Overcoming the challenges of interprofessional teams to improve quality of care

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Health systems in Canada and around the world are experiencing fundamental change, driven by the need to more effectively coordinate the provision of quality care (Romanow, 2002; AMA, 2003; Government of Alberta, Backgrounder, 2003; Premier's Advisory Council, 2001; Scott & Hofmeyer, 2007; Smith, 2001). Enhancing the effectiveness of interprofessional teams is central to the provision of quality care and, as such, has been central to many of these healthcare reforms (McPherson, Headrick & Moss, 2002). This article is based on research conducted between 2007 and 2011 within the context of primary healthcare (PHC) reforms (Scott & Lagendyk, 2012). The results have implications for the delivery of care across contexts. The objectives of the research were to document a range of primary health care models, with specific focus on interprofessional teams. The ability to work in interprofessional teams requires knowledge and skills that are one of twenty-two core competencies required for health professional practice in the 21st century (O’Neil and the Pew Health Professions Commission, 1998). Despite support for the concept of interprofessional practice, changing traditional working relationships remains elusive. Barriers to changing traditional working relationships can emerge at many stages of program or organizational development and from many directions. At times, the barriers appear to be based on differing use of terminology; “interprofessional” may mean one thing to one person and something completely different to another. In addition to communication difficulties, barriers to interprofessional ways of working have been well documented and include: territoriality and turf battles; professional rivalries; resistance to innovation; lack of integrative skills; lack of time; space constraints; budget limitations; and limited interprofessional interaction during professional training programs (Klein, 2001; Lattuca, 2003; Scott & Hofmeyer, 2007). Debates about how to address each of these problems have been equally well documented and are unlikely to be quickly resolved.

There is, however, some clarity around meanings attached to terms. While clarifying terminology won’t address many of the issues that face people who are attempting to work across professional boundaries, it is a useful starting point. In writing about academic disciplines (rather than professions) Jantsch (1980) distinguished multi-, inter-, and transdisciplinary relations as connecting, coordinating and transcending levels of understanding respectively. Scott & Hofmeyer (2007) further described these concepts in terms of the relationships with other disciplines (or professions):

- Multidisciplinary – different disciplines working in parallel on common issues or projects; disciplines recognize they remain unconnected;
- Interdisciplinary – different disciplines coordinating their approach to an issue – disciplinary boundaries remain permeable;
- Transdisciplinary – disciplines become mutually embedded in each other – disciplinary boundaries are transformed.

"Each type of relationship may be more or less appropriate for answering specific types of questions (or addressing specific types of problems)" (Scott & Hofmeyer, 2007, p. 494). There is no single right way; the approach to cross-professional relationships depends on the context and problem at hand.

The cost of working in teams may initially seem higher than the cost of paying individuals to provide service independently – if we only examine "cost per procedure" or "number of patients seen". As people experiment with new ways of working, challenges emerge. Some of these challenges include:

- being unfamiliar with different ways of working and the value within each way of working (e.g., understanding roles within the team, scope of practice of various professions, differences in approach);
- needing time to establish a pattern of care within the team so work is not duplicated or missed (e.g., who does initial consults, who does nutritional counselling, who follows up on meds);
- lack of common understanding related to use basic terms (e.g., the definition of a "physical" may differ between professions);
- working out very real resource issues – such as physical space or lack of compatibility of IT systems with provider needs.

Failure to identify, understand and address such challenges and their underlying assumptions perpetuates them. For example, there is a common assumption that co-location will overcome relational woes; however, co-location itself is insufficient to ensure effective interprofessional working relationships. Communication strategies, whether face-to-face or virtual, are essential if trust, respect and common understanding are to be achieved. Without these, no amount of resource will be sufficient to achieve desired outcomes (Scott & Lagendyk, 2008).

In summary, a great deal is known about factors that contribute to the success of interprofessional teams; however, what is missing is commitment to taking risks and strategic support for implementation of such change. Despite what might seem like insurmountable obstacles, tackling these challenges has the potential to stimulate great gains in quality of patient care.

References

Government of Alberta (2003). Background: Primary Care Initiative Agreement. Edmonton, AB: GoA.


