29, 34].

Finally, specifically in the community, a team must also collaborate with other professionals, such as primary care providers, as they need support from palliative care specialists [25, 26].

Working as a team with unrelated members belonging to different organizations and dealing with different competencies and accepting others' abilities, qualities, and roles in the delivery of care is challenging [25, 26, 35]. Furthermore, it may also be necessary to collaborate with hospital professionals.

The Care Within the Team

Although less prevalent than in other healthcare sectors [34, 36, 37], burnout syndrome in palliative care is an issue that needs addressing. It is strongly related to workload, with a scarce number of professionals equipped with adequate knowledge and skills to deal with palliative care patients, and also to the strong impact that comes with helping patients in this critical moment of life. Fortunately, the interdisciplinary focus of community-based palliative care seems to carry a protective factor, facilitating communication between professionals and tightening their bond [34]. Job satisfaction has also been proven as another positive aspect, since it still presents high levels in this sector [38].

Burnout syndrome was initially described in the 1970s [39], and the current definition divides it into three categories: exhaustion and feelings of failure to give more, depersonalization and distancing from colleagues and patients, and reduced satisfaction in performance [40]. A related concept is compassion fatigue, which was first described by Jonison, relating symptoms such as decreased energy and depression to work-related stress [41]. Compassion fatigue is defined as the emotional exhaustion due to caring for patients [42], but differentiates from burnout because the former is focused specifically on the result of caring for patients and being empathetic, while the latter is influenced not only by the emotional load but also by the professional's own perspective on their work, the workplace environment, team management, and system dissatisfaction [43, 44].

Symptoms of burnout in a palliative care setting can be related to dealing with existential issues and delicate decisions, such as withdrawing treatment and discussing end of life with patients and families; constantly facing ethical problems might reinforce feeling burnt out [34]. Increasing time spent with patient and family can be a prevention and also a risk – intense relationships developed in a palliative care setting are usually marked by professional satisfaction due to the significance of the work done but also by patient suffering. Another area well documented as a risk factor is communication – lack of training and confidence in this area can lead to exhaustion and distancing oneself from work, as analyzed by Pereira et al. [34].

Several signs and symptoms can be present in workers from a palliative care team, thus the need to prevent it and treat it when necessary. Moreover, burnout is a long-term process and requires constant monitoring and care. Different strategies have been studied, and a recent investigation [45] shows that professionals working in community-based PC have significant differences in burnout categories compared to other sectors – they are less emotionally exhausted, but distance themselves more from work. Another interesting aspect is that levels of emotional exhaustion and depersonalization are similar among different professional categories in this specialty.

Ercolani et al. [45] also analyze different coping strategies in a community-based palliative care setting and conclude that acting positively, focusing on solving problems, and relying on religion are good ways to lessen the risk of burnout. In addition, it emphasizes the need for specific training programs based on the needs of professionals and levels of experience in home care. Another research suggests hope, resilience, and optimism are also ways of dealing with symptoms of burnout, while reinforcing the need for palliative care education for all professionals working in the area [46]. Finding time for self-care and being aware of its important are other crucial aspects of coping with burnout symptoms [38].

Thus, different validated questionnaires for assessing risk of burnout in palliative care teams can be used in the community setting [47–50], along with coping strategies already mentioned.

Specific strategies and programs should be created in each and every palliative care team to equip professionals with adequate knowledge in the area and prepare them to deal with the difficulties of working in a community-based team, which can differ from other settings. Focusing on education in palliative care, the gain of communication skills, and having a space to talk about the work challenges are paramount, and there is a need for further research in this area.

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