
The multidisciplinary team – fact or fiction?

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While there may be agreement about what constitutes palliative care, there is less obvious consensus over what constitutes the palliative care team. Other than the general rhetoric that palliative care is best provided by ‘the multidisciplinary team’ and that the person and family should be the central focus for teamwork, there appears to be little to guide us.¹ Questions such as ‘How should palliative care teams operate?’ and ‘What is effective teamworking?’ are not fully explained within palliative care literature. While there are studies describing the work of palliative care teams, the relationships engendered within teams, styles of teamworking and the effectiveness or otherwise of different approaches to teamwork have not been the subject of thorough investigation. Indeed, work that has been undertaken suggests there is such heterogeneity among services and teams^{2–4} that one might be led to conclude that ‘the multidisciplinary team’, as suggested in many palliative care texts, may be a somewhat fictional representation of what we desire palliative care to be, rather than the reality of palliative care service provision.

More often than not palliative care is a web of loosely connected services and individuals who provide support to people with advanced or terminal illness. In this context, it might be more appropriate to talk of intersectoral and interagency working as the means by which palliative care is achieved rather than teamwork as such.⁵ Within an interagency care context, the skills required for effective teamworking are wholly different from those required when operating within a team that sits within a single employer organisation and provides a service on the basis of shared teamwork – as in what is more traditionally understood as palliative care in hospice or specialist palliative care teams. I am, therefore, considering the question in relation to both these contexts, although I particularly want to focus on issues surrounding teamwork in the latter. I offer here some challenging thoughts on multidisciplinary teamwork as it is currently constituted and some suggestions as to how teamwork might fruitfully be developed in the future. For definitions of different types of teamwork, see Box 1, opposite.

Bliss *et al*⁵ identify the features underlying successful interprofessional working in palliative care. These include: the importance of team members sharing a common language; the need for individuals in teams to be prepared to work together and not to feel under threat from other professional groups; the need for individual team members to value the different contributions that can be made; and professional values and cultures to be shared. Finally, there must be collaborative relationships which include shared

planning, shared decision-making, shared responsibility and non-hierarchical relationships. There is plenty of evidence to suggest that many of these conditions are not achieved in practice. Some of the most basic preconditions for a shared language are not present. For example, in community health and social care settings, there is considerable debate and confusion among healthcare professionals over what palliative care is and at what point of the illness it should be provided, or even who should ‘own’ palliative care.⁶ Individual practitioners often do not understand the contribution of other professional groups,⁷ and there is a lack of clarity about the particular contribution that each makes. There is also evidence of role tension and confusion between various professionals who contribute to palliative care in the community.⁸ Closely knit teams may be resistant to bringing in other partners – even when this may be beneficial – preferring instead to provide the total care package themselves.⁹

Paradoxically, the concept of multidisciplinary specialist palliative care teams may run counter to effective interprofessional working. Although the team itself may function well and have invested considerable energy in fostering its own team dynamics, the very success of this may hinder open and effective working with outside individuals, groups and organisations who may contribute in important ways to the total package of care that patients and families may need.

Within established palliative care teams, it is worth exploring the extent to which interprofessional working has been achieved, but also to question the concept and consider the variety of issues at play in developing successful teams. There is a developing critique of palliative care as it is currently constructed; one aspect of this critique is the so-called ‘medicalisation’ argument.^{10,11} It suggests that palliative care has become professionalised and colonised by an increasingly biomedical and technical approach. Consequently, dying is no longer treated as a natural event, but one that requires biomedical management in order to relieve or minimise symptoms and other difficulties experienced by people who are dying. Palliative care teams that have been developed in line with this ‘medicalised’ version of palliative care are made up of a variety of professionals, but leadership is often assumed to be the province of doctors because of their superior knowledge and skills in biomedical treatment. These teams also implicitly operate according to a hierarchical structure since the doctor, as leader of the team, is in charge and, however nicely, directs the work of other team members. Teams operating according to this model, therefore, violate

certain established principles of interprofessional working. While describing teams in this way may not recognise the very great efforts that many doctor-led teams make to develop egalitarian teamworking, the dynamic of medical leadership is difficult to replace entirely. Indeed, attempts to move beyond this rather traditional team model are often frustrated by deeply engrained power relationships between professional groupings in healthcare.

