

# **Topic 2: Team Member Roles and Responsibilities**<sup>1</sup>

## **Overview**

Although one might be familiar with the care delivery process, many health professionals are not familiar with the education base, the roles, or the range of functions of members of other disciplines. This lack of familiarity is due, in part, to the manner in which each group is trained – a unique professional environment with its own language, terminology, problem-solving methods, and professional behaviors. This approach to training coupled with a general lack of knowledge leads to under utilization of skills and capabilities and to disputes about areas of overlapping practice<sup>2</sup>. Each member of a team needs to understand the unique expertise contributed by each profession represented and the areas where skills overlap among different professions<sup>3</sup>. The information and exercises in this section are designed to introduce each team member to the specific preparation for practice and the accepted responsibilities of each professional serving on the interdisciplinary care team in geriatrics.

## **Objectives**

- Develop an awareness of team member role differentiation
- Recognize leadership potential and roles
- Understand the principles of successful teamwork

## **Skills of Different Professionals on Teams**

Team members from different disciplines bring a unique set of skills (Table 2.1)<sup>3</sup>. It is also important to recognize that skills overlap. Understanding the skills and education of various team members contributes to respect. By knowing the skills of other health professionals, team members can also refer elderly clients appropriately to other professionals. It is important to recognize that each profession trains its members in a culture that reflects a common language, professional behaviors, values, and beliefs. Sometimes there is disagreement because the expectations and language create confusion. Most professionals do not recognize the training of others and learn what other professionals do only after they are practicing as professionals.

Team members on an interdisciplinary team interface with five distinct groups:

1) the other team members, 2) students, 3) patients, 4) families, and 5) caregivers.

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<sup>1</sup> Topic 2 is compiled from: Fasser C. *Interdisciplinary Team Training Curriculum Resource Document*. New York: The Geriatric Interdisciplinary Team Training Resource Center of New York University; 1999.; Long DM, Wilson NL, (eds.) *Houston Geriatric Interdisciplinary Team Training Curriculum*. Houston, TX: Baylor College of Medicine's Huffington Center on Aging; 2001

<sup>2</sup> Campbell, L.J., Eisenberg, M.G., Elliott, T.R., & et. al. (1992). Knowledge of disciplines, roles, and functions of team members. In (1992). *Guide to interdisciplinary practice in rehabilitation settings* (p.44). Glenview: American Congress of Rehabilitation Medicine.

<sup>3</sup> Long, D.M., Fay, V., & Wilson, N.L. (2001). Interdisciplinary teams – members and their roles. In D.M. Long, & N.L. Wilson (Eds.) *Houston geriatric interdisciplinary team training curriculum*. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

A team focus identifies the older person's problems from the following perspectives:

- Medical issues and treatments
- Psychological/emotional issues and treatments
- Social issues and treatments
- Economic issues and treatments
- Living conditions and treatments

Though there is a range of individuals who can be found as members of an interdisciplinary team in geriatrics, the core professional members are typically the:

1) physician, 2) nurse, 3) social worker, 4) psychologist, and 5) pharmacist. The extended professional members of the team might include: 1) non-physician providers (nurse practitioners, physician assistants), 2) physical therapist, 3) occupational therapist, 4) dietitian, 5) dentist, and 6) chiropractor.

It should be noted that the older client and family are also important members of the team.

## **Specific Roles/Skills of Team Members**

Table 2.1 provides an overview of the different practice roles/skills, education/training, and licensure/credentials of different professionals who commonly participate as members of interdisciplinary teams.

### *The Physician*

The physician treats diseases and injuries, provides preventive care, performs routine checkups, prescribes drugs, and some perform surgery. A geriatrician is a physician with special training in the diagnosis, treatment, and prevention of disorders affecting older people. The geriatrician recognizes that aging is a normal process and not a disease state.

The GITT Medicine Special Interest Group has provided guidelines on the physician's role on an interdisciplinary team:<sup>4</sup>

- Responsibilities to team members don't differ according to discipline. They involve cooperation, participation in the tasks at hand, and respect for the contributions of others.
- The physician should model these behaviors and teach them to students, as well.
- The physician should serve as a mentor not only to physicians-in-training but also to students from all disciplines.
- The physician should ensure that medical issues are given the proper weight in the decision-making process. He or she can accomplish this by describing the relevant medical aspects of cases, so that they are fully understood by everyone participating in the development of the interdisciplinary care plan.

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<sup>4</sup> GITT Medicine Special Interest Group. [GITT Web Site]. Available at <http://www.gitt.org/medicine.htm>. Accessed July 15, 2000.

*The Geriatric Nurse Practitioner*<sup>5,4</sup>

The GITT Nursing Special Interest Group defined the professional skills and interdisciplinary team skills of the nurse practitioner. Upon completion of a formal educational program, gerontological nurse practitioners are able to do the following:

- Elicit a comprehensive health history from the client and/or caregivers, including an evaluation of developmental maturation, physiological/psychosocial/functional status, cultural orientation, perception of health, health-promoting behaviors, risk factors for illness, response to stressors, activities of daily living (instrumental and functional), service utilization, and support systems.
- Complete a comprehensive functional assessment, mental status assessment, and psychoemotional assessment.
- Perform a complete physical examination on the older adult, employing techniques of observation, inspection, palpation, auscultation, and percussion.
- Discriminate among normal findings, normal changes of aging, pathological findings, and abnormal findings that require collaboration with a physician.
- Use pertinent screening tools to determine health status.
- Order and/or perform pertinent diagnostic tests.
- Analyze the data collected in collaboration with the health care team to determine health status and need for consultation with or referral to other agencies or resources.
- Formulate a problem list.
- Develop and implement, with the client, caregiver(s) and/or significant other(s), and health care team, a plan of care to promote, maintain, and rehabilitate health.
- Evaluate the client's response to the health care provided and the effectiveness of the care with the client.
- Collaborate with other health professionals and agencies involved in the client's care.
- Modify the plan and intervention as needed.
- Record all pertinent data about the client, including the health history, functional assessment, physical examination, problems identified, interventions planned and/or provided, results of care, and plans for consultation or referral.
- Coordinate the services required to meet the client's need for primary health care and/or long-term care and monitor outcomes.
- Act as an advocate for the older adult to improve his/her health status.
- Provide for continuity of care over time and in a variety of settings.
- PT/family centered care.
- Participate in lifelong learning, peer review, and CQI.

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<sup>5</sup> This section has been adapted from the American Nurses Credentialing Center Guidelines for graduating nurse practitioners, National Organization of Nurse Practitioner Faculty and the American Nurses' Association Standards of Practice for the Primary Health Care Practitioner. Competencies have been modified to include an interdisciplinary focus reflecting our recognition of the importance of interdisciplinary care for elders.]

**Table 2.1 Team Members Overview**

Long DM, Wilson NL, (eds.) Houston Geriatric Interdisciplinary Team Training Curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging; 2001

