

1: Interprofessional teamwork

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In the allied health professions there is an acknowledgement that the transition from graduate to clinician can be challenging. The transition from student to practitioner requires health professionals to work as an effective team member within complex organisations. Hence clinicians need to possess a wide range of hard and soft skills. Hard skills refer to problem solving, clinical expertise, critical thinking and self-reflection, whilst soft skills refer to skills such as time management, listening, ability to get on with people, empathy and networking skills. The issue is whether interprofessional working is of any benefit to the growth and promotion of the allied health professions? What are the current trials and tribulations of teamwork? How can teams work effectively? This chapter outlines the problems of interprofessional practice in health and social care. It examines the meaning of teamwork, why interprofessional working is important, factors that impact upon teamworking, how to resolve team issues and how to manage conflict or difficult situations in teams. Examples from research based in practice will be used to analyse such problems, how they arose and ways in which they might be addressed.

Membership and composition of teams

Multidisciplinary teams were formulated in order to respond to the changes which were occurring in medicine in the 1950s and 1960s, namely the growth of 'holistic' medicine (Brown, 1982). Teams were perceived to be the most effective means to manage the patient's social, medical, psychological, cognitive, environmental and rehabilitative needs. Teams are considered to have numerous advantages over traditional care. The frequently cited advantages include improved planning, more clinically effective services, a more responsive and patient-focused service, avoidance of duplication and fragmentation and more satisfying roles for healthcare professionals (Royal Pharmaceutical Society of Great Britain and British Medical Association, 2000). In some cases, multidisciplinary teams may not have an outcome that can be measured (Box 1.1).

Most therapists, nurses, doctors and social workers become members of a team by default, i.e. the post which they occupy requires them to work in a multidisciplinary team. Consequently we do not choose who

Box 1.1 Multidisciplinary teams need to have clear outcomes

Multidisciplinary team meetings that do not have an outcome that can be measured can be viewed as ineffective (Atwal, 2002). This is a view of a staff nurse:

I have been to others (multidisciplinary team meetings) where nothing has been sorted out and everything still remains the same. . . You know seven months in an acute hospital bed taking up space when nothing happens.

we work with. Moreover, in most instances support workers and users of services are often excluded from team meetings.

Interestingly, current journal articles regularly fail to include occupational therapy assistants as members of an occupational therapy or multidisciplinary team; this is a concerning oversight. Effective collaboration between therapists and assistants will be needed to deliver more effective and responsive care to clients. Therefore it is vital that therapists develop a good understanding and appreciation of their differing roles and that training is in place to enhance the roles of therapy assistants.

The exclusion of therapy assistants from team meetings can impact upon clinical decision making. Our own anecdotal evidence suggests that despite having valuable information regarding a patient's condition and progress, most healthcare assistants are excluded from team meetings (Atwal & Jones, 2007). One healthcare assistant told us:

We are the closest of the staff to the patient so we assess them and we can tell, even though we haven't a part to tell anybody else, . . . we know what they are capable of doing. They don't ask us, they ask the people who are far from them. . . Therefore the assessment is really faulty.

HCA's should be actively encouraged to participate in team meetings, and supported to do so by their colleagues. This in turn could allow accurate information to be shared with members of the team, which will subsequently enhance and improve decision making and, ultimately, patient care.

Professionals need to consider how the patient voice is heard within teams. How do we ensure that the patients' opinions are truly represented within multidisciplinary teams? How do we feel about or even manage service users who are assertive and articulate and can challenge individual members of the teams and the decisions that have been made about them? Service users are the most important members of the team, but little research has occurred regarding how they can be integrated into teams. There is some evidence that involving service users in interprofessional education can enable students to become more patient centred (Barnes et al, 2006).

Box 1.2 How effective is your team?

How does your profession cultivate teamworking?
 What is your experience of teamworking in your organisation?
 What kind of team do you work in?
 Could it be enhanced?
 Do teams work in your setting?