Other forms of teams operate in palliative care. In the UK, Macmillan specialist palliative care nurses may work in a variety of teams, including nurse-led teams and uniprofessional nursing teams. A recent study into the work of these teams suggests that teamworking may be fraught with difficulties. In the 12 services studied, the extent to which the team was 'multidisciplinary' varied considerably and the majority of teams could not be described as having reached maturity in full interdisciplinary relations and working practices. Most were in the process of changing from 'uni-' to 'multi-' disciplinary teams.^{4,12} While doctors saw themselves in a facilitative role in relation to their Macmillan nurse colleagues, this was from a position of implied superiority. In some instances, multidisciplinary teamworking led to greater restrictions. For example, one service where the team was progressing towards multidisciplinary working meant moving to physician-to-physician referrals, when previously the Macmillan nurses received direct referrals from ward staff and, therefore, their work became more restricted. However, one team that had matured as a multidisciplinary team over a 12-year period clearly demonstrated the benefits of a long, stable history, in which team dynamics can be allowed to evolve and develop. This suggests an important issue in teamworking: working patterns and relations take time and considerable effort to develop.

Farrell *et al*¹³ have observed that multiprofessional healthcare teams develop over time, becoming more collaborative and consensual, with individual members of teams becoming less dominant. More equality of participation is developed over time and the group operates more as a 'coalition of colleagues' as it develops greater maturity. However, regardless of the stage of team development, the more education the team members have, the more prominent and task-oriented they are. In general, physicians were found to be more prominent and task-oriented than other group members. This will reinforce the view that effective teamworking will be related to team maturity, and physicians may naturally assume a leadership function within the group. Fried *et al*¹⁴ identified different types of team organisation in renal units and cancer clinics – sequential, primary, nucleus and dynamic – and notes that the ideology of equal participation is the most difficult to sustain.

Rosenfield¹⁵ has described a taxonomy of cross-disciplinary working in the context of research (Box 1). For Rosenfield, the ultimate goal is for representatives from different disciplines to transcend their separate conceptual, theoretical and methodological orientations to develop a shared approach, building on a common conceptual framework. In such circumstances, new fields of enquiry can emerge, and new solutions to challenging health problems found. Given the challenging nature of health problems addressed by palliative care, transdisciplinary

working seems an important goal. However, Opie¹⁶ observes that most teams working in healthcare fluctuate between multidisciplinary and interdisciplinary forms of working and few, if any, work at the level of a transdisciplinary team by thinking and working 'jointly'. Opie has offered important insights into issues of teamworking in healthcare, and suggests that the benefits of working in teams may be offset by problems that lead to ineffective working (Box 2).

Opie illustrates how difficulties may operate in teamwork, using the example of a team attempting to address the complex needs of a man with faecal incontinence. While the team under observation saw part of their work as acting as advocates for the man and taking an holistic or client-centred approach to care, team discussions focused on medical issues and tasks to be accomplished, so that other issues such as 'What does the man hope for?' and 'What does he see are his problems?' were not discussed. Each team member contributed to the narrative about the man, but there was no method adopted by the team to develop a deeper understanding about the man's problems or to think reflexively (that is, using the group process for team members to consciously critique the way the team works with the man's problems). Thus, the man himself was marginalised from the team's discussions. Opie argues that the team did not use their discussions to question their own representations of him or of their way of working. Their thinking never moved beyond 'medicalising' the problem, and there was no full participation of the man himself. Given these modes of working, Opie questions the effectiveness of teams. If it is

Box 1. Rosenfield's taxonomy of cross-disciplinary working¹⁵

- Multidisciplinary teams – where members work in parallel or sequentially from a specific disciplinary base to address a common problem
- Interdisciplinary teams – where members work jointly but still from a disciplinary base to address a common problem
- Transdisciplinary work – where members work using a shared conceptual framework, drawing together disciplinary-specific theories, concepts and approaches to address a common problem