Discipline	Practice Roles/Skills	Education/Training	Licensure/Credentials
<b>Nurse</b>	Licensed vocational nurse (LVN)----basic nursing skills that are dictated by the facility; registered nurse (RN)----BA or higher and has increased scope of practice, including planning for optimal functioning, coordination of care, teaching, and direct and indirect patient care.	LVN---1 year of training; RN with associate degree---2 years of training, usually in a community college; BS, RN----4 years in college; MS, RN----2 years of postgraduate specialty study; PhD RN----3-4 yearsof postgraduate studies	LVN--exam required for licensing; CE requirements. RN---can be RN; BS, RN; APN; MS, GNP or other specialty RNs; PhD, RN: all must pass the national licensure exam and are required to have 20 hours of CEUs per year.
<b>Nurse practitioner</b>	Health assessment, health promotion skills, histories and physicals in outpatient settings; order, conduct,and interpret some lab and diagnostic tests; teaching and counseling.	Master's degree with a defined specialty area such as gerontology (GNP).	In addition to RN licensure, NP must pass a National Certification Exam in the appropriate specialty area (e.g., gerontology or family practice)
<b>Physician</b>	Treat diseases and injuries, provide preventive care, do routine checkups prescribe drugs, and do some surgery.	Physicians complete medical school (4 years) plus 3 to 7 years of graduate medical education.	State licensure required for doctor of medicine degree; exam required and possible exams required for specialty areas. CE requirements.
<b>Geriatrician</b>	Physician will special training in the diagnosis, treatment, and prevention of disorders in older people; recognizes aging as a normal process and not a disease state.	Complete a 1- to 3-year postgraduate fellowship training program in geriatric medicine or pass an exam Certificate of Added Qualification (CAQ) in geriatrics.	Doctor of medicine state exam required as above.
<b>Physician assistant</b>	Practice medicine with the supervision of licensed physicians; exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services; practice is centered on patient care.	Specially designed 2-year PA program located at medical colleges and universities. Mose have bachelor's degree and over 4 years of health care experience before entering a PA program.	NCCPA certifying exam---the credentials PAC will be used if certified; PA will be used if not certified. This exam is given every fall (October) for first time takers. Every 6 years a PA must take a recertification exam and this is given in the spring. Requires 100 hours of CEUs every 2 years.
<b>Social Worker</b>	Assessment of individual and family psychosocial functioning and provision of care to help enhance or restore capacities; this can include locating services or providing counseling.	There is a 4-year college degree (BSW); 2 years of graduate work (MSW), and doctoral degree (Ph.D.); 15 hours of continuing education is required every year.	State certification is required for clinical social workers. The LMSW (for masters level); LSW (BS level); SWA is a social work associate with a combination of education and experience. ACP---signifies licensure for independent clinical practice.
<b>Psychologist</b>	Assessment, treatment and management of mental disorders; psychotherapy with individuals, groups, and families.	Graduate training consists of 5 years beyond undergraduate training; most course work includes gerontology and	Ph.D. or EdD or PsyD are degrees awarded. State licensure; the American Psychological Association has ethics codes as do most states.
<b>Psychiatrist</b>	Medical doctors who treat patients' mental, emotional, and behavioral	Medical school and residency specializing in psychiatry. Residency	State exam to practice medicine; Board of Psychiatry and Neurology offers exam for diplomat in psychiatry,

Discipline	Practice Roles/Skills	Education/Training	Licensure/Credentials
<b>Psychiatrist (con't)</b>	symptoms.	includes both general residency training and 2-3 years in area of specialization (e.g., geriatrics, pediatrics).	though not required for psychiatric practice in Texas.
<b>Pharmacist</b>	Devised and revise a patient's medication therapy to achieve the optimal regime that suits the individual's medical and therapeutic needs; information resource for the patient and medical team.	Pharmacists can receive a baccalaureate (B.S.) - 5 year program; or doctorate degree (Pharm.D.) Annual CEUs required range from 10 to 15 hours	State exam required - Texas uses the national exam (NABPLEX); given every quarter; RPh is the title for a registered pharmacist in Texas; board certifications in specialties available (pharmacotherapy, nuclear pharmacy, nutrition, psychiatric, and oncology in near future).
<b>Occupational Therapist</b>	One who utilizes therapeutic goal-directed activities to evaluate, prevent, or correct physical, mental, or emotional dysfunction or to maximize function in the life of the individual.	BS or MS in OT with a minimum of 6 months of field work; for OT assistant, an associate degree or OT assistant certificate is required with a minimum of 2 months' field work.	State exam required for the credential of O.T.R. (occupational therapist registered). Exam also required for COTA (certified occupational therapy assistant). These exams are given at least 2 times/year.
<b>Physical Therapist</b>	The evaluation, examination, and utilization of exercises, rehabilitative procedures, massage, manipulations, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound in the aid of diagnosis or treatment.	Four-year college degree in physical therapy is required to be eligible for the state exam; master's degree in physical therapy is available; 3 CEUs every 2 years are required.	PT is the credential that is used by licensed physical therapists and PTA is the credential for licensed physical therapist assistant. To use either of these titles, one must pass a state exam. CEUs are required for both; titles and licenses must be renewed bi-annually.
<b>Chaplain</b>	Provide visits and ministry to patients and family.	Master's degree in theology, plus a minimum of 1 year of clinical supervision. If fully certified, can work in some settings without being fully certified.	Certification is through the Chaplaincy Board of Certification -----credentials for this are BCC; however, credentials are not normally used. Most chaplains are ordained ministers, but not all. CEUs required are 50 hours per year.
<b>Dietitian</b>	Evaluate the nutritional status of patients; work with family members and medical team to determine appropriate nutrition goals for patient.	BS degree in food and nutrition and experience are required to be eligible for exam; CE's are required for both the LD (6 clock hrs/year) and RD (67 clock hrs every 5 years); MS degree is available also.	RD is the credential for a registered dietitian in the state of Texas. For RD, must pass the national exam of the American Dietetic Association; LD is the credential for a licensed dietitian in the state of Texas; same exam is required but processing of paperwork/ fees are different.

In addition to the above areas, gerontological nurse practitioners who have completed the GITT Program will be able to:

- Define the gerontological nurse practitioner's role in various health care settings.
- Identify and implement assertiveness and leadership strategies to strengthen the gerontological nurse practitioner's role in various health care settings.
- Identify complex geriatric clients who would benefit most from collaboration of other health care team members.
- Demonstrate sensitivity to cultural and economic issues of clients in planning care as a team.
- Identify team dynamics that promote collaboration among disciplines.
- Develop skills in communicating and networking with health care team members.
- Demonstrate knowledge of conflict management techniques for resolving conflict among health care team members.
- Demonstrate skills in leading and coordinating health care team meetings.
- Develop and implement strategies that have a positive effect on the advancement of knowledge, political and regulatory processes, and systems affecting the health and welfare of older adults, gerontological nurse practitioners, and the health care system.

### *The Social Worker*

The role of the social worker on an interdisciplinary team includes but is not limited to the following.<sup>6</sup>

1. Diagnosis/Assessment.- The goal of a bio-psycho-social assessment is to identify the strengths and limitations of the patient and family and to assist them in creating a treatment plan with clearly defined goals. It provides a holistic view of the patient/family. The social worker can identify barriers to medical compliance and assist others on the team in the management of an acute or chronic illness. The social worker can also help to assess whether the presenting medical problem is compounded by mental health problems. The social work assessment takes into consideration how well the patient (and the family or caregiver) is functioning in six areas:
  - Physical -- a brief medical history, functional abilities, appearance, and observed behavior.
  - Psychological -- affect, mood, outlook, attitude, personality characteristics, cognitive functioning, self-image.
  - Social -- vocation, social roles, support networks, education, and financial status.
  - Cultural -- values, general rules of behavior, definition of the "sick role," beliefs about the root causes of illness and prescribed treatments, communication patterns that encompass varied language and speech patterns, as well as bilingual issues.
  - Environmental -- living conditions and home surroundings, with focus on safety and maintaining functional independence.
  - Spiritual -- beliefs about people's roles and responsibilities, rules for living, belief system, diet, and acceptable medical treatments.

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<sup>6</sup> West, Mellor, & Robinson, GITT - Social Work Interest Group of the John A. Hartford Foundation Geriatric Interdisciplinary Team Training Program. 1998

2. Care Management. Equally referred to as case management, this social work role includes problem identification (e.g., lack of financial resources, need for help with ADLs, or mental health intervention), as well as links to and coordination of community resources to facilitate the highest practical level of functioning for the patient and family. It requires knowledge of community resources and entitlements, and skills in matching patient/family with resources, linking resources, and serving as an interpreter and advocate for the patient/family.
3. Individual Counseling. Psychosocial counseling includes treatment of mental health problems such as depression and anxiety through various techniques, including family therapy, relaxation, and stress management training for the patient and/or caregiver. This is intended to assist patients and families to adjust to major life stressors and transitions such as illness, disability, institutionalization, and loss, as well as to empower the client. A patient's ability to adapt to an illness has a profound impact on quality of life, as well as on the patient's willingness/ability to comply with the prescribed treatment and is paramount to recovery, physical, and emotional healing, timely discharge from the hospital, risk management, and effective decision making. The social worker brings skills in listening, problem resolution, and negotiation, with attention to community and environmental factors.
4. Group Work. Group psychotherapy and supportive psychoeducational groups are designed to help patients/families and/or caregivers cope with a specific illness, e.g., depression, Alzheimer's disease, cancer, or diabetes. The social worker brings skills in group development and facilitation.
5. Liaison. The social worker can also serve as a liaison between the patient/family and the professional community. This is particularly pertinent when the family lives out of the area and their input must be obtained via long-distance communication.
6. Advocacy. Social workers' training, including a working knowledge of ethics, confidentiality, advance directives, cultural/ethnic factors, and patient/family rights, serves to help teams face the challenge of balancing patient needs with the system demands. Often the most important service provided by a geriatric/gerontological social worker to patients is assistance negotiating an overwhelmingly bureaucratic system, such as Medicaid, Social Security disability, funeral arrangements, or dealing with insurance and hospital paperwork, by acting on the patient's behalf and/or teaching them to help themselves.
7. Community Resource Expertise.- Knowledge of community resources and how to access them is an invaluable piece of the social work profession. This involves high-level skills in negotiation and bargaining in order to broker for appropriate resource allocation. A working knowledge of financial systems, including federal, state, and county programs is part of this expertise. Serving as a resource referral coordinator requires negotiation and collaboration to assist patients and families in setting priorities, care goals, and balancing issues.