From our own experience, one of the most essential aspects to ensure good partnership working is to develop good listening and communication skills. It is essential that professionals spend time listening to users and can evidence decisions that have been made. Some users are taking the initiative and the time to understand specific health conditions. In the past the emphasis has always been on the healthcare professional imparting information to the service user in conversation and with leaflets. Now the service user will already be well informed with information they have researched and downloaded from the Internet. It is important that healthcare professionals are not threatened by the fact the patient may know extensive detail about their condition. What it does mean is that professionals must be able to effectively evidence their interventions with users (see Chapter 9). It is also important to be aware that service users may think they have insight into their condition, which may actually be misplaced. It can require skill to undertake a conversation explaining that the facts the service user has extracted from Wikipedia are not necessarily comparable to the randomised controlled trial that advocates a specific direction for treatment (Rampil, 1998). Supporting the service user to understand the need to separate the 'wheat' from the 'chaff' on the Internet can be an important part of developing a relationship which enables the user to participate in the service offered.

In clinical practice, we have observed and participated in three different models of teamworking. The first model (which appears to be the norm within acute care settings) is when the patient is absent from all team meetings. The second model is when the consultant performs a bedside ward round and the patient is asked to comment on 'how they are feeling'. Our experience of this model usually results in the patient agreeing to everything the doctor says. The third model, which can occur in psychiatry, is when the patient is asked to attend the team meeting. In this instance, the experience can be daunting for the service user. The question is, if the patient is not a member of the team can you really say that you have adopted a person-centred approach? We would suggest that therapists and other professionals need to consider the use of experts in practice that could act as advocates for patients. Please answer the questions in Box 1.2 about the team you work in or have worked in.

Preparation for teamwork

In order for a team to work effectively, its members must be 'competent to collaborate' (Barr, 1998:183). Barr (1998) has identified competencies which are thought to be necessary for effective interprofessional working:

- contribute to the development and knowledge of others;
- enable practitioners and agencies to work collaboratively;
- develop, sustain and evaluate collaborative approaches;
- contribute to joint planning, implementation, monitoring and review;
- coordinate an interdisciplinary team;
- provide assessment of needs so that others can take action;
- evaluate the outcome of another practitioner's assessment.

The need for pre-qualifying education to prepare students to work as part of a team has been clearly articulated (Miller et al, 1999; Barr, 2000). However, opportunities for interprofessional education are far scarcer in relation to pre-qualifying educational programmes than in post-qualification (Koppel et al, 2001). One of the major difficulties in considering interprofessional education is the lack of clarity in the use of terminology (Cooper et al, 2001). A systematic review on interdisciplinary education of undergraduate healthcare professional students found that student healthcare professionals benefited from interdisciplinary education with outcome effects relating mainly to changes in knowledge, skills, attitudes and beliefs. However, effects upon professional practice were not apparent (Cooper et al, 2001). At present, the research available into the effectiveness of interprofessional education is contradictory and there is little evidence to demonstrate its effectiveness (Zwarenstein et al, 1999, 2001). In the literature some authors argue that interprofessional education enhances motivation to collaborate (Barr 1998; Parsell et al 1998), contributes to the development of effective collaborative teamwork (Freeth & Reeves 2000) and overcomes prejudice and negative stereotypes (Carpenter 1995). On the other hand, it has been suggested that interprofessional education reinforces negative attitudes and stereotypes and that it may encourage role confusion and loss of professional expertise (Tope, 1996; Leaviss, 2000). In addition, educators themselves can reinforce negative stereotypes and prejudices which can hinder interprofessional learning (Barr, 2000). Besides, opinion varies concerning the timing of interprofessional education. It has been suggested that it should take place at pre-registration level to mitigate the risk of developing negative attitudes and to prepare future healthcare professionals to work effectively as team members (Miller et al, 1999; Freeth & Reeves, 2000).

The terminology associated with 'shared learning', such as 'interprofessional', 'collaborative' and 'multiprofessional', is often used interchangeably. The authors make a clear distinction between multiprofessional

Box 1.3 Do you have the skills needed to be an effective team player?

Are you competent to collaborate?

What additional skills/training do you need to be a competent team player?

How will you acquire such skills?

education as ‘simply learning together’ and interprofessional education as ‘learning together to promote collaborative practice’, and relate this closely to the distinction made between multidisciplinary and interprofessional practice. Consequently newly qualified practitioners can be unprepared for teamwork in the real world. Please answer the questions in Box 1.3 about your own collaborative skills.

