Comparison of language used and patterns of communication in interprofessional and multidisciplinary teams

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Abstract
Can the language used and the patterns of communication differentiate a multidisciplinary team from an interprofessional team? This research question arose from an unexpected outcome of a study that investigated clinical reasoning of health professional team members in the elder care wards of two different hospitals. The issue at stake was the apparent disparity in the way in which the two teams communicated. To further explore this, the original transcribed interview data was analysed from a symbolic interactionist perspective in order that the language and communication patterns between the two teams could be identified and compared. Differences appeared to parallel the distinctions between multidisciplinary and interprofessional teams as reported in the literature. Our observations were that an interprofessional team was characterized by its use of inclusive language, continual sharing of information between team members and a collaborative working approach. In the multidisciplinary team, the members worked in parallel, drawing information from one another but did not have a common understanding of issues that could influence intervention. The implications of these communication differences for team members, team leaders and future research are then discussed.

Keywords: Interprofessional, multidisciplinary, communication patterns, language used, teamwork

Introduction
In an earlier study, we explored how the focus of clinical reasoning differed among health professionals (Sheehan, Robertson, & Ormond, 2005). The participants in this study were from a range of disciplines and worked within two eldercare rehabilitation teams in two New Zealand metropolitan hospitals. When analysing the interview data, we noticed differences in the way team members communicated and shared information. It appeared that the “talk” within a team indicated differences in the style of the team. Surmising that the variations captured in the data illustrated differences in the way individuals communicate in multidisciplinary and interdisciplinary teams, we decided to re-analyse the interview data to test our idea. Our goal was not to provide an accurate description of multidisciplinary and interdisciplinary teams, but to identify concepts and ideas that may be tested and refined to build a theory about how language and communication influences these different styles of
teams. The focus of the analysis is therefore on the language used and the patterns of communication. This paper presents our findings and discusses implications for team members wanting to enhance their own team functioning; team leaders involved in the teaching, supervision development and management of interprofessional teams; and offers suggestions for future research.

**Literature review**

Teamwork as a preferred way of working in health care has been prevalent since the 1960s, as described by Weiland, Kramer, Waite, & Rubenstein (1996). Ovrettöit (1997) refers to the different types of teamwork as representing degrees of integration, from loose-knit networks, where professionals work in parallel according to their own priorities, to a recognized team, which has policies of collective accountability and agreed objectives. Three styles of teams most commonly referred to in the literature are multidisciplinary, interdisciplinary and transdisciplinary (Paul & Peterson, 2001; Weiland et al., 1996). The multidisciplinary team is usually regarded as one where professionals each work within their particular scope of practice and interact formally. Interdisciplinary teams are characterized by greater overlapping of professional roles, formal and informal communication and shared problem solving for the good of the patient. The transdisciplinary team operates an even greater blending (or blurring) of the roles, where one team member might take on, for instance, the role of a case manager charged with coordinating all services for the patient. Transdisciplinary teams were not represented in this study.

In their explication of teamwork within health settings, Freeman et al. (2000) identify “individual philosophies” of teamwork that impact on team communication and role understanding. One of these they termed “directive”, stating that it is members of the medical profession who generally hold it, because they view their role as that of team leader. The researchers referred to a second approach as “integrative”, explaining that it upholds notions of collaborative care and team player. The researchers thought that the health professionals most likely to hold this view would be therapists, social workers and some nurses, a view supported by Cohen (2003) who suggests that one important aspect of teamwork involves the rituals that ensure group cohesion. The third perspective that Freeman and colleagues identified was “elective”, which values a system of liaison and is preferred by those who work autonomously, maintain role distinctions and favour brief communications. Mental health workers were seen as the health professionals most likely to utilize this approach however it could equally applied to professionals who work in a consultative role to a health team.

