16 Interdisciplinary Team Approach to Clinical Care

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16.1 Introduction

The concept of health integrates a complex and holistic system involving biological, psychological, physical, cultural, socioeconomic, and environmental factors interacting with each other. Addressing complex problems including health problems requires the use of diverse information and skill set that cannot be provided by one profession. As Rowe [31] indicated health problems are broad and complex and need to be looked at from an interdisciplinary approach.

The interdisciplinary team approach is widely recognized as an important organizational factor in providing quality patient care. This approach is supported by a growing research evidence that demonstrates that team functioning is asso-

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J.E. Mezzich et al. (eds.), *Person Centered Psychiatry*,
DOI 10.1007/978-3-319-39724-5_16

ciated with better patient outcomes, cost savings, reduced hospitalization, improved service provision, and enhanced patient and staff satisfaction.

Research evidence suggests that these benefits occur because well-functioning teams make good decisions, cope effectively with complex tasks, and are able to coordinate their interventions and expertise. However, despite the growing awareness of potential benefits, many heath care organizations lack effective teamwork, with negative consequences on patient outcomes. The barriers to team approach have been attributed to several factors including lack of interprofessional education, professional hierarchy, frequent changes in caregivers due to shift work and patient transfers that make coordination and teamwork complicated.

This chapter highlights the interdisciplinary team approach in health care including definition, effectiveness in terms of patient outcomes, cost savings, and patient and provider satisfactions.

16.2 Definitions: What to Call the Team

The word "team" is often used as a catchword to mean different types of teams that can range from two people to more than 10; could have members of the same discipline or of different disciplines; and comprise specialists or generalists. A health team can be described as a group of health providers with diverse skills and different responsibilities but with common objectives related to patient outcomes and cost of health care [8].

Despite the seemingly clear definition of a team, several terms are often used interchangeably to refer to health care teams resulting in lack of clarity and miscommunication. These include: multidisciplinary, interdisciplinary, collaborative, Interprofessional, cross-disciplinary, polydisciplinary, and transdisciplinary. Despite this terminological jungle, health administrators, and health care provides assume and they understand each other when they may be referring to different concepts of teams Drinka and Clark [15].

After much pondering about which term to use, Drinka and Clark, argue that the term *interdisciplinary* seems more appropriate for its inclusiveness and it has been in use for a long time. In line with this argument, the health care team that the authors refer to in this chapter are interdisciplinary health teams. According to the free encyclopedia Wikipedia [40] "interdisciplinarity" is defined as "the use of approaches, ways of thinking, or at least methods of different disciplines." In contrast to "multi-disciplinarity," which represents the weakest form of cooperation with regard to content in subject-transcending work [41], "interdisciplinarity" is regarded as methodological, terminological, or conceptional exchange and integration between the disciplines, developing an uniform conceptual frame and working on common strategies for solving problems. What is at stake is a frame of work that allows for interactive and reciprocal activities as opposed to working side-by-side. For the interdisciplinarity and its integration, eclecticism is a possible component to integrate clinical methods of different sources. Eclecticism is the weakest form of cooperation between the various disciplines.

According to Küchenhoff [27], the prerequisites for an effective integration process are the ability to cooperate, curiosity, knowledge of and respect for the perspectives of the other participants, competence, not claiming methodological omnipotence, and the refraining from participating in "religious wars" within the profession. The metatheory requested by him should relate the different methods to each other and bring them into a structural interrelation. In addition, it should reveal what effect is performed by which elements on the whole structure. A common language has to be found, a language that is creative, innovative, and motional.

To go further in this line, let us define multidisciplinary and interdisciplinary health teams with the intention to show the difference and clarity of these terms.

In multidisciplinary teams: Health professionals from diverse backgrounds share information and consult each other in planning care. However, members identify with their discipline more than the team. In contrast, in interdisciplinary teams, health professionals work collaboratively to define and achieve commonly defined goals. Members have strong team identity, mutual respect, and view their actions as interwoven. Roles change based on client needs. A working definition of interdisciplinary health team is provided by Drinka and Clark [15]:

> An interdisciplinary health team integrates a group of individuals with diverse training and backgrounds who work together as an identified unit or system. Team members consistently collaborate to solve patient problems that are too complex to be solved by one discipline or many disciplines in sequence. …An interdisciplinary health team creates formal and informal structures that encourage collaborative problem solving. Team members determine the team's mission and common goals; work interdependently to define and treat patient problems; and learn to accept and capitalise on disciplinary differences, differential power and overlapping roles. …They share leadership that is appropriate to the presenting problem and promote the use of differences for confrontation and collaboration. They also use differences of opinion and problems to evaluate the team's work and its development (page 6).