Perceptions of teamwork

Within the health and social services the term multidisciplinary is used to denote almost any form of cooperation between professionals and agencies. Hence multidisciplinary teamwork may be regarded as everyone performing his or her own thing with little or no awareness of other disciplines’ work. This confusion regarding what is meant by teamworking has arisen from the miscellaneous terms which have been used to represent the multidisciplinary team concept (Coleman, 1982; Mariano, 1989). The reason for this is that the resemblance of a ‘team’ masks the range and complexity possible in interdisciplinary interaction and cooperation (Kane, 1983; Gregson et al, 1991). Occupational therapists’ and physiotherapists’ perceptions of teams have not been researched in great detail. One study (Atwal & Caldwell, 2006) found that there was remarkable scepticism surrounding the concept of the multidisciplinary team. Nurses described the multidisciplinary team as a ‘complete myth’, ‘idealistic’ and ‘shambolic’.

There have been many attempts to define collaboration, which, once again like the term multidisciplinary, can be defined according to those implementing the concept; this has resulted in a superficial definition (Kraus, 1980). Webb (1986:155) refers to collaboration as:

The pursuit of a coordinated course of actions usually through face to face interaction by means of achieving consensus about a field of interests and goals which are to be furthered by mutually acceptable means.

Armitage (1983) has introduced taxonomy of collaboration within five stages which is helpful since it measures and defines collaboration. The first stage is isolation, where members never meet, talk or write to one another. The second stage is where members communicate with each

Box 1.4 Can integrated care pathways enhance teamworking?

This study evaluated multidisciplinary integrated care pathways to improve interprofessional collaboration (Atwal & Caldwell, 2002). It was part of a larger action research study to analyse and improve multidisciplinary teamwork and discharge planning. Integrated care pathways are interdisciplinary plans of the outline optimal sequencing and timing of interventions for patients with a particular diagnosis, procedure or symptom (Ignatavicius & Hausman, 1995). They were believed to develop multidisciplinary teamworking (de Luc, 2000). This research study found that integrated care pathways did not enhance interprofessional collaboration and that professionals did not regard recording team goals as a priority. Moreover the study highlighted the need for effective documentation; if the notes were not completed, communication was fragmented. However the implementation of integrated care pathways did improve the quality of the management of the patient and reduced length of stay.

other but do not interact meaningfully. The third stage is concerned with communication which includes the exchange of information. The fourth stage is partial collaboration where members who act on that information sympathetically participate in patterns of joint working and subscribe to the same general objectives as others on a one-to-one basis in the same organisation. The fifth stage is full collaboration which occurs in an organisation where the work of all members is fully integrated.

Within your own team it is essential to explore the many definitions in order to ascertain whether these terms are distinguishable or one and the same. Moreover it is essential to ascertain whether all team members perceive teamwork in the same way. However, teamworking is a sensitive area and other members of the team may not wish to acknowledge that there is an underlying problem. Hence in our experience, the first hurdle of any change or exploration work is to discuss informally with key stakeholders your feeling and perceptions. It has also been suggested that team members must be involved in developing criteria to assess the competence of the various professional members and the effectiveness of each contribution (Kane, 1983). Box 1.4 outlines a study which evaluated the impact of integrated care pathways on interprofessional collaboration.

Integrative and transdisciplinary teams

The term multidisciplinary has further evolved into the 'integrative' and the 'transdisciplinary' approach which is the most advanced and sophisticated form of teamwork (Woodruff & McGonigle, 1988; Orelove & Sobsey, 1991). The unique features of an integrative team are that the whole team makes decisions together, so that professionalism is levelled,

and that there is shifting leadership focus according to the needs of a particular patient (United Cerebral Palsy, 1976). The concept central to both these models is that of role blurring and role release (Lyon & Lyon, 1980). Thus each individual member of the team is involved in role extension that is improving the clinical knowledge skills in one discipline. Each member of the team is involved in role enrichment, which entails learning about other roles and disciplines, whilst role exchange is learning and beginning to implement techniques from other disciplines. Once these skills are acquired they are then released, which involves putting newly acquired techniques into practice with consultation from team members. In addition other members of the team offer role support in order to allow the role expansion to be successful.

