CHAPTER 16

Interdisciplinary collaboration: working in teams for patient care

Eileen McKinlay is a registered nurse and Senior Lecturer in the Department of Primary Health Care and General Practice, University of Otago, Wellington.

Ben Gray is a general practitioner and Senior Lecturer in the Department of Primary Health Care and General Practice, University of Otago, Wellington.

Sue Pullon is a general practitioner, Associate Professor, and Head of Department in the Department of Primary Health Care and General Practice, University of Otago, Wellington.


Collaboration: always needed? 143
What is collaboration? 144
Roles and skills 145
The patient as a member of the care team 146
Benefits of collaboration 146
Barriers to collaboration 147
Interdisciplinary collaboration in primary care 147
Shared care 148
Conclusion 148
New Zealand health care relies on the skills of many health and other professionals. For those with chronic or complex needs, collaboration between a range of disciplines is needed. Doctors have a key role in enabling a collaborative approach, with growing agreement that the “pitcrew” interdisciplinary model of care results in safer, higher quality care for patients, providers and systems rather than a unidisciplinary “solo operator” model.

**Collaboration: always needed?**

While necessary for patients who have chronic or complex conditions, interdisciplinary fully collaborative care is not always appropriate, needed or cost effective: for example the diagnosis and treatment of a sore throat in an otherwise well person is generally and appropriately undertaken by one health professional. The spectrum of collaboration (see Figure 2) best explains this continuum.

*Figure 2. The spectrum of collaboration*  

**What is collaboration?**

Collaborative interdisciplinary care is enshrined in the Health and Disability Code of Consumers’ Rights in Right 4: Right to Services of an Appropriate Standard, which requires in point 5 that: Every consumer has the right to cooperation among providers to ensure quality and continuity of services.  

While the terms “team work” and “collaboration” are often used in the same breath — they are not the same. Individuals of different disciplines may provide care to the same patient without considering they are part of a team. However, for teamwork to be effective there must be collaboration.

We all recognise collaborative team work when it’s working well. The experienced Emergency Department (ED) team undertaking resuscitation is a good example. The team train together and know and trust each other. Each person has a particular role and yet there is flexibility, with some skills (chest compressions, cannulation) able to be undertaken by a range of health professionals and others such as intubation which are discipline specific.
Collaborative interdisciplinary teams explicitly commit to cooperate in order to meet shared goals. Members allow their activity to be directed through shared decision making or by the team leader. These sorts of teams are “characterised by a greater interdependence, jointly defined goals and client centred plans”, as giving recognition and value to the expertise and perspectives of other disciplines. Like the ED team, all are reliant on the skills of others to achieve the necessary goals of treatment or care.

The specialist skills of each discipline are well utilised and common values and skills affirmed for all. Communication equity means all disciplines are able to contribute to care and speak up with safety concerns. Different disciplines take the lead or share leadership in a distributed model which acknowledges “no one leader can provide all the leadership in any complex situation”. A bonus of this model is that the burden of caring is shared between all disciplines and burnout reduced.

In contrast, in some so called multidisciplinary teams (MDTs), clinicians from different disciplines are each involved in the patient’s care but report back on referrals solely to the senior doctor leader, who then unilaterally directs patient care. The limitation of this model is not that the senior doctor is the team leader per se, (they may indeed be the best person to lead the team at a particular time) but that there is little or no opportunity for shared wisdom or shared decision making. This might be appropriate in some settings (perhaps in the consultation/referral stage in the Spectrum of Collaboration) but has significant limitations wherever ongoing complex care is needed. Not only does it inadvertently restrict possible alternative quality options for patients but it also tends to easily disempower junior staff, making it hard for them to contribute to care or speak up, even about issues of basic safety.

Roles and skills

Knowing what your own role is in a team (e.g. leader, or the person responsible for a particular task), is just as important as knowing what others’ roles are. Roles may be defined by the specific skill sets you possess but where skills are held in common (communication or clinical skills), roles need to be negotiated. It is only by discussing and practising how the different team members each contribute to patient care that role clarification is achieved. Role clarification is one of the most important requirements of a well functioning team. Once it is achieved, the team is well placed to swing into action in any given situation, often with just a few well chosen words, as each member anticipates and trusts in each other’s respective roles.
The patient as a member of the care team

There are many benefits of involving patients in the care team. Involvement increases patient motivation to change behaviour, enhances concordance with health care advice and leads to greater adoption of self management skills. Patients are empowered by becoming more knowledgeable about their conditions and are more able to participate in decisions about treatment. Wherever possible patients also need to be able to both establish and revisit their role in the team; some may choose at some times to be passive receivers of proffered treatment, but at other times to reject or substantially alter management recommendations. That is not to say that patients either need or should be expected to take sole responsibility for all care decisions. Patients and families are entitled to hear clearly expressed, thoughtfully considered recommendations for care from health professionals, particularly in complex situations where there is no one right answer.

Benefits of collaboration

The Health Quality & Safety Commission has found that interdisciplinary collaboration reduces medical error as well functioning teams make fewer mistakes than individuals. More timely referrals occur with better use of disciplinary skill sets and holistic care provision and patients are less likely to fall between services. Taken together patients have higher levels of satisfaction and are more likely to have better access to health care and improved self management skills. Staff also enjoy higher levels of work satisfaction and cost savings are likely to occur. This approach benefits not only our patients, but health professionals and health organisations.

