

Multi-disciplinary Teams at Waikato Hospital

The view
from social workers



Rationale

- MDT work is one of seven key domain's Practice Framework for Health Social work (Haultain, 2013)
- Time and resource – social workers
- Group theory and skills inter-personal and collaborative practice are core - strength
- Espoused approach within Hospital
- Call for ongoing quantitative and qualitative research
(Zwarenstein et al, 2008)



Terminology

- MD team refers to any form of consultation between different disciplines – often but not exclusively scheduled weekly meetings





Methodology



Qualitative study

Practitioner research (opportunity to present at Ground Round)

11 out of 20 social workers from Acute hospital team-

1 focus group

8 individual interviews

Ethical approval : University of Waikato, Waikato Hospital, Te Puna Oranga

Discourses analysis of data

Literature

- 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 between professionals cause 72% of 47 cases looked at (Joint Commission, 2004).





Literature



Zwarenstein et al's (2009) research – 5 high quality quantitative 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)
- Interventions that support positive team work and positively impact on patient care include Inter-professional education, expert facilitation, policy changes to support MDT functioning and maintenance.

Literature

- 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.





Literature



- The impact of factors such as housing, employment, poverty are the biggest determinants of health outcomes – so contextualized psycho-social factors which social workers are focused upon with clients (WHO, 2011)



Literature



- ▶ Opie (1997) important research looking at the functioning of MD teams. Dialogue in team meetings direct influence of discourses impacting particularly in the way patients were represented.

The breadth or richness of a representation of an event, situation, or client can restrict or expand the team's field of play and its perceived options for action, thus highlighting the sociological significance of ongoing work on representations generated in multi-disciplinary teams (Opie, 1997)



Literature



- Within certain institutional and social contexts particular disciplines and practices are privileged and dominate, disempowering other disciplines and ways of practicing that are within the same institutional space (Foucault, 1978)
- Medical dominance subjugates non-medical views, leaving little room for other perspectives – can seem out of place or unconventional (Holmes et al. , 2006)
- Professional hierarchy can limit members' contributions impacting on effectiveness of entire team (Atwall and Caldwell, 2005)

Literature

- Good (1994) research into medical case presentations – patients are related to as the site of disease -focus of medical concern a project to be acted upon using scientific method. It constructs a view of reality. Eg a Noff , the ` pregnancy`
- Promotes a narrow view unconsciously adhered to within a team – purely medical or physiological factors. Psycho-social factors or organisational/structural influences which can broaden perspectives and options for work are not included (Opie, 1994).
- Opie's (1997) finding: awareness of narrowed `site of disease' view . Can decrease teams' effectiveness and disempower patients



Literature

- ▶ 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 (Pollack, 2010)
- ▶ Overzealous consideration of risk, Deficit focus - oppressive practice (Browne, 2011).
- ▶ Social workers need to respond by use of reflective client-centered practice, ethical focus promoting dignity and worth, self-determination and human agency (Beddoe, 2014).






Findings: outcomes of poor team work for patients

- ▶ There were examples of teams functioning well and the positive impact on patients.
- ▶ However social workers provided a lot of material about team not working well together:
- ▶ *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 the space of a few hours. It is incredibly confusing and distressing and that's what happens when we are working from different points of view*




Findings

- *ACC forms had not been done, medical certificates hadn't been done, and patients rushed off the ward to the transit lounge with the promise that things would follow and they didn't follow and the repercussion is that they either re-presented or they are on the phone saying my home help hasn't come .*



Findings : dominance of medical knowledge

- ▶ Lack of skill or expertise in meeting facilitation - mostly lead doctors or nurses assume the facilitation role – knowledge skill expertise of facilitation is not acknowledged or understood:
- ▶ Meetings 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"*
- ▶ *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.*



Findings : dominance of medical knowledge

- All of the social workers commented that they thought they should be facilitating MDT meetings:
- *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, in communicating and keeping that communication workingWe are trained as facilitators, we know how to run meetings and I think we should be running them.*



