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Qualitative Research

Interprofessional primary care team meetings: a qualitative approach comparing observations with personal opinions

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Abstract

Background. The number of people with multiple chronic conditions requiring primary care services increases. Professionals from different disciplines collaborate and coordinate care to deal with the complex health care needs. There is lack of information on current practices regarding interprofessional team (IPT) meetings.

Objectives. This study aimed to improve our understanding of the process of interprofessional collaboration in primary care team meetings in the Netherlands by observing the current practice and exploring personal opinions.

Methods. Qualitative study involving observations of team meetings and interviews with participants. Eight different IPT meetings ($n = 8$) in different primary care practices were observed by means of video recordings. Experiences were explored by conducting individual semi-structured interviews ($n = 60$) with participants (i.e. health care professionals from different disciplines) of the observed team meetings. The data were analysed by means of content analysis.

Results. Most participants expressed favourable opinions about their team meetings. However, observations showed that team meetings were more or less hectic, and lacked a clear structure and team coordinator or leader. There appears to be a discrepancy between findings from observations and interviews. From the interviews, four main themes were extracted: (1) Team structure and composition, (2) Patient-centredness, (3) Interaction and (4) Attitude and motivation.

Conclusion. IPT meetings could benefit from improvements in structure, patient-centredness and leadership by the chairpersons. Given the discrepancy between observations and interviews, it would appear useful to improve team members' awareness of aspects that could be improved before training them in dealing with specific challenges.

Key words: Cooperative behaviour, interdisciplinary communication, interprofessional relations, patient care team, primary health care, qualitative research.

Introduction

The number of patients with multiple chronic conditions requiring primary care services is increasing in European countries (1–3). Nowadays, care delivery for these chronically ill people is moving towards patient-centred care, highlighting the need for health care to be more explicitly focused on individual patients' personal needs and wishes (4). Dealing with this complex care demand and the patient-centred care approach involves efforts over a long time period, comprising coordinated inputs from a wide range of health care professionals (5). It appears valuable to encourage and achieve interprofessional collaboration (IPC) by working in partnership with patients and health care professionals from different disciplines to enhance the quality of care (6). A cohesive and cooperative team of professionals seems to be an important element of patient-centred care (7), as quality of care is influenced by effective interaction between patients and health care professionals, as well as by successful cooperation among the team of professionals (8). This interprofessional team (IPT) identifies the best options and facilitates the patient's involvement in decision-making using those options, also known as interprofessional shared decision-making (9).

In Dutch primary care practice, IPC is often implemented in periodic IPT meetings, in which health care professionals from a diversity of disciplines collaborate, discuss and work towards a shared patient-centred care plan. This shared care plan can be seen as a collaborative and shared document (10), summarizing the patient's current and preferred situation, and personal goals and actions (11). IPC appears to be a promising approach to the development of shared care plans.

Working in teams enables health care professionals to communicate and address the complex and challenging needs of the chronically ill (12). In addition, working together enables health care professionals to share their expertise and perspectives to set common goals, in order to improve or maintain patients' quality of life. Furthermore, IPT meetings can be seen as learning opportunities, as health care professionals learn from each other's expertise (13).

Conducting IPT meetings is regarded as complex and influenced by many interrelated factors (12,14–17). Frequently mentioned favourable factors are: shared vision, common goals, respect and trust among team members, communication, effective leadership, shared reflection (12,14,15) and a clear description of roles and responsibilities (17). A review by Xyrichis and Lowton (2008) revealed that team processes as well as team structure impact on successful IPT meetings in a primary care setting (14). A study by Jaruseviciene and colleagues (2013) found that both formal and individual behavioural factors should be targeted in efforts to strengthen IPT meetings (17).

Although various influencing factors are known, it is unclear how effective team meetings can be accomplished, and there seems to be no consensus about the key features of successful interprofessional teamwork in primary care (18). In addition, since IPC is gaining in popularity, it seems important to explore the experiences of team members participating in primary care team meetings, to allow the voices of the health care professionals themselves to be heard (12). There also seems to be a lack of information on current practices regarding interprofessional teamwork and developing shared care plans in primary care in the Netherlands. In order to examine the current practices in greater depth, and to answer the 'how' question, it is important to use multiple data collection methods. According to Morgan (2015), direct observations of collaborative practice in everyday work settings are a promising approach to exploring the complex phenomena of IPC. Interviews can be used to examine professionals' personal experiences. However, there seems to be a lack of studies attempting to directly observe such practices (19), and most of the existing studies have applied a survey approach or only included a small number of different professions. Overall, there seems to be a lack of studies based on observations of interprofessional teamwork combined with interviews (20). The aim of the present study was therefore to examine current practices in IPT meetings in primary care, as well as 'how' they are conducted, as well as to explore health care professionals' personal opinions regarding the current practice.

