

Interdisciplinarity: is it a trend or a necessity?

“ From the beginning of the EAPC, the importance of interdisciplinarity has been highlighted. There is almost no congress, national or local meeting announcement without reference to this concept. But what does it actually mean? Is it a trend? Is it an inevitable element of palliative care? If yes, what is it necessary for and for whom?

Overall, the most important thing is to focus our attention on the patients and their families. They are the ones who should guide us. Severe and life-threatening disease represents a storm in their lives at a physical and psychological as well as existential level and the interdisciplinary approach constitutes one of the main guarantees of caring for the patient and family in their suffering. Sharing as a common goal the quality of life of those we care for is certainly the *raison d'être* of interdisciplinarity.

As a team member, we should question ourselves. Do I know the other professional? Do I recognise their competencies? Do I listen to them? Do I take into account their ideas, particularly when they are not similar to mine? Do I trust them? As a team, we can only build a common vision by asking ourselves: which values do we share? What are our common objectives? Can the patient and their family benefit from our complementary competencies? How can we improve our weak points?

Communication between professionals represents the grounding of interdisciplinary teamwork. Dame Cicely Saunders reminds us that there are rules for efficient interdisciplinary meetings. One must learn the right and appropriate language to communicate. Professional jargon, even with other professionals, is unproductive.¹ Communication is time-consuming and requires time to get to know the other professional and identify how their competencies can contribute to the patient's wellbeing. There is also a need for willingness to put aside prejudices and become aware of power struggles that alter relationships between colleagues and, consequently, quality of care.² It is right that each profession's contribution to interdisciplinary teamwork is of

equal importance, but it is not necessary that all team members are involved in decision-making. Cummings³ mentions that the process requires the answers to three questions. Who has the information to make the decision? Which team members should be consulted before making the decision? Who should be informed after the decision has been made?

Clarifying roles and responsibilities within the team, problem-solving and decision-making processes are key elements for fruitful interdisciplinary teamwork. This means that successful teamwork depends not only on the will of the professionals, but also on institutional requirements.

Togetherness – this should be the key principle in our daily practice. No professional could pretend that they would be able to meet the complex needs of palliative care patients on their own. The ability to work together can be learned. Clinical practice is certainly the most privileged learning opportunity. But let's not forget that education represents also a favourable learning field, especially when the group of students is multiprofessional. In basic, continuous and postgraduate training, pluriprofessional education presents numerous advantages:⁴ among other things, it teaches participants teamworking by favouring mutual respect and understanding and by improving knowledge of each other's strong points and limitations. It also contributes positively to interdisciplinary research and guarantees that all aspects of a problem will be taken in account.

Interdisciplinary teamwork means taking risks, and first of all the risk of transforming one's practice by other professionals' contact.⁵ It means becoming aware that each of us could be enriched by sharing knowledge and competencies, as long as we show humility, respect and trust to one another. It provides us with a way of improving our patients' and families' quality of life.

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References

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