

EDITORIAL INTRODUCTION

Interdisciplinary Collaboration and the Construction of Person Centered Medicine

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Keywords

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Introduction

One of the core concepts of Person Centered Medicine is the cultivation and promotion of relationships at all levels. In fact, this concept is one the eight key ideas emerging from an ongoing study on the systematic conceptualization and measurement of person- and people-centered care [1]. Interest in the importance of relationships in medicine and healthcare has been long and widely observed and has even led to attempts to rethink and organize medical care by focusing on this concept under terms such as relationship-based and relational medicine [2].

A fundamental aspect of relationships is the establishment of a dialogue (or even a triologue) among the persons involved. In connection to this, it has been argued that there is a dialogal base at the core of the work of health professionals [3]. Furthermore, it has been posited that working *with* the person in a respectful and empowering manner is a crucial feature of Person Centered Medicine [4].

A basic concern for the development of person- and people-centered integrated care is awareness of and appreciation for the important elements of a relationship matrix. These elements include the clinician-patient relationship; the relationship among health professionals, patients and their families; and the collaborative relations among health professionals of different disciplines and specialties [5].

Interdisciplinary Cooperation and Team Work

A health team can be described as a group of health providers with diverse skills and different responsibilities but with common objectives related to patient outcomes and cost of health care [6]. Several terms are often used interchangeably to refer to health care teams. These include: multidisciplinary, interdisciplinary, collaborative, interprofessional, cross-disciplinary, polydisciplinary, and transdisciplinary.

Upon pondering about which term to use, Drinka and Clark [7] argue that the term interdisciplinary seems most appropriate for its inclusiveness and enduring use. A working definition of interdisciplinary health team is provided by these authors as follows: "An interdisciplinary health team integrates a group of individuals with diverse training and backgrounds who work together as an identified unit or system. Team members consistently collaborate to solve patient problems that are too complex to be solved by one discipline or many disciplines in sequence. ...An interdisciplinary health team creates formal and informal structures that encourage collaborative problem solving. Team members determine the team's mission and common goals; work interdependently to define and treat patient problems; and learn to accept and capitalise on disciplinary differences, differential power and overlapping roles. ...They share leadership that is appropriate to the presenting problem and promote the use of differences for confrontation and collaboration .They

also use differences of opinion and problems to evaluate the team's work and its development" (page 6).

At the core of the interdisciplinary team approach is the person who has health problems and who should be an active partner in care. The provision of quality patient care requires an identifiable team structure and functioning.

Team Formation and Functioning

The shift from the traditional biomedical view of the human body to a biopsychosocial approach has resulted in greater understanding of the complex relationships among health, illness and disease. This holistic view of the complexity of the multiple dimensions of illness and disease requires the involvement of professionals with varied skills and knowledge working in interdisciplinary teams to provide quality patient care [8].

In its broad sense, the term interdisciplinary refers to an interprofessional perspective that includes physicians, nurses, occupational therapists, social workers and other health-related professionals. The interdisciplinary team approach may help in preventing fragmentation of care due to specialization as patients who receive care from a team can benefit from the perspectives of different professionals with wider skills [9].

The use of teams in health care delivery is driven by a number of factors including demographic changes with an ageing population, health system restructuring and reorganisation, cost containment and the increasing complexity of health care knowledge and work [10]. In the current complex landscape of health care systems with rapid growth in information that is required to solve problems, no single health professional can have all the knowledge or skills to provide the continuum of services needed. Because of the increasing complexity and scope of patient problems including presence of multiple diseases or co-morbid conditions presenting to the health care environment, patient care needs to combine the efforts of physicians of different disciplines, skilled nursing professionals, and other health care professionals, as solving these problems are beyond the scope of expertise and training of any one provider [11].

A key tenet of interdisciplinary team work is communication between the different members on continuous basis. High quality communication, mutual respect, trust, and active participation by all team members often result in stronger team identity, reduction in status differential and hierarchy, increased responsiveness to job demands, higher job satisfaction and better staff retention [12]. Similarly, an organizational culture that institutionalizes consistent and effective communication leads to low staff turnover, better clinical outcomes, shorter hospital stay, and higher quality of care [13]. Gittel [14] observed that interdisciplinary teams that successfully manage their differences through well designed and maintained communication are more likely to demonstrate continual high performance and achieve positive patient outcomes.