Methods

Study design

We conducted a qualitative study involving both observations of team meetings and individual semi-structured interviews with participating health care professionals. Relevant aspects of this study are reported here following the Consolidated Criteria for Reporting Qualitative Research (COREQ).

Setting and participants

Both observations and interviews took place in various health care centres and primary care practices in the Province of Limburg, the Netherlands. Data were collected between 2012 and 2013. Primary care teams were recruited and selected by pragmatic sampling, using the researchers' network. Teams meeting the following criteria were included: (1) the IPT had to consist of three or more health care professionals from different professional backgrounds and (2) primary care team meetings had to focus on discussing complex health care demands of individual (adult) patients (embracing conditions related to physical, mental and social aspects) and developing shared care plans. Practices were approached by e-mail or, in case of non-response, by telephone. The teams' contact persons received a letter with background information about the nature of the study and the confidentiality of the data. After a team had been selected, the other team members received oral background information from the researcher. Before the observations and interviews took place, oral informed consent was obtained from all participating health care professionals. Further, we obtained written informed consent from the patient and informal caregiver participating in team 7. In total, eight primary care teams (n = 8) were included. From those eight teams, only a few members were unable to attend an interview due to lack of available time, so eventually 60 team members took part in an interview (n = 60). The 60 team members we interviewed included family physicians, nurse practitioners, occupational therapists, physical therapists, psychologists, nurses, social workers, pharmacists, case managers for dementia, a human resource consultant, patient advisors, and one patient and his informal caregiver. Table 1 gives an overview of the interviewees in each team.

Observations

Access to the meetings was arranged by the teams' contact person or coordinator. Team meetings were audio and video recorded. During the observations, field notes were taken by one of the researchers (JvD or SL). In addition, regular features of the meeting (e.g. presence of a chairperson, agenda, shared reporting and number of participants) were recorded, using an observation list (Supplementary Data File S1). In order to better understand the communication and behaviour in the teams we observed meetings at three different levels of communication (procedural level, content level and interaction level) as described by Remmerswaal (21). The procedural level refers to the way a team works on a task, such as the methods and procedures used to achieve the goal. The content level concerns the topic of the conversations, their content and the information discussed. The interaction level refers to

Table 1. Characteristics of the participating interprofessional primary care teams conducted in the Netherlands, in 2012–13

Team	Setting	Duration in minutes	Frequency of team meetings	Number of participants	Number of disciplines	Patient present	Number of patients discussed	Chairperson	Shared reporting	Interviewed team members
1	Physical and occupational therapy practice	60	Weekly	11	6	No	22	Occupational therapist	Yes	1.1 Occupational therapist 1.2 Occupational therapist 1.3 Physical therapist 1.4 Physical therapist 1.5 Physical therapist 1.6 Geriatric nurse
2	Family Practice[a]	90	Once every 6 weeks	8	5	No	9	Practice nurse	Yes	2.1 Occupational therapist 2.2 Family doctor 2.3 Social worker 2.4 Practice nurse 2.5 Practice nurse 2.6 Practice nurse 2.7 Practice nurse
3	Family Practice[a]	60	Once every 6 weeks	14	7	No	8	Practice nurse	No	3.1 Case manager for dementia 3.2 Occupational therapist 3.3 Physical therapist 3.4 Family doctor 3.5 Family doctor 3.6 Family doctor 3.7 Patient advisor for elderly care 3.8 Patient advisor for elderly care 3.9 Social worker 3.10 Practice nurse 3.11 Practice nurse 3.12 District nurse 3.13 District nurse 3.14 District nurse
4	Family Practice[a]	60	Once every 2 months	13	9	No	11	Practice nurse	Yes	4.1 Pharmacist 4.2 Case manager for dementia 4.3 Physical therapist 4.4 Family doctor 4.5 Practice nurse 4.6 Practice nurse 4.7 District nurse
5	Home care agency	60	Once every 6 weeks	11	5	No	29	N/A	No	5.1 Case manager for dementia 5.2 Day care coordinator 5.3 Practice nurse 5.4 Practice nurse 5.5 Home care provider 5.6 Care programme supervisor 5.7 Care programme supervisor