Given these different philosophies of team work, it is not surprising that since the inception of health-care teams, there has been fraught discussion about the nature of team work – both the problems that arise when working this way and the satisfaction of working alongside professional colleagues. One issue that arises frequently is that of cultural power which Jones (2005) refers to as “turf battles” between professionals vying for status (see also Abramson & Rosenthal, 1995). This stance undermines not only attitudes conducive to effective team functioning, such as valuing the voices of the different members of the group (Clark, 1997), but also the perception that team cohesion provides greater gain for the patient. As Clark points out, each health profession inevitably has its own subculture that socializes its members into ways of thinking that may fundamentally differ from those evident in other health professions. Clark notes, for example, that professions who take self-determination as the hallmark of their approach to the patient can contradict the stance taken by other professionals who do more “for” the patient rather than “with” the patient.
This diversity in approach to the patient points to the importance of recognizing the skills and values of those who make up the team.

While it might be tempting to accuse medical practitioners of dominating team decisions, this is not always the case. Unsworth, Thomas, and Greenwood (1997), for example, found that occupational therapists were just as important as medical practitioners in making and promoting decisions regarding the discharge of patients in a rehabilitation setting. Gair and Hartery (2001) found that doctors were more likely than other health professionals to have their proposals questioned and were willing to accept decisions contrary to their initial suggestions. Overall, they found that while there was evidence of medical dominance in both chairing meetings and in initiating discharge proceedings, this dominance was not demonstrated in contributions made to the meetings, including the discharge proposals.

Along with the different attitudes and values of the individuals who comprise a team, there are organizational factors within the work setting that impact highly on team structure and functioning (Abramson & Rosenthal, 1995). For example, managers who tend to promote formal, impersonal processes can be seen to contradict the more dynamic, personal and informal nature of social processes within a team (Strasser, Smits, Falconer, Herrin, & Bowen, 2002; Whyte & Brooker, 2001). Cohen (2003) suggests that professional groups entrench their position in response to threats on their professional status. Feiger and Schmitt (1979) specifically address the issue of status within teams and recommend that the high status members of a group should be studied to gain a better understanding of their role in influencing the collegial nature of the group. The importance of team leadership in the development of effective team functioning is echoed by other authors (Atwal & Caldwell, 2002; McCallin, 1999).

Despite these unresolved differences in understandings of teamwork, policy-makers continue to promote health care teams as an effective and efficient way of using the skills of multiple professionals to provide the best possible service to the patients (Freeman et al., 2000). These differences may also help explain why suggestions for improving teamwork are also various and contradictory. Some commentators stress the need to compromise and set aside traditional professional differences (American College of Nurse-Midwives, 1998). Others focus on the importance of maintaining professional identification. Glen (1999), an adherent of this position, argues forcefully for members of each professional group to be clear about their own professional values and to communicate this to the team. Atwal (2002) makes a similar point but suggests that such sharing is for diffusing role ambiguity. The most common approach to overcoming teamwork difficulties is to provide training (both undergraduate and post-graduate) for health professionals that has as its primary focus on interprofessional communication (see, for example, Cohen, 2003; Humphris, 2002). In support of this third approach, Weiland et al. (1996) provide evidence that effective teams are able to prolong life in geriatric care. Reeves, Freeth, McCorrie, and Perry (2002) found from their evaluation of a special training ward for health professionals, that patient satisfaction increased due to higher incidences of contact and good communication among the team members. These studies by Weiland et al. and Reeves et al. are among only a handful that have examined the effectiveness of teamwork in health settings.

Other techniques thought to improve team interaction focus on the day-to-day tasks of teams such as setting common goals and integrating documentation (Atwal & Caldwell, 2002). Cohen (2003) advocates for a process where health professionals collaborate in a single assessment based on patient need rather than on each professional carrying out a separate assessment. Jones (2005) identifies the need to ensure that competencies for professional practice in teamwork are considered integral to ongoing professional development. Consistent with this, Whyte and Brooker (2001) recommend individual
coaching for team leaders and managers. As indicated above, there is no master plan for ensuring effective group work. It takes time to develop an identity as a member of a profession and then to reconcile this to being a team member committed to shared values (Cohen, 2003; Gibbon et al., 2002).