Another important tenet of team work is team leadership. Successful team leadership acknowledges the need for team members to contribute and collaborate in a

positive manner. Skills in team building and team functioning are fundamental to the success of the interdisciplinary health team in setting common goals and in achieving positive patient outcomes.

Effective leaders facilitate the team's environment so that members feel that their perspectives are welcomed and appreciated, their expertise is trusted, expectations are clear, accountability and excellence are the norm, and there are common goals [15]. Team leadership means that the leader and the members must be willing to share team leadership responsibilities and be aware of group dynamics in order to work with professionals that have widely diverse skills, values and interests [16].

Team Effectiveness

There is a growing body of research literature that demonstrates the effectiveness of team approach to patients, providers and organizations. After an extensive review of the literature on health care team effectiveness, Lemieux-Charles and McGuire [17], and Bosch et al. [18] found that there is evidence that shows interdisciplinary team care can lead to better clinical outcomes and patient satisfaction. For example, studies that examined geriatric teams reported higher functional status, better mental health, decreased dependence and decreased mortality [19, 20].

Patient satisfaction and health-related quality of life were higher when care was provided by interdisciplinary health teams [20]. Similarly, studies of teams in critical care reported increased survival to discharge and decreased readmission to critical care [21] as well as fewer adverse events, lower mortality rates after surgery, and shorter length of hospital stay [22]. Care provided by a team in a primary care setting resulted in improvements in symptoms of depression, but resulted in increased cost [23]. Provider satisfaction was found associated with lower staff turnover [24]. Overall, a review of the research evidence shows interdisciplinary team care can lead to better clinical outcomes and patient and staff satisfaction as well as cost-savings than traditional care that did not use a team approach.

Organizational support and resources influence team functioning and higher functioning teams achieve better patient outcomes [25]. These outcomes seem to occur because well-functioning teams make quality decisions, cope effectively with complex tasks, and are able to coordinate their interventions and expertise [26].

However, despite the growing literature on the benefits of team approach to care, many health care organizations lack effective teamwork, with negative consequences on patient outcomes. The barriers to team approach have been attributed to several factors including professional hierarchy frequent changes in caregivers due to shift-work and patient transfers that make coordination and teamwork complicated [27]. At the same time health professionals tend to resist to a team-based care model because of poor organizational support, system-wide barriers such as fragmentation in reimbursement for health care services, regulatory restrictions, and the education of health professionals which takes place in silos [28, 29].

Interprofessional Education for Team Work

The World Health Organization [30] identifies Interprofessional Education as the process by which a group of more than two profession-specific students from health-related occupations with different educational backgrounds learn together during certain periods of their education with interaction as an important goal. Governments around the world are looking for innovative solutions to ensure the appropriate supply, mix and distribution of the health workforce. One of the most promising solutions appears to be interprofessional collaboration [30].

The interdisciplinary team approach is the hallmark of positive outcomes for the health of patients, families and communities. However, a number of reports affirm team formation and team functioning do not come naturally to health professionals and require a paradigm shift in educational programs [31, 32]. As Frenk et al. [33] have affirmed, the excessive focus on hospital-based education that is segregated into professional silos does not prepare health professionals for team work, and for leadership skills in the 21st century health services.

In general, most health care organisations and health profession educational institutions devote little or no time and resources to promote interdisciplinary functioning [7]. In fact, the different health profession training programmes take place in different buildings, and in different colleges or schools often within the same campus. Similar courses are taught separately for the different health professions, adding to the silo approach of educational institutions [7].

As a result, there is a lacunae in the education of health professionals in relation to team formation and team functioning. As Lee [18] has noted, the dominant model of health profession education does not emphasize collaboration, shared team decision making, or shared team leadership. Most health professionals tend to be trained to function in independent tracks and they may have difficulty to function in interdisciplinary teams with negative consequences on patient care.