Table 1. *Continued*

Team	Setting	Duration in minutes	Frequency of team meetings	Number of participants	Number of disciplines	Patient present	Number of patients discussed	Chairperson	Shared reporting	Interviewed team members
6	Health Centre[b]	90	Four times a year	8	5	No	7	Practice nurse	No	6.1 Pharmacist 6.2 Occupational therapist 6.3 Physical therapist 6.4 Physical therapist 6.5 Family doctor 6.6 Practice nurse 6.7 Practice nurse
7	Health Centre[b]	45	Only on demand	6	4	Yes	1	Practice nurse	No	7.1 Patient and informal caregiver 7.2 Family doctor 7.3 Human resource consultant 7.4 Practice nurse
8	Health Centre[b]	60	Four times a year	8	5	No	12	Practice nurse	Yes	8.1 Pharmacist 8.2 Physical therapist 8.3 Physical therapist 8.4 Physical therapist 8.5 Family doctor 8.6 Family doctor 8.7 Practice nurse 8.8 Care programme supervisor

[a]Practice housing family physicians, physician's assistants and family nurse practitioners serving as the patient's first point of entry in the health care system.
[b]Health care centre in which different disciplines (e.g. family practice, occupational therapy, physical therapy and pharmacy) are located in one building.

the team process and to what happens between the team members. In observing the content, we specifically focussed on the patients' background and health condition, the professionals' questions to the team, whether or not the patients' goals were mentioned, the exchange of information, clarification of patients' values/preferences, concrete actions and decisions, and evaluation of the care plan, based on the structure of the 'interprofessional shared decision-making model' (22).

Interviews

Immediately after a team meeting took place, the team members were interviewed individually but simultaneously by a team of trained interviewers (under supervision of JvD and SL) from the Faculty of Health (Zuyd University). This method ensured that the team members did not have to wait to be interviewed and they could immediately reflect on the team meeting. The individual interviews lasted an average of 15 minutes and were recorded using voice recorders. A semi-structured interview guide with open-ended questions guided the individual interviews (Supplementary Data File S2). All interviews started with an open-ended question to explore respondents' experiences with the IPT meetings that had just taken place. Subsequently, respondents were asked about their experiences, barriers and facilitators for effective IPT meetings, and possible improvements to their IPT meetings, in relation to the development of patient-centred care plans. Follow-up questions were used to gain more in-depth information and elicit rich information. Before being actually used, the interview guide was tested in a pilot interview and adjusted where needed.

Analysis

Observations as well as interviews were transcribed verbatim. The primary transcription was made from the audio recordings, while the video recordings were used during transcription to clarify who was speaking. NVivo 9 software was used to store and structure the transcripts and code the data from both observations and interviews. Observations were analysed by means of directed content analysis (23). A detailed description of each observation was made, concentrating on the focal points mentioned in Supplementary Data File S1. The interview data were analysed using thematic content analysis (24). Two researchers, JvD and SB (an external and experienced coder), analysed all the transcripts independently and carried out the open coding of all quotes relevant to the aim of the study. Concepts were identified and grouped into subcategories. In the next step, the two researchers compared and discussed their codes until they reached consensus and subsequently categorized into the different subcategories. In case of disagreement, a third researcher (LvB) was asked for advice. In the final step, the researchers identified key theme categories into which the subcategories could be divided.

Trustworthiness

The researchers' field notes and written comments were used in the analysis process to enhance the trustworthiness of the study. Furthermore, two researchers coded the data independently and then discussed and compared categories and subcategories, consulting a third researcher in case of disagreement. Moreover, combining data from both observations and interviews, also known as data triangulation, provided additional perspectives and a more complete picture, and enhanced internal validity (25).

Results

We observed eight interprofessional primary care team meetings in different practices and interviewed 60 participants individually. After having analysed 5 observations of different IPT meetings and 40 individual interviews, we found that analysing additional observations and interviews did not bring new insights, so data saturation had been achieved. Table 1 gives an overview of the teams' characteristics.