### *The Patient, Family, and/or Caregivers*<sup>3</sup>

The patient's, family's, or caregiver's roles as team members can be described in terms of their contributions to care planning process of the interdisciplinary team:

1. Extent of commitment to problem management plan;

2. Understanding of goals and components of treatment plan; and
3. Self-determination and rights.

Knowledge about the about the preparation, expertise, and scope of practice affects individual team member performance, in that it can:

1. Reduce tension that occurs around who is doing what,
2. Help members accept role overlap as necessary and positive,
3. Foster positive views toward the efforts of several disciplines, and
4. Increase the ability to problem solve beyond a single discipline.

Clinicians may find the tool, "Conducting a Family Meeting," helpful for identifying ways to elicit the participation of patients and family members on the team.

## **The Culture of Team Care**

Team health care of the elderly occurs within many cultures. The elderly patient and the family represent at least one culture of care, in that families develop their own understandings of care and pass them on from generation to generation. In addition, providers are educated within cultures that pass on instructions and assumptions about how care should be provided and who should receive it. These cultures in turn influence a larger culture of care that involves cooperation among clinicians, the patient, and the family. This culture is influenced by the opinions of experts in ethics, some of whom recommend that the elderly reduce their demands on the health care system. Quite apart from this influence of certain ethicists, many clinicians accept an ageist bias that exists in the general culture.

Moreover, much of the task of teamwork in health care for the elderly is to negotiate the territory between general agreement among cultures of care about goals of care and the specific perspective of each discipline on what is the best outcome and on each discipline's contribution toward that goal. The work concerning care of the elderly through representatives of various cultures is not just external. It is also an inner task of members of the team, who have to negotiate the agreement and disagreement about expectations of team members concerning what the patient needs, how it should be provided, and who should provide it.

### *Professional Cultures*

Each of the cultures that influences team health care of the elderly has its own view of its responsibility toward the patient and of the patient's responsibility for her/himself. In the view of Y.H. Poortinga, culture is "shared constraints that limit the behavior repertoire available to members of a certain sociocultural group in a way different from individuals belonging to some other group."<sup>7</sup> Poortinga's view parallels the reference by Hill et al. to "strategies" that health care professions employ to assemble their members around a common core, to establish their professional identity and appropriate behavior; and to distinguish their profession from other professions.<sup>8</sup> Consequently, much of the energy in teamwork is about the interaction between

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<sup>7</sup> Poortinga, Y.H. (1997). Towards a conceptualization of culture for psychology. *Cross-Cultural Psychology Bulletin*, 24(3):2-10. Cited in Pederson, P.B. (1997). *Culture-centered counseling interventions: striving for accuracy*. Thousand Oaks: Sage Publications.

<sup>8</sup> Hill RF, Fortenberry JD, and Stein HF, Culture in Clinical Medicine, *Southern Medical Journal* 83 (9):1071-1080, 1990, Sept, p. 1072.

the "shared constraints" of the individual disciplines and the focus of all the disciplines on the well-being of the patient.

Certain cultures of healthcare, particularly medicine and nursing, constrain the behavior repertoire available to health care professionals who are not physicians or nurses. At the same time, the cultures of other health care disciplines impose fewer constraints on medicine and, perhaps, nursing. If they choose to or are permitted to, physicians and nurses can do many of the things that other disciplines do.

Nevertheless, representatives of individual professions frequently have little understanding of the ethical commitments of other health care professions or of the service that the other professions provide to the elderly.

Cultures of health care express some of the constraints that they impose on their members in ethical codes or guidelines. We do not put a lot of stock in written codes of ethics, which are often used in a rigid or in a loose, advisory manner. Levine and Zuckerman claim that negative presumptions about families derive from the ethical commitments of the health care professions as stated in the codes to focus on individual patients<sup>9</sup>. This observation is relevant to the claim that the patient and family should be the core of the health care team. When codes are used rigidly, the user implicitly delegates his or her moral responsibility to the code and its writers, rather than using the code as a guide to action or even as a guide to reflection on action.

When codes are used in an advisory manner, practitioners may not take them seriously enough. Rodwin notes that,

"some historians suggest that the AMA has used its code to 'discredit interlopers,' to boost the profession's prestige, to stave off attacks, and to discourage external regulation. Codes may have helped the medical profession to reduce external competition, to promote an oligopoly status, and to protect prominent physicians against challenges. Nevertheless, codes also establish norms that can protect individual patients. They articulate organizational policies and official standards of conduct, and show how the organized profession frames issues."<sup>10</sup>

Rodwin goes on to argue that when faced with ethical issues like fee splitting, the AMA's "stance on these matters became weaker. . . . Later the AMA weakened its code to placate its members."

Finally, some practitioners simply ignore codes. When practitioners ignore codes, it does not mean that the practitioners are wrong or mistaken, but it does mean that there are limits to codes' effectiveness and power. Nevertheless, we mention codes here, because they draw our attention to matters that disciplines emphasize. A code provides a window on, or a snapshot of, a discipline's view of human suffering, perhaps of human flourishing, and of the discipline's understanding of its responsibility in the relief of suffering and the fostering of flourishing.

At the same time, Berwick, et al. claim that major codes of ethics "can divide a world of healthcare that badly needs unity in its work." Accordingly, the American College of Physicians-

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<sup>9</sup> Levine C, Zuckerman C, The Trouble with Families: Toward an Ethic of Accommodation. *Annals of Internal Medicine*. 130(2):148-152, 19 January, 1999, p. 148.

<sup>10</sup> Rodwin MA, The organized American medical profession's response to financial conflicts of interest: 1890-1992. *Milbank Quarterly*. 70(4):703-41, 1992., p. 707.

American Society of Internal Medicine (ACP-ASIM) drafted a set of ethical guidelines relevant to team and system characteristics of caregiving. The Preamble states,”

“The purpose of this statement of ethical principles is to heighten awareness of the need for principles to guide all who are involved in the delivery of health care. The principles offered here focus health care delivery systems on the service of individuals and the good of society as a whole and can offer a foundation for new and enhanced levels of cooperation among all involved.”<sup>11</sup>

One feature interfering with the development of a larger culture of care is that none of the codes of individual disciplines comes to grips with the fact that patient care is not a matter of individual caregiving or responsibility, but a team effort.

## **Leadership**<sup>12</sup>

The concept of different roles held by members of a geriatric interdisciplinary team is an essential and very complex element of effective team function. Such teams are typically situated in a health care setting. One might assume that a physician team member would be expected to serve as the single team leader by virtue of historical and medicolegal precedents. Another view is that leadership is only associated with certain personality traits; however, team approaches to geriatric care require shared responsibility for the team process and outcome. Membership and leadership roles are inseparable and involve an emphasis on role functions rather than on a particular discipline or a set of personality traits. Success involves the effective utilization of a team’s total resources. Although one or more individuals may have a formal designation as a group leader, the effective use of resources means that all team members need to share responsibility for informal and formal leadership. In true interdisciplinary teams, the functions of leadership and membership are viewed as synonymous. Because all team members have an investment in seeing the team achieve its goals and objectives, each member has the responsibility to help the team progress.

The functions of leadership, according to Sampson (1981), are:

1. Helping the group decide on its purposes and goals.
2. Helping the group focus on its own process of work together so that it may become more effective rather than becoming trapped by faulty ways of problem solving and decision making.
3. Helping the group become aware of its own resources and how best to use them.
4. Helping the group evaluate its progress and development.
5. Helping the group to be open to new and different ideas without becoming immobilized by conflict.
6. Helping the group learn from its failures and frustrations as well as from its success.