At the core of the interdisciplinary team approach is the person who has health problems and who should be an active partner in care. The provision of quality patient care requires an identifiable team structure and functioning.

16.3 Interdisciplinary Team Formation and Team Functioning

The shift from the traditional biomedical view of the human body to a biopsychosocial approach has resulted in greater understanding of the complex relationships between health, illness, and disease. This holistic view of the complexity of the multiple dimensions of illness and disease requires the involvement of professionals with varied skills and knowledge working in interdisciplinary teams to provide quality patient care [9]. However, the growing trend toward specialization in the health professions may lead to a narrow understanding of interdisciplinary team comprising professionals with the same basic training but with a speciality

such as internists, psychiatrists, and endocrinologists that may lead to fragmentation of care.

In its broad sense, the term interdisciplinary refers to an interprofessional perspective that includes physicians, nurses, occupational therapists, social workers, and other health-related professionals. The interdisciplinary team approach may help in preventing fragmentation of care due to specialization as patients who receive care from a team can benefit from the perspectives of different professionals with wider skills [37].

Historically, health care delivery was hierarchical and dominated by physicians. However, the current trend shows a shift to broader and inclusive teams of professionals. A more recent development shows that the concept of health team has been broadened to include the perspectives of patients giving rise to the notion of person-centered medicine. According to Ammon, the criterion for interdisciplinarity and its method integration should be the human being, together with an understanding for illnesses and also for constructive, creative development opportunities. Thus, Ammon recommends a holistic approach in clinical care that integrates the findings of different branches of science but also aspects of diverse schools. All this is put under a central principle, the holistically formulated image of man. A model for interdisciplinarity and integration should be measured by the benefit for the person, i.e., to understand them better and to develop better healing methods [3]. The theoretical model should never be systemized or inflexible according to Ammon. It should be an open system with the possibility of change and constant integration processes.

To integrate different disciplines in clinical care it needs to have a theoretical concept as a basis to rely on. The central theoretical basic conceptions of the interdisciplinary methods—integrative approach of Dynamic Psychiatry are: in the first place the concept of social energy, furthermore the personality structure model in connection with the identity concept [2].

For the person-centered care, this means the involvement of the whole team into the treatment process, including nurses, psychotherapeutically trained psychiatrists, doctors and psychologists, social-workers, milieu therapists, therapists for the expressive therapies, as well as the administration and kitchen personnel into treatment as parts of the social-energetic field.

Interdisciplinary team approach for person-centered clinical care implies,

1. that all people and professions involved in the interdisciplinary healing process cooperate in the various designated groups on the basis of a commonly shared holistic image of man, and, derived from it, a model of personality and a common understanding of health, illness, healing, and development.
2. Since, the goal of dynamic-psychiatric treatment is to open up patients by emotionally corrective and new group dynamic experiences so that they will regain their health, it is important that the total hospital, as well as its different team and patients groups are structured and dynamized as spaces for con-

structive social-energetic exchange processes as much as possible. It is therefore the daily task of the leader group and of the team to reflect and regulate both conscious and unconscious group dynamics that develop within and between the various groups, including the dynamics of the 'plenary group' [1]. A real interdisciplinary approach is always open for development and further integrative possibilities which will be necessary for the treatment of patients.

The use of teams in health care delivery is driven by a number of factors including demographic changes with an aging population, health system restructuring and reorganization, cost containment, and the increasing complexity of health care knowledge and work [20]. In the current complex landscape of health care systems with rapid growth in information that is required to solve problems, no single health professional can have all the knowledge or skills to provide the continuum of services needed. Because of the increasing complexity and scope of patient problems including presence of multiple diseases or comorbid conditions presenting to the health care environment, patient care needs to combine the efforts of physicians of different disciplines, skilled nursing professionals, and other health care professionals, as solving these problems are beyond the scope of expertise and training of any one provider [36].

The diagnosis and treatment of disease as well as health promotion and disease prevention require the expertise of different health professionals engaged in collaborative work. That is why an interdisciplinary health team is needed to provide quality health care that is accessible and cost-effective. Team approach enables health professionals with diverse skills to view clients and their families as whole persons, and in this regard it is compatible with person-centered medicine.

A key tenet of interdisciplinary team work is communication between the different members on continuous basis. High quality communication, mutual respect, trust, and active participation by all team members often result in stronger team identity, reduction in status differential and hierarchy, increased responsiveness to job demands, higher job satisfaction, and better staff retention [38]. Similarly, an organizational culture that institutionalizes consistent and effective communication leads to low staff turnover, better clinical outcomes, shorter hospital stay, and higher quality of care [35]. Gittel [18] observed that interdisciplinary teams that successfully manage their differences through well designed and maintained communication are more likely to demonstrate continual high performance and achieve positive patient outcomes.