Findings : Dominance of Medical knowledge

- Social workers talked about the difficulty in getting to speak:
- *“So you have to feel the MDT is a welcoming place and a place where you feel like you can contributewithout 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 ...”*
- *They’d rather turn a blind eye and rather not take that into account, so you have to fight sometimes to get your point of view across and you don’t always succeed.*



Findings : Dominance of Medical knowledge

- ▶ They commented on silence by MDT members - knowledge and expertise not available in team discussions.
- ▶ *“Depending on the participation level ... everyone sits silently in the meeting and just ticks referrals whereas others there’s a genuine discussion”*
- ▶ They commented on other team members’ perception of the social workers role as very simplified:
- ▶ *Transport, accommodation. All the finance. Finance. Budget advisors.*




Findings : Dominance of Medical knowledge

- Poor facilitation extends to lack of discussion regarding the purpose of meetings. MD team meetings are hijacked for ward administration and become nursing or medically oriented:
- *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*



Findings : Dominance of Medical knowledge

- ▶ when medical staff don't attend MD team meetings and don't read the non-medical patient notes – non-medical knowledge not relevant- discharge
- ▶ *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.....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 .*



Findings: Dominating narrowed medical perspective - 'Site of disease'

- ▶ When a narrowed 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'. It becomes a pervasive way of seeing things within a team.
- ▶ *" They may be missing some of the psycho- social factors that may impact on health and discharge planning so it can be frustrating ... and the medical teams don't attend the meeting so we have to run around and try to get everyone on the same page. "*

Findings: Dominating narrowed medical perspective - 'Site of disease'

- *That does happen quite regularly where there's tunnel vision, you've done your piece, you've looked at this organ or from the physio view... can they walk and if they can't walk, do they need an aid? 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 the physio - Discharge home!*





Findings: Dominating narrowed medical perspective - 'Site of disease'

- The social workers gave examples of initiating discussions to broaden out the view
- *They will say this person is on the Liverpool Pathway, so the nurse will try to just flick over them because the Liverpool Pathway is very prescribed and they think "that's sorted, put it to the side". So then I would try to bring up "How's the family doing? Do they need any support? Are they staying in the room" and then they might say "Oh do you want to see them?"*
- Complex cases were referred to by a number of Social workers as especially challenging for MD teams
- *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.*



Findings : Risk Discourse

- ▶ When issues of risk are present social workers can find they are under pressure to practice in ways defined by those in hierarchical positions and this impacts on being part of a team:
- ▶ *I found that the Charge Nurse can be quite judgmental, especially if its someone like a mental health patient..... 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


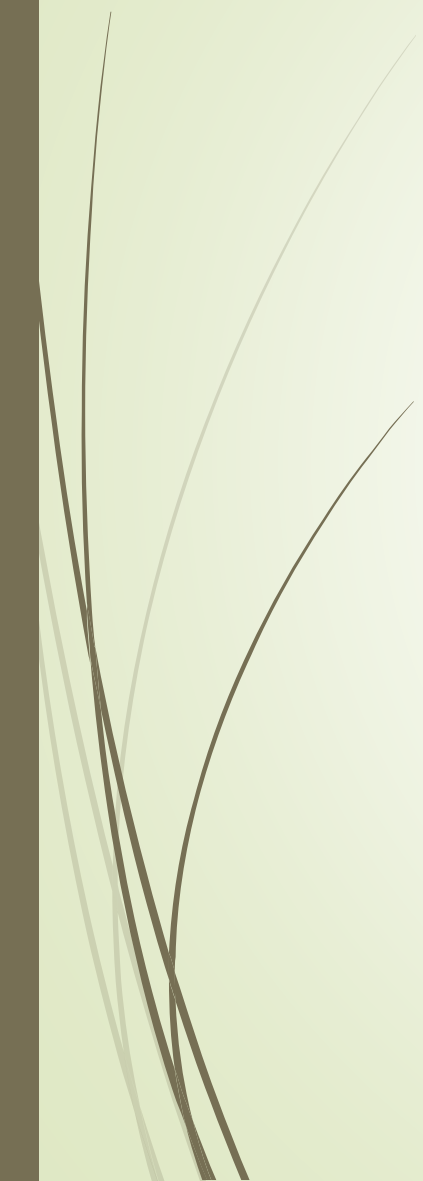
Ironic that social workers experience this pressure around risk when they continue to highlight on going systemic concerns as they always have:

- ▶ *Because we often get women who come in and go directly to theatre and then go straight home. They 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.*



Finally

- Struck by:
- The constant balancing tensions to maintain ethical client centred anti-oppressive reflective practice – demoted narrowly defined role, pressure to act defensively around situations defined as risky.
- Hard environment
- Valuable work – resilient.

