

Growing Pains: Health Care Enters “*Team*”-Age

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PALLIATOR’S DIARIES

“**H**HEY SHARON,* do you have a minute?” I walked into our palliative care social work office and caught her just as she was rushing out.

I was entering the second quarter of my fellowship and I knew just enough palliative care to be both cocky and dangerous. I had mastered the opioid dose conversions in the first couple of months and also knew how to prescribe most palliative care medications appropriately. In fact, I felt that this palliative care business was pretty easy overall and I was beginning to enjoy myself. It was basically the same medications like internal medicine and mostly the same issues. The only snag that I could see was the high mortality rate of the patients. Once I got over my initial shock and learned to deal with that, there was (seemingly) not much else to it.

“I literally have about a couple of minutes as I am going into an important meeting with my boss,” Sharon said.

“Oh! I won’t keep you then. I am going to meet with Mr. C’s family in about 20 minutes. Just wanted to keep you in the loop, that’s all!” Mr. C was an 80-year-old man with advanced dementia. He was nonverbal, bed-bound, and receiving artificial nutrition and hydration at the insistence of his family. I had recently done a literature review on this topic. As the evidence on artificial nutrition in advanced dementia was not very positive, I decided that it was time to put a stop to this futile treatment on my patient.

“Why the sudden meeting? Is there a problem?,” enquired Sharon guardedly. Years of social work expertise (and dealing with medical trainees like me) had fine-tuned her senses and she had an uncanny knack for picking up on potential trouble.

“Nothing really. It is pretty straightforward. I am just going to discontinue his feeding tube.” I stated airily, getting ready to leave.

Sharon’s ears perked up. “Does his family know about this?”

“Of course,” I assured her. “I talked to his daughter on the phone and she is on her way.”

“Which daughter: Hannah* or Suzanna*?” said Sharon, looking a little alarmed.

“Don’t remember her name. It is the local one. Why, does it matter?”

Sharon was beginning to look a little harassed. “Hannah, who lives locally, is the stepdaughter. Suzanna, who lives out of town, is the decision-maker. The artificial nutrition issue is a touchy one for Suzanna and she and Hannah don’t get along. I have counseled them about this issue many times,” she explained painstakingly.

Peering hurriedly into her wrist watch, she continued, “I am getting late for my meeting. Does Jim (palliative care attending) know about your plan? I assume he is running the family meeting?”

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*Names have been changed.

"Nope. He is teaching on campus. I guess, I'm in charge," I grinned.

"Have you run a family meeting before?" asked Sharon, now looking distinctly alarmed. "Do you have a plan?"

"A plan for *what*?" I was starting to get a little annoyed. Sharon's questions were making me feel like a very green intern once again. "I will meet with this Hannah or Suzanna or *whoever*, just inform her about the plan and then pull the gastrostomy tube. I have already turned down the feeding volume."

Looking a little queasy now, Sharon requested, "Can you give me a minute?" and quickly went back into her office while I stood awkwardly outside, wondering uneasily if I was maybe missing something.

Behind closed doors, I could hear Sharon calling her boss. Muffled phrases like "have to cancel," "it's a clinical crisis," "brand-new fellow," "very green," "completely clueless," came through the thin office walls despite my valiant efforts to blank them out.

Sharon emerged from her office a few minutes later with the determined stride of a field marshal. "Guess what? My meeting just got cancelled unexpectedly. This is great as I can help you with the family meeting. Let's chat first so that we are on the same page."

Postscript: For those of you who may be wondering about the outcome of that fateful family meeting, suffice it to say that Sharon and I are now good friends. Whether this is a testimony to her enduring patience or to my accrual of palliative care skills is a story for another day.

DISCUSSION

THE DAYS of the lone-ranger clinician are over. The "parallel play" model of health care, with each discipline structuring cross-sectional interventions in a silo, is terminally ill and on firm do-not-resuscitate status. The era of chronic illness has begun and this has completely rearranged the terrain of health and illness. Chronic illness management is best done by health care teams where the team members are willing to play

in the same sandbox and work collaboratively on an ongoing basis toward a common goal.