Another important tenet of team work is team leadership. Successful team leadership acknowledges the need for team members to contribute and collaborate in a positive manner. Skills in team building and team functioning are fundamental to the success of the interdisciplinary health team in setting common goals and in achieving positive patient outcomes.

Effective leaders facilitate the team's environment so that members feel that their perspectives are welcomed and appreciated, their expertise is trusted, expectations are clear, accountability and excellence are the norm, and there are common goals [33].

Team leadership means that the leader and the members must be willing to share team leadership responsibilities and be aware of group dynamics in order to work with professionals that have widely diverse skills, values, and interests [29].

16.4 Interdisciplinary Team Approach and Person-Centeredness

Psychological dimensions and subjectivity are crucial components of person-centered cares [11]. It challenges the ideal of objectivity which is a crucial component of disorder-centered medicine: in its attempt to approach this ideal, this disorder-centered medicine neglects the subjective aspects and the complexity of the person, adopting a perspective in which reductionism is not only a methodological tool but also a theoretical assumption (see Botbol et al.: Categories, dimensions and Narratives for person-centered diagnostic assessment, in this book). However, person-centered psychiatry‘s ideal is not antiscientific when tackling the issue of subjectivity: on the contrary, one of its main objective is to find a non-metaphysic way to integrate subjectivity (including spirituality) as a key component of psychiatry and medicine. The naturalistic observation of what health professionals do in clinical settings, shows that empathy is an essential tool to understand the patient state of mind and subjective feelings. Defined as the affect induced in the professional by the relation with a patient through what he says or does, empathy appears then as a first methodological step to go behind the screen of the visible: an holistic way to approach the patient's subjectivity as an holistic dimension, through the mirroring of the patient's feeling.

However, this mirroring function is not sufficient to access the patient's subjective life and to understand his personal needs and his psychic problematic. To be able to access these aspects, essential in a person-centered perspective, the professional has to resort to a second methodological step: metaphorization and narratives to give meaning to these mirroring feelings. Patients' Narratives are indeed the best way for him to trigger the professional's empathy as long as the latter gives enough attention to them. But the professional's auto-narratives are of equal importance because they are the best way for him to recognize and give meaning to the empathic affects induced in him by the contact with the patient. This second step is then required to shift from mirror empathy (which, following [6], we think preferable to call sympathy) to a metaphorizing empathy where the professional mirrors the patient without giving up on the recognition of his irreducible otherness. Team work becomes then a necessary third methodological step to limit the risk that the integration of the professional's subjectivity in the diagnostic and therapeutic process would lead to their scholastic or projective interpretations. In this work, the team uses the idiosyncratic sensitivity of its members to amplify various aspects of the patient's subjective life and put it into more or less common narratives. In this perspective, team members subjectivity is not considered an adverse side effect of the therapeutic relation but an important tool for diagnostic and care, given that the team members are adequately trained to use their affects and representations as

central dimensions of their team work, in close interaction with the patient and his carers.

16.5 Effectiveness of Interdisciplinary Health Care Team

There is a growing body of research literature that demonstrates the effectiveness of team approach to patients, providers, and organizations. After an extensive review of the literature on health care team effectiveness, Lemieux-Charles and McGuire [30], and Bosch et al. [10] found that there is some evidence that shows interdisciplinary team care which can lead to better clinical outcomes and patient satisfaction. For example, studies that examined geriatric teams reported higher functional status, better mental health, decreased dependence, and decreased mortality [13, 26]. Patient satisfaction and health-related quality of life were higher when care was provided by interdisciplinary health teams [13]. Similarly, studies of teams in critical care reported increased survival to discharge and decreased readmission to critical care [4]: fewer adverse events, lower mortality rates after surgery, and shorter length of hospital stay [5]. Care provided by a team in a primary care setting resulted in improvements in symptoms of depression, but resulted in increased cost [21].

Overall, a review of the research evidence shows interdisciplinary team care which can lead to better clinical outcomes and patient and staff satisfaction as well as cost savings than traditional care that did not use a team approach. These include:

- Increased survival to hospital discharge and decreased readmission to critical care [4].
- Fewer adverse events, lower mortality rates after surgery, and shorter hospital stays [5].
- Higher patient satisfaction and health-related quality of life [13].
- Higher patient and staff satisfaction [13, 17].
- Cost-effectiveness and cost savings [19].
- Reduced hospitalization [32].
- Improved service provision [25].

To sum up, the research shows that team functioning is associated with better patient outcomes, cost savings, reduced hospitalization, improved service provision, as well as increased patient and provider satisfaction. The provider satisfaction is associated with lower staff turnover [17].