- 
- 
- ▶ *I am very clear is to allow people to have the power in 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.*
 - ▶ *Because in the MDT I think our role is the one that does that the most really, because 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 do that. They don’t check that the information that they heard or that they’ve given is the same.*



Conclusion



- General:
- Unexamined unspoken assumptions that value medical knowledge over other forms of knowledge are still prevalent and can compromise work of MD teams impacting on patient care
- This is evident particularly when patients discharged without consideration of recommendations by non-medical team members
- MD team meetings are often strongly medically or nursing oriented rather than a collaborative discussion where the different expertise of different disciplines is valued.



Conclusion

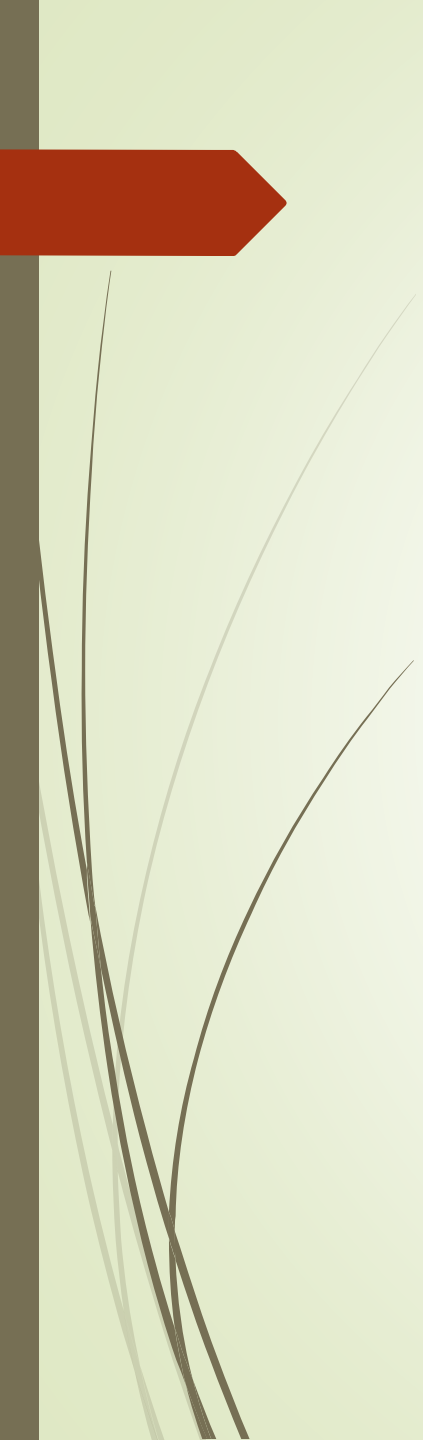
- ▶ When expertise of facilitating is not acknowledged or understood medical knowledge dominance is operating
- ▶ When leaders of teams value MD collaboration teams are more effective at collaboration



Conclusion



- Social workers:
- MD Teams can be a difficult environment for social workers
- Social workers have important roles to play in MD teams providing a contextualized perspective, bringing the patient's voice and can support teams' functioning through providing facilitation of meetings.
- Social workers need to guard against inadvertently adopting medical discourses that demote their perspective, knowledge and skills

- 
- Social workers need to promote their entire skill set and knowledge in MD team environments
 - Socially and medically complex cases can be especially challenging for MD teams, teams need support to accept the complexity and to remain client - centred.
 - Social workers practice continues to be critically aware, anti-oppressive client-centred
 - Social worker's role in hospital settings - patient's voice - implications of patient's health condition in their wider lives.

