Achieving Coordinated Cancer Care Through Interprofessional Communication
and Collaboration in Multidisciplinary Teams

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Introduction

Cancer is a heterogeneous disease that often requires multiple interventions provided by a variety of health professionals over prolonged periods of time (Walsh, Harrison, Young, Butow, Solomon, & Masya, 2010). The cancer care process is complex and challenging for all involved, especially for patients and their families, for informal caregivers or supporters, and for health care providers. Given the wide range and numbers of health-care professionals involved in cancer care, an enormous potential for poor coordination and miscommunication exists (Fleissig, Jenkins, Catt, & Fallowfield, 2006). Multidisciplinary teams, composed of practitioners from multiple disciplines who work in conjunction with each other but function autonomously, have been organized and promoted to improve coordination, communication, and decision making between health-care team members and patients, and produce more positive health outcomes (Kresevic & Holder, 1998; Fleissig, Jenkins, Catt, & Fallowfield, 2006). In cancer care, a multidisciplinary team provides a rational and coordinated mechanism for evaluation and treatment of patients with complex diseases by bringing health care providers in the surgical, medical, and radiation oncology disciplines together (Bunnell, Weingart, Swanson, Mamon, & Shulman, 2010). During the past 30 decades, multidisciplinary teams have been playing an increasingly prominent role in the care of patients with cancer in both the community and in academic cancer centers.
Most cancer and palliative/end-of-life programs propose interprofessional collaboration in multidisciplinary teams as a key modality for improving quality of cancer care (Tremblay, Drouin, Lang, Roberge, Ritchie, & Plante, 2010). Collaboration in health care is defined as health care professionals assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans for patient care (O’Daniel & Rosenstein, 2008). Collaboration between physicians, nurses, and other health care professionals increases team members’ awareness of each others’ type of knowledge and skills, leading to continued improvement in quality of cancer care.

Another character of effective multidisciplinary teams is a good communication system that can directly or indirectly inform members of what others are doing (Poole & Real, 2003). Effective communication among health care professionals encourages effective teamwork and promotes continuity and clarity within the cancer care team. At its best, good communication encourages collaboration, fosters teamwork, and helps prevent medication errors (O’Daniel & Rosenstein, 2008).

Health professionals noted that the multidisciplinary teams is now considered an integral component for providing coordinated, collaborative cancer care (Walsh et. al., 2010). Coordinated care is integrated care that involves providers and patients working together to address the myriad issues affecting millions of cancer survivors, from the time they are diagnosed throughout their survivorship (Yates, 2004). It ensures that someone manages the care process, including the development and communication of the care plan and ensures that all of the care needed is arranged and delivered. Other key elements intrinsic to coordinated care include psychosocial assessment, suitable and timely
referral, information provision and individualized treatment that considers each patient’s needs and preferences (Walsh et al., 2010). For instance, in Kaiser Permanente in Colorado, high-performing clinical and non-clinical teams are designed around patient needs to ensure coordinated care. There are three programs in place to achieve coordinated care: cost and benefit information, shared decision making, and team-based care. Each of the programs has its own measures, providing guidelines for health care professionals to deliver patient-centered care. Literature also found that a lack of coordinated care can lead to fragmented care, patients getting “lost” in the system and failing to access appropriate services, as well as more unplanned health utilization (Walsh et al., 2010).

The Models of Cancer Care by Multidisciplinary Teams

Models of multidisciplinary care varied among cancer center or hospitals, but they seemed to cluster around two primary models (Bunnell et al., 2010). The first model, which is termed the “sequential model,” is characterized by centralized scheduling of patients by a new patient coordinator. The coordinator gathers medical information from the patient by telephone and schedules the patient to see the appropriate cancer care providers from radiation, surgical, and medical oncology. In this model, patients are generally scheduled to see the physicians sequentially, with each physician rendering his or her opinion and recommended treatment plan. Frequently, one of these providers assumes the coordinating role. Physicians generally do not see the patient together, but they communicate with one another between visits.

The second model begins in the same fashion, with a new patient coordinator who gathers the necessary medical information and schedules for the patient to see all the
appropriate providers on the same day (Bunnell et al., 2010). In this model, however, the practitioners from each discipline see the patient concurrently. In this concurrent model, the patient is initially evaluated by a member of a team of physicians made up of members from each discipline. This provider presents the patient’s case to the physicians from the other disciplines. The team usually reviews any radiologic scans as a group and subsequently interviews and examines the patient together. Together, they present the options and a consensus treatment plan to the patient.

**Barriers to Effective Interprofessional Communication and Collaboration in Multidisciplinary Teams**

Communication should be viewed as a core clinical skill that merits a considerable investment of time and resources in cancer care teams (Fallowfield & Jenkins, 1999). Unfortunately, few oncologists or nurses have received adequate formal education in communication skills using methods likely to promote change, confidence and competence. This is a serious omission as good communication has many positive effects on the patients’ cancer treatment, whereas poor communication has negative consequences for both healthcare professionals and patients. A good communication system is key to ensure effective communication among health care professionals in cancer care teams. For example, in KPCO, physicians and nurses also use the internal webmail system (Lotus Notes) to communicate with each other besides sending letters or making phone calls. The stability of the system and the confidentiality of the messages sent via the system ensure the efficiency and the quality of the communication among health care professionals.
However, efforts to improve health care safety and quality are often jeopardized by the communication and collaboration barriers that exist between health care professionals in cancer care teams. Table 1 indicates some common barriers to interprofessional communication and collaboration learned from the health communication literature.