Box 2. Problems that lead to ineffective teamwork¹⁶

- Inadequate organisational support
- Lack of training in teamwork
- Lack of interprofessional trust resulting in complicated power relations and conflict within teams
- Lack of clear goals or direction
- Lack of continuity of team members
- The dominance of particular discourses and the exclusion of others
- Teamwork that takes the form of client discussions rather than addressing client goals, marginalising clients and contributing to disempowerment

simply to bring about co-ordinated care then this may be sufficient, but more fruitful may be '... bringing together knowledge from different professionals and from clients in order to allow these differently sited knowledges to interrogate each other, so setting in train a much more complex process ... it suggests different access among disciplines to power in decision-making, different team processes and modes of operation, different ways of conceptualising information ... and the development of means of empowerment of clients'.¹⁶ Opie also argues that such forms of teamworking can only be sustained within appropriately supportive organisational contexts.

Opie's analysis raises an important question regarding teamwork in palliative care: what part should the patient play in team discussions and teamwork? Current practice in palliative care largely maintains the patient, and family members, on the outside. Even when consulted over their care, patients rarely participate as full members of palliative care teams. Yet there is an argument that patients, wherever possible, should be directing their own care, expressing their own needs and goals and through this determining, in consultation with team members, the kind of care package that best provides for them. I have recently argued that 'self-management' may be an important new direction for palliative care.¹⁷ By this, I mean that palliative care should pay greater attention to helping people maintain their usual practices of self-care; those things that are important and unique to oneself in maintaining one's sense of self. Self-management implies being given the means to master or deal with problems, rather than having someone else deal with them on one's behalf, and is an active strategy used and owned by people who are ill. Participating in team discussions may be an important means of achieving this. The idea that palliative care teams might concentrate more on how to facilitate various forms of self-management accords with

Opie's argument for full client empowerment within teamwork.

This brief overview raises some questions about teamwork in palliative care. Teamwork constantly evolves and develops. Multidisciplinary teams as currently conceptualised may limit opportunities for more sophisticated and mature working practices. Transdisciplinary teamwork may be a goal for the future and strategies for involving patients and families in their own case management would seem an important objective.

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Response

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Professor Corner doubts the reality of the multidisciplinary team, as suggested in many palliative care texts. She identifies features of successful interprofessional working, regrets the potential impact of the medicalisation of palliative care and points out the difficulties of some teams when evolving from 'uni-' to 'multi-' disciplinary work. Finally, she asks if patients should participate in team discussions so that they are not forgotten in treatment plans.

It looks like we have to reinvent the patient in palliative care. Despite the concepts of 'multi-', 'inter-' and 'transdisciplinarity', palliative care seems to suffer from the same disease as all the other medical specialties: autistic thinking, narcissistic overestimation and the struggle for power. How mediocre and shameful in the face of human suffering and the finality of our existence? Have the champions of the respect for the limits of life and medicine, the sharing interprofessional team

players and the advocates of the patient become the ordinary members of just another medical discipline?

If this is the case: should we ban the medicalisation of palliative care? Should we participate in survivor weekends to recognise that our colleagues of the interdisciplinary team are human beings? Or should we run for group therapy or total quality management? Rather, we should just be invited by Corner's challenging and somehow pessimistic analysis to start thinking about the unachieved concepts of interdisciplinarity.

From my point of view, thinking about interdisciplinarity and possible obstacles to effective teamwork requires a reflection on a few basic issues. The following will be discussed and illustrated by examples.

- Professional identity and its hidden dynamics: professional objectives are important, but satisfying own needs by practising palliative care may be more powerful.

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- Group dynamics and how it influences each member's perception to be part of a whole: to change the rules of the team is an impossible mission, but to acknowledge and negotiate them can help.
 - Communication and its challenges: to ask that everyone should listen to each other is nice, but to

think about how information can be shaped in a way that others are able to benefit is more effective.

- Reflexivity of the team: how can the group produce an added value ($1 + 1 = 3$)? To incorporate different points of view is not enough, but to identify blind spots in discussions is crucial.