Methodology

Because the literature stresses the social nature of teams, we utilized a symbolic interaction perspective when analysing the data from this present study. This perspective places importance on the social meaning people attach to the world. For instance, Blumer (cited in Taylor & Bogdan, 1998) suggests that people act toward other people according to the meanings that events have for them. The symbolic interactionist believes that people learn to “see” the world from their interactions with other people and will therefore develop shared meaning of situations, people and themselves through a process of interpretation. Thus, members of a team are viewed as saying and doing things because they have learned to “see” things in a particular way.

The symbolic interactionist approach has the potential to highlight the complex interactions that occur in teams and how this shapes individuals’ understanding of themselves and others within the team. One way that such social meaning can become evident is in the language used, as it is a symbol of the underlying values and beliefs of the individual. In our study we were particularly interested in exploring the relationship between the use of language and how individual health professionals develop a sense of their own identities and construct perceptions of others (in this instance, the team). We also considered that the symbolic interactionist perspective would allow us to map what team members accepted as “normal” in relation to their interactions with and expectations of one another.

Research design

Research team and identification of participants

The three researchers who conducted this study and the original study (Sheehan, Robertson & Ormond, 2005) are New Zealand educators from speech/language, medical radiation technology and occupational therapy professional backgrounds. Two were actively involved in the data collection while the third person took the role of analysing the data from a non-involved stance. In the initial study we identified a team in each of the two hospitals in different cities and obtained permission to conduct a series of semi-structured interviews with the team members. The criteria that we used to identify the teams were that they be multidisciplinary (that is, each professional having autonomy and his/her own goals for the patient), well established (been in existence for a minimum of one year) and comprising members of at least four different health professions. The two teams selected were assessment and rehabilitation wards for elder care. The team members across the two city sites included a consultant, house surgeon, nurse, physiotherapist, occupational therapist, social worker, speech/language therapist, and psychologist. In terms of this study the selection of teams was essentially blind as we did not select the teams on the basis of communication or work practices but the basis that they met the criteria described above.

The interviews involved three ten-minute sessions with each team member. So that we could compare the reasoning of different team members, we focused the interviews around the management of one patient, but we did not interact with that person. We directed the
interviews towards the initial concerns that the health professional had, their priority for intervention, their satisfaction with the ongoing treatment, and what they considered was the most important information for the client. After the patient had been discharged, we conducted a final 30-minute interview with each team member. This interview centred on analysis of the ten-minute interviews and asked the participants to comment on what they saw as their major contribution to the client’s rehabilitation and their understanding of the roles of their team members and the links among them. The interviews were taped and transcribed verbatim for analysis. Throughout the period of conducting the interviews, we also kept field notes documenting our observations of communication between the professionals, their non-verbal reactions in the interviews, and the group dynamics in team meetings.

Ethical approval
The project was approved by three ethics committees – one from the educational institution supervising the project, and two from the district health boards associated with the hospitals. Confidentiality was ensured for all health professionals who contributed to this project, their written consent was obtained and all participants advised of their right to withdraw from the project at any stage.

Data analysis
We used a multi-stage approach to data analysis. In the first two stages, our focus was on the individuals in each of the teams; in the third stage, we made comparisons across the two teams. Trustworthiness was enhanced by having the analyses checked independently by the different researchers (after Taylor & Bogdan, 1998).

Stage 1. We read each interview transcript to identify statements that indicated the communication pattern used within the team. We specifically noted the following:

1. Reference to other team members
2. Reference to interactions between team members
3. Comments indicating shared understandings and shared patients’ goals.

We reviewed the field notes to identify comments relating to the management, organization and leadership within the team.

Stage 2. We shared our identified themes and field notes with one another and agreed on a framework that would allow us to map and categorise interview statements and the observations collected for each team. Following presentations on this study at professional forums, the framework was refined as a result of feedback from our colleagues the final four themes were:

1. Shared understanding between professionals
2. Interactions affecting patient outcomes
3. Lack of communication
4. Valuing of other team members.

