Multi-disciplinary Teams at Waikato Hospital

The View

from social work

Outline of presentation

- Rationale for study
- Study itself
- Discourse analysis
- Conclusions

Research Question?

- How do the MDTs at Waikato Hospital look from the point of view of social workers who are the teams?

What the research involved

- Masters of Education, Waikato University

- Ethical approval – Waikato Hospital, University, Te Puna Oranga: Confidentiality for participants

- 11 social workers from Acute team interviewed: 8 individually and 3 in a group

- Open questions derived from literature

Rationale for study

- Time and resource

- Why social workers? – group theory and skills inter-personal and collaborative practice are core

- Strength of study

Some background research

- Cochrane Collaboration (2009) cite numerous international studies - poor inter-professional communication, organizational culture –impact patient safety and care (Zwarenstein, Goldman & Reeves, 2009)

- United States infant death and injury during delivery events investigation system– communication root cause 72% of 47 cases looked at (Joint Commission, 2004).

Some background research

Zwarenstein et al's (2009) research – 5 quantitive studies concluded:

- The extent to which different healthcare professionals work well together can affect the quality of the health care that they provide. If there are problems in how healthcare professionals communicate and interact with each other, then problems in patient care can occur" (Zwarenstein, 2009, p. 2)

- Qualitative research as well as quantitative- increases our understanding. continual examination, particularly for complex cases

Social work and Inter-disciplinary collaboration

- USA -wide study by Liepzig, et al (2002) Social workers value inter-disciplinary collaboration more, have more knowledge, experience and skills in collaborating. Higher expectations of value of Teams.

- MDT work is one of seven key domain's Practice Framework for Health Social work (Haultain, 2013)

- Dual professional responsibility of improving systemic factors (ANZASW Code of Ethics, 2003)

Social Determinants of Health

- Complex relationship between health and well-being, socio-economic factors, social participation well understood

- Contextual factors such as housing, employment, poverty biggest determinants of health outcomes (WHO, 2011)

- Social workers understand this relationship – skills knowledge perspective

Medical Dominance and Definition of Health

- Medical dominance maintained -powerful entities medical profession and multi-national pharmaceutical companies

- They influence accepted definition of health through their control of which aspects of health enter the political arena.

- Bambra, Fox , and Scott - Samuel (2004) argue that health in developed countries is defined one-dimensionally and individualistically as the absence of disease.

- Medical health systems, hospitals, their administration, not social determinants of health, are housing, poverty and employment, not part of this focus

Medical Dominance and Definition of Health

- Broader definition of health as a political concern:

- Health is political because, like any other resource or commodity under a neo-liberal economic system, some social groups have more of it than others. Health is political because its social determinants are amenable to political interventions and are thereby dependent on political action (or more usually, inaction) (Bambra et al. 2004, p.187).

Discourse Analysis

- Within certain institutional and social contexts particular disciplines and practices are privileged and dominate, disempowering other disciplines and ways of practising that are within the same institutional space (Foucault, 1978)

- Discourse – reveals power relations

- Power differences between different MD team members is very evident . Who has most influence in deciding what priorities are given attention, what type of knowledge is given attention, meeting processes.

Dominance of medical knowledge

- Medical knowledge dominance omits, dismisses renders invisible other types of knowledge.

- Dominance can detract from quality of MD team work compromising patient care

- Team members involvement restricted by differential status (Atwal and Caldwell, 2005)

- Silence by MDT members - knowledge and expertise not available in team discussions.

Dominance of Medical knowledge

- *So you have to feel the MDT is a welcoming place and a place where you feel like you can contribute ……..without feeling you have to make an excuse for opening your mouth or that you'd better have something really good to say before you even think of opening your mouth …*

Dominance of medical knowledge

- *In this environment it's still quite hierarchical so it defers often to medical opinion, I think in the ideal world that we would be working together and it would be crucial for the doctors to attend those meetings and if possible attend them quite regularly or if necessary send someone to attend because that's the only way that communication can happen is through them. My experience has been that often many medical teams will miss the information in the notes , that's not all but some do and they miss the recommendations that have been made by the MDT in the notes and they miss that .*