WHY TEAMWORK?

Teamwork is a complex and time-intensive endeavor. It is also true that a simple problem that can be solved by the cross-sectional intervention of a single clinician does not need a team approach (for example: prescribing antibiotics for an upper respiratory infection in a healthy adult). However, patients with chronic illnesses have undulating and unpredictable health trajectories that often result in a variety of ongoing health care needs that ebb and flow over time. Such patient needs are well beyond the scope of any individual clinician. The modern patient with chronic illness needs a group of multidomain experts who work together and interdigitate longitudinally to collectively orchestrate chronic care.

COOPERATIVE TEAMS VERSUS COLLABORATIVE TEAMS

While the need for teams in health care is well acknowledged,¹⁻⁵ most teams still focus on cooperative work flow instead of collaborative work flow. Some key differences between the two modes are:

1. **Organic structure:** A cooperative team is like a group of unicellular organisms that decide to work together towards solving a problem. A collaborative team is like a multicellular organism that engages in a coordinated, synchronous activity that is the result of iterative attempts to construct and maintain a shared understanding of a problem. Distributed responsibilities allow the collaborative team to process massive amounts of patient information, reducing the cognitive load on individuals.⁶
2. **Rules of engagement:** Cooperative work is accomplished by the division of labor among participants into activities where each person is responsible for a portion of the problem solving and there is often minimal sharing of information. In contrast, collaboration involves the mutual engagement of participants or stakeholders in a coordinated effort to solve a complex problem.⁷ In a collaborative process, different team members provide generous access to their domain knowledge and this collective pool of knowledge results in a synthesis of solutions for functionally and temporally distributed tasks.

3. **Communication and collective problem solving:** Just like a multicellular organism, the collaborative team should strive to create and maintain the same internal milieu in which there is free ongoing access to information and the ability to collectively process and assimilate new data. The aim of collaboration is to synthesize creative modes of solution/palliation for complex problems that are well beyond the scope of any individual. Thus in a collaborative team, the individual members often hold key pieces of information that may not be of much value by itself. But when such information is shared and processed collaboratively, the team members are able to construct the underlying story which often results in shared meaning and emergence of novel solutions. In contrast, cooperative teams typically share information on a need-to-know basis thereby restricting collective problem solving.
4. **Role shifting:** Role shifting is common in collaborative teams where one member may serve as a teacher in relation to one aspect of a complex problem, but may need coaching to manage another aspect of the same problem. It is to be noted that within the collaborative state there can be sub-processes that are cooperative or even ones that may be associated with conflict.

As Dr. Foley describes in her pioneer essay,⁸ collaborative efforts are essential in order to create robust model health care programs and novel ideas that will set the standards of research and care.

SUCCESSFUL COLLABORATION IN A HEALTH CARE TEAM

Some key factors (adapted from the model proposed by Matlessich et al.)⁹ that are a prerequisite for the success of a collaborative team are:

1. **Team Purpose:** Time should be spent in identifying a clear vision that is shared by all the team members. Once identified, the team should engage in vision building actions and identify the roadmap to actualize their vision.
 - a. **Concrete and attainable goals and objectives:** A collaborative should work together to identify very specific and concrete short and long term goals and objectives that are both visible, attainable and also directly related to their vision. Concrete goals will heighten enthusiasm and fuzzy abstract goals will diminish enthusiasm. Collaboration *per se* should not be a pri-

mary goal. Instead, collaboration should be a behavior that is used to achieve the primary goals.

- b. **A step-wise approach to success:** A collaborative team should experience a progression of small successes in order to continue the collaborative process. Defining success too narrowly or distantly will clamp down the morale and fragment the team.
2. **A Conducive Environment:** A favorable socio-political local climate is necessary in order for the team to succeed. If the goal of the team is to effect system-wide changes, it is critical that the environment will permit (or at least not prevent) such changes. It is critical that the team leader should be a person who is recognized and respected as a legitimate leader within the local organization. In addition, the team itself should be perceived as a leader within the local community as related to the goals that it is setting out to accomplish. It is important to take time to assess the environment for its conduciveness to success. If perceived to be less than optimal, time should be devoted to strategically optimize the environment.