Stage 3. The Stage 2 data indicated differences in the language used within teams which suggested a difference in the shared understandings. To confirm our impressions, we
conducted a simple search of the final interview data, which indicated that one team used the word “we” more frequently than the other (100 times for the former team and 34 for the latter). Having confirmed a difference in language usage between the two teams, we developed a typology and coding system that allowed us to conduct a more robust analysis of the language used (after Taylor & Bogdan, 1998). The two elements of the typology were:

- Evidence of shared goals
- Referral to other health professionals.

To identify statements that illustrated these two elements, one researcher reviewed and coded the data from the Stage 2 analysis then the other two researchers tested the reliability of the coding by also applying the codes to the grids.

Results

Our initial analysis focused on identifying the language that team members used when they spoke about their interactions with each other and on their shared understanding of patient communications. The two multidisciplinary teams that participated in the study are referred to as A and B and the findings are summarized under each if the four themes listed above.

Shared understanding between professionals

There was considerable evidence that Team A worked co-operatively and shared many common understandings and goals. The following comments from the team members are typical of how they spoke.

**Doctor**: “We are not getting far with rehabilitation.”

**Occupational therapist** (commenting on a combined session with physiotherapist): “We meet on a Thursday and plan . . . . . . I can watch the transfer techniques.”

**Physiotherapist** (referring to working with an occupational therapist): “We plan the session together; we were going to look at standing together so that the OT could attend to [patient’s] clothing.”

**Speech/language therapist**: “[I] discussed with the OT regarding level of cognition and understanding.”

**Occupational therapist** (in reference to working with the physiotherapist): “She can do the sitting balance where I can purely concentrate on her cognition and perceptual side of it rather than having to balance the patient at the same time so [the physiotherapist] is facilitating in the normal movements and patterns while I can just sit back and do my side, and it does work well.”

In contrast, in Team B, there was considerably less evidence of working collaboratively. The team members tended to refer to the role of others in a way that suggested they were aware of their patient care contribution rather than actively seeking out their support and advice.

**Occupational therapist**: “[The] physio showed me what she [patient] can do, that is, walk with [the] frame.”

**Nurse**: “She’s [patient] still independent . . . . . . . . . . this is purely my interpretation; [it] is that she needs to have that assurance.”

**Psychologist**: “[The patient] had a joint session with the OT.”
The field notes revealed that the use of patient documentation was an element that contributed to a shared understanding. While both teams held regular formal meetings to discuss patient’s progress, it was noted that team A made frequent use of progress notes held at the nursing station to both record and to check in for any updates. This included a daily discussion around the progress notes. (Each team member following any patient/family interaction completed the patient notes.) Team members reported referring to each other’s notes in the interviews and team/family meetings. This regular discussion of documentation was not observed in Team B.

Interactions affecting patient outcomes

For Team A, decisions that affected patient outcomes appeared to be made as a team, with team members acknowledging individual contributions.

Doctor: “The SLT tried to help us work out whether there was a language problem as part of her stroke or [whether it was] related to her delirium.”

Occupational therapist: “We had a family meeting last week and the decision was made that we were going to give her a couple of weeks because she started making some real progress…there is still some potential.”

Nurse: Describes a discussion with the physiotherapist about walking the patient and “just doing careful transfers”, which had resulted in the patient “transferring fine”.

Physiotherapist: “[There is good] communication between all of us, I think, and is on this ward brilliant and primarily with this management, goal setting. I think that was really, really important in B’s case because she changed quite dramatically; we actually all knew where we were heading.”

For Team B, there was evidence that clinical decisions made by individuals drew on other health professionals’ information.

Doctor: “…major person also involved is the physio…gives lots of feedback and identifies what needs to be worked on.”

Psychologist: “I felt the occupational therapist was trying to push this issue but the patient was saying, ‘I do not want to know about this.’…It resulted in the trial [to have the patient go to a flat] not being carried out.”

Lack of communication

There were only three examples of this for Team A, and these referred to communication about test results and information from others outside the team.