Medical Dominance

- *I do think we are in a good place to facilitate those meetings because I find that the social work role sits in the middle of all those other ones and in communicating keeping that communication and to me and again it's maybe my personality but it's about communicating and clarifying that communication. We are trained as facilitators, we know how to run meetings and I think we should be running those meetings.*
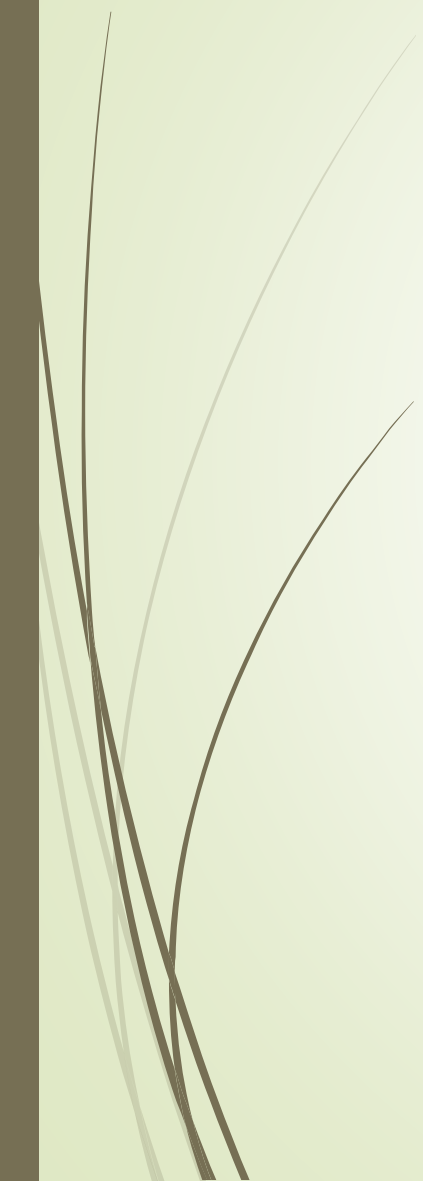
Site of disease discourse

- Good (1994) medical case presentations – patient is related to as the `site of disease' -focus of medical concern a project to be acted upon using scientific method.

- Not asserting that medical professionals are not compassionate or highly committed to holistic health ideas and practice.

- It *is* to assert that a narrow view of patients can be unconsciously adopted by the whole team as the mode of discussion and can limit options for work by teams.

- Opie's (1994) research highlights what happens in MD teams when attention is upon purely medical or physiological factors rather than areas such as organisational/structural and psycho-social factors which can broaden perspectives.

Site of Disease discourse

- *They may be missing some of the psycho- social factors that may impact on health and discharge planning so it can be frustrating when the don't value some of those things as highly as I would and the medical teams don't attend the meeting so we have to run around and try to get everyone on the same page.*

Site of disease discourse

- When site of disease discourse combines with dominance of medical knowledge over other forms of knowledge– easy to see how knowledge of psycho-social aspects are discounted as irrelevant or `missing the point'

- Opie's (1997) finding: awareness of narrowed `site of disease' view . Can decrease teams' effectiveness and disempower patients.

Site of disease discourse

- Power imbalance between patients and staff

- Baillie's (2008) research: what impacts on patient's sense of dignity/control while in hospital? Staff's manner has largest impact.

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Site of Disease discourse

- *There are difficulties in family meetings when there's dominance and overload of information as if it were a medical meeting. When there is no family involved you can use all the lingo you like, but when there are family members involved problems occur when staff run ahead of where the family are at in terms of terminology, planning, assumptions. They (doctors) bring their own world view their own expectations and the family isn't elevated enough. But actually we are all here to serve the family. So when it's not family centred, when its medically centred, it is a disempowering experience for the family not empowering.*

Site of disease discourse

➡ *That does happen quite regularly where there's tunnel vision, where you've done your piece, you've looked at this organ or from **** view on our wards purely can they walk and if they can't walk, do they need an aid, so any other **** doesn't really happen on my wards so their focus is just on that and they will make a recommendation just on that and you think but there is all these other factors, but according to *****- Discharge home!*

