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Interprofessional teamwork in the ICU

Panacea or illusion?

Reflections on key research insights into interprofessional teamwork in the ICU with a critical yet optimistic view for its future.

Over the years, interprofessional teamwork in the intensive care unit (ICU) has been viewed as a panacea to most ills and indeed described as a core value of critical care practice (Parker 2016; Donovan et al. 2018; Lyons 2018). However, my recent conversations with ICU colleagues from the UK, US, Canada, Brazil and Hong Kong reveal that challenges to this way of working still abound. In this article, I reflect on key research insights and experience I developed from studying this issue over a number of years; and seek to provide a critical yet optimistic view for the future.

The interest in interprofessional working in ICU can be traced back to the 1980s, following studies by Knauss and colleagues in the U.S. (Knaus et al. 1986). Analysis of large datasets made the problem clear, which can be summarised in the following conclusion: in units rated better on teamwork 55% more patients survived than were expected to, while in the worst rated units 58% more patients died than were expected to. Let us be clear then, poor interprofessional teamwork costs lives and compromises quality of care. This is no big revelation, as anyone who has ever worked in ICU can attest to. However, it does beg a bigger question—why do we need research to point out and encourage people to practise the obvious?

There are very few ICU clinicians, and there are some, to be sure, who can confidently argue teamwork is not an aspiration worth pursuing. Indeed, being a team player is a requirement that pops up in most interviews for an ICU post. And, at its most basic level, everyone understands what it is about: respect, trust, communication, supportive leadership, coordination, and so on. Yet, after decades of talking about it progress remains slow. Why is interprofessional teamwork so difficult to achieve? As someone who has been fascinated about this topic for years, I have come to the simple conclusion that interprofessional teamwork in ICU, as in much of healthcare, does not come naturally.

Interprofessional teamwork does not take place in a vacuum. There are a number of variables that can affect adoption of this way of working to one extent or another, many of which have been the subject of intense debate, such as staffing, resources, facilities, guidelines, to name a few. Here, I want to explore the issue at a more primal level, and to do so we must acknowledge it as situated in the wider healthcare delivery system in which clinicians operate: the system of professions (Abbott 1988).

> "good leadership is the catalyst to good teamwork"

The social organisation of the different professions making up what we call a healthcare delivery system can be likened to an ecology, a very fragile ecology indeed. Each profession exists, as a distinct grouping, on the basis of exclusive expertise and authority over an area of activity—what sociologists call jurisdictions. Examples include diagnosis, prescribing, mobility and family support. This is a key way in which professions are distinguished from one another. Some jurisdictions can indeed be shared, but others are retained exclusively. Evidence of this way of thinking is found in job descriptions, professional codes of conduct and regulatory bodies. The problem with interprofessional teamwork is that some people see it as challenging some traditional, well-ingrained understandings of who is responsible for and gets to do what.

Of course, in ICU, professionals do not go around contemplating their job descriptions or the pressures of their professional society or regulatory body. They are far too busy to even think about these issues. Agreements about how ICU work is organised and how care is delivered are not set in stone, but are negotiated at the level of everyday practice through discussion, often conflict and ultimately compromise (Xyrichis et al. 2017). One of our challenges, ICU colleagues say to me, is that we do not have time to have such discussions. And, even when we do, the ephemeral nature of ICU teams means these discussions need to be repeated quite a lot.

To be fair, researchers, academics and policy makers have not made the situation any easier. Setting unrealistic expectations without providing people with the tools needed to implement and operationalise change in day-to-day practice is not acceptable. Complex phrases can impress senior management but mean little to people on the shop floor: consider the popular call for 'flattened hierarchies', an oxymoron if ever there was one. Teamwork has never been about working without a leader and I have never met a clinician to say so. The opposite is true—good leadership is the catalyst to good teamwork. A good leader's job is to bring the best out of their team, facilitate discussion and direct decision-making; and, when necessary, cast the deciding vote—but it is never their job to ignore others, put them down and fend off legitimate concern. The discussion above tackles only some of the issues, what I consider to be most critical, misunderstood and under-appreciated. I could go on for pages, but let me now move away from pointing out problems to suggesting solutions.

How to improve interprofessional teamwork in the ICU

Is there anything we can do to improve interprofessional teamwork in the ICU? Lots of things, but most important is to talk to each other, at all levels, starting from senior leadership. Have an open discussion about perceived, and actual, barriers to teamwork in your unit including the issue of who is responsible for what. Start with a common example known to cause tension in your unit, for example getting a patient out of bed, prescribing a new drug, weaning or withdrawing treatment—these are all issues that demand the attention of different professionals and are a good starting point for discussions.

If you are really serious about improving teamwork in your unit, try a self-assessment exercise using something like the Interprofessional Activity Classification Tool (InterPACT) (Xyrichis et al. 2018). This can help trigger conversations about the different kinds of interprofessional activity, and diagnose weaknesses or areas needing reinforcement. Each ICU is unique, and not one tool or model can apply everywhere—it is up to the team to take ownership of their way of working, but it needs commitment from the top. A senior intensivist said to me once during an interview: 'monkey see, monkey do'—if there is teamwork at the top the rest of the team will follow.

For those of you intrigued by this brief introduction to the many and complex issues surrounding interprofessional team practice in the ICU, and want to learn more, I suggest you take a look at this recent book by Reeves and colleagues: *Collaborative practice in critical care settings: a workbook* (Reeves et al. 2018). Part of the collaborative practice series of the UK-based Centre for the Advancement of Interprofessional Education (CAIPE), this book provides a rich analysis of the main issues and provides practical advice, exercises and templates applicable to different contexts. ■

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For full references, please email editorial@icu-management.org or visit https://iii.hm/qpc

Dr. Theodoros Kyprianou joins Editorial Board

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Kyprianou Theodoros

ICU Management & Practice is delighted to announce that Dr. Theodoros Kyprianou, MD, PhD, EDIC, has joined the Editorial Board. Dr. Kyprianou will be Section Editor for the new Informatics & Technology section in the journal, starting in 2019.

Dr. Kyprianou is a consultant physician in Respiratory & Intensive Care Medicine, practising in Cyprus and the UK. He holds the post of Associate Professor at St George's University of London 4-year MBBS Programme, delivered at the Medical School, University of Nicosia since 2013. He was the founding Head of the Department of Intensive Care at Nicosia General Hospital in Cyprus (2006-2018).

He has a long-standing interest in the applications of informatics in medicine and in intensive care medicine in particular. He coordinates the MSc Applied Health Informatics & Telemedicine distance learning programme at the Open University of Cyprus and served as Chair (2015-2017) of the Technology Assessment & Health Informatics Working Group and as deputy chair of the e-Learning Committee (2016-2018) at the European Society of Intensive Care Medicine. His research interests focus on ICU ehealth, bio-signals and big data analytics. He is currently a member of the standing programme committee of EU HORIZON 2020 (SC1-Health, Demographic Change and Wellbeing) based in Brussels.

Prof. Jean-Louis Vincent, Editor-in-Chief, said: "Technology is vital to the ICU, and we want to examine and consider the benefits and challenges of this rapidly changing area. We welcome Dr. Kyprianou's experience and expertise and look forward to bringing this new section to our readers."

ICU Management & Practice launches Informatics & Technology section

As informatics & technology advances invade health professionals' clinical routine, especially in intensive care medicine, practical advice and clear reviews are needed on topics such as artificial intelligence, big data, clinical information and decision support systems, closed-loop automations and so on. Submissions and ideas for the new section are welcome, and should be sent to the managing editor in the first instance - **editorial@icu-management.org.**

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