Transdisciplinary Teamwork

In 1987 Clare O'Hagan, the founder of Therapy Professionals Ltd attended the World Congress of Physical Therapy and heard a lecture by Carol Davis on Transdisciplinary Teamwork. From that moment Clare wanted to develop such a team. It wasn't until 1997 when she got the opportunity. It was a slow process to start with as the disciplines were struggling to work in a multidisciplinary way. By the early 2000's the team was humming and her dream was realised.

Below is Carol Davis's article on transdisciplinary teamwork.

Philosophical Foundations of Interdisciplinarity in caring for the Elderly: or, the willingness to change your mind.

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INTRODUCTION

Medicine alone rarely, if ever, meets all of most patients' needs. Other health professionals assume the responsibility of caring for patients' multiple other needs with a common goal of the highest level of independent function, thus the greatest quality of life possible, for each person.

When health professionals from many disciplines attempt to work together in caring for the elderly patient, the end product of this effort can have various characteristics. This paper examines the characteristics of various outcomes, and describes what factors enhance the process. Finally the suggestion is made that the processes of interdisciplinary or transdisciplinary result in the best possible outcome of care for the patient.

THE CONTINUUM TOWARD TRANSDISCIPLINARITY

Few health care professional students in the United States receive adequate training in learning how to work well with others for the good of patients. Indeed, young beginning practitioners often feel more than stressed in simply maintaining access to their own professional knowledge and skill. Learning to work with others takes place on a continuum of growth that can be described in the following model:

Unidisciplinary
Feeling confident and competent in one's own discipline

Intradisciplinary
Believing that you and other fellow professionals in your own discipline can make an important contribution in care

Multidisciplinary
Recognising that other disciplines also have important contributions to make

Interdisciplinary
Willing and able to work with others in the joint evaluation, planning and care of the patient

Transdisciplinary
Making the commitment to teach and practice with other disciplines across traditional disciplinary boundaries for the benefit of the patient's immediate needs. (United Cerebral Palsy 1.)

The increasing effectiveness of each of these processes can be illustrated with the help of the following case example.

An 85-year-old patient is admitted to the geriatric evaluation unit with a cerebral vascular accident with right hemiplegia, hemianopsia, and aphasia. He is accompanied by his 78-year-old wife. They had been living together at home prior to his stroke one month ago. Since that time the patient was in the hospital for resolution of his acute problem, then transferred to a nursing home for careful nursing care until he stabilised.

Mr Walker was a tailor and lives on a modest social security income. His wife receives no social security. Their finances are assisted by monthly cheques from their son who lives in another state 1000 miles away. Mr Walker is diabetic. Mrs Waker is quite well but very lonely without her husband of 60 years. They were active in the Methodist church but were driven to church each Sunday before Mr Walker's stroke, as neither could drive any longer.

Mr Walker's physician illustrates unidisciplinarity and intradisciplinarity as he evaluates the patient upon admission to the hospital. He believes that his discipline of internal medicine is very suited to the care of this patient, but his area of expertise in gastrointestinal cancer restricts his confidence that he can uncover and treat Mr Walker's circulatory problem to resolve it adequately. Thus, he requests his colleague in internal medicine who is a cardiac specialist to see the patient as well.

Multidisciplinarity occurs as he writes the order for the patient to be seen by the physical therapist, occupational therapist, speech therapist, the psychologist, the social worker and the nutritionist.

When this group of practitioners evaluate the patient and plan their care, all separate from each other, communicating only by way of the patient's record, they are practicing multidisciplinarity. Just as in a 'jar of jelly' beans, the end product of care is no more than the sum total of all the parts.

Patients complain about multidisciplinary care when they say, "I'm not answering that question one more time!". Or, "I'll only give blood once today – you people get together and figure out which one of you is going to stick me and when."

Practitioners complain about multidisciplinary care when the goal of the physical therapist to increase Mr Walker's endurance in ambulation is thwarted by the nurse who ties him in bed so he cannot get up and walk around for he might fall.

Interdisciplinarity can be recognised as superior to the aforementioned when it's working well. In the Journal of Medicine and Philosophy Maurice de Wachter offers five steps to interdisciplinarity (De Wachter 2):

1) One starts by accepting the "methodological epoch".
Each person agrees to abstain from approaching the topic along the lines of his or her monodisciplinary method alone.

2) The entire team tries to formulate, in an interdisciplinary way, the global question, acknowledging all aspects of the patient's problem and all disciplines required to solve it.

3) One translates the global question into the specific language of each participating discipline.

4) Answers to this global question (translated to each discipline) are constantly checked for relevance with regard to the overall global question.

5) One agrees upon a global answer, which must not be produced by any one particular discipline but rather integrates all particular answers available.

Thus, interdisciplinary process is composed of more than just several health professionals gathered around a table to discuss Mr Walker. Each sits down and, in essence, brackets his or her professional-discipline identity, places it to the side and assumes the new identity of "team member."

This act of bracketing is critical to the success of interdisciplinarity. Just as in algebra or language analysis, brackets serve the purpose of setting aside, without destroying, what is bracketed. In other words, identity as a physical therapist, for example, is available to me and, indeed, informs my contribution to the team, but I do not allow it to keep me from hearing the reports of other team members and helping to decide on a team goal and plan of care for this patient. In short, each of us sits down at the table and listens to the others with a willingness to allow others to change our minds. In this way the very best of all possible plans is agreed upon. Unlike the "jar of jelly beans", the product of this effort is larger than the sum of all the parts. Indeed, ideally professional boundaries are transcended and flow into each other with ease, much like the colours of a rainbow.

Finally, transdisciplinarity represents the highest progression in the process of patient care. Hospice care illustrates this process quite adequately. Health professionals teach each other, the patient and the patient's family how to perform aspects of care reaching beyond professional boundaries with the immediate need of the patient being foremost. If the physical therapists arrives to work with a patient at home and learns she has not yet taken her pain medication, she doesn't wait for the nurse to arrive to give it, nor the husband to make the toast to take with it. She does it herself. Likewise she teachers the nurse, husband and volunteers how to help the patient move about in bed and walk to the bathroom.

Integrated, smooth, coordinated congruent care with the patient's immediate needs at the centre of the effort marks transdisciplinary care. Individuals come together without territorial professional boundary needs to guide their role and responsibilities. This is what makes it the highest form of care.

Transdisciplinary care is a mature and humble way of being in the world. Factors which interfere with interdisciplinary and transdisciplinary care include:

- lack of personal commitment in the process
- lack of personal commitment to accepting the risk of bracketing one's professional role
- feelings of insecurity that are revealed in the need for clear territorial boundary roles
- lack of shared values
- lack of skill in interpersonal interaction
- perception of threat from other team members (Darling 3)

Factors that enhance interdisciplinarity and transdisciplinarity are the opposite of these limiting factors. Central to these two processes is a mature, secure, self-confident practitioner with excellent skills in communication and teaching who primarily values that the patient's needs be met regardless of who meets them. The making of such persons takes time and commitment to the beauty and value of the rainbow.