

# Challenges and Celebrations in a Primary Care Interdisciplinary Practice Environment:

Themes identified from the  
McMaster Family Health Team Inter professional  
Mentorship and Evaluation (MIME) Program



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# Background

- Family Health Teams - improve primary care - MFHT
- About healthcare organisations:
  - networks of continuously evolving relationships, expressed as ongoing conversations (Suchman, 2001)
  - within them, culture and leadership style shape conversations and relationships, which influence organizational function / staff well-being
- Barriers to effective interprofessional teamwork include:
  - lack of clarity around expectations for team functioning/ role definition
  - absence of methods to evaluate team success
  - organizational constraints (fiscal/inter/intradisciplinary/team conflicts)
  - poor communication between disciplines
  - power differentials among disciplines (Choi, 2007)

# Background...

Health care team relationships have an impact on:

- **clinical outcomes** (Kaplan et al, 1989, Williams et al, 1998)
- **quality and safety** (Knaus et al 1986)
- **COST** (Anderson, McDaniel, 1999, Ashmos et al, 1998)
- **patient retention** (Safran et al, 2001)
- **workforce health and satisfaction** (Revans, 1996, Suchman et al, 1993)
- **staff recruitment and retention** (Verdejo, 2001)
- **capacity for culture change and innovation**  
(Edmonson et al, 2001, Wesorick et al, 1997)

# Purpose/Research Question

To explore staff perceptions of teamwork and role responsibilities within the MFHT

# Methods

# Intervention: MIME Program

- The MIME Program implemented an inter-professional mentoring approach using intentional conversations to achieve the project goals
- MIME defined mentoring as a reciprocal learning alliance between two professionally autonomous individuals, working in pairs, which may stimulate new learning, insight and personal growth for both participants (Poulsen, 2006)

# MIME goals

- Through purposeful pairings and intentional conversations MIME aimed to...
  - increase FHT staff members' satisfaction with their professional and working environments
  - enhance awareness and understanding of different roles within the FHT
  - expand inter-professional interaction within the FHT

# Participants

- The MIME program was designed to involve all inter-professional FHT staff, both management and non-management and clinical and non-clinical...

**Physicians:** GFTs,  
Community Drs, Unit Directors

**Administrative Support Staff:**

Unit Managers, Clerks  
(Business, Billing & Scanning),  
Education Assistants, Clinic  
Aides, I.T. Technician

**Allied Health**

**Professionals:** Nurse  
Practitioners, Registered  
Practical Nurses,  
Dieticians, Social Workers,  
Pharmacist, Lactation  
Consultant

# Mentorship

- Roles of mentor and mentee alternated
- ‘Mentor’
  - openly presented personal reflections about issues introduced to the mentee, considered how reflections could be used in mentor’s own work (Poulsen, 2006)

# Intentional conversations

- Pairs - 7 intentional conversations
  - discussed practice-related issues
  - explored different perspectives
  - creative discussion
  - new solutions
- Participants independently completed worksheets capturing
  - essence of conversations
  - additional items
  - roles discussed
  - lessons learned

# Data gathering

- 3 points of qualitative data collection
  - **after each conversation**, participants filled out worksheets, recording what roles and events they discussed with their partner, detailing the content of the conversation and noting any “ah ha’s”, or new learnings or realizations that resulted from the conversation process.
  - participants **“journalled” their reflections** on their conversations and the MIME process using a digital recorder
  - **focus groups of participants** at a closing MIME workshop collected information concerning the MIME process and the sharing of issues

# Qualitative Methods

- NVIVO database
- Thematic Analysis
  - Of 3 groups of data
  - **Iterative** qualitative data analysis (following the rules of grounded theory analysis)
  - **Grounded theory** used because we wanted to analyse WHY participants brought the subject matter that they did to the table (Glaser and Strauss 1967)
  - **Thematic and comparative analysis** involved intense reflection by project team
  - **Triangulation** - each team member (**multi-disciplinary**) analyzed transcripts **individually** and then weekly meetings were held for collaborative analysis

# Participant demographics

	Administrative staff % (n=27)	Allied Health % (n=21)	Physicians % (n=16)
Mean age (SD)	47.1 (9.75)	44.2 (9.35)	45.3 (7.3)
Education: University graduate	8 (2)	86 (18)	100 (16)
Length of work at unit:			
<5 years	41 (11)	62 (13)	44 (7)
5-9 years	33 (9)	24 (5)	44 (7)
10-14 years	15 (4)	5 (1)	6 (1)
15-19 years	7 (2)	0	6 (1)
>20 years	0	10 (2)	0

# Participation rate

- Participation rate 62%
- Response rate:
  - 73% worksheets
  - 54% reflections

# Qualitative results

# Major themes identified were.....

- impact of **hierarchy** on team work and decision making
- need for **role clarity** to facilitate role competence
- essential role of **communication**, relationships and support (positive reinforcement) on teamwork
- consequences of **behaviours** by staff, patients and learners on teamwork.