Site of disease discourse

- *I find there's reality: complex issues are complex! That's just the reality of it! And somehow we want to simplify it we want one little diagnosis but we actually can't and aren't ever going to a make it simple.*
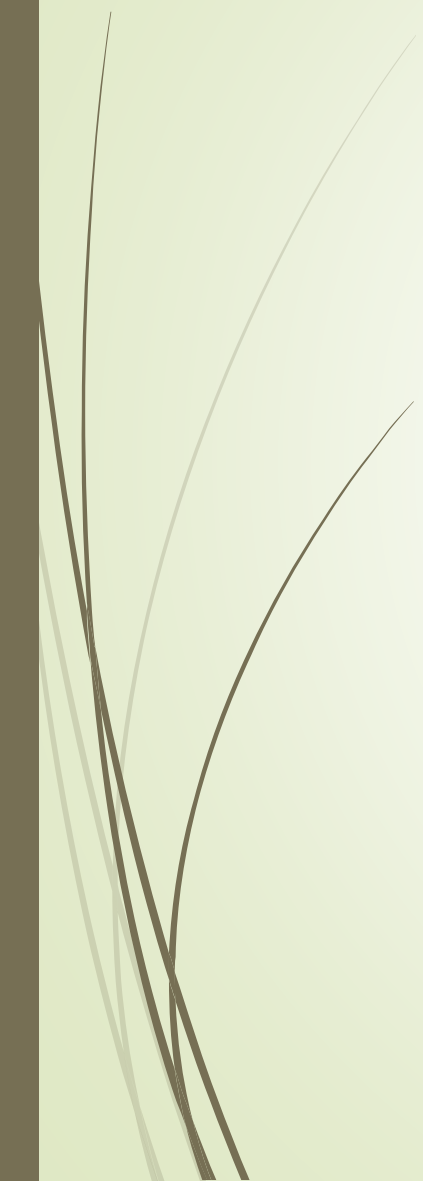
Risk Discourse

- Pre-occupation with being organised in response to risk and the notion of controlling the future (Giddens, 1999).

- Defensibility of decisions rather than quality decisions

- Overzealous consideration of risk - oppressive practice (Browne, 2011).

Risk Discourse

- Social workers are commonly involved

- When the risk discourse prevails alongside the demoted position of knowledge and expertise - pressure to practice defensively constituting oppressive practice.

- Reflective practice client-centered ethical focus promoting dignity and worth, self-determination and human agency (Beddoe, 2014).

Risk discourse

- *I found that the CNM can be quite judgmental, especially if its someone like a mental health patient. Some of the nurses can be very judgmental right from the start so it makes it difficult to work with them around best outcome for the client because they have a particular view of this client so you try to get the best outcome for the client but there's this bias. That makes it really difficult to work in a team.*

Risk Discourse

- *It's about taking that more holistic view of a client and advocating for them if necessary, being open minded as to what is the best outcome for this client and that can be quite an interesting dance. You've got to listen to the opinion (of staff) because it could be a safety issue for a child but at the same time you don't want it to be clouding your judgement or your perception. We are there to advocate for our client and have empathy, empathy is a big one because sometimes that is missing from the nurses so if we get our chance we introduce that to the conversation, the discussion about the client -the client's voice.*
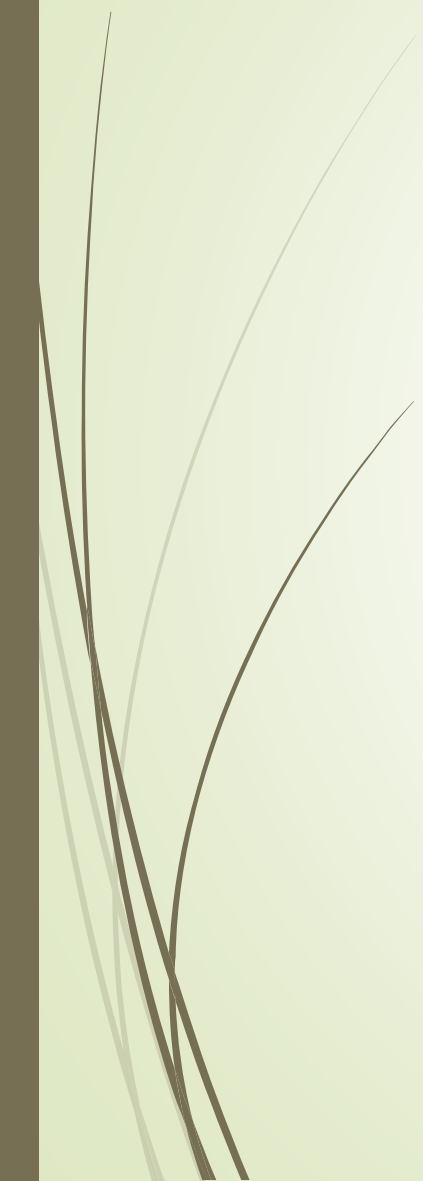
Risk Discourse

