Does interprofesionality work in Swiss ICUs and should it be encouraged?

Fumeaux Thierrya, Wehrlb Michaelb, for the Swiss Intensive Care Medicine Society (SGI-SSMI)

a Physician President Swiss Intensive Care Medicine Society (SGI-SSMI), GHOL - Hôpital de Nyon, Switzerland
b President Swiss Intensive Care Medicine Society (SGI-SSMI), Basel, Switzerland

Summary

A charter for the collaboration of healthcare specialists has recently been proposed by the Swiss Academy of Medical Sciences, to promote interprofesionality in daily clinical practice. This article reviews several aspects of this concept, from definition and basic principles to the potential benefit for the patients and caregivers, and it discusses the difficulties in implementing interprofessional teamwork in the daily practice of an intensive care unit (ICU). Although collaborative and interprofessional teamwork seems a logical approach in the care of critically ill patients, little published evidence shows that it really improves the level of care, meaning that this may be harder to implement than to promote. Eventually, some clues to achieve a successful realisation of interprofessional collaboration in the ICU are proposed.

Key words: interproffesionality, teamwork, intensive care medicine, educational training, critically ill patient

What is interprofesionality?

All definitions of interprofesionality encompass the collaborative engagement in a complex task of professionals with specific knowledge and competencies, heading to a common goal. Interprofesional work is not just simple coordination, but represents the highest level of team inter-action, when members work in an integrated and independent way, with shared identity and responsibility [1]. In 2003, the US Institute of Medicine (IOM) defined interprofesional teamwork as the collaborative interaction of healthcare professionals to provide high quality and individualised care [2]. The most important components of interprofesionality in medicine were identified as appropriate team structure, abolition of rigid hierarchies and promotion of shared decision making [3]. In 2010 report, the World Health Organization recognised that interprofesional collaboration was an “innovative strategy that will play an important role in mitigating the global health workforce crisis” [4]. Interprofesional healthcare was defined as the capacity “to understand how to optimize the skills of members, share case management and provide better health-services to patients and the community”. Key components were identified both in education and practice. In education, various professions should engage in common teaching activities, learning about, from and with each other, in order to develop a sense of effective collaboration, and to become “collaborative practice-ready” people. In clinical practice, they bring their individual knowledge and skills to achieve a common goal, taking care together of patients and relatives, with the highest level of quality. Such a level of interprofesional collaboration can be achieved only with active policies; therefore, health policy-makers were strongly encouraged to use adequate tools to reach this goal, such as the identification and support of local champions, the necessary change of health workers culture and attitudes, the revision of training curricula, and the development of appropriate legislation rules.

In Switzerland, back in 2007, the Swiss Academy of Medical Sciences (SAMS) proposed a charter to promote the collaboration of healthcare specialists, a document that was later published in 2014 [5]. As a basic principle of this charter, healthcare professionals are encouraged to engage in high-quality and optimal level care, adapted to the needs and expectations of the population, with patients as the focus of care and as active partners. Other fundamental resolutions are the concerted and clear definition of respective tasks and responsibilities, the development of common teaching modules in networks, and the adaptation of the organisation of work.

Are nurses and physicians really practicing interprofesionality?

Nurses and physicians have distinct educational tracks, different levels of knowledge, specific skills and competencies, specific and different perspectives on the patient, and even unique corporate identities. We differ in experience, work organisation and clinical practice, but we have a lot in common: we share our patients, their relatives, and we work in joint collective organisations, within our hospitals and units. We therefore are like theatre actors, sharing a unity of place, time and action, with the patient at the centre. Even though differences should not be denied, they should be overcome, and we should seek ways to build efficient collaborative teams, and this is the basis of the Swiss charter for interprofesionality. Historically, the decision-making power was held by physicians, because of their higher academic educational
level. Nurses were simply considered supportive auxiliaries, applying decisions taken by physicians alone. Even the nurses’ hierarchical structure was under physicians’ dominance. Progressively, nurses developed specific knowledge and technical skills, mostly in domains where physicians were not willing to be involved in anymore. From the late 1970s, nurses were progressively integrated in the decision process, initially by bringing information and only making passive recommendations, the leadership still in the physicians’ hands [6]. In the early 1990s, it was recognised that nurses could make their own decisions, within the limits of their competence and knowledge [7]. In parallel, apart from the classical practical non-university-based nurses’ educational track, a higher level of education gradually emerged, culminating in university-based programmes and academic certifications. These two nurses’ educational tracks should be viewed as additional and not as discordant or mutually exclusive. These changes in the nurses’ curriculum stimulated the development of interprofessionalism.