# Impact of hierarchy

Hierarchy in the clinic came into play in all aspects of clinic life:

- Delegation of tasks
- Clinical disputes
  - where there was a clinical dispute, the physicians' decision would always take precedence
    - "...we feel that there really is a hierarchy in terms of decision-making. We feel that if the doctors had one idea and allied health had another there was no question that we would do what the doctors thought."*
- Non-clinical decision making not always hierarchical
  - business clerks, support staff indicated that planning can go smoothly when management actively solicited their input and acted on their suggestions
    - "...decisions are team-based"*

# Impact of hierarchy

- Other non-clinical issues
  - access to shared office space specially important for staff working at both sites

*“...every day I have to look for a place to work. ....”*

*“...if ..... they don't want an allied health in a certain space it doesn't happen, the allied health is moved”*

- Some participants felt status differences would continue unless management structure changed

# Physicians perspective on hierarchy

- Hierarchy is difficult to change

*“...that no matter how much collegiality and respect there is in the workplace, there is a very definite hierarchy of power that can't be really be changed, at least in [my MIME partner]'s point of view.”*

- Physicians understood the feeling

*“...there is a power differential. But the extent that, that is always factored into interactions was interesting to consider. And actually not that surprising when I think of situations which I myself feel on the less powerful end of things... sometimes with specialists.”*

- Physicians felt both ‘scrutinised’ and ‘scrutinisers’

*“...there really is asymmetry in terms of how much a physician might depend on another healthcare provider..... nurses, social workers, physio, everybody who wasn't an MD... And this asymmetry means in a sense that other health professionals are always going to be mindful and watching what the physician does.”*

# Role clarity needed to facilitate role competence

- Transition to multidisciplinary setting - challenges regarding role clarity / job descriptions
- Difficulty of defining roles despite similarity in job function
  - “Combining like-roles from different teams who operate very differently causes friction among workers. This tension may lead to self consciousness and second guessing .....*”
- New team members
  - where do they fit?
  - fear of crossing “role boundaries/scope of practice”

# Role clarity to facilitate role competence...

- A physician expressed concern about the difficulty of working as a team for fear of crossing a hidden barrier:

*“If I am afraid to ask for help, why am I afraid? I fear crossing a “role” line. Can't work successfully in a team without being able to talk/ask/respond/ask without fear.”*

- Staff expressed hopes for true interdisciplinary collaboration and teamwork at the clinical level

*“We are optimistic that as we continue here together that we will become more of a truly interdisciplinary thing...”*

# Essential role of communication, relationships and support

- Participants commented on:
  - need to communicate effectively
  - benefits of one form of communication over another
  - consequences of poor communication.
- Participants felt that poor communication affected patient care negatively
- Need for communication and information exchange in an interprofessional group practice was perceived as key to ensure continuity of care
- Staff members have to make their information needs known to others

# Essential role of communication, relationships and support....

- Participants felt that in person conversations were superior and had implications for encouraging and building team relationships:

*“Face to face communication about “issues” is often easier and more beneficial than OSCAR messages.”*

*“.. I think being able to share on a more personal level will also help to build trust in our working relationships, um, bonding of sorts I suppose.”*

- Everybody on a team should be able to communicate with each other on a daily basis
- Communication should encompass new information and other team changes
- Support staff feel the need to know about patient information that would affect their interactions with patients

# Essential role of communication, relationships and support

- Importance of positive reinforcement on teamwork

*“.....it’s nice to get a pat on the back.....”*

- Most participants felt supported by their co-workers
- Several conversations noted the impact an unexpected compliment could have in the interprofessional setting

# Consequences of behaviours

- Behaviour by physicians

- Can affect teamwork and staff performance

*“There are days that even when we try extra hard ..... (he/she) snaps at us in front of our peers, and it is very embarrassing.”*

- Some staff feel able to address physicians with their feelings

*“I realized that since I have worked for this long for this doctor that I'm probably the only one who could talk to (him/her) about this and still have the respectful relationship with (him/her) that I used to have.”* “

# Consequences of behaviours

- Behaviour initiated by patients
  - Inappropriate joking and touching with support staff
  - Anger over appointments
  - Approach to staff may be based on a hierarchical model

*“Often patients feel a sense of entitlement to be rude [to staff] where they otherwise might not be with the physician. [I] know that often times the receptionist gets the brunt of .. people’s frustrations and.... anger. And people ... take liberties with somebody they perceive to have less power.”*

- Staff and co-worker support can be very helpful in resolving patient issues

*“...that behaviour needs to be accountable somehow ..... And if we have to have ground rules for that, then maybe that’s where we have to go”*

# Conclusions

# Key Messages

- Face to face communication preferred
- Ongoing positive reinforcement of teamwork essential
- Continual role exploration necessary

# Limitations

- Small sample (2 practices)
- Views of non-participants
- Academic setting
- Confounders (PIER)
- Qualitative work not generalisable

# Concluding thoughts

- MIME has only exposed the tip of the iceberg
- These themes are likely to be common to the workings of any inter disciplinary primary care clinic
- Main areas of role clarity, hierarchy and communication need to be worked on
  - Hierarchy (physician vs. others) is a key issue that must be clarified in the interdisciplinary environment