Consider the many leadership tasks associated with effective functioning of a geriatric ambulatory care program offering both consultative service and primary care in several

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<sup>11</sup> Berwick D, Hiatt H, Janeway P, Smith R. An ethical code for everybody in health care. *BMJ*. 1997;315:1633-4. The authors cite the American Medical Association, the American Hospital Association, and the American Nurses' Association's Code for Nurses with Interpretive Statements

<sup>12</sup> Wilson, NL and Gleason, M. (2001) *Team Roles and Leadership*. In Long DM, Wilson NL, (eds.) *Houston Geriatric Interdisciplinary Team Training Curriculum*. Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

environments. In one such program called GERICARE, the service requires team members of different disciplines to confer in team care planning meetings and to assign coverage for both regular and emergency patient calls. Like most programs, GERICARE has a designated formal leader, Dr. L, the clinic physician with the most expertise. However, Dr. L relies on colleagues of many other disciplines to help the team progress in its duties and maintain itself. A variety of administrative tasks (e.g., development of clinic policies and procedures, mobilization of resources for clinic operations, arrangement of schedules) and clinical care tasks (e.g., establishing priorities for patient-specific care plans, coordinating family conferences) require leadership.

### *Shifting Leadership Roles on Teams*

Historically, physicians have had the role of team leader in health care settings because of various factors, including culture, sex, and power; however, an emerging pattern in many primary care teams demands equal participation and responsibility from all team members with shifting leadership determined by the nature of the problem to be solved. Even when one team member, often a physician, has administrative authority over others (e.g., as supervisor), members of an interdisciplinary team treat one another as colleagues rather than as a single leader and subordinates. Emphasis by the team on geriatric health care rather than the more narrow focus of medical care broadens the roles and responsibilities of non-physician care providers. For example, when a patient's primary problems are due to an abusive and neglectful family situation, the social worker may assume the primary leadership role in helping the team take the allowable actions to improve the patient's situation.

### *What Behaviors Do Leaders Exhibit on Teams?*

There are different types of key leadership behaviors exhibited by members of a team. Ducanis and Golin (1978) make the distinction between task-oriented and socioemotional leadership. The task leader assumes those functions of coordination and planning necessary for task performance, while the socioemotional leader is responsible for team maintenance activities, often serving as a mediator and calming force for the group.

Drinka believes that leadership, more than anything else, is about noticing and solving problems and getting others to follow through or to recognize a leader's direction in solving problems. Reflecting on 10 years of experience with teams, including studies on leadership in geriatric interdisciplinary health care teams, Drinka suggests three kinds of tasks: socioemotional, patient care, and building and maintaining. The more effectively and consistently team members perform all three types of tasks, the more they are seen as strong leaders on the interdisciplinary team, whether they were informal or formal leaders (Drinka, personal communication, March 2000.)

As illustrated in Table 2.2, there are different types of task and maintenance functions required for an effective interdisciplinary team. The members and leaders, then, must attend to a balance of all tasks to achieve the intended goals of the interprofessional team.

**Table 2.2 Interdisciplinary Health Care Teams: Leadership Tasks**

<b>Organizer/Mover</b> <ul style="list-style-type: none"> <li>• initiate team development</li> <li>• identify team tasks</li> <li>• identify strength/weaknesses</li> <li>• call meetings</li> <li>• provide structure</li> <li>• review team needs</li> <li>• identify appropriate patients</li> </ul>	<b>Finisher</b> <ul style="list-style-type: none"> <li>• impose time constraints</li> <li>• focus on outputs (patients treated, goals achieved)</li> <li>• seek progress</li> <li>• show high commitment to task</li> <li>• manage projects</li> </ul>	<b>Expert</b> <ul style="list-style-type: none"> <li>• have special expertise</li> <li>• offer professional viewpoint</li> <li>• identify interdisciplinary patient problems</li> <li>• use expertise of other disciplines</li> <li>• understand patient needs</li> <li>• know team's expertise and limits</li> </ul>
<b>Ambassador</b> <ul style="list-style-type: none"> <li>• build external relationships</li> <li>• promote awareness of the team's work</li> <li>• build bridges</li> <li>• show concern for external team environment</li> </ul>	<b>Diplomat</b> <ul style="list-style-type: none"> <li>• build understanding between members</li> <li>• negotiate</li> <li>• mediate</li> <li>• facilitate decision making</li> </ul>	<b>Supporter</b> <ul style="list-style-type: none"> <li>• build team morale</li> <li>• put team members at ease</li> <li>• ensure job satisfaction</li> <li>• help patient work with team</li> </ul>
<b>Judge/Evaluator</b> <ul style="list-style-type: none"> <li>• listen critically</li> <li>• evaluate clinical process</li> <li>• evaluate clinical outcomes</li> <li>• help team reflect</li> <li>• promote appropriate treatment</li> <li>• act logically</li> <li>• seek truth</li> </ul>	<b>Process Analyzer</b> <ul style="list-style-type: none"> <li>• identify team problems</li> <li>• analyze team problems</li> <li>• consult with team members</li> <li>• offer observations</li> <li>• offers potential solutions to team problems</li> </ul>	<b>Facilitator</b> <ul style="list-style-type: none"> <li>• identify member conflicts</li> <li>• help team members find ways to resolve conflicts</li> <li>• help implement solutions</li> </ul>
<b>Creator</b> <ul style="list-style-type: none"> <li>• generate new ideas</li> <li>• visualize new programs/projects</li> <li>• visualize new alliances</li> </ul>	<b>Innovator</b> <ul style="list-style-type: none"> <li>• discover resources</li> <li>• identify opportunities</li> <li>• transform ideas to strategy</li> <li>• propose new methods</li> </ul>	<b>Challenger</b> <ul style="list-style-type: none"> <li>• offer skepticism</li> <li>• look in new ways</li> <li>• question accepted order</li> </ul>
<b>Reviewer</b> <ul style="list-style-type: none"> <li>• observe</li> <li>• review team performance</li> <li>• promote review of process</li> <li>• give feedback</li> <li>• mirror team's actions</li> </ul>	<b>Quality Controller</b> <ul style="list-style-type: none"> <li>• check output alignment</li> <li>• act as conscience regarding team goals</li> <li>• inspire higher standards</li> <li>• assure team reviews outcomes</li> </ul>	<b>Conformer/Follower</b> <ul style="list-style-type: none"> <li>• seek agreement</li> <li>• fill gaps in teamwork</li> <li>• cooperate</li> <li>• help relationships</li> <li>• avoid challenges</li> <li>• maintains continuity</li> </ul>
<b>Guard</b> <ul style="list-style-type: none"> <li>• protect team from too much output</li> <li>• protect team from too much input</li> </ul>	<b>Teacher</b> <ul style="list-style-type: none"> <li>• help new members learn the norms and values of the team</li> <li>• teach shared leadership skills to other members</li> <li>• recognize members' leadership potential</li> <li>• teach others when to seek specialty advice</li> </ul>	<b>Learner</b> <ul style="list-style-type: none"> <li>• raise questions to enhance understanding across disciplines or areas</li> <li>• raise questions regarding need for interdisciplinary input</li> </ul>

Source: Drinka, T.J.K., & Clark, P.G. (2000). Health care teamwork: interdisciplinary practice and teaching. Westport CT:Auburn House.

## **Team Meetings**

Although team members work in many situations in which leadership roles and functions can be shared and assumed, a critical arena for effective leadership is the team conference or meeting. Managing the team meeting process in order to achieve the team objectives demands a high level of skill and should not be taken lightly. The team coordinator or facilitator is responsible for moving the team efficiently through the process of the team meeting to make sure that the work of patient care planning is completed. Some teams rotate this leadership responsibility to ensure leadership and the associated tasks are shared.

### *Responsibilities of the Team Coordinator, the Recorder, and the Timekeeper<sup>12</sup>*

What are the meeting responsibilities of the team coordinator/facilitator? They include the following:

- Schedules, arranges, and conducts the meeting.
- Prepares and distributes agenda before the meeting and ensures that agenda is followed during the meeting.
- Clarifies purpose and helps the team identify goals.
- Ensures that all team functions are assigned to various team members.
- Encourages everyone to participate throughout the discussion.
- Summarizes and organizes the ideas discussed to gain commitment (with help of recorder).
- Identifies common topics or subjects in discussion to maintain direction of discussion.
- Asks questions to clarify comments and restates if members are confused.
- Encourages team to finish each agenda item before moving on to the next.
- Encourages the integration of new members.