In parallel, interprofessional educational activity always existed: physicians have been involved in nurses’ education, and experienced nurses give advice and teach young residents in many practical aspects of their work. Most physicians should acknowledge the role of nurses and other non-physician professionals in the development of useful professional competencies [8]. But the evolution of the nurses’ educational track, together with some degree of decreasing physicians’ skills, paved the way towards increased interprofessional cooperation, from more organised collective training to collaborative teamwork in clinical activities.

But do these developments really translate in the clinic? It seems that interprofessionalism still remains hard to apply effectively in the field. Nurses and physicians may not be able to correctly assess the pros and cons of such a level of collaboration, with a feeling that there is more to lose than to gain. Particularly, the sense of losing definite borders separating professions may be very strong: physicians are not willing to abandon some of their “historical” prerogatives, and nurses very often fear that they will be dominated [9]. In this context, and despite support from various authorities, evidence of successful top-down implementation of interprofessionalism is often difficult to find.

Can we measure the benefit of interprofessionalism?

Even though it seems difficult to challenge the interest of increasing interprofessionality in medicine, the balance between positive and negative consequences may be difficult to assess, as they could also differ with regard to the patients’ outcome or to the working conditions of nurses and physicians. Ideally, the effect of a better interprofessional collaboration should be the improvement of significant patient-centred outcomes, such as mortality or morbidity, but also related to increased patient comfort, satisfaction or “good care” experience.

Although a great amount of medical literature shows that interprofessional training, particularly with simulation, does increase global competence of caregivers and teamwork coordination [10–12], there is only scanty evidence that this really translates into interprofessional collaborative teamwork in daily activities, and to improved outcomes [13]. A recent Cochrane review found only nine relevant studies, with great heterogeneity in the interventions and settings, and also significant methodological weaknesses, and could therefore not draw any conclusion on the effect of interprofessional education on outcomes [14].

Regarding the satisfaction of caregivers, the literature generally seems very enthusiastic, principally in review or concept papers [15], but there are few objective published data to support this enthusiasm [16, 17]. In summary, even if it is tempting to think that better collaboration between health workers favours collective competence development and enhances job satisfaction, logically allowing improvement of care, and consequently improving outcomes, this still has to be demonstrated.

Do we need to support interprofessionalism in the intensive care unit?

The intensive care unit (ICU) is a complex and stressful universe, where admitted patients present intricate clinical problems, with possible quick changes in the situation and often a significant risk of dying. The difficult management of ICU patients therefore requires the collaboration of various professionals (nurses, physicians, therapists, dieticians, pharmacists, etc.), mixing their levels of knowledge, skills and competencies, from young residents/nurses to “old” and experienced physicians/nurses. Patients depend for their survival on this collective expertise and on the effective collaboration and cohesion of the team, particularly to avoid errors [18, 19]. Not surprisingly, interprofessional tensions may therefore arise in the ICU [20], resulting from conflicts of authority, differences in the levels of education, knowledge or experience, but also from various perceptions of patient needs. Eventually, restraints in resources and time amplify these strains. If we remember that our mission as caregivers is to deliver high-value care to patients, it should help us to overcome the barriers for the implementation of interprofessionality in the ICU, and decrease the resistance. But this does not seem to be enough to overcome our natural tendency to work on our own. Lingard et al. described ICU teamwork as a game of power, with variable intensity, depending on circumstances, and based on rituals of “ownership and trade” [21]. The ICU team is a compilation of individuals with distinct professional identities, different skills and knowledge, diverse economic situations, and very often competitive “political” agendas. A way to decrease these tensions is to separate territories and to avoid direct confrontation, in an atmosphere of “fair cooperation” or cold peace (or war!). But Lingard et al. proposed a move towards a more authentic and ambitious model of collaboration that requires skills to function together. In this model, each individual and each profession should identify its “valued commodities”, such as its specialised knowledge and technical skills, and its own control of specific technical equipment, all these elements culminating in the clinical territory around the patient. This allows “small” negotiations involving the members of the team in their daily clinical practice, in order to better define these commodities’ ownership and rule their trade. Territories can move, depending on the individuals and the circumstances, thus avoiding conflicts if the process is well appreciated and correctly handled. By bet-
of the importance of involving the nurses in the weaning process all led to a more collaborative approach [30]. Nowadays, nurses and physicians work together around the patient and ventilator and share their knowledge, skills and experience, with an effect on outcome [10, 31, 32]. Continuous renal replacement therapies, extracorporeal techniques such as extracorporeal membrane oxygenation (ECMO), and also early mobilisation and nutrition are other complex interventions for which the development of collaborative teamwork in the ICU may significantly improve the outcome of ICU patients, although this remains to be demonstrated for most of them [33]. Eventually, end-of-life care and communication with the patients and families are “human” interventions that require a close collaboration of all the members of the ICU team, with a measurable positive effect [34]. Ethical round-table discussions and interprofessional opinion development allow collective decision making, which can be accepted by the whole team. This is an important condition for homogenous and harmonious verbal and nonverbal messages delivered by all members of team, in order to reduce the risk of incomprehension and triangulation with the patient and relatives. Only mature teams, very conscious of the paramount importance of this aspect, can be felt as a cohesive team by the patients. These competencies may be difficult to acquire collectively. Such simple approaches as regular joint communication session with the family, preferably in the presence of the patient, or the writing of a patient’s dairies, shared by nurses, doctors, other team members and relatives, may be reinforce this maturation process.