- *Because we often get women who come in and go directly to theatre and then go straight home and may have come straight through ED really quickly and have not been properly assessed for family violence. Or young men with assault injuries and so it's about trying to find out whether there are children involved which is not often asked. It may be quite a significant fight at home so there can be a teaching role for the social worker as well, giving people the things outside of just the medical.*

Conclusion

- Unexamined unspoken assumption that values medical knowledge over other forms of knowledge compromise work of MD teams

- Evident particularly when patients discharged without consideration of recommendations by non-medical team members

- Strongly medically or nursing dominated MD team meetings are not MD collaboration

Conclusion

- When expertise of facilitating not acknowledged or understood medical knowledge dominance is operating

- When leaders of teams value MD collaboration teams are more effective at collaboration

- Solely physiological, medical, task oriented perspective –limited - compromises quality work of MD teams and is disempowering

- Prevalence of risk discourse can create defensive oppressive practice

- Other knowledge and expertise needs to be valued, utilized and expressed

Conclusion

- Utilization of skilled facilitators for MD team activities

- Social workers need to guard against inadvertently adopting medical discourse that demotes their perspective, knowledge and skills *(suggestion to change name)*

- Social Workers promoting their **entire skill set and knowledge**

- Critically aware, anti-oppressive client-centred social work

- Providing the patient's voice in MDT - implications of patient's health condition in their wider lives.

Thematic analysis

- Purpose of team meetings
- Good outcomes from effective work
- Poor outcomes from poor team functioning
- Social Work Role

Purpose

The CNM sees it as a way of overseeing what's where and making sure they haven't forgotten anything, so it's more about their work …..

It is nursing focused or medically focused, its still very very prominent

Good Outcomes from Effective team work

Everything fits together better and you get a much much clearer picture so the person's going to get a more accurate support system if the MDTs working well.

There were better outcomes because more planning went into their discharge, their ACC payments were worked out earlier they were hooked up with outside services earlier they had their expectations of when they were to be leaving confirmed earlier, they were able to liaise with their family sooner, ……whereas the other wards no one actually knew what was going on…

Poor Team functioning

- Dominated by one person, long winded monologues, people distracted, repeated interruptions, speaking over one another, bringing their own `stuff', very unfocussed and a lot of time wasting.

- *"It was just painful – on the phone during meeting, talking ad-nauseum about things that weren't appropriate just dragged it out"*

- Not valuing the ethos of inter-disciplinary work:

  "Nurse Star views the meeting as 'just another meeting'   doesn't understand or value the need for interdisciplinary meeting and discussion around client's or patients".

Outcomes of Poor Team functioning

- *If we are not working well together the patient has a steady stream of different people proposing different discharge plans. I have had patients who have thought they were going to a rest home and then in patient rehab and then thought they were going home all in a short space of time. It is incredibly confusing and distressing and that's what happens when we are working from different points of view*

Social Work Role: Client's voice:

- *Transport accommodation. All the finance. Finance. budget advisors!*

- *I see it as an opportunity to support staff to see the person we are talking about other than just their health issue. So they will say this is such and such and they are waiting for this procedure and I will say "So where are they from, and who lives at home with them, do we know anything about their family" ….*

Social Work Role: Realist, wider situation

➡ *I also think its being the realist around their social situations; say those stairs. We often find out that information long before the doctors do and we know that that's not going to work, or when the doctors say well they just need to go to a rest home. So you have to go in and say well they are very clear they don't want to go to a rest home and then being realistic about how this is going to work out. Being the realist.*

Social Work Role: Contextual picture; co-ordinator

- *Ensuring family are involved and that other aspects that impact on health such as housing are addressed or at least highlighted.*

- *Very often I feel as though I am the one who joins the dots and I need to be able to step back far enough from my MDTs to see that's how it should be. My experience of it has been that my role is to join the dots and put that all together, so we have a complete picture.*

Social work Role: Supporting communication

- *So much of our role is to say "What I heard you say was this… and allowing for clarification of that and I don't see that with the other disciplines that I work with. I don't see that they check the information they heard or information they've given is the same. I think that we are in a place to facilitate that because so much of our role is around communicating and breaking through some of those communication issues that block the process a bit.*

Social Work Role: educator

- *Ensuring family are involved and that other aspects that impact on health such as housing are addressed or at least highlighted.*

- *I think the SW has a role to play in health and especially to allowing people to take more control of their health issues. That is the main role even though that isn't the focus. I am very clear it is to allow people to have the power regarding their own health issues even though I hardly ever have the opportunity to really promote that in a big way, but that is what I see the role of the social worker being. Make their own choices. I think that is our role.*

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