Another important role is that of the recorder. The recorder has four major tasks during meetings, including:

- Documenting the efforts of the group, including summaries of decisions, action items (or assigned tasks), and deadlines.
- Maintaining the group's focus and direction.
- Actively clarifying the group's progress by using strategies such as summarizing and seeking.
- Producing written summaries.

Responsibilities of the team timekeeper include:

- Informing the group of the beginning time and ending time, allowing enough time for the members to begin and come to an end to the discussion.
- Indicating when the group is using more time than available on one issue and remind them of the number of tasks and time remaining.
- Helping the team use its time on issues on which the whole team is needed.

Techniques for facilitating a meeting are shown in Table 2.3.

**Table 2.3 Facilitator Roles and Tools for Meetings**<sup>13</sup>

<b>Facilitator Roles</b>	<b>Dialogue Examples</b>
1. Get the meeting started.	“Today we need to review__ patients. Are there any urgent concerns?”
2. Encourage communication and involvement of all members.	“What are the rehabilitation needs you see?”
3. Ask team members for opinions and feelings to encourage discussion.	“What is your view of the family’s request?”
4. Ask for a summary of the discussion.	“What are the care plan goals we have agreed upon? Can someone summarize?”
5. Paraphrase what someone has said to help members understand each other.	“Are you saying that we need more information on liver function?”
6. Ask for specific examples to improve understanding.	“Please give some examples.”
7. Clarify assumptions.	“Your recommendation assumes that the patient is too confused to make an independent decision.”
8. Ask for explanation in order to eliminate confusion and repetition	“We keep avoiding a plan for this. Can someone suggest how we should proceed?”
9. Probe an idea in greater depth.	“What are other ways to help Mrs. S stay at home.”
10. Suggest a break or rest.	“Let’s take a brief break.”
11. Move the team toward an action.	“What should we do first?”

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<sup>13</sup> Adapted by Nancy Wilson from Harrington-Mackin, 1994; cited in D. Long, & N. Wilson (Eds.), (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX. , Baylor College of Medicine’s Huffington Center on Aging ([www.hcoa.org](http://www.hcoa.org), 713-798-5804).

## **Exercises**

### *1. Overlapping Professions Case Study: Alex Green<sup>3</sup>*

This case study was designed to exhibit the different roles of each discipline on a team and their individual effects on the patient and the other professions on the team.

#### Facilitator's Notes

1. *Have the students read the case study.*
2. *Conduct a discussion about the issues involved in the case.*
3. *Have the students fill out the Case Role Map individually based on the questions, "Which disciplines should be involved in the case?" and "What can each discipline contribute to the care plan development?"*
4. *Ask the students to return to the group and share their ideas to create a group Case Role Map on a large flip chart of board in front of the group.*
5. *Conduct a discussion on the differences and similarities within each case role map. These differences will expose themselves as the group map is created. To aid the discussion, make brief notes when you notice a disagreement between the roles.*
6. *Administer the Summary Questions.*

### *2. Interprofessional Perception Scales<sup>14</sup>*

This is a series of tests that provide students with a self-assessment tool for their own disciplines and perceptions and perceived perceptions of the other disciplines in the team.

#### Facilitator's Notes

1. *Administer these tests before teaching Topic 2.*
2. *Attempt to determine the group's mentality towards their own and other professions by assessing which tests had a higher percentage of 1s or 4s.*
3. *Have a group discussion of the reasons for these possible differences.*

### *3. Professional Perceptions Quiz*

This exercise assesses the students' security with their own geriatric care skills. The levels of security can be broken down into profession for a later assessment.

#### Facilitator's Notes

1. *Have the students complete the exercise during a Topic 3 seminar.*

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<sup>14</sup> Grant, R.W., & Finocchio, L.J. (1995). California primary care consortium subcommittee on interdisciplinary collaborative teams in primary care. A model curriculum & resource guide. San Francisco: Pew Health Professions. Adapted D.M. Long, N.L. Wilson, T. Drinka, A.M. Woods, & M.S. Gill (Eds.), (1998). Houston geriatric interdisciplinary team training manual (pp. 7-14). Houston, TX: Baylor College of Medicine's Huffington Center on Aging.

2. *Collect the surveys.*
3. *Compile the data and determine the group's security level by profession.*
4. *Lead a discussion about the results and how that relates to team training and practice.*

#### 4. *Learning about Each Other's Disciplines*<sup>15</sup>

This exercise provides the student with a series of directive statements to help formulate thoughts to write a short report on their disciplines.

##### Facilitator's Notes

1. *Allow the students to prepare a short report about their disciplines using the questions provided.*
2. *Use the answers to these questions as a basis for a discussion with members of other disciplines.*

#### 5. *GITT Learner Weekly Team Meeting Team Dynamics Checklist*<sup>16</sup>

This is a tool to give your students before they meet. They are to spend the last 10-15 minutes of the meeting using the checklist to critique the team's dynamics. This questionnaire also provides opportunities for discussion of any problems the team is having that the questions raise.

##### Facilitator's Notes

1. *Hand out the questionnaire to students before they meet, usually at the end of a seminar.*
2. *Assign the exercise so that the students will take the time to work through the questionnaire.*

#### 6. *Conducting a Family Meeting*<sup>17</sup>

This tool provides a guide for conducting a family conference. The tool can be used in conjunction with any of the case studies provided throughout the GITT core curriculum. The guide provides an opportunity for students to consider their role in conducting a family meeting as well as the family members' roles on the team.

##### Facilitator's Notes

1. *Select an appropriate case study.*
2. *Have students read the guide, "Conducting a Family Meeting," and the chosen case study.*

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<sup>15</sup> Whitelaw, N., & Moore, S. (1997). Great lakes GITT team learning guide. Detroit, MI: Great Lakes GITT.

<sup>16</sup> Adapted from Minnesota Geriatric Interdisciplinary Team Training Program Faculty Manual (1999).

<sup>17</sup> McDaniel, S.H. (2000). Conducting a family meeting. Available at: [http://gitt.cwru.edu/family\\_meeting.html](http://gitt.cwru.edu/family_meeting.html). [Access date: August 28, 2000].

3. *Choose one student to role play as the patient and others to role play as appropriate family members.*
4. *Have students conduct the family meeting to discuss the plan of care.*
5. *Analyze students' behaviors as team members representing their profession and as interacting with the patient and family.*
6. *Facilitator can use the GITT learner weekly team meeting team dynamics checklist to grade student behaviors.*

## **References**

Campbell, L.J., Eisenberg, M.G., Elliott, T.R., & et al. (1992). Knowledge of disciplines, roles, and functions of team members. In Guide to interdisciplinary practice in rehabilitation settings (pp. 44). Glenview: American Congress of Rehabilitation Medicine.

Ducanis, A.J., & Golis, A.K. (1978). Interdisciplinary health care teams: a handbook. Germantown, MD: Aspen Systems Corporation.

Fasser, C. (1999). Interdisciplinary team training curriculum resource document. New York: The Geriatric Interdisciplinary Team Training Resource Center of New York University.

GITT Medicine Special Interest Group. [GITT Web Site]. Available at <http://www.gitt.org/medicine.htm>. Accessed July 15, 2000.

GITT Nursing Special Interest Group. [GITT Web Site]. Available at <http://www.gitt.org/nursing.htm>. Accessed July 15, 2000.

Grant, R.W., & Finocchio, L.J. (1995). California primary care consortium subcommittee on interdisciplinary collaborative teams in primary care. A model curriculum & resource guide. San Francisco: Pew Health Professions.

Long, D., Fay, V., & Wilson, N. (2001). Interdisciplinary teams – members and their roles. In D. Long & N. Wilson (Eds.), Houston geriatric interdisciplinary team training curriculum. Houston, TX : Baylor College of Medicine's Huffington Center on Aging ([www.hcoa.org](http://www.hcoa.org), 713-798-5804)

Long, D., & Wilson, N. (Eds.). (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX : Baylor College of Medicine's Huffington Center on Aging ([www.hcoa.org](http://www.hcoa.org), 713-798-5804).

Mariano, C., Gould, E., Mezey, M., & Fulmer, T. (Eds.). (1999). Best nursing practices in care for older adults. New York: John A. Hartford Foundation, Inc.

Sampson, E.E. (1981). Concepts and types of leadership. In E.E. Sampson & M. Marthas (Eds), Group process for the health professions (pp. 198-225). New York: John Wiley & Sons.

West, Mellor, & Robinson. [personal communication] (1998). GITT - Social work interest group of the John A. Hartford Foundation geriatric interdisciplinary team training program.