The key aspects of interdisciplinary, integrative and transdisciplinary models is the foundation of 'patient-focused care'. Heyman and Culling (1994:3) point out that there is no single definition for patient-focused care or patient-centred care:

... Their thrust is to shorten or eliminate process steps and ease administration and co-ordination burden through limiting the number of staff involved with each patient.

It calls for traditional professional skill boundaries to be re-appraised, the roles of staff to be redesigned, and cross-skilling and multi-skilling, which allow members of care teams to deliver a wide range of services according to the patient's needs and requirements (Lehmann-Spitzer & Yahn, 1992).

Components of unsuccessful teams

The NHS Plan (Department of Health, 2000) has encouraged professionals to consider implementing role integration in healthcare teams. This involves professionals developing new roles as well as sharing skills with members of the multidisciplinary team. There is considerable evidence that unsuccessful teams occur because they are composed of members with undefined roles (Belbin, 1981). Hence it has been suggested that successful teams consist of individuals who not only know their professional roles but also know their own individual style of working in a team. For example you may be a person who enjoys solving difficult problems but is a poor communicator or a person who is well organised and makes ideas happen in practice. On the other hand you may be someone who has lots of energy but can be insensitive to the needs of others. Hence within any team there needs to be an awareness of individual personalities and an understanding of the roles people within the team are fulfilling. This may lead to the identification that a particular characteristic is missing from the team, which if, undertaken and fulfilled, may lead to rapid acceptance into the team. However, beware of trying to fulfil a role that is already successfully

filled within that team. In particular, avoid trying to fulfil a role for which several people are already competing. It is unlikely this will be accepted by the team, but instead will contribute to irresolvable conflict (see http://www.belbin.com/downloads/Belbin_Team_Role_Summary_Descriptions.pdf).

Thus ambiguity and overlap within the health profession can be one of the difficulties in developing teamwork (Cass, 1978). One of the key problems associated with interprofessional conflict is role perception. Forsyth (1990:495) defines a role as 'a behaviour characteristic of persons in a context; the part played by a member of a group'. However Burr (1975:833) is of the opinion that a rigid role may be used by insecure member of the team 'as a basis for demarcation disputes'. In order for professionals to gain an understanding of the roles of other professionals it is essential that they are able to clearly state their role within the healthcare team. Pritchard (1981) notes that the lack of clarity of roles within a multidisciplinary team leads to the development of stereotypical attitudes. Stereotyping is defined by William and William (1982:17) as an 'attempt by an individual to understand his or her social environment'. One study (Dalley & Sim, 2001) found that nurses perceived that physiotherapists did not understand the external pressures that they operated within and that there was a lack of awareness of nurses' professional autonomy and decision making in rehabilitation. Box 1.5 outlines a study by Pietroni (1991) which examined stereotypes in medical, nursing and social work students.

Box 1.5 Archetypes and stereotypes

Pietroni (1991) undertook a study of medical students, nursing and social work students to examine stereotypes and archetypes, and found unexpressed archetypes and stereotypes. At Brunel university we undertake a similar exercise based on the work of Pietroni, but ask students to complete a questionnaire before and after an interprofessional model.

We ask students to write:

What car do you think occupational therapists, physiotherapists, social workers, nurses and doctors drive?

What sort of clothes do they wear?

What newspaper do they read?

What do they do?

What do they do in their spare time?

Can you describe their personalities?

How would you describe occupational therapists, physiotherapists, social workers, nurses and doctors?

How would you describe their team-playing skills?

Do you perceive occupational therapists, physiotherapists, social workers, nurses and doctors as being interested in interprofessional working?