References

- A.N.Z.A.S.W.(2013). *Code of Ethics*. Christchurch: Author. ISBN: 0-908888-015.
-
- Atwal, A. & Caldwell, K. (2005) Do all health and social care professionals interact equally: A study of interactions in multidisciplinary teams in the United Kingdom. *Scandinavian Journal of Caring Sciences* , 19 . pp. 268-273. ISSN 0283-9318
-
- Atwal, A. & Caldwell, K. (2006) Nurse's Perceptions of multidisciplinary team work in acute care. *International Journal of Nursing Practice*, 2006; 12 359-365. doi:10.1111/j.1440-172X.2006.00595.x
- [Avis, M. \(2005\) Is there an epistemology in qualitative research?](#) Holloway, I. (Ed), *Qualitative Research in Health Care*. England: Open University Press. ISBN: 13: 978033521293 4.
- Baillie, L. (2008) Patient dignity in an acute hospital setting: A Case study. *International Journal of Nursing Studies*, 46 (2009) 23-37. doi:10.1016/j.ijnurstu.2008.08.003
- Bamba,C. Fox, D., &Scott-Samuel, A. (2005). Towards a Politics of Health. *Health Promotion International*. 20 (2), 187- 193. Doi: 10.1093/heapro/dah608.2005.2.18
- Beck, U. (1992). *Risk Society: Towards a New Modernity*. London: Sage.
- Beddoe, E. (2014) Risk and Vulnerability Discourses in health. IN L. Beddoe & J. Maidment (Eds.) *Social Work Practice for Promoting Health and Wellbeing: Critical Issues* (pp51-62). Oxon: Routledge.
- Bronstein, L. (2003). A Model for Interdisciplinary Collaboration. *Social Work*. 48 (3), 297- 306. Retrieved from pal-teach database
- Cheater, F. M., Hearnshaw, H., & Baker, R., & Keane, M., (2004) Can a facilitated programme promote effective audit in secondary care teams: An exploratory trial. *International Journal of Nursing*, 42 (2005) 779-791. DOI: <http://dx.doi.org/10.1016/j.ijnurstu.2004.11.002>
- Cheyne, O' Brien & Belgrave. (2000) *Social Policy in Aotearoa New Zealand: A Critical Introduction*.(2nd ed.).Auckland, New Zealand: Oxford University Press. ISBN: 0 19 5584422.
- Connolly, M. & Harms, L. (2009) *Social Work: contexts and practice*.(2nd ed.) South Melbourne, Victoria: Oxford University Press Australia and New Zealand. ISBN: 9780195562873 (pbk).
- Coombes & Esser (2004) Medical hegemony in decision-making – a barrier to interdisciplinary working in intensive care? *Journal of Advanced Nursing*. Vol 46, Issue 3, pp 245-252. DOI: 10.1111/j.1365-2648.2004.02984.