Whitelaw, N., & Moore, S. (197). Great lakes GITT team learning guide. Detroit, MI: Great Lakes GITT.

## GITT Exercises: Topic 2

### Case Study: Overlapping Professions: Mr. Alex Green<sup>18</sup>

You are part of a home care team consisting of a geriatric nurse practitioner, an occupational therapist, a medical social worker, and a primary care physician. Other disciplines, services, and service providers (for example, physical therapy, speech pathology, home health aide, homemaker service, pharmacy, and nutritionist) are available to participate on your team but must be invited to a team meeting on an as-needed basis. The philosophy of your home care agency is that patients and/or family members are also members of the health care team in that they must be part of setting goals and implementing any plans.

You have received a referral from a preferred provider organization (PPO) for Mr. Alex Green, a sixty-four year old man with congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, hypertension, and diabetes.

Mr. Green has a history of presenting to the emergency room short of breath with fluid retention. He is sometimes admitted and sometimes treated as an outpatient by his primary physician. Little has been done to break the cycle of treatment failure. The PPO wants to try another approach. Out patient treatment will be authorized together, and bundled into one payment for the primary care physician, home care, and any other community-based care.

His current medications are as follows:

- Diltiazem hydrochloride (Cardizem) 240 mg four times per day
- Furosemide (Lasix) 40 mg four times per day
- Theophylline anhydrous (Theo-Dur) 200 mg three times per day
- Potassium chloride (K-Dur 20) 20 mEq every day
- Glipizide (Glucotrol) 5 mg twice per day
- Transdermal nitroglycerin system (Nitodisc) every 4-6 hours as needed for chest pain

Mr. Green is on a low-sodium diet with 1500-ml fluid restriction, but has not followed it in the past. He lives with his daughter, son-in-law, and their three children, ages seventeen, nineteen, and twenty-three. He also has a son who lives with his family in the neighborhood within easy walking distance. The daughter-in-law likes Mr. Green, but doesn't like his daughter and, as a result, refuses to visit him.

The family is described by emergency room staff as dysfunctional, unaware of the seriousness of Mr. Green's condition, and "unwilling to be a part of his treatment plan." They believe that it is too much trouble to prepare a special meal for Mr. Green and that the emergency room is an appropriate place to bring him for treatment after he has eaten a high-sodium and high-carbohydrate meals.

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<sup>18</sup> (Long DM, Wilson NL, (eds.) *Houston Geriatric Interdisciplinary Team Training Curriculum*. Houston, TX: Baylor College of Medicine's Huffington Center on Aging; 2001; This case was adapted from one developed by the Rush Presbyterian-St. Luke's Medical Center, Rush Institute on Aging Geriatric Interdisciplinary Team Training Project

There are also several smokers in the family, and they refuse to limit their smoking or smoke outside. They say, "It's our house; he is a guest. If he shouldn't be around smoke, then he should go outside."

The outpatient plan of care calls for the following services:

- Administer O<sub>2</sub> @ 2L/nasal cannula
- Check O<sub>2</sub> saturation readings per oximeter every week
- Draw SMA in one week
- Check of weight, abdominal girth, and pedal edema (coordinate with primary care physician) daily.
- Teach low-sodium diet and restricted fluid intake
- Evaluate home situation and family's ability to participate in the plan of care
- Teach energy conservation techniques
- Test pulmonary function and obtain X-ray
- Review and adjust medicine and improve compliance

The PPO will authorize \$800/month to cover the outpatient care (physician office, home care, community care) charges and is allowing the providers involved to distribute the money in a manner that best supports a plan to provide care to Mr. Green and reduce emergency room visits.

### *Discussion*

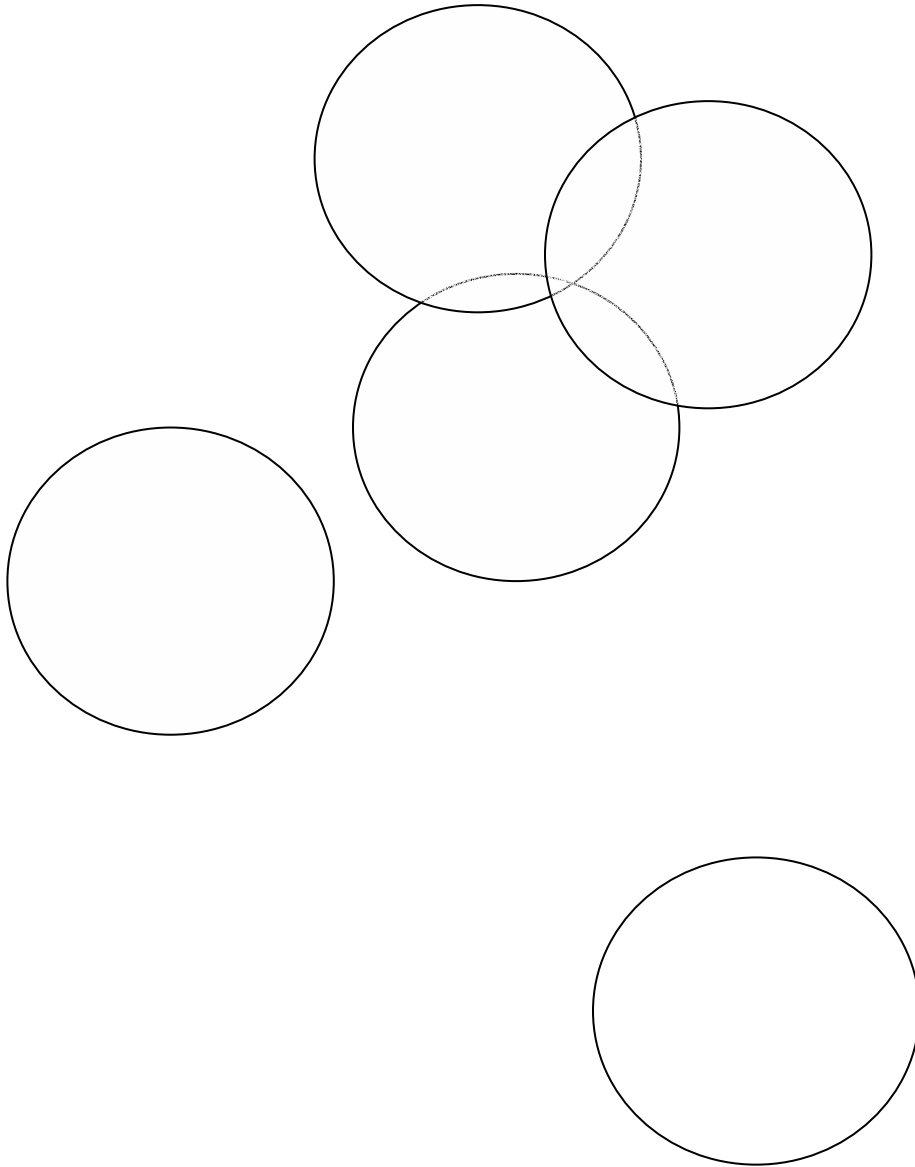
The questions central to this case include:

- What are the issues involved in this case?
- What disciplines should be involved in this case?
- What can each discipline contribute to the care plan development?

On the next page, you will find a case role map. This is a pictorial representation of who is involved in a case and which professional roles might overlap. On the Circles, write the names of the disciplines that need to be involved in the development of Mr. Green's care plan. Indicate the disciplines whose roles may overlap by writing their names in the circles that intersect. Some circles will need to be added and others may not be used. One possible solution is also appended.

## **Case Role Map**

Fill in the circles with the names of the disciplines that need to be involved in Mr. Green's case. Indicate the disciplines whose roles overlap by writing their names in the circles that overlap. Add circles or ignore them as necessary. Circle size does not connote meaning.



## **Questions About Team Involvement and Role Overlap**

From the previous case example and experience in identifying which disciplines should be involved, it can be seen that there may be different levels of involvement from team members, depending on the patient's needs. In addition to their professional roles, members of a team assume roles that characterize their personality, longevity with the team, sex, ethnicity and culture. Team members need to understand each other and respect the roles played by each professional.

There is always potential for role overlap between professionals, and the team members are responsible for deciding who does what when. Roles should and will change, depending on the needs of the patient and team. A team will continually need to clarify these role responsibilities.