Observations

Procedural level

As described in Table 1, the IPT meetings were conducted in various ways. They varied in terms of setting, duration, frequency, numbers of participants, disciplines and numbers of patients discussed. In some practices, an agenda was used to prepare for the meeting, indicating which patients were to be discussed. The number of participants of the team meetings ranged from 6 to 14, and included 4 to 9 different disciplines. It should be noted, however, that not all participants were present for the entire meeting. The number of patients discussed during a meeting also differed between the teams. One team meeting discussed 29 patients, while the team meeting that was attended by the patient only discussed this particular patient's case. Half of the teams applied shared reporting, capturing the teams' main agreements. Most of the observed team meetings did not have a clear structure, though in a minority of practices the chairperson actively structured the meeting, introduced patient cases, summarized agreements and kept track of the time. In all but one team was the role of chairperson fulfilled by the practice nurse, who guided the meeting. However, the interpretation of this role differed per team, ranging from active and directive to more or less passive.

Content level

All teams observed discussed patients with complex health care demands requiring an interprofessional approach. These patients suffered from multiple chronic conditions and experienced problems related to the physical, mental and social domain. Almost all case discussions during the meetings started with a description of the patients' history and background. In most of the observed meetings, a lot of time was spent on this history and background. In the majority of the team meetings, no clear question was put before to the team and the attendees did not ask for such a question. As a result, most of the meetings did not result in concrete agreements and adjustments to the care plan but remained descriptive and noncommittal, lacking actual decision-making. During some of the discussions, however, it became clear from the context what problem or question the health care professional wanted to be dealt with.

We observed that in most cases, the professionals' perspective on a patient's case appeared to be superior to the patient's individual perspective and personal goals, since patients' goals and concerns were not introduced and problems were discussed as perceived by the professionals. Even during the meeting where the patient was present, no clear patient goals were formulated. Only in one case did a health care professional ask about the patient's goals during the meeting.

Throughout most of the cases discussed, team members proposed specific ideas, interventions or possible actions to deal with the patients' health care demand and support the patients in managing their situation. Suggestions and ideas differed in nature and covered various domains, including practical adjustments to the home situation, informal care, day care, adjusting medication or transfer to a nursing home. Suggested actions rarely concerned contributions by the patients themselves. Based on the suggested actions and interventions, most of the teams prioritized and decided on actions which could be presented to the patient. Only for a minority of the suggested actions did the team agree on who would be responsible and at what moment feedback would be given to the team.

Interaction level

We observed a pleasant atmosphere during all of the meetings and did not detect any visible conflicts or irritations. During some of the meetings, we observed a dominant role of the family doctors. When it came to making decisions, most of the team members looked towards the family doctor. We further observed a close relationship and 'short lines of communication' between health care professionals. Professionals were able to find and consult each other easily. Moreover, we did not observe any negative or fractious participants. Most of the team members seem to have an open attitude in which they asked each other questions and reacted positively towards other people's insights. We further observed that not all team members played an active role during the meeting. For most of the meetings, only a small proportion of the members participated actively. The patients' family doctors and practice nurses were talking most of the time, while the professionals from other disciplines talked less frequently.

Interviews

Four main themes emerged from the interviews, describing current practices and personal experiences of health care professionals regarding IPT meetings: (1) Team structure and composition, (2) Patient-centredness, (3) Interaction and (4) Attitude and motivation. The main themes with their subthemes are presented in Figure 1.

Team structure and composition

Most of the respondents reported having perceived a structured team meeting. Nevertheless, some of the respondents did recognize structure as a target for improvement. Some of the respondents mentioned that the team does not usually discuss patients according to a fixed structure. They acknowledged that elements like the patient's care demand and goals, a summary of agreements, conclusions, suggestions or action points were mixed or missing.

> "Sometimes the purpose of the topic discussed is unclear; is it a matter of informing? Or coordinating? Or a question for the group to answer?" (Social worker, team 2)

Some of the respondents thought that the introduction and description of the patients could be improved, so that all participants quickly get a good picture of each patient.

> "The person who introduces the patient should present a clear case and a question" (Social worker, team 2)

Working on the basis of an agenda, keeping minutes, time management and working in a problem-oriented fashion were mentioned as possible strategies to structure the meetings. Some of the respondents suggested disclosing the patients' name and date of birth and stating a specific question on the agenda, allowing the attendees to know in advance which patient is involved so they suitably prepare the meeting. Another factor mentioned as a precondition for a structured meeting was an active and directive role of the person chairing the meeting. Respondents argued that it is not easy to find an appropriate chairperson because of a lack of expertise and time.

> "I'm a family doctor, not a chairperson. I did not go to chairpersons college, but studied medicine. Those are two very different things" (Family doctor, team 3)

Some respondents mentioned that the large number of team members sometimes meant it was not clear who was who. They also stated that a group which is too large has a negative effect on group processes, efficiency and time, and confuses team members, resulting in chaotic meetings. As a solution, they recommended working with nametags and spending time introducing themselves to the others.