We also know that collaborative teams do not happen by chance. In New Zealand a number of factors have been shown to contribute to successful interdisciplinary teams including: skilful leadership in each discipline, readiness for an interdisciplinary culture, commitment to change, interdisciplinary respect and opportunity for trust to develop between individuals and across the team.

Organisational structures have supported institutional change as well as “alterations to existing health professionals values, socialisation patterns and workplace structures”. Interdisciplinary competencies can be taught at undergraduate level and this is happening in New Zealand. Similarly experienced doctors and other health professionals can achieve these competencies through intentionally learning about roles and skills of others and engaging in interdisciplinary programmes of study.

Doctors have had a key role in supporting this change by fostering professional respect for and trust in other disciplines and leading a willingness to use different forms of clinical decision making.
Barriers to collaboration

Even though the evidence points to the benefits of collaborative approaches in health care delivery for chronic and complex patients, the application of these models is variable and far from being universally adopted. Meeting in teams can be time and resource intensive with organisational and funding support being necessary. Professional regulation and legislation are also given as reasons to limit collaboration. Entrenched attitudes about scopes of practice, professional “turf” and historical power structures can sabotage the essence of what good teamwork is.

A common concern when a team of disciplines is involved is the issue of who is ultimately responsible for the patient’s care. In the past doctors have assumed varying degrees of responsibility for the practice of other clinicians involved in patient care. The regulatory framework is now clear that each professional is responsible for their work in their scope of practice.

Student health professionals (including medical students) hold a limited responsibility for patient care, as they are working under the direct supervision of a more experienced colleague. Once junior staff are registered, they must work in a scope of practice commensurate with their qualification and level of experience, reporting to more senior colleagues, but still responsible for their own practice in their expected scope. Adequate communication and collaboration with all health professional colleagues is also expected and essential practice. The Health and Disability Commissioner reports more frequently on a breakdown of collaboration between professionals than on the responsibility of the individual clinicians being deficient.

Nevertheless, there is still a need to ensure that good communication and good team processes are followed by everyone in the team; part of the leadership role. Teams need good leaders and teams need good members. Knowing when it is appropriate to take the leader role and when it is time to be a supporting member of a team is a key skill in being a good team player. For example, in the ED resuscitation situation, a resuscitation nurse specialist may take the lead to ensure good communication and that all essential tasks are undertaken, while the more junior nurse does chest compressions and the ED physician concentrates on intubating the patient.

Interdisciplinary collaboration in primary care

In NZ we know that great gains can be made in reducing inequalities in health care if health disciplines as well as other professionals work collaboratively in primary care services. Collaborative service delivery models can enable best use of other disciplines’ skill sets in a time when general practitioners are dealing with increasingly complex patients in the community.

This means patients may not access general practitioners for all health presentations but can receive excellent and appropriate care from nurses, community pharmacists or other health professionals working in primary care services.

The care of someone with diabetes requires a team approach which includes the patient and family. Likely others in the team are: community dietician, community pharmacist, diabetes educator, practice nurse, general practitioner and endocrinologist, as well as other professionals such as exercise or sports instructors and self management trainers.
Some factors may need to be changed when developing new collaborative teams or enhancing existing teams. Limited geographical colocation of services, mixed capitation/fee for service funding and the owner operated business model of many NZ general practices can make collaboration more difficult. Thought needs to be given to increase opportunities to meet together, develop processes for equal access to funding and ensure equality in decision making.\(^{14}\)

**Shared care**

The management of people with long term conditions is often shared between primary and secondary services and is an area where more attention to effective team work can reap dividends. This means “sharing responsibilities for maintaining and improving health and includes making and carrying out a collaborative plan to do so. Care can be shared by two or more agencies and the individuals in those agencies”.\(^{15}\)

A well described New Zealand example of effective shared care comes from South Auckland with chronic obstructive pulmonary disease patients who had frequent winter time hospital admissions. A concerted collaborative effort between primary and secondary care health professionals was developed and for the intervention group this significantly decreased inpatient bed days.\(^{16}\)

An approach which is being increasingly adopted is the use of a care plan developed in primary care by the general practitioner and practice nurse, oriented around the needs and goals of the patient and available electronically across sectors and agencies. In collaboration with the patient, the care plan can be accessed and edited by the hospital specialists, specialist nurses, physiotherapist, community pharmacist and others. There is facility for electronic messaging and tasking between all the professionals involved to facilitate necessary changes in care. Patients can also access summary information (including medications and goals of care) through an electronic portal.

**Conclusion**

In New Zealand, doctors are increasingly working in collaborative interdisciplin ary teams, particularly in the management of patients with chronic and complex conditions, and have an important role in supporting the further development of these models. Increasingly we are seeing models of shared care between disciplines, across health sectors and including a range of professional groups. There is a particular need to see further development of these models of care in primary care settings. In teams, role clarification is being recognised as necessary together with the building of professional trust in other disciplines’ specialist skills.

Current regulatory processes enable shared decision making and shared leadership however institutional policies and funding mechanisms may not and these need to be worked on. Champions are also needed to support collaborative processes wherever these are appropriate for best patient care, regardless of tradition or discipline.
References


15. healthAlliance, CareConnect 2012. Shared Care for Mental Health & Addictions Services, Northern Region. Auckland.