Temporal-spatial and social factors

Developing and sustaining interprofessional relationships are further complicated by temporal-spatial challenges. Due to the nature of professional practice, health and social care practitioners often work in different clinics, wards or organisations at different times of the day (and night). As effective interprofessional collaboration is dependent on open channels of communication, the incompatible working hours of the different professions may result in much of their work being hidden from the eyes of others. Consequently, it is essential that team members spend time with one another to understand each other's roles and their preferred methods of working. In health and social care this can be difficult since professionals rotate at different times and spend limited periods within each speciality (Atwal & Jones, 2007). Consequently it is essential that senior members of a team invest time enabling professionals to meet different team members. Moreover senior members must lead by example and ensure that they promote the value and importance of the team and do not allow so-called 'more important tasks' to come first.

Weak interaction in teams

Multidisciplinary teams are settings in which assumptions are constantly challenged and where team members can share skills and knowledge (Central Council for the Education and Training of Social Workers, 1989). Mackay (1997:176) found that nurses were often reluctant to voice their opinions even if it was a 'matter of life and death'.

The type and amount of interaction in team meetings can be used as an indication of teamwork. Power and status differentials between the different professionals have been explored and indicated the limited involvement of therapists, social worker/care managers and nurses in multidisciplinary team decision making. Wise et al (1974) concluded that high-status members tended to speak first and most convincingly on all issues. A remarkable finding by Fewtrell and Toms (1985) was that in traditional psychiatric ward rounds medical staff talked considerably more than all the other participants put together. Stein (1967) explored the interaction between doctors and nurses and introduced the concept of the doctor-nurse game. He describes how nurses learn to show initiative and offer significant advice while appearing to defer passively to the doctors' authority. Nurses use subtle non-verbal and cryptic cues which, in retrospect, appear to have been initiated by the doctor. The game ensures that open disagreement is avoided at all costs and has advantages for both parties. The doctors gain from the nurses' knowledge and experience, whilst the nurses gain increased satisfaction from his or her more demanding role. One study (Atwal & Caldwell, 2002) explored the interaction patterns of multidisciplinary teams in orthopaedics, elder

Box 1.6 Case study: communication in a team

Rory is a newly qualified occupational therapist working on the medical wards. It is Friday and he has had Norman, aged 67, down to the OT kitchen to demonstrate his ability to make a cup of tea, following a long period of bed rest due to a serious deterioration to his health that was eventually diagnosed as prostate cancer. Whilst working together Norman complains to Rory that he has not been able to go to the toilet all day; he feels he has a full bladder but he just can't go. Rory knows that urine retention is a sign of spinal cord compression and is concerned. He tries to raise the issue with the house officer, Cas. Unfortunately the two of them have never got along, Rory is quite shy and Cas has interpreted his aloofness as incompetence. Rory is unable to convince Cas that there is any cause for concern. When Rory returns to work on Monday, he learns that Norman is permanently paralysed. He had a secondary tumour in his spinal cord. Rory is mortified that his inability to communicate the situation effectively to Cas could have contributed to this situation.

How can the situation be resolved?

On his next rotation Rory is working on the elderly rehabilitation wards. Cas is now the senior house officer for these wards. Rory is determined to ensure that no one else comes to harm because of his relationship with Cas. He discusses his problems with his line manager who suggests seeing Cas as a human being first and a doctor second. Rory puts a lot of effort into talking to Cas about things that are unrelated with work. He learns that her grandmother is unwell and always remembers to ask her how she is when they meet. The relationship between them improves.

care and medicine, found that the team was task orientated and suggests that doctors and, in particular, consultants had a more dominant role in teams. Within the nursing team, especially, it was apparent that there was unequal participation between different nurses. However amongst social workers, therapists and nurses similar rates of participation occurred in the different teams. The differing types and amounts of interaction that occurred in all four teams may suggest that the teams were not working effectively. Professionals may lack confidence to voice opinions and ask for information in team meetings. Hence in practice this means that professionals are not respecting their own individual autonomy or being an effective advocate for the client.

Box 1.6 outlines a case study about Rory, a newly qualified occupational therapist. In this instance communication differences are caused by misunderstandings between two members of the team which impacts upon how a patient is managed by a junior doctor in the team. What would you have done in this instance? What will their relationship be like if they work together in another team?

Communication within physiotherapy and occupational therapy teams

Most newly qualified therapists have a senior member of a team (either a physiotherapist or occupational therapist) as their mentor or line manager.