> "The meeting is chaotic because there are many people present and everyone wants to have their say" (Physical therapist, team 1)

Patient-centredness

Some of the respondents mentioned that they had developed an overall picture and helicopter view of the patient during the team meeting, since each team member knew the patient from the perspective of his or her own discipline and experience.

> "By joining such a meeting you get a complete picture of the patient" (Physical therapist, team 6)

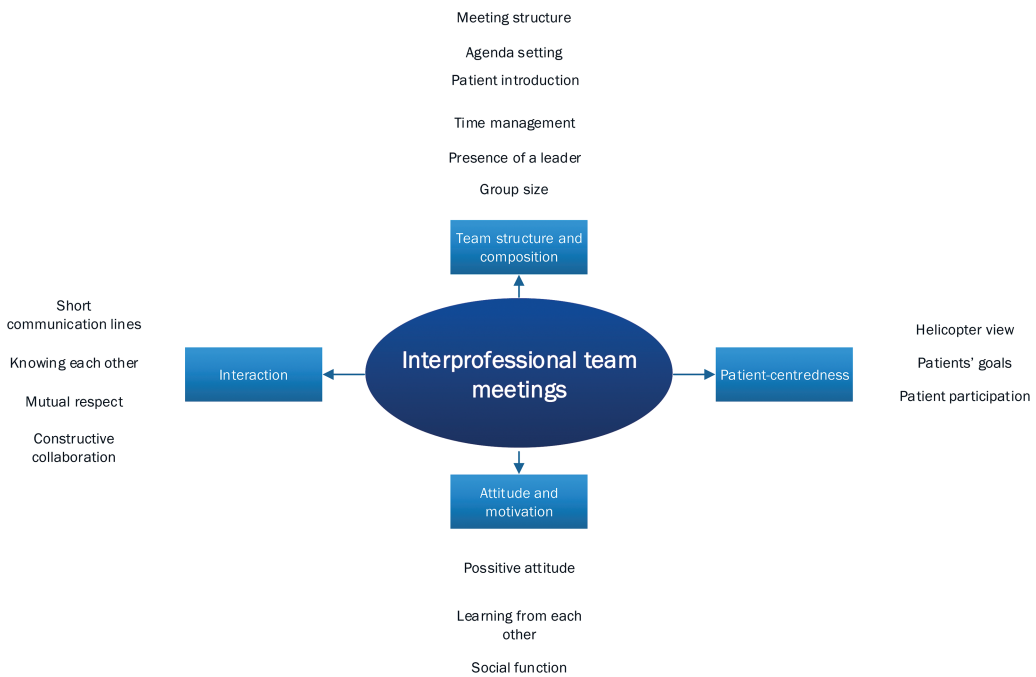

Figure 1. Key themes regarding interprofessional team meetings derived from observations and interviews in the Netherlands, conducted in 2012–13.

Some respondents said they appreciated team meetings more when the patients' goals were addressed. During one of the meetings, a patient and his partner were present. Both the patient and the health care professionals attending this specific meeting mentioned that the personal goals of the patient had been introduced. During this meeting, the patient was given the opportunity to tell and explain his personal story. However, due to the emotionally charged nature of the story, this meeting was perceived as being very stressful for the patient and his partner.

> "The conversation was very stressful for the patient, in an emotional sense as well. It makes you wonder if this is the right thing to do?" (Practice nurse, team 7)

Interaction

Some of the interviewees appreciated the short lines of communication between health care professionals. They mentioned that these led to greater efficiency, more accessibility and thus faster decision-making. In addition, it allows tasks to be divided, which supports care coordination.

> "If you have any questions, you can immediately contact the appropriate colleague" (Occupational therapist, team 1)

Getting to know the other professionals personally was also perceived as positive by the respondents. They stated that it enhanced trust.

> "As you get to know each other better, you get a better idea what to expect from a person" (Case manager for dementia, team 4)

Respondents also appreciated the fact that everyone could have their say and that team members did not interrupt each other. Team members listened carefully to each other in a constructive way. Another respondent mentioned the importance of mutual respect.

Attitude and motivation

In general, the respondents had a favourable impression of the team meetings, and had enjoyed attending the meeting. Respondents said they appreciated the possibility to ask questions and express their opinions. They further mentioned the social value of meeting people face to face, and enjoyed seeing each other regularly. In addition, the informal approach during the team meetings and the positive team climate made respondents enjoy their work more. A number of participants indicated that they actively learned from each other's input and expertise. Some respondents valued the fact that interesting topics, like care reforms and practical applications of laws and regulations, were sometimes discussed.