Nurse: “It was the experience of the consultant that enabled us to get on to [the] back-pain problem, because we [the nurses] were not fully believed”. [Note: The reference here is to a health professional external to the team.]

Evidence of lack of shared understandings among the Team B members came from field notes and comparison of responses to a particular issue as well as from statements about team communication problems. On one occasion, for example, there had not been a team meeting due to a holiday, and the impact of this was that the team members had different understandings of a patient’s setback. These included “back pain” (doctor), “hip and knee
“pain” (nurse), “pain in affected leg” as well as “not enough walking over the weekend” (occupational therapist) and “[pain due to] position of her leg on bed-rest” (physiotherapist). Later in the progress of the patient, the doctor said that her lack of progress was “limited by pain in right knee” while others in the team attributed the lack of mobility and slowness to the patient not being confident. Team members seemed unsure of others contributions and for instance, the occupational therapist said that the patient “has had nerve conduction studies but I do not know what came out of that.” Also, the physiotherapist “felt uninformed” [about the “mood issue”] and also wondered if people were “guarding their own patch”. In some instances, lack of collaboration was specifically referred to, e.g., the physiotherapists considered that bed transfers were “everyone’s problems to solve” and did not agree with others who said she should solve this problem. The psychologist noted that “the communication of goals is not adequate and the patient has no idea what they need to do”.

Valuing team members

A wealth of quotes and examples of valuing team members were evident for Team A, and the examples included here are only a small proportion of these. Team members indicated that there was not only an understanding of one another’s roles but also of the necessity for joint communication and for knowing and understanding what each team member was contributing to both patient care and team functioning.

Doctor:
“I rely on hearing from the nurses how the patient is.”
“The nurses are very good at picking up the subtle changes.”
“I very much value working in a team and having the input of all the other team members.”

Nurse:
“Physio role is very much part of the team, advising us and liasing together about common goals and what we can do – what this person’s able to realistically achieve.”

Physiotherapist:
“Optimum communication between all of us… on this ward, and primarily it is management, goal-setting. We all knew where we were heading – we all knew we were heading together, so that we weren’t all working separately and pulling her in completely different directions.”

The statements from the Team B members tended to focus on what they perceived the value of the roles of others to be. They did, however, recognize the contribution of individuals to patient care. In contrast to Team A, the Team B members said very little about communication.

Doctor: “I am dependent on team input as [I] only see her [the patient] for 15 minutes.”

Occupational therapist (regarding the physiotherapist): “I think we work quite closely together” [this referred to knowing how to transfer and walk the patient.] However, she also said: “I am in limbo – waiting for the physio to tell me [what is needed].”

Physiotherapist: “The OT is going to take her [the patient] on a home visit.”
Language usage

These results described above were further refined to allow us to compare the language and phrases used by team A & B. Table I shows how we developed the analysis typology and includes a sample of statements drawn from the full data set.

Note that Team A members used inclusive language to a large extent when describing their discussions and the recommendations made by other team members. Also, their discussions centred on being part of the team. Team B members simply acknowledged one another’s roles.

The Team B physiotherapist exemplified this language difference between professionals when discussing team functioning. For instance, when talking about an earlier team she had worked in, she immediately changed her language by frequently using the inclusive term “we”. She appeared to be recalling a strong identity as a member of a collaborative group – an identity that was not apparent in her language describing her current work environment.

Summary

Table II is a summary of the differences in the two teams with team A being compared to an interprofessional team and team B to a multidisciplinary team.

Discussion

The results from the analysis of the communication patterns and language used confirmed the researchers subjective observation that the two teams had different styles of working and that this was evident in their communications with and about one another. Both teams worked together to meet the needs of the patient in ways that were satisfactory to the majority of the team members. However, they used different communication strategies to coordinate their services even though both had regular team meetings. Team A (the interprofessional team) met informally every morning to update knowledge and shared understandings of the patient’s situation by reading the progress notes and revising treatment goals. It was apparent that these records were a regular source of communication between the Team A members. So, too, were informal conversations, as indicated by the occupational therapist’s comment about ongoing discussion “in the corridors”. The framework that Team A had established for patient documentation rested on such principles as consistency of terminology and ease of understanding between team members. The multidisciplinary team (B) was very dependent on ward meetings to convey information and make decisions about the contribution of the individual team members.

