Communication in interprofessional health and social care teams: a realist synthesis

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Interprofessional teamwork across stroke care pathways: outcomes and patient and carer experience

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The realist approach

Ray Pawson and Nick Tilley

- Realist evaluation (1997)
- Realist synthesis (2002)
Realist synthesis

• A strategy for synthesising research evidence on *complex social interventions*

• It does not seek to identify whether a social intervention *‘works’* or *‘doesn’t work’* but instead seeks to explore *how* they work or *why* they fail in particularly contexts and settings

• It does this by:
  * Unpacking the *‘mechanisms’* of how social interventions work
  * Exploring the *contexts* which trigger or deactivate these mechanisms
  * Linking these *contexts* and *mechanisms* to their subsequent *outcomes*
Mechanisms, contexts and outcomes

• Mechanisms are *theories* about what is happening within an intervention or programme; they describe how effects are produced by an intervention.

• Contexts describe the *conditions* that activate or deactivate the different mechanisms within the programme.

• Contexts and mechanisms interact to produce a *pattern* of outcomes.
The core principle of realist synthesis is to make explicit the **underlying assumptions** about how an intervention is supposed to work (i.e. the ‘programme theories’ or ‘**mechanisms**’), and then to gather evidence to test and refine those theories.

**Through what mechanisms does team working affect outcomes and experience (patient, carer, staff and service), and how does context influence those mechanisms and outcomes?**
Method – first stage

• Aim: identify the theories that underlie interprofessional teamwork in the policy maker’s or manager’s mind

• Search of health policy documents and health and social care databases for theories of teamwork and the purported attributes of ‘good’ teams

• Identified 10 mechanisms
Method – second stage

- Aim: populate the framework of 10 mechanisms with empirical evidence

- A further, broader search of health and social care databases looking for original research on interprofessional teamwork in healthcare.

  ➢ Is there evidence that those 10 mechanisms occur and if so in what contexts?

  ➢ Are there other, unpredicted mechanisms through which teams work?
Interprofessional Teamworking: 10 mechanisms

- Shared sense of purpose
- Pooling of resources
- Collaboration and coordination
- Efficient, open and equitable communication
- Shared responsibility and influence
- Support and value
- Critically reviewing performance and decisions
- Generating and implementing new ideas
- Individual learning
- Leadership
Mechanism: *Efficient, open and equitable communication*

All members of a team can offer their opinion, constructively challenge one another and mutually resolve disagreements, regardless of perceived professional status, and each member’s contribution is given due consideration by all other members.

Teams make use of aids to communication such as multi-disciplinary team meetings, shared patient records and protocols for resolving conflicts.

Free and efficient flow of information within the team helps avoid error (patient safety), builds trust in the team, and allows ideas and decisions to be rigorously debated.
3 new mechanisms identified during second search stage:

- Tactical communication
- Role blurring
- Team behavioural norms
Mechanism:
*Tactical communication*

Team members consciously control the amount or type of information that they share with other team members in order to achieve an outcome that is either to their own advantage (e.g. controlling their own workload) or that they perceive to be to their patient’s advantage (e.g. delaying another professions’ intervention).

Team members can do this alone or in small groups within the team.

Tactical communication can offer a means to avoid disagreement or to negotiate team hierarchies or conflicting treatment models within the team.
Open communication: mechanism

• Discussion is dominated by senior medical staff and the biomedical model.

• ‘What was striking about this discussion was that the precedence given to determining diagnosis and establishing causation at the beginning of the meeting set limits on the way in which women were perceived within the MDM. Instead of being individuals with varying needs and priorities, they materialized in the MDM as the semi-predictable embodiment of medical science.’

Lanceley et al, 2008
Open communication: mechanism

• Discussion draws contributions from across the team and integrates medical and psychosocial knowledge of the patient.

• “I think it is really challenging everyone, and she’s been on the list for case discussion oh for a number of things really ... and when I sort of look at the room and I’ll just think that’s really nice and how important it is, and everyone is listening and, well, talking about her choices.” (Nurse) Lanceley et al, 2008
Open communication: contexts

- Government policy → strain on MDM capacity
- Personal knowledge of patients
Open communication: outcomes

• Open communication present:
  * Discussion becomes more person-centred
  * Team members gain satisfaction from sharing their knowledge and generating a common narrative that draws the team together

• Open communication absent:
  * Discussion becomes more biomedical
  * Team members feel dissatisfied with the meeting

  “a horrible, incomplete feeling afterwards, like something hadn’t been fleshed out” (surgeon)

Lanceley et al, 2008
Tactical communication: mechanism

• Team members consciously phrase their communications to achieve an outcome they want

• “The doctor gave the order for initial pain medication, but she [the nurse] obviously wanted a drip to give continuous pain medication. So she said, ‘Did you want me to write the order for that drip right now, or did you want to come in and see the patient?’ That did plant it in his mind that it would be a good idea for the baby to have a drip.” Apker et al, 2005
Tactical communication: contexts

- Status hierarchy within interprofessional team
Tactical communication: outcomes

• Nurses gain influence on team decisions, but at the expense of losing credit for their ideas.

• “We have learned how to make excellent, brilliant ideas seem to be someone else’s idea so the job can get done. We have all been able to let someone else take the credit because we know it’s in the best interest of the patient” Apker et al, 2005
Conclusions

• Realist synthesis is a challenging but insightful way of tackling the teamwork literature which provided a useful analytical framework for the rest of the study.

• It articulates and interrogates the assumptions made in interprofessional teamwork policy.

• It helps us understand the nature of communication in teams in a wide variety of settings and begin to unpick how context influences communication patterns within teams.
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