Discussion

Both the observations and interviews showed that IPT meetings took place in a pleasant atmosphere, and that they varied in both form and content. However, the ultimate goal of such meetings, to jointly develop a shared care plan, summarizing the patient's current and preferred situation, and personal goals and actions, was frequently not reached. This was, however, often not recognized by the professionals themselves, who perceived the meetings as more or less structured and patient-centred.

Certain targets for improvement can be identified, especially regarding structure and patient-centredness, both of which have been recommended in the literature to strengthen IPT meetings (14,26,27). Similar to the findings of our study, Xyrichis identified group size and composition, as well as clear goals and objectives as important indicators of successful teamwork (14). Xyrichis also identified organizational support and support for innovation as factors influencing teamwork, which were indeed also mentioned by the participants of our study. As regards structure, we observed a lack of clarity regarding the purpose of the meetings and the topics discussed, resulting in rather superficial discussions. This was confirmed by the interviews, in which respondents suggested that the person who introduces the patient, should also pose a clear question to the team. The chairperson appears to play a significant role in structuring and guiding the team meeting, as has also been emphasized in the literature (12,28,29). In addition to their 'technical' role, it has also been claimed that the chairperson should adopt the role of a leader who is responsible for the team's performance, and guides the team through its development over time (12). This role might require sufficient authority and sometimes a directive leadership style (27). The 2015 CanMEDS medical competency framework recognizes the importance of leadership competencies in the increasingly complex health care (30).

Prior to the IPT meeting, professionals need to explore goals and meaningful activities of the patients they would like to discuss (31). As regards patient-centredness, the professionals we interviewed stated that they did introduce the personal goals of the patients during the IPT meetings. However, our observations showed that it was the professionals' perspective which dominated, and that patients' personal goals were only mentioned in exceptional cases. The literature reveals that professionals appear to have difficulties regarding the implementation of goal setting in their routine practice (32,33), which can be explained by the fact that guidelines rarely offer information on how the goal setting should be realized (34). Another possible explanation could be that professionals have 'blind spots' with regard to patient-centredness and are in need of support to increase their awareness and self-reflective power as a first step towards improving current practice and the patients' health. An alternative to exploring patients' goals prior to the IPT meeting, is that patients participate themselves and introduce their own goals. However, our observations demonstrate that patients seldom participate during team meetings. Due to patient participation, the decision-making process and care of chronic illness improves (35), therefore it seems to be interesting to explore possibilities to increase patient participation during team meetings.

Scientific literature shows that improved IPC is positively related to the care and health outcomes of patients (36,37). Further, from oncology setting, we know that conducting IPT meetings can lead to significant changes in the way patients are assessed and managed (36). This study offers insight into current practices of the process of IPC in IPT meetings and enlightens opportunities to improve.

Strengths and limitations

The qualitative approach of this study provides an in-depth understanding of 'how' IPT meetings in primary care are actually conducted and the health care professionals' opinions. By conducting the interviews immediately after the IPT meetings took place, we gave the team members an opportunity to reflect on their experiences with the meetings. Furthermore, this approach provided us with an opportunity to detect blind spots that team members were often not aware of. We were not able to interview all participating team members. Therefore, we have to take into account the potential influence of selective participation impacting our findings. However, we were able to interview 76% of all participating team members, (range 55% to 100%, n = 60) from 15 different disciplines (range 3 to 7). Therefore, we assume the sample representative of health care professionals participating in IPT meetings. Data saturation

was reached after observations of five different IPT meetings and 40 individual interviews had been analysed. A possible limitation to his study could be the fact that we hired a team of students to conduct some of the interviews. Given the inexperience of these students, this might have resulted in underreporting of findings. However, we trained these students in qualitative interviewing and therefore assume they were able to conduct individual interviews appropriately.

Conclusion

The current practice of IPT meetings leaves room for improvement in terms of structure and patient-centredness. The chairperson of the team, when appropriately trained, may play the role of a change agent. Given the discrepancy between our observations and the interviews, it would seem to be useful to improve team members' awareness of the aspects that need to be improved before training them in dealing with the specific challenges of these meetings. Further research is needed to identify opportunities to increase professionals' self-reflective power.

Supplementary material

Supplementary material is available at *Family Practice* online.

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Declaration

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