Despite their clinical expertise, health professionals are often hampered to provide quality care due to lack of effective team work and collaboration. As the Institute of Medicine [34] reported, a lack of interprofessional collaboration was one of the most often cited reasons for medical errors. In contrast effective interprofessional collaboration is linked with better patient care outcomes [35].

While acknowledging the value of team-based models of care, Jansen [27] raises doubts about implementation because of, among other things, the lack of interprofessional education of health professionals. Jansen argues that investments in health professionals must be made in terms of system support and interprofessional education if the notion of interdisciplinary team approach is to be implemented. For example, educational institutions must provide interdisciplinary team-based learning opportunities including knowledge of collaborative practice, participation in team decision-making and an appreciation of the values and competencies of other professionals.

Teams are their most effective when all the members share the same broad ethical values and they have a common goal to which each member contributes according to his or her experience and expertise and there is clear clinical leadership and responsibility. There are real dangers when the team structure becomes rigidified or "institutionalized" as the responsibility of each individual member of the team to the person of the patient becomes diluted and subject to the authoritarian will of the team [36]. Some of the negative features of rigidified teams are particularly prominent when set up to manage both physical and sexual child abuse with the team mirroring the conflict they are trying to manage [37]. This further emphasizes the importance of shared training and shared understanding. Along these lines, the Department of Health of the United Kingdom since 2000, the Institute of Medicine [34], and the World Health Organization [30] continue to advocate for educational programs for health professionals to include opportunities of working in interdisciplinary teams.

As articulated by the International College of Person-centred Medicine (ICPCM) in its Zagreb Declaration [38, 39], education of health professionals for person-centered care need to address the different aspects and levels of the educational domain, including conceptual bases, institutional and organisational culture, selection and development of health profession students, educators, patients and families, curriculum development as well as broader issues on health and society.

Inter-Institutional Professional Collaboration

The relationship matrix referred to earlier as key to person centered medicine also plays out in terms of inter-institutional professional collaboration. In fact, it was the series of annual Geneva Conferences on Person Centered Medicine, which started in 2008 and continue to the present, that led to the emergence of the International Network (later named College) of Person Centered Medicine (INPCM, ICPCM)[40-42]. The College provides a key focus of fellowship to the cultivation and sharing of research and ideas in an international and multi-professional setting.

The Geneva Conferences on Person Centered Medicine constituted since their beginning a forum for the top global institutions in medicine and healthcare, as well as associations of patients and families, to meet annually and through this process build an organizational base for person centered medicine. These collaborating organizations numbered ten at the first Geneva Conference and its number has grown in time to over 30. Two of them, the World Medical Association and the International Council of Nurses, are of particular pertinence to this paper on interdisciplinary collaboration as they correspond to the physicians and nurses that are key protagonists in such collaboration.

The World Medical Association

The World Medical Association (WMA) was formally launched in 1947 with the major objective of promoting the highest ethical behavior and care by physicians. Around the same time, the World Health Organization was established defining health as the state of complete physical, emotional and social wellbeing and not merely the absence of disease.

While these lofty ideals were being set, modern medicine has been experiencing challenging developments. Impressive scientific advances on diseases and specific organs have resulted in breakthroughs for diagnosis and treatment. These, however, have been accompanied by weakening of the doctor-patient relationship, depersonalization and fragmentation of clinical care as well as commoditization and commercialization of health [43].

In response to these distortions in the cultivation and practice of medicine, some noteworthy initiatives have been emerging. In 1948, the World Medical Association consistent with its foundational ethical aspirations issued its Geneva Declaration as an update of the Hippocratic Oath for the use of graduating medical students across the world.

In 1964, the World Medical Association developed the Helsinki Declaration on medical ethics as the preeminent reference in this field, and has periodically updated it since then. The International College of Person Centered Medicine has had the opportunity to contribute to the Helsinki Declaration's recent revisions.

In 2005 the WMA published *Caring Physicians of the World* [44] to profile exemplary doctors from 58 countries across all continents, who in the words of its editor, former WMA president Yank Coble, display the three fundamental and enduring traditions of the medical profession, caring, ethics and science.