According to Opie (2000), “the beginnings of shared linguistic practices” (p. 39) mark the development of an interprofessional team. This confirmation that inclusive language is one of the hallmarks of an interprofessional team has implications for team leaders who wish to work in this way. For example, it would be important to role model the use of inclusive language when talking with the members of their teams. Raising awareness of language in this way could also be an important factor in influencing effective collaborative behaviour.

As noted earlier, Glen (1999) presented a forceful argument for members of professional teams needing to be clear about their own professional roles and values and to communicate these to the other members of their teams. In the present study the clarity of role identification was not a discriminating factor between the teams. Both teams understood and valued the roles of each team member although they worked in different ways – cooperatively and in parallel. Thus it seems that while role clarity is necessary for team
<table>
<thead>
<tr>
<th>References to one or two other professionals</th>
<th>Examples of a shared perspective across the team</th>
<th>Analysis proposition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Team A</strong></td>
<td>“Nurses have been brilliant, kind of been a bit of everyone.”</td>
<td>“I rely on the people that are caring for her.”</td>
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<td></td>
<td>“The speech and language therapist was quite involved with that, making sure that she was on the correct diet.”</td>
<td>“Very much part of the team, advising, liasing.”</td>
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<td></td>
<td></td>
<td>“We had a lot of kind of overlap of areas.”</td>
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<td></td>
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<td>“We will discuss her care and if she [patient] is in agreement, we will…”</td>
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<td></td>
<td></td>
<td>“[We are]…carrying out what [the] therapists have recommended.”</td>
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<td>“We all make our recommendations on our professional findings but the consultant has the final say in the discharge plan.”</td>
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<td>“[We are]…making everyone aware” (referring to patient’s delirium).”</td>
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<tr>
<td><strong>Team B</strong></td>
<td>“Physio gives lots of feedback – identifies what needs to be worked on.”</td>
<td>“We have not got to the bottom of the issues.”</td>
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<td></td>
<td>“I think we [physio and OT] work quite closely together.”</td>
<td>Health professionals recognize others – liaise with and talk to others.</td>
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<td></td>
<td>“I am sort of in limbo waiting for physio to tell me.”</td>
<td>Sense of a range of people caring for the patient.</td>
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<td></td>
<td>“The OT and social worker work closely.”</td>
<td>Health professionals need to know one another’s roles and to draw on one another’s observations.</td>
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<td></td>
<td>“We read the notes and see what the physio has done.”</td>
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Table I. Analysis typology of the words/statements used by members of Team A and Team B.
Table II. Summary of the differences in communication patterns of Team A and Team B.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Team A (Interprofessional)</th>
<th>Team B (Multidisciplinary)</th>
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</thead>
<tbody>
<tr>
<td>Shared understanding between professionals</td>
<td>Team members worked co-operatively and shared many common understandings and goals.</td>
<td>Individual team members worked in parallel, noticing others’ contributions to patient care and passing on information.</td>
</tr>
<tr>
<td>Interactions affecting patient outcomes</td>
<td>There was a level of professional communication that went beyond an understanding of roles to a commitment to joint communication and a genuine valuing and interest in what each team member was contributing to patient outcomes and the common goals.</td>
<td>Clinical decisions made by individuals drew on other health professionals’ information.</td>
</tr>
<tr>
<td>Communication</td>
<td>There were clear communication processes within the team.</td>
<td>There were fewer statements that reflected team communication.</td>
</tr>
<tr>
<td></td>
<td>Very few examples of failed communication channels.</td>
<td>Team members’ comments exhibited a lack of common understanding of patient management issues which had the potential to impact adversely on intervention.</td>
</tr>
<tr>
<td>Valuing of team members</td>
<td>Clear understanding of each others roles and the need to be a team member and contribute to and learn form team opinions and solutions.</td>
<td>Recognition of all the team’s contribution.</td>
</tr>
<tr>
<td>Language usage</td>
<td>Language was inclusive with frequent use of the words “team” and “we”.</td>
<td>There was minimal use of inclusive language, but the contributions of team members were valued.</td>
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</tbody>
</table>
functioning, it is not the hallmark of the different styles of teams. Rather, the hallmark seems to relate more in the attitudes each person within the teams held about himself/herself and towards the others. As described by the literature (Atwal, 2002; Crepeau, 1994) being able to state opinions freely and feeling valued may well be the most important features of a collaborative team approach.