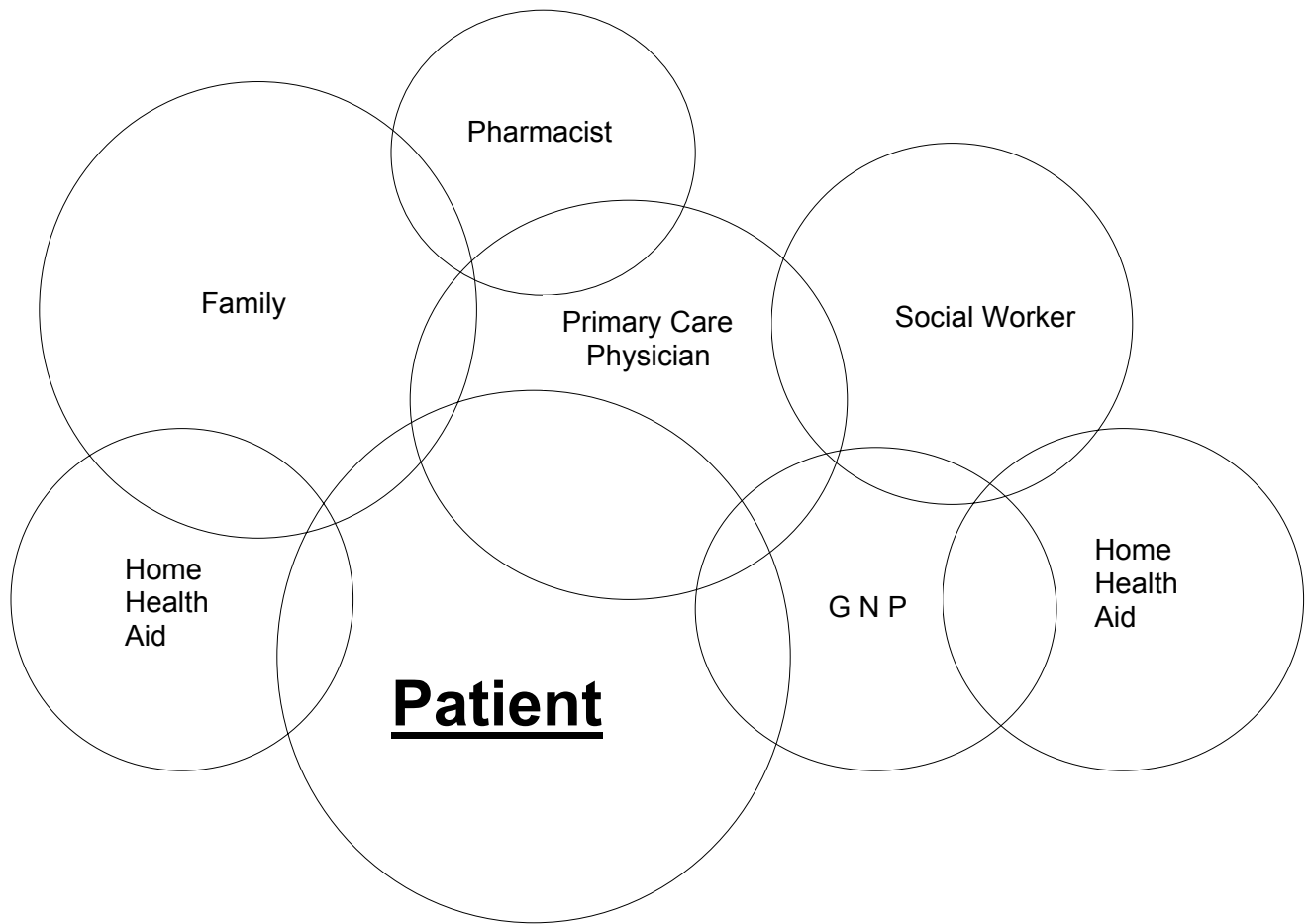
Effective team members possess professional competence, have a patient's care as their highest priority and respect and trust other professionals on the team.

### *Summary Questions<sup>3</sup>*

Answer the following multiple choice questions. Choose one answer for each question.

- \_\_\_ 1 The contributions of one discipline to a patient's health care plan can be understood by other disciplines by:
- A. Respecting each other as health care professionals
  - B. Listening to each other's health care plan concerns and comments
  - C. Recognizing the need for all contributions for the good of the patient
  - D. All of the above
- \_\_\_ 2. The discipline on the care team most likely to provide drug combination information to the care team would be:
- A. Primary care physician
  - B. Geriatric nurse practitioner
  - C. Pharmacist
- \_\_\_ 3 One discipline that is most likely to help with Mr. Greene's family becoming more involved with his case:
- A. Pharmacist
  - B. Social worker
  - C. Primary care physician

**Sample Answer for Case Role Map**<sup>19</sup>



<sup>19</sup> Long, D., Fay, V., & Wilson, N.L. (2001). Interdisciplinary teams: members and their roles. In D. Long, , & N. Wilson (Eds.). (2001). Houston geriatric interdisciplinary team training curriculum. Houston, TX: Baylor College of Medicine's Huffington Center on Aging. ([www.hcoa.org](http://www.hcoa.org), 713-798-5804).

**Interprofessional Perception Scale: Part A**<sup>20</sup>

Persons in my profession:	<b>Very Untrue</b>		<b>Very True</b>	
1. Are competent.	1	2	3	4
2. Have very little autonomy.	1	2	2	3
3. Understand the capabilities of other professions.	1	2	3	4
4. Are highly concerned with the welfare of the patient.	1	2	3	4
5. Sometimes encroach on other professional territories.	1	2	3	4
6. Are highly ethical.	1	2	3	4
7. Expect too much of other professions.	1	2	3	4
8. Have a higher status than other professions.	1	2	3	4
9. Are very defensive about the professional prerogatives.	1	2	3	4
10. Trust others' professional judgments.	1	2	3	4
11. Seldom ask for others' professional advice.	1	2	3	4
12. Fully utilize the capabilities of other professions.	1	2	3	4
13. Do not cooperate well with other professions.	1	2	3	4
14. Are well trained.	1	2	3	4
15. Have good relations with other professionals.	1	2	3	4

*Discuss responses as a group.*

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<sup>20</sup> Mariano, C., et al. (1999). Modified from Ducarris, A., & Golin, K. (1979). The interdisciplinary health care team: a handbook. MD: Aspen Publishing Co.

## **Interprofessional Perception Scale: Part B**

**What is your opinion of persons in other professions?**

*Instruct the participants to fill in the column blanks with two professions that are not their own.*

Persons in this profession:	_____				_____			
	Very Untrue			Very True	Very Untrue			Very True
1. Are competent	1	2	3	4	1	2	3	4
2. Have very little autonomy	1	2	3	4	1	2	3	4
3. Understand the capabilities of your profession	1	2	3	4	1	2	3	4
4. Are highly concerned with the welfare of the patient	1	2	3	4	1	2	3	4
5. Sometimes encroach on your professional territory	1	2	3	4	1	2	3	4
6. Are highly ethical	1	2	3	4	1	2	3	4
7. Expect too much of your profession	1	2	3	4	1	2	3	4
8. Have a higher status than your profession	1	2	3	4	1	2	3	4
9. Are very defensive about their professional prerogatives	1	2	3	4	1	2	3	4
10. Trust your professional judgement	1	2	3	4	1	2	3	4
11. Seldom ask your professional advice	1	2	3	4	1	2	3	4
12. Fully utilize the capabilities of your profession	1	2	3	4	1	2	3	4
13. Do not cooperate well with your profession	1	2	3	4	1	2	3	4
14. Are well trained	1	2	3	4	1	2	3	4
15. Have good relations with your profession	1	2	3	4	1	2	3	4

## **Interprofessional Perception Scale: Part C**

**How do you think members of other professions view your profession?**

*Instruct the participants to fill in the column blanks with two professions that are not their own.*

Persons in my profession:	_____				_____			
	Very Untrue			Very True	Very Untrue			Very True
1. Are competent	1	2	3	4	1	2	3	4
2. Have very little autonomy	1	2	3	4	1	2	3	4
3. Understand the capabilities of your profession	1	2	3	4	1	2	3	4
4. Are highly concerned with the welfare of the patient	1	2	3	4	1	2	3	4
5. Sometimes encroach on your professional territory	1	2	3	4	1	2	3	4
6. Are highly ethical	1	2	3	4	1	2	3	4
7. Expect too much of your profession	1	2	3	4	1	2	3	4
8. Have a higher status than your profession	1	2	3	4	1	2	3	4
9. Are very defensive about their professional prerogatives	1	2	3	4	1	2	3	4
10. Trust your professional judgement	1	2	3	4	1	2	3	4
11. Seldom ask your professional advice	1	2	3	4	1	2	3	4
12. Fully utilize the capabilities of your profession	1	2	3	4	1	2	3	4
13. Do not cooperate well with your profession	1	2	3	4	1	2	3	4
14. Are well trained	1	2	3	4	1	2	3	4
15. Have good relations with your profession	1	2	3	4	1	2	3	4