- Personal values and expectations
- Personality differences
- Hierarchy
- Disruptive behavior
- Culture and ethnicity
- Generational differences
- Gender
- Historical interprofessional and intraprofessional rivalries
- Differences in language and jargon
- Differences in schedules and professional routines
- Varying levels of preparation, qualifications, and status
- Differences in requirements, regulations, and norms of professional education
- Fears of diluted professional identity
- Differences in accountability, payment, and rewards
- Concerns regarding clinical responsibility
- Complexity of care
- Emphasis on rapid decisionmaking

**Table 1 Common Barriers to Interprofessional Communication and Collaboration**


The barriers indicated in Table 1 can occur within disciplines, most notably between physicians and residents, surgeons and anesthesiologists, and nurses and nurse managers (O’Daniel, M., Rosenstein, A. H., 2008). However, most often the barriers manifest between nurses and physicians. Even though doctors and nurses interact numerous times a day, they often have different perceptions of their roles and responsibilities as to patient needs, and thus different goals for patient care. One barrier
compounding this issue is that because the United States is one of the most ethnically and culturally diverse countries in the world, many clinicians come from a variety of cultural backgrounds. In all interactions, cultural differences can exacerbate communication problems. For example, in some cultures, individuals refrain from being assertive or challenging opinions openly. As a result, it is very difficult for nurses from such cultures to speak up if they see something wrong. In cultures such as these, nurses may communicate their concern in very indirect ways. Culture barriers can also hinder nonverbal communication. For example, some cultures ascribe specific meaning to eye contact, certain facial expressions, touch, tone of voice, and nods of the head.

Based on Walsh and his colleagues’ (2010) qualitative study on barriers to coordinated cancer care, the barrier most frequently mentioned by health professionals involved in cancer care in the results was inconsistent, delayed and incomplete communication amongst the health care team, particularly between family physicians and specialists which inhibited the delivery of coordinated cancer care. Family physicians noted that the delay in delivery of diagnostic findings, treatment, complications and follow-up hindered their ability to provide appropriate advice to patients when they approached them in-between visits to their hospital cancer care team, or when they had completed surgery or other adjuvant treatments. This situation was often exacerbated by not knowing who to contact in the hospital care team to get the information required. Family physicians also identified that they lost touch with their patients while they were having specialist treatment.

A review of the organizational communication literature shows that a common barrier to effective communication and collaboration is hierarchies (Jablin, 1987).
Communication is likely to be distorted or withheld in situations where there are hierarchical differences between two communicators, particularly when one person is concerned about appearing incompetent, does not want to offend the other, or perceives that the other is not open to communication.

The problem of competing identifications to multiple identities might be another challenge for health care professionals to overcome in their collaboration with other cancer care team members.

In the literature of organizational communication, organizational identification is defined as “the perception of oneness with or belongingness to an organization, where the individual defines him or herself in terms of the organization(s) of which he or she is a member” (Mael and Ashforth, 1992, p. 814). Unlike conventional organizations, health care organizations involve situations in which some of their organization members are not typically employed by them and may be affiliated with multiple competing organizations. That is, most physicians in health care systems have their own membership or affiliations that prohibit them from receiving payment referring patients to a particular health care system, and they are likely to frequently find the interests of the organization at odds with the norms of their profession or the interests of their patients (Dukerich, Golden and Shortell, 2002). In contrast to this common physician-organization relationship in many health care organizations, KPCO is an exception. During my shadowing with KPCO’s faculty from across the organization, I was surprised to learn that 100 % of KPCO’s physicians are directly employed and they are fully committed to KPCO. In that sense, it’s easier for KPCO to develop and maintain their physicians’ organizational identification compared to other health care organizations where some
physicians are not directly employed. However, looking for strategies to maintain and promote organizational identification should always be a concern for health care managers. 

In cancer care context, organizational identification may be complicated by the presence of multiple organizational identity targets (Ashforth and Mael, 1989). For example, cancer care team members from functional units are assigned to the team but still formally under the command of their functional unit head. That is, they are subject to dual control. In that situation, how do they negotiate their identities in cancer care? If they identify with their functional units more, will it affect the team effectiveness, cohesiveness, and their motivation to collaborate? Given the limited studies on the relationship between health care professionals’ identification in organizational level with their willingness to collaborate in cancer care teams, these questions might be worthy of examining in future organizational or cancer communication research.

Discussion

Multidisciplinary approach has been widely introduced around US for the provision of cancer care, but there is little evidence for its direct effect on the quality of patient care.

In addition, though there is an abundance of literature on the need for coordinated cancer care for people affected by cancer, there is a paucity of research identifying solutions to overcome current barriers to achieve successful coordinated cancer care. The identification of current obstacles has the potential to guide the development of future initiatives to improve quality coordinated cancer care.
Finally, in the literature of organizational communication, organizational identification is found to be strongly related to effectiveness of teamwork and quality of health care, little academic effort has been made to understand the possible positive relationship between health care professionals’ identification in organizational level with their willingness to cooperate effectively in multidisciplinary cancer care team. Thus, exploring the linkage becomes theoretically and practically significant.

References:


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