The World Health Organization at its 2009 World Health Assembly declared for the first time people-centered care as a pivotal health care strategy. This remains a central strategic principle along with integrative and universally accessible care in WHO's 2014-2019 Work Program. People-centered care is that focused and organized around people (their health experience, culture, circumstances, and values), rather than diseases.

A series of annual Geneva Conferences on Person Centered Medicine started in 2008 with the goal of placing the whole person at the center of health care, by articulating science and humanism and striving for a medicine of, for, by, and with the person. The Geneva Conferences have been consistently co-sponsored by the World Medical Association in collaboration with the World Health Organization, the International Council of Nurses, and the International Alliance of Patients' Organizations among over 30 global health institutions. From that process emerged an International Network (now International College) for Person Centered Medicine, which conducts scholarly debates and research on the systematic conceptualization and methodology in this field and publishes an International Journal of Person Centered Medicine.

WMA leaders have participated actively in the proceedings of all seven Geneva Conferences to date. For example, former WMA president Jim Appleyard has stated that "Trust can only be assured if patients believe that the physician respects them as individuals". WPA secretary general Otmar Kloiber affirmed "Working with and for people is a moral imperative." And former WMA president Jon Snaedal pointed out that "WMA has been formally involved in the organization of the Geneva Conferences on Person-centered Medicine since 2008 and is a formal member of the International Network for Person-centered Medicine. In most of the policy documents of the WMA, patients are mentioned rather than persons with a disease or symptoms. In face of the dialogue that now has been ongoing for some years on person centered medicine, it could be time to change these phrases and the WMA should establish a policy on person centered medicine."

The International Council of Nurses

From the nursing perspective, a focus on the patient in a holistic way- as a whole person, not simply a health problem - has always been at the centre of nursing care. Nursing leaders and theorists have always promoted self-care, focusing on enabling people to do as much as possible for themselves. In this model, the nurse strives to get deep into the person by listening and establishing a dialogue with a view to creating a therapeutic relationship in which the person is a key partner [45].

McCormack and colleagues [46], for example, identified several values related to person-centred health care based on the assumption that human autonomy can be retained in the presence of debilitating illness and disability through partnership with nurses obtained by getting close to the person, providing care that is consistent with the person's values, taking a biographical approach to assessment and ensuring a focus on ability, rather than on dysfunction.

In order to centre care on the person, competencies are needed in communication and assessment, counselling and behaviour change strategies, supporting self-management of illness and wellness, and in coordinating care across time and with other health professionals. The International Council of Nurses (ICN)'s Framework of Competencies [47] identify a cluster or set of skills, knowledge, judgements and behaviours that allows the nurse to deliver culturally appropriate and effective care.

The team approach is the cornerstone of person-centred health care and nurses have a major contribution to the functioning and effectiveness of health teams. In today's complex health care delivery systems it is impossible for any one professional group to provide person-centred care and wide consultations, linkages and referrals are needed to achieve desired health outcomes. All health care professionals have this responsibility, but nurses have perhaps the greatest opportunity as they work in many settings and are often the first point of contact for the public.

Nurses' role in and contribution to the health team is shaped by ethical and professional obligations. The ICN

Code of Ethics for Nurses [48], for example, affirms that the nurse must cultivate a co-operative relationship with co-workers in nursing and other fields. By their presence in varied health care settings and proximity to patient care, nurses are the link that holds health teams together. This ICN Code also affirms the need for identifying and respecting the person's preferences, values, differences and expressed needs.

Similarly, ICN's policy statement on *Continuing Competence as a Professional Responsibility and Public Right* [49] calls for sharing decision-making and management of illness with patients, including adherence to medical and other regimens.

The International Council of Nurses has co-sponsored and actively participated in the Geneva Conferences on Person Centered Medicine since its first edition. Its officers and policy consultants have spoken at and chaired sessions in virtually all these Geneva Conferences and one of them (now a former ICN officer) is a member of the ICPCM Board of Directors.