Box 1.7 Case study: policies, procedures and teamwork

A therapy manager, who likes to run a tight ship, runs a therapy team in the community. He has policies and procedures for everything and expects the therapists within the team to apply them vigorously. Lola has just joined the team as a newly qualified member of staff. She is eager to please but has found it difficult to integrate herself within the team as she finds her peers to be very cliquey. In order to impress and get integrated with her peers she has been applying the policies and procedures to the letter.

Lola has been allocated a 20-year-old wheelchair user, William, who has just started work and needs some assistance with reorganising his exercise routine to fit in with his full-time job. William has requested that he have an appointment outside of normal working hours as he contends that he is not ill and therefore cannot ask for time off work. The therapy department policy states that all home visits must be completed before 16:00 to ensure people get their notes written on the day of the visit and for staff safety. Lola has read the policy and therefore refuses to grant this request. William is forced to ask his employers for time off. They refuse as he has only just started working with them and it confirms all their fears about employing a wheelchair user; they see this as the thin end of the wedge. William is therefore denied his right to treatment due to the inflexibility of the organisation. William makes a complaint about Lola's attitude.

Indeed some therapy teams have removed traditional boundaries and introduced cross-therapy management where physiotherapists are line managed by occupational therapists and vice versa. However, there are instances when policies and procedures can impact upon how teams work and more importantly on how members of teams interact with users of services. For example, the management style of the therapy manager may be strangling flexible working and, more importantly, failing to create a sense of autonomy to the therapists working in the department. The effect means that the principles of client-centred working cannot be implemented. How does one challenge the style of the therapy manager? Box 1.7 outlines a case study about a therapy manager who believes strongly in policies and procedures.

In each team it is essential to establish how you communicate with colleagues within your own professional team. When do team members meet? Are these meetings effective? Can you talk openly and honestly in these meetings without fear of retribution? What do they achieve? How are issues within teams dealt with? When do team members actually get to talk to each other? This means not just about work issues but issues that impact upon work, for example family issues? Do you have a good mentor and access to good clinical supervision?

In the Box 1.8, a grade 5 physiotherapist, Ethan, is unclear about who he communicates with in the team to assist him with the management and treatment of complex patients. Moreover he is being pressurised by other members of the team who have certain expectations regarding

Box 1.8 Case study: caseload management

Ethan has been qualified for nearly a year. He works in a small community hospital that has a two-bedded ITU attached to the surgical ward. He is nearly at the end of his medical rotation that includes covering the ITU beds. Normally he is working with either the medical physiotherapy team leader or the band 6 physiotherapist. However, today the team leader is on a course and the band 6 physiotherapist is absent. Therefore, Ethan is alone with the nurses in ITU. Both cases are complex and beyond Ethan's limited experience. One has a fistula between the oesophagus and trachea and has several pints of Guinness in his lungs. A chest drain is *in situ* and the nurses are asking for Ethan to do something to facilitate expectoration. The other case is a patient with Legionnaire's disease, who is expectorating large blood clots; once again the nurses are expecting Ethan to intervene.

Ethan is very worried, as he does not know who to prioritise or how to treat them. He does not know how to contact the team leader or whether he is even allowed to. He rings the physiotherapy department to explain his plight. He speaks to one of his peers in outpatients who immediately reports the problem to her line manager. Phone calls are made to the medical physiotherapy team leader on her course for advice and to ITU to explain the situation. All the senior In-patient therapists are bleeped and it is determined which of them has the time and the experience to be able to deal with ITU. Another senior is asked to provide support for Ethan for the rest of the day. Work is shared to ensure that it is completed. The extra work means they all finish late at which point it is suggested that a trip to the pub is called for.

his role and competencies. In this instance it is a junior colleague who ensures that members of his team are aware of his difficulties and senior members of the team are supportive. In the first instance, Ethan should have known which senior member he could have contacted for clinical advice and supervision.