Organizational support and resources influence team functioning and higher functioning teams achieve better patient outcomes [12]. These outcomes occur because well-functioning teams make quality decisions, cope effectively with complex tasks, and are able to coordinate their interventions and expertise [19].

However, despite the growing literature on the benefits of team approach to care, many heath care organizations lack effective teamwork, with negative consequences on patient outcomes. The barriers to team approach have been attributed to several

factors including professional hierarchy frequent changes in caregivers due to shift work and patient transfers that make coordination and teamwork complicated [34]. At the same time, health professionals tend to resist to a team-based care model because of poor organizational support, system-wide barriers such as fragmentation in reimbursement for health care services, regulatory restrictions, and the education of health professionals which takes place in silos [24, 28].

16.6 Interprofessional Education (IPE) for Team Work

The World Health Organization, WHO [42] identifies IPE as the process by which a group of more than two profession-specific students from health-related occupations with different educational backgrounds learn together during certain periods of their education with interaction as an important goal. Governments around the world are looking for innovative solutions to ensure the appropriate supply, mix, and distribution of the health workforce. One of the most promising solutions can be found in interprofessional collaboration [42].

Interdisciplinary team approach is the hallmark of positive outcomes for the health of patients, families, and communities. However, a number of reports affirm team formation and team functioning do not come naturally to health professionals and require a paradigm shift in educational programs [7, 22]. As Frenk et al. [16] have affirmed, the excessive focus on hospital-based education that is segregated into professional silos does not prepare health professionals for team work, and for leadership skills in the twenty-first century health services.

In general, most health care organizations and health profession educational institutions devote little or no time and resources to promote interdisciplinary functioning [15]. In fact, the different health profession training programs take place in different buildings, and in different colleges or schools often within the same campus. Often similar courses are taught separately for the different health professions, adding to the silo approach of educational institutions [15].

As shown in Table 16.1, a WHO environmental scan of interprofessional education practices in 42 countries with 396 respondents showed generally low levels of IPE among different health professionals.

Table 16.1 Types of learners who received IPE at their institutions

Health Professional	% Reporting IPE
Community health workers	4.3
Doctors	10.2
Nurses	16.0
Social workers	9.3
Pharmacists	7.7
Physiotherapists	10.1

Adapted from Framework for Action on Interprofessional Education and Collaborative Practice: WHO [42]. http://www.who.int/hrh/nursing_midwifery/en/.

As a result, there is a lacuna in the education of health profession in relation to team formation and team functioning. As Lee [29] has noted, the dominant model of health profession education does not emphasize collaboration, shared team decision making, or shared team leadership. Most health professionals tend to be trained to function in silos and they may have difficulty to function in interdisciplinary teams with negative consequences on patient care.

Despite their clinical expertise, health professionals are often hampered to provide quality care due to lack of effective team work and collaboration. As the Institute of Medicine [23] reported a lack of interprofessional collaboration as one of the most often cited reasons for medical errors. In contrast effective interprofessional collaboration is linked with better patient care outcomes [39].

While acknowledging the value of team-based models of care, Jansen [24] raises doubts about implementation because, among other things, of the lack of interprofessional education of health professionals. Jansen argues that investments in health professionals must be made in terms of system support and interprofessional education if the notion of interdisciplinary team approach is to be implemented. For example, educational institutions must provide interdisciplinary team-based learning opportunities including knowledge of collaborative practice, participation in team decision making and an appreciation of the values and competencies of other professionals.

To this end, the Department of Health of the United Kingdom [14], the US Institute of Medicine [23], and the World Health Organization [42] continue to advocate for educational programs for health professionals to include opportunities for working in interdisciplinary teams.

16.7 Conclusions

The literature on team approach to health care is vast and an exhaustive review is beyond the scope of this chapter. However, a comprehensive review showed the benefits of team approach to patients, organizations, and health professionals. The type and diversity of clinical expertise involved in team decision making largely accounts for improvements in patient care and organizational effectiveness. Collaboration, conflict resolution, participation, and cohesion are most likely to influence staff satisfaction and perceived team effectiveness. Quality and outcome of care was better when care was provided by teams compared to traditional care where this model of care is lacking. Organizations also benefit in terms of cost savings and system efficiency when team care is implemented. Team care improves patient and staff satisfaction resulting in lower staff turnover. However, despite the benefits and value of team-based care there is reluctance on the part of organizations and health professionals to shift to this model because of a number of barriers and challenges.

The implications for practice include the need for providing teams with organizational support, resources such as development guidelines; access to training and team building; and opportunities for interprofessional education.

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