Introducing the Papers in this Issue of the Journal

Interdisciplinary collaboration in its relation to the construction of person centered medicine is illustrated in several articles in the present issue of the Journal, particularly those related to the roles of the World Medical Association and the International Council of Nurses.

The fundamental significance of the World Medical Association in the initiation and the nurturing of the person centered medicine movement is allegorized by the publication at the outset of the WMA Declaration of Geneva [50], the updated Hippocratic Oath offered for medical graduates to read at the solemn initiation of their life-long professional journey.

The first full article is authored by Jon Snaedal [51], a professor of geriatric medicine in Reykjavik and former president of the World Medical Association who has had a substantial role in the development of person centered medicine. He reviews WMA perspectives on ethics, including the widely respected WMA Declaration of Helsinki on research involving human subjects. Another important document reviewed is the Lisbon Declaration on the rights of patients. Finally, he discusses the Association's current processing of international views on Person Centered Medicine, as it has decided to produce a white paper, describing the various terms that exist on person centeredness in health care.

Yukiko Kusano, policy officer of the International Council of Nurses (ICN) in Geneva, discusses in the next article nursing perspectives on person- and people-centered integrated care for all [52]. She traces the bases of ICN commitment on the above goal to the ICN Code of Ethics for Nurses [48] and other ICN policy documents, programs and research. She argues that achieving person- and people-centred healthcare requires commitment of individual nurses and other health professionals, healthcare systems, and even non-health sectors.

From the Centre for Palliative Medicine, Medical Ethics and Communication Skills of the School of

Medicine at the University of Zagreb, clinical psychologist Lovorka Brajkovic presents and discusses their approach to teaching communication skills to medical students [53]. It is within this centre that the education of students and healthcare professionals takes place on the topic of communication in medicine and the person-centred medical interview. She points out that person-centred medicine relies on strong teamwork, a concept emphasized in their program. This connects well to the thrust of the Journal's present issue.

Next, a study grounded in Australian general practice towards learning to provide patient-centered care for patients with medically unexplained symptoms is reported by Luis Stone, an academic general practitioner, and Jill Gordon, a professor of values, ethics and the law in medicine [54]. They found that in hospital practice, biomedical language and explanations predominate, but in general practice patients bring different explanatory illness models to the consultation, using their own language, beliefs and cultural frameworks. Medically unexplained symptoms seem to occupy a contested space in both the social and medical worlds of the doctor and patient. They argue that negative feelings and a lack of diagnostic language and frameworks may prevent registrars/residents from providing patient-centered care.

An innovative approach to training on humanism and bioethics is presented by S. Nalliah, A. Thuraisingham and A.S. Ping, from the International Medical University, Jalan Rasah, Seremban, Malaysia [55]. They explored through a pilot study if reading fictional works of medical writers could be used as a tool to formatively assess learning in the above fields. A medical student in her elective rotation was assigned to read a story-book dealing with daily life and suffering authored by a medical-writer. Subsequently, she was expected to write a reflective narrative report which was assessed and reflected on by her mentor. From the student's report, it appeared evident that she had gained experiential learning in three areas, i.e., self-reflection and self-awareness, empathy, and ethical reasoning skills.

In the last full article in this Journal issue, Esta Sušić, Ema Gruber, and Blaženka Guberina Korotaj present and discuss their training program for person centered medicine in a prison hospital in Croatia [56]. They use a bio-psycho-social model of treatment and rehabilitation. The point is that professional skills to be cultivated include capabilities to provide person-centered psychiatric treatment aimed at reducing psychopathology, articulating theoretical concepts, therapeutic procedures, self-understanding, and addressing interpersonal issues and relations between patient/prisoner and health professional. Skills to interact effectively with other health professionals, particularly social workers and occupational therapists, as well as with prison, court, and state officers also need to be developed.

Concluding Remarks

The Journal's present issue reviews through several papers the importance, intricacies and implications of

interdisciplinary professional collaboration for person-centered care. It highlights the contributions of physicians and nurses as individual professionals as well as through their global associations, the World Medical Association and the International Council of Nurses, respectively. The issue's last pages offer information about upcoming events of central relevance to person centered medicine.

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