- Davys, A. & Beddoe, E., (2008). Interprofessional learning for supervision: 'taking the blinkers off'. *Learning in Health and Social Care*. 8(1), 58-69. Doi: 10.1111/j.1473-6861.2008.00197.x
- Dingwall, R. & Murray, T., (1980) Problems of Teamwork in Primary Care. In S. Lonsdale, & A. Webb, & T.Briggs (Eds.)*Teamwork in the Personal Social Services and Health Care*. London: Croon Helm.
- Drewery, W. (2014) *Discourse Analysis: An Introduction to Deconstructive Reading and Listening* (Power point slides). Hamilton, NZ: University of Waikato
- Engestrom, Y., (2001). Expansive Learning at Work: towards an activity theoretical reconceptualisation. *Journal of Education and Work*. 14(1), 133-156. Doi: 10.1080/1363908002002874
- Frost, N., Robinson, M., & Anning, A. (2005) Social Workers in multidisciplinary teams: issues and dilemmas for professional practice. *Child and Family Social Work 2005*, 10 , pp 187-196. Retrieved from Wiley On-line Library
- Gair, G. & Hartery, T. (2001) Medical Dominance in multidisciplinary teamwork: a case study of discharge decision-making in a geriatric assesemnt unit. *Journal of Nursing Management*, 2001, 9, 3-11.Retrieved from Wilet Online Library
- Giddens, A. (1999) Risk and responsibility. *Modern Law Review*, 62(1), pp.1-10. DOI: 10.1111/1468-2230.00188
- Haultain, L. (2013). Facing the Challenges Together: Fututre Vision for Health Social Work. In Beddoe, E. &Maidment, J. (Eds.), *Social Work Practice for Promoting Health and Wellbeing: Critical Issues* (pp39-50). Oxon: Routledge.
- Holloway, I. (2005). *Qualitative Research in Health Care*. England: Open University Press. ISBN: 13: 978033521293 4.
- Holmes, D., Murray, S., & Perron, A., & Rail, G., (2006) Deconstructing the evidence-based discourse in health sciences: truth, power and facism. *International Journal of Evidence- based Health Care*, 4(3), 180-186. DOI: 10.1111/j.1479-6988.2006.00041.x
- Jansen. (2008) Collaborative and Interdisciplinary Health Care Teams : Ready or Not? *Journal Of Professional Nursing*, 24(1)218 – 227.doi : 10.1016/j.profnurs.2007.06.013
- Katzenback, L. & Smith, D., (1993) *The Wisdom of Teams: Creating the High Performance Organization*. Boston: Harvard Business School Press.

- Kitzinger, J. (2005) Focus group research: using group dynamics to explore perceptions, experiences and understandings. In Holloway, I. (Ed), *Qualitative Research in Health Care* (pp56 – 70). England: Open University Press. ISBN: 13: 978033521293 4.
- Liepzig, R.M., Hyer, K., & Wallenstein, S., & Vezina, M., & Fairchild, S., & Cassel, C.K., & Howe, J.L. (2002) Attitudes Toward Working on Interdisciplinary Healthcare Teams: A Comparison by Discipline. *JAGS*, 50 (6) Retrieved from Researchgate database.
- Mattessich, P. & Monsey, B. (1992). *Collaboration: What Makes it Work*. (5th ed.) . St. Paul, MN: Amherst H. Wilder Foundation.
- Opie, A. (1997) Thinking teams thinking clients: issues of discourse and representation in the work of health care teams. *Sociology of Health & Illness*. Vol 19, Issue 3, pp259-280, June 1997. DOI:10.1111/j.1467-9566.
- Pollack, S., (2010). Labelling Clients `Risky`: Social Work and the Neo-Liberal Welfare State. *British Journal of Social Work* (2010) 40,pp1263-1278. doi:10.1093/bjsw/bcn079
- Quinlan, E. & Robertson, S. (2010). Mutual understanding in multi-disciplinary primary health care teams. *Journal of Interprofessional Care*, 24 (5) , 565-578. DOI: 10.3109/13561820903520385
- Solar, O. Irwin, A. A Conceptual framework for action on the Social Determinants of Health. *Social Determinants of Health*,2. WHO. ISBN: 978924150085 2.
- Stanford, S., (2010). `Speaking Back` to Fear: Responding to the Moral Dilemmas of Risk in Social Work Prctice. *British Journal of Social Work* (2010) 40 , Doi: 1065-1080/bjsw/bop156.
- Taylor, M. C. (2005). Interviewing. In Holloway, I. (Ed), *Qualitative Research in Health Care*. England: Open University Press. ISBN: 13: 978033521293 4.
- The Joint Commission.Sentinel Event Alert: Preventing infant death and injury during delivery. *The Joint Comission* 2004. Issue 30 – July 21, 2004.
-
- Wenger, E. (2000). Communities of Practice and Social learning System. *Organization Science*, 7(2), pp 225-246. Retrieved from umb.edu online
-
- Willis, E. (2006) Introduction: Taking Stock of Medical Dominance. *Health Sociology Review*, 15 (5), 421-431. e-contentmanagement.com
-
- Zwarenstein, Goldman & Reeves (2009) Interprofessional collaboration: effects of practice-based interventions on professional practice and healthcare outcomes (Review) Copyright © 2009 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd issue 3