In all these examples, it is interesting to see that simultaneous interprofessional training has become a key component of practical implementation. Simulation, whether low- or high-fidelity, is an important component of training, because it puts the working team in contact with reality without fear of consequences for the patient [35, 36]. In the future, it is highly probable that many frequent and complex clinical situations requiring technical procedures and high-intensity work will be simulated very precisely and will allow interprofessional teams to be better prepared to face these challenging conditions. But it should not be forgotten that the goal of better interprofessional work is to improve the outcome of the patients, and that this is not well demonstrated so far.

The Swiss Society of Intensive Care Medicine (SSICM): a successful interprofessional society?

The Society for Critical Care Medicine (SCCM) in the USA was one of the first medical societies to welcome nurses as regular members. The Swiss Society for Intensive Care Medicine (SGI-SSMI) was founded in 1972 as a physicians’ organisation, but very early initiated close collaboration with nurses within a common working group that developed education and training of ICU nurses. The medical and nursing postgraduate trainings advanced in parallel and both tracks are now certified by the Swiss Federal State. The two professions decided to tighten their links and the Swiss Society for Intensive Care became an interprofessional organization in 2011. A lot of work was necessary to translate this wish of working together into...
a practically functioning society. As a witness of this successful development, the board and major working committees of the society, such as the certification commission of intensive care units (ZK-IS) [37] or the commission for congress [38] are joint interprofessional structures. In the educational field, both training commissions, which had to stay separate to cope with very different regulatory and legal frameworks, worked together to develop a recognition programme of continuous education for nurses, based on the system that has been used for physicians for years. Eventually, the corporate identity of the society became clearly oriented towards its interprofessional character. As recognition for this entire process, the SSICM was awarded in 2016 by the Swiss Academy of Medical Science for its interprofessional approach [39]. Even if the SSICM defines itself as interprofessional, this does not mean that interprofessionality is actually applied in the Swiss ICUs, and that this increases the quality of care. It is therefore expected that all Swiss ICUs will gradually apply the guiding principles of the charter for interprofessionality, and modify their daily clinical activity and the collaborative work of nurses and physicians, both in the educational programmes and in the everyday management of patients. Even though this may seem a top-down process, it is important to point out that the change of mentality at the level of the members of society is palpable and is reflected in many collaborative projects. Undoubtedly, the current process is in a development phase, sustained with the validation of innovative tools [40], and will possibly serve as an example for other professional societies.

Conclusions

The ICU is a complex universe, with high intensity of care and emotional stress, and may be an experimental environment to study and develop interprofessionality. With the critically ill patient at the centre, all members of the ICU team must learn how to work together, sharing common values and respecting the differences, in order to deliver the best of care, keeping an appropriate level of satisfaction among the members of the team. Nurses and physicians should not be opposed, but should combine their knowledge, their experience, and their competencies. This process should take place in the daily clinical practice and as much as possible in the training and teaching activities. Even if scientific data do not formally prove that interprofessionality is effectively improving the care of patients, common sense and indirect evidence are convincing enough to encourage the development of this collaborative process. The Swiss Society for Intensive Care Medicine is an interprofessional organisation, that encourages all ICU professionals to work together to deliver a high level of care for critically ill patients. The SSICM expressed in its 2020 profile the utmost importance of developing further the conditions for a successful interprofessional collaborative work among its members, and has consequently included the mandatory principle of interprofessionality in all its actual and future projects.

Disclosure statement

No financial support and no other potential conflict of interest relevant to this article was reported.

References


https://www.swiss-icu-cert.ch/de/Zertifikation.html


http://www.sams.ch/Projekte/InterprofessionaeltAward.html