It is essential not to forget that therapy assistants play a significant role supporting the work of occupational therapists and physiotherapists. It is our opinion that therapy assistants and healthcare assistants also require effective communication skills (both written and verbal) to work effectively in health and social care. Hence, therapists will also need to consider how they will communicate and interact with these staff while continuing to collaborate with their professional colleagues from medicine, nursing, social work and physiotherapy. Within nursing Spilsbury and Meyer (2004) acknowledged work-related tensions which existed between healthcare assistants and registered nurses, and recognised the potentially negative effects this had on teamworking and subsequent patient care. These authors suggested that a power struggle arose between the two groups as a result of some traditionally viewed 'nursing roles' now being undertaken by healthcare assistants. They state the importance of recognising that potential conflict may occur during the negotiations of roles and duties and advocate that managers take these issues into consideration when formalising service delivery (Spilsbury & Meyer, 2004).

Conflict

Most professionals do not like conflict, however conflict is a natural part of interprofessional working; within the literature conflict is often regarded as an indicator that teamwork is absent. The Central Council for the Education of Training of Social Workers (1989:9) is unique in that it emphasises the positive aspects of conflict: 'multi-disciplinary teamwork is a two-edged sword'. The tensions and conflicts within it are also its creative force. Janis (1972) identified a 'disease' which infects cohesive groups which he termed groupthink. During groupthink, the members do not voice alternative opinions, therefore the group often makes mistakes which could have been avoided. It is defined by Janis (1982:9) as:

A mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when the members' striving for unanimity overrides their motivation to realistically appraise alternative courses of actions.

The causes of groupthink have been identified as cohesiveness, isolation, leadership and decisional stress (Janis, 1972; Janis & Mann, 1977). Very often teams do not have agreed procedures for resolving conflict. Spiegel and Spiegel (1984) found that multidisciplinary meetings resolved such difficulties by each team member recording and submitting therapy plans prior to the multidisciplinary meeting. These and the actual plans made at the meeting were recorded and the data showed that 46% of physicians changed their plans after the meetings.

In practice it is important to understand what motivates each team member. Discussions can be undertaken using words and expressions, which will stimulate them. For example, if you know the consultant is worried about length of stay on his/her ward then you can explain how your way of doing things would have an impact on length of stay in the long term. Even if they do not agree with individuals on the team, make sure you are attentive to listening to their point of view. If you do this well they will do the same for you and they might just hear you say something that causes them to change their mind. Do not allow their disagreement to bring conflict into the relationship you are trying to nurture (Booij, 2007). You might not be achieving much in the short term but in the longer term your perseverance may change things.

Status and power

As a professional, you can be a member of more than one team, where conflicting loyalties may occur. The report *Social Workers: their Role and Tasks* (National Institute of Social Work, 1982:125) warns that 'goodwill is not enough to guarantee adequate collaboration'. It is essential that desired outcomes are reported and agreed as professionals or organisations

Box 1.9 Case study: voicing opinions in a team

Cas's consultant has an old fashioned attitude to his work and believes that therapy has very little to do with people getting better or getting home. Rory has a patient who the consultant was asked to see in A&E. Doris was complaining that her legs were getting weak. Dr Elton told her it was old age and sent her home. She represented at A&E following a fall and was admitted. Dr Elton is annoyed that she was admitted and is determined to send her home as soon as possible as she did not sustain an injury.

Rory is undertaking washing practice with her to assess her ability to manage at home. He asks her to transfer from the porter's chair to the perching stool. Doris tries but her legs give way and Rory is forced to manhandle her back into the porter's chair. As he grabs her trunk she screams very loudly. Once she is safely back in the porter's chair Rory checks whether she was screaming in fear. Doris denies this and says she was in excruciating pain from within her back. She gets a similar pain when she tries to stand but not as bad. Once Doris is back on the ward Rory bleeps Cas and discusses the case with her. He is able to explain how he does not feel that this is ordinary back pain. Cas is much more open to listen to his concerns. She agrees to send Doris for an MRI and to explain to Dr Elton why she supports his concerns regarding Doris. When the results come back they are informed that Doris has a spinal abscess and later it transpires that it is tubercular in origin. Dr Elton thanks Rory for saving his reputation.

may be reluctant to invest scarce resources and energy into developing and maintaining relationships with other organisations, when the potential returns on their investment are unclear or intangible.