**Professional Perception Quiz<sup>21</sup>**

Circle abbreviation indicating your discipline: MD GNP MSW PSY PA LTCA Other

<b>Geriatric Care Skills</b>	<b>I Am Most Secure</b>	<b>I Am Least Secure</b>	<b>Other Discipline(s) Better Qualified or Similarly Qualified at Performing This Skill Than Mine</b>
Eliciting and understanding patient's chief complaint or concern			
Performing a physical exam			
Educating patient about how to take medications			
Discussing advanced directives, such as living wills and power of attorney for health care			
Educating patients about health insurance benefits and eligibility requirements			
Connecting patient with other community and social services (SI, housing agencies)			
Screening patient for sensory disorders			
Helping patients and families mediate decisions about living arrangements			
Assessing older patients for surgical risk			
Screening patients for drug misuse			
Arranging for appropriate home care equipment			
Assessing home safety			
Initiating discussions about hospice care			
Evaluating caregiver burden			
Prescribing medications			
Evaluating/assessing mobility			
Referring to probate court, legal service			
Explaining laboratory test results to patient/family			

<sup>21</sup> Adapted by Wilson, N.L. from: Grant, R.W., Finocchio, L.J., and the California Primary Care Consortium Subcommittee on Interdisciplinary Collaborative Teams in Primary Care. (1995). A model curriculum and resource guide (pp.32-33). San Francisco, CA: Pew Health Professions Commission.

## **Learning About Each Others' Disciplines**

*Please prepare a short report about your discipline using the questions below. Use the answers to these questions as a basis for a discussion with members of other disciplines on your team.*

*Please address the following issues in your report:*

Briefly describe the key points of the history of your profession.

What are some important tenets of the modern philosophy of your profession?

Briefly describe how the members of your profession are educated.

Describe some examples of modern practice environments in which practitioners in your profession practice.

Describe any long-standing historical conflicts your discipline has had with other disciplines.

## **GITT LEARNER WEEKLY TEAM MEETING TEAM DYNAMICS CHECKLIST**

Use this checklist during the last 10-15 minutes of your meeting to critique the team's dynamics. Discuss any problem(s) raised by the items. Why did it occur? What can be done to prevent its reoccurrence?

### Participation

- ✓ Did each team member adequately participate in the discussion; contribute ideas to the problem definition, to the care plan?
- ✓ Did members express themselves clearly? Address the point at hand?
- ✓ Did members follow up/ask for clarification on vague comments or positions by others?

### Conflict

- ✓ Did conflict or disagreement occur? Should there have been conflict? If so, why didn't it occur?
- ✓ When conflict or disagreement occurred,
  - did some members dominate, push their ideas on others?
  - did some members withdraw, fail to voice or pursue their position?
  - did the team know how to reach an agreement?
  - did the team move too quickly in reaching an agreement?
- ✓ Which of the following styles of dealing with conflict were used?
  - Withdrawal/Avoidance      • Competition      • Accommodation
  - Compromise                  • Cooperation      • Coercion
  - Denial

### Leadership

- ✓ Who was the leader?
- ✓ Which of the following leadership roles were used?
  - Organizer/Mover      • Ambassador      • Conformer/Follower      • Creator
  - Quality Controller      • Finisher      • Expert      • Diplomat
  - Supporter      • Judge (Evaluator)      • Innovator      • Reviewer
  - Process Analyzer      • Challenger/Opposer      • Guard
- ✓ Did the team process business in a way that allowed each member to contribute his or her viewpoint/role?
- ✓ Was there leadership to create the necessary structure and organization for the team to complete its business?
- ✓ Was there adequate leadership for creating, challenging, and analyzing ideas?
- ✓ Were there leadership roles to help maintain team process (e.g., good negotiators, evaluators and reviewers, morale builders)

### Other Concerns

## **Conducting A Family Meeting**

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McDaniel, S. (1991) Conducting a family meeting. Medical Encounter p. 11-12. Available at: [http://gitt.cwru.edu/family\\_meeting.html](http://gitt.cwru.edu/family_meeting.html)

Families can be important allies to the physician in the evaluation and treatment process. The physician usually sees the patient for some brief period of time every few weeks or months, while the family lives with the patient.

Family meetings allow the physician to obtain a more thorough assessment of a patient's problem, determine the impact of the illness on the patient and the family, and assess the resources available to help the patient. Then, with this information in mind, the physician can negotiate a comprehensive treatment plan and obtain the family's assistance in carrying out that plan. Family meetings are useful in many medical situations. Who is involved may be negotiated with the patient. Typically, that includes at least members of the patient's household, as well as other family or friends who are in direct contact with the patient as a caretaker or as someone who may influence the patient's health care. Table I describes both routine and specific circumstances when it is useful to convene a family meeting.<sup>1</sup> It is important when convening a family conference to be positive and direct about the need to meet with the family, emphasizing the importance of the family as a resource in caring for the patient.

The following is a guide for conducting a family conference, including pre-conference, conference, and post-conference tasks.<sup>22</sup> This guide outlines a comprehensive 45-minute family meeting. For the purpose of clarity and pacing, phases are demarcated and assigned approximate time frames. However, the actual process of conducting a family meeting demands a good measure of sensitivity to the natural flow from one phase to another. Some less complicated issues can be handled in a 20-30 minute meeting, while other very serious or complicated concerns may require an hour. In any case, the outline can be adapted to the specific goals of the conference.

### *Pre-conference Tasks*

1. Set the stage
  - A. Choose the contact person.
  - B. Clarify the rationale.
  - C. Establish which family members, friends, and or professional should attend
  - D. Set up the appointment.

### *Discuss the Illness or Issue (approximately 15 minutes).*

1. Solicit each participant's view of the illness or issue. Ask about other recent changes in the family that could have an impact on the issue of concern, such as moves, occupational changes, other illness, marriages, divorces, births, or deaths. Observe repetitive family

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<sup>22</sup> McDaniel, S.H., Campbell, T.L., Seaburn, D.B., & Medalie, J.H. (1990). Family oriented primary care. A manual for medical providers (pp.59-72). New York: Springer.

interactional patterns. Final treatment plans should not go against these patterns, unless specifically planned for and negotiated.

2. Encourage the patient and family to ask any questions they might have.
3. Ask how the family dealt with similar illnesses or issues in the past.

*Identify Resources (approximately 10 minutes).*

1. Identify family strengths and resources of all kinds.
2. Identify medical resources.
3. Identify community resources.

*Establish a Plan (approximately 10 minutes).*

1. Ask the family about their involvement in the treatment plan:  
"What is your plan from here?"
2. Negotiate a formal or an informal contract with the family.  
Have each person state what s/he will contribute.
3. Discuss any referrals, if relevant, at this point.
4. Ask for any final questions.
5. Thank everyone for coming and participating in the meeting.

*Post-conference Tasks*

1. Revise the genogram.
2. Revise the hypotheses and plan for future treatment.
3. Write a report of the meeting, including the attendance, the problem list, a global assessment of individual and family functioning (including family structure, family process, and family life cycle stages - see Seaburn article), the family strengths and resources, and the treatment plan (both the medical regimen and the roles to be played by the patient and family members).

**Table 2.4. When To Convene The Family<sup>23</sup>**

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| <ol style="list-style-type: none"><li>1. Hospitalization</li><li>2. Diagnosis of a serious illness</li><li>3. Diagnosis of a terminal illness</li><li>4. Compliance problems</li><li>5. Poor control of a chronic illness</li><li>6. High utilization of medical services</li><li>7. Somatization</li><li>8. Anxiety or depression</li><li>9. Substance abuse</li><li>10. Marital or sexual difficulties</li></ol> |
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<sup>23</sup> McDaniel S., Campbell, T. & Seaburn, D. (1990). Family Oriented Primary Care: A Manual for Medical Providers. New York: Springer-Verling. p.59-72