3. Essential Resources

- a. **Beyond activism:** While a functional administrative structure and adequate financial support is needed on an ongoing basis, they are critical especially during the initial phase. It may be somewhat unrealistic for the budding team to devote energy to the tasks at hand if they are distracted by the need to secure funding to support their salaries. While individual efforts and activism may be sufficient to create a fledgling palliative care team, long-term team growth is well near impossible without adequate financial support from local organizational leaders.
- b. **Building alliances:** Significant effort must be devoted to creating and fostering strategic in-trainstitutional and interinstitutional alliances and partnerships as accruing “political chips” and securing in-kind support is very valuable.

4. Team Structure and Process

- a. **Transparent administrative structure:** Identifying priorities, defining the scope, roles and responsibilities of individual members is a key early step. While the principles of democracy are helpful in identifying the team leader, it is unrealistic and unduly chaotic to practice

democracy in making decisions on a day to day basis. While individual team members may take the lead on specific tasks related to their domain expertise, the need for an overall process leader is emphasized.

- b. **Trust is a must:** A significant part of the team leader's time should be devoted to analyzing and strengthening intermember relationships and creating a trustful atmosphere. Building trust will eventually result in transparency in team member agendas and also a willingness to share both information and honest opinions.
- c. **Mediating conflict:** True ongoing collaboration will inevitably result in productive conflict. Productive conflict is a good prognostic sign as it indicates that the team members trust each other enough to share their honest opinions. A key role of the team leader will be to serve as a skilled mediator of conflict on an ongoing basis.

5. Citizenship

- a. **Learning to work together:** Team members should have a realistic and respectful understanding of each others values, cultural norms, expectations, and limitations as pertaining to their work together. New teams should invest significant time to learn about each other and to learn to collaborate in an efficient and mutually acceptable manner. The membership of the team tends to change over time. Any change in membership should serve as a trigger to review and readjust the team's working styles to accommodate the new members and to avoid getting overly attached to old ways.
- b. **What is in it for me:** Team members should have a clear sense of ownership in both the way the team works and in the product of such work. They must see that collaboration to attain a common goal is in their self-interest. Their incentives should be tied to and their success should be aligned with that of the team to ensure ongoing productivity.

- 6. **Communication:** A team should have structured time for both formal and informal communication. The communication principles are helpful in dealing with both fellow team members as well as others.

- a. **Catch them doing something right:** Look for positives and draw attention to what you appreciate. *"Perfectly timed palliative care consult. I*

always enjoy working with you because . . . (fill in the blank).

- b. **Comment on effort:** It is important to validate effort even if such effort has been ultimately unsuccessful. Statements like "You are very thorough" "You sure have put in lot of work on this challenging problem" help boost the morale even in the face of failure.
- c. **Stress on behavior accountability:** Reinforce positive behavior and point out negative behavior (preferably in private) gently in a calm and matter-of-fact manner.
- d. **Sell solutions not expertise:** While it is often easy and usually helpful to identify problems, more energy should be focused on identifying solutions.
- e. **Net gain principle:** In order to foster ongoing relationships, keep the net gain of any intervention more than or equal to one. This has also been described³ as the help-hurt¹⁰ ratio:

$$\text{Help/Hurt ratio} \geq 1$$

- 7. Thus, when working with others, care should be taken to ensure that the sum totals of our interventions are *perceived to be* helpful. Thus our efforts should make them feel that we are decreasing the volume and complexity of their workload rather than increasing it.
- a. **Celebrate success:** Ask the team members to identify what success would look like. Then point out and celebrate even small successes as and when they occur.

To conclude, Victor Hugo once said, "There is one thing more powerful than all the armies of the world, and that is an idea whose time has come." The time for health care teams has come.

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