When comparing the status of professions it is important to take gender into account. It has been suggested that the high presence of women has actually contributed to their lower autonomy and professional status. Davies (1990) found that the average female physiotherapist is less likely than her male colleague to see herself as an independent practitioner. Mackay (1997) found that male nurses are more likely to question a male doctor than a female doctor.

In the example in Box 1.9, because of Rory's improved interprofessional relationship with Cas, he is able to convince her that further tests are needed. Moreover, Rory has been able to reflect upon his previous experiences and has been able to challenge the professional opinion and attitude of a consultant. Indeed, implementing the realities of client-centred practice in the real world takes courage. However because Rory has voiced his concerns, the client's needs are met and a positive result is obtained.

The leader of the multidisciplinary team is usually a member of the medical profession. Kane (1983) analysed 229 teams and found that a typical team consisted of a group with six to ten members led either by a psychiatrist or a physician. The medical profession, in particular hospital consultants, meet many of the characteristics associated with a leader.

Stogdill (1974), after reviewing 106 studies, found that leaders in relation to other members were higher in achievement, orientation, adaptability, ascendancy, energy levels, responsibility taking, self-confidence and sociability. It was the National Institute of Social Workers (1982) which reported that difficulties in collaboration occurred because of the common assumption that the doctor must always be a leader of any team. A national survey was conducted to compare the structure, purpose and restraints of multidisciplinary teamwork across the UK. The data from the research found that most meetings were still led by a consultant in elder care, orthopaedics and acute medicine (Atwal, 2001).

Conclusion

This chapter has highlighted the complex skills that professionals need to function as competent team members. It is not easy to work in a team, since often team members are different in style, attitude, commitment and work ethic. It is essential that family members are viewed as part of the team and need to be regularly updated and involved in the decision-making process. In order to work effectively it is suggested that you should have the following guidelines (Bachi, 2008):

- Do not get into a blaming cycle as teams can blame individuals in a team when things go wrong, for example when a discharge is delayed.
- Focus on the present and future.
- Hold regular team meetings so that you can reflect on the team's successes and failures to help the team determine where they need to go to improve.
- Do not get involved in character assassinations of fellow team members. Talking about team members in private with another team member usually involves the blaming process.
- Take responsibility for your individual professional contribution to the team and your own behaviour but not the contribution or roles of your team mates.

From a management perspective the common problem for a newly qualified healthcare professional entering employment in the NHS or Social Services is understanding where they 'fit' in the hierarchy. Even for the most confident newly qualified healthcare professional the organisation and hierarchy can be initially confusing. Managers advocate that new healthcare professionals should aim to 'join in' and express their ideas, as they often have a new and objective view of the service, which is valuable for service development. Managers place importance on any individual's contribution to the team irrespective of their level of experience or duration of service; it is the quality of the ideas and the enthusiasm to put them into practice, which count.

Box 1.10 Check list (adapted from the National School Board Association, 2007)

- Purpose – does your team share a sense of pride in why the team exists and is this essential in accomplishing its mission and goals?
- Priorities – do your team members know what needs to be done, in what order and by whom to achieve team goals?
- Roles – do team members know their role in achieving tasks and are they able to identify when a more skilful member should be allocated the task?
- Decisions – are authority and decision-making lines clearly understood?
- Conflict – is this dealt with openly and considered important to decision making and personal growth?
- Personal traits – do members feel their unique personalities are appreciated and well utilised?
- Norms – have the group norms for working together been agreed and set and are they regarded as standards for everyone in the team?
- Effectiveness – do team members find team meetings efficient and productive and look forward to the time together?
- Success – do team members clearly know when the team has met with success and share in this equally and proudly?
- Training – are opportunities for feedback and updating skills provided and taken advantage of by team members?

Professionals need to be confident in their own role, be able to clearly articulate their role, be able to exchange and receive information and to be able to use their skills to deal with conflicts and tensions within teams. More importantly this chapter has emphasised the need to consider the role of the patient within the team and to consider ways of ensuring that the patient's voice is heard in the team.

Complete the exercise in Box 1.10 to rate your team against the characteristics needed for a well functioning team.

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