In this regard, there is room for research on the essentials for empowering all members of teams.

Health professions working in a team (such as these rehabilitation teams) are also members of a particular profession so have these professional team alliances as well. This dual membership was well illustrated by Team B. For instance, the medical and nursing professionals referred to themselves and each other as the “medical team” and the “nursing team”. The occupational therapist, physiotherapist and social worker all referred to “liaising” among “themselves” (that is, the members of their own profession) before admitting a patient to the rehabilitation and assessment ward and when planning post-discharge services. This points to the need for health professionals in teams to remain mindful that they need to foster this dual membership. (see Wheelan & Hochberger, 1996, in this regard).

This issue of allegiance raises interesting questions around who provides supervision. Should it be the professional expert or the rehabilitation or service delivery specialist with generic skills who provides supervision? It also calls for examination of how to maintain competency at a level that satisfies membership of both the profession and the service delivery team. From the perspective of the individual team member, it takes energy to maintain this dual competency – a concern that suggests possible future research questions. Does a person have to sacrifice some of the skills (or level of skills) required of a health professional in a specialist profession so that he or she can fulfil the expectations of being a team player, and if so, what are these? How can he or she maintain the balance and what are the implications for the maintenance of competence and continuing professional development plans? This last question also raises questions regarding the undergraduate education of the relevant health professionals. For example, how can institutions best prepare students to work in teams? The teaching of clinical reasoning, role-sharing, how to work with others, and the appropriate language to use also come into play here. Even the selection process is relevant, with selectors looking out for qualities that predispose a person to being a team player.

Although the literature implies that bringing a multiprofessional approach to health teams contributes to different ways of working with patients and impedes common understandings among team members (see, for example, Freeman et al., 2000), this was not evident in this study. We could find no pattern suggesting that Team A or Team B included or excluded particular individuals or undermined effective functioning. However, one individual team member who had worked in various teams could readily identify “better” teams, and these were collaborative. What may be at stake is not professional difference but “team attitude”. An attitude that may be developed, maintained and strengthened at least partly through language and communication patterns within the team. We, in line with commentators in the literature (Atwal & Caldwell, 2002; McCallin, 1999) consider that this responsibility resides with the team leader and merits further study.

Conclusions

The symbolic interactionist approach was piloted in this study as a way of highlighting the complex interactions that occur in teams and how this shapes individuals’ understanding of
themselves and others within the team. We believe this approach has allowed us to map what team members accepted as “normal” in relation to their interactions and expectations of one another. As identified in this study, working in a multidisciplinary team is based on recognizing professional expertise and dividing the labour accordingly, whereas working in an interprofessional team requires greater sensitivity to social issues within the team and willingness to share roles to develop collaborative ways of working.

Where team members have a sense of belonging and mutual sharing; this is reflected in the language which is steeped in innuendoes about collaborating. Once a health professional has worked in this way, it is evidently frustrating to be in an environment where expectations for collegial work are limited. Apart from one member of the multidisciplinary team, there was little awareness that there was another way to operate, which raises the question about how teams learn the difference between multidisciplinary and interprofessional team relationships. It seems likely that this needs to be experienced to be appreciated. The literature makes the point that effective teamwork is an indicator of a satisfactory work environment and in a health environment where resources are continually squeezed may prove to be essential to maintaining a motivated work force. For this reason, the fundamentals necessary for effective team functioning warrant greater exploration.

References


