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Interprofessional teamwork is the foundation of effective psychosocial work in organ transplantation

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Abstract

Interprofessional teamwork (IPT) is a well-established idea spanning multiple professional fields and supported by decades of literature. IPT is underemphasized in the medical literature despite its known impact on patient safety and care delivery. While many transplant teams adeptly work together, little has been written about team dynamics in organ transplantation and less on how IPT principles apply to transplant psychosocial clinicians. This editorial summarizes IPT principles, extrapolates key elements to psychosocial work in organ transplantation, flags potential barriers, collates practical strategies for teamwork enhancement, and identifies areas for future study.

Keywords

Psychosocial; Transplantation; Interprofessional; Teamwork; Multidisciplinary

Medical teamwork affects patient care and safety in intensive care units [1–4], operating rooms [5–9], emergency departments [10–12], rehabilitation units [13,14], and clinics [15,16] and prominent organizations have long called for improvement [17,18]. Teamwork's importance and complexity increases when it involves distinct training backgrounds. Such interprofessional teamwork (IPT) is an "interpersonal process characterized by healthcare professionals from multiple disciplines with shared objectives, decision-making, responsibility, and power working together to solve patient care problems…best attained through interprofessional education [which] promotes an atmosphere of mutual trust and respect, effective and open communication, and awareness and acceptance of the roles, skills, and responsibilities of the participating disciplines [20]." IPT is an established idea supported by decades of literature which spans multiple fields [17,21].

Organ transplantation is a quintessential healthcare domain which relies on IPT [22]. Over timespans of hours to years, multidisciplinary clinicians evaluate prospective transplant

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recipients and living donors across psychological, social, medical, and surgical domains. Across regions and centers, there is substantial variability in the composition of transplant psychosocial teams. They range from a single clinician with limited transplant integration to an entire psychosocial team fully embedded into the transplant center.

Psychosocial clinicians, whether working alone or with other psychosocial disciplines, often simultaneously evaluate and treat diverse liver, kidney, heart, and lung patients before and after transplant and thus must efficiently and longitudinally collaborate with multiple medical and surgical teams over long time periods. IPT concepts apply to collaboration among psychosocial, medical, and surgical clinicians as well as among discrete psychosocial disciplines (psychiatry, psychology, social work, addiction medicine). Little has been written about discrete transplant IPT factors and processes despite their broad implications and fundamental importance; they are easily overlooked and deprioritized amidst a center's numerous other functions and concerns. To our knowledge, this is the first article which seeks to extrapolate IPT principles to psychosocial work by the whole transplant team and among subgroups of psychosocial clinicians.

1. Potential barriers to transplant psychosocial IPT

Stress in all health professionals is under-recognized, narrows a professional's attention and thought processes, and negatively affects collaboration [23]. Transplant psychosocial work entails unique stressors including high stakes of end-stage disease, binary decision-making (i.e. listing versus not listing a candidate) amid multifactorial circumstances, preponderance of subjective psychosocial data open to interpretation, remorse resulting from difficult decisions and outcomes, pressure from colleagues to endorse or decline patients, and stewardship of donor organs as precious resources. Such stress may manifest in team relationships (strain between members or groups), tasks (discord regarding their necessity or utility), and processes (disputes regarding performance and improvement). Team conflict may be open or concealed and, depending on how it is handled, constructive or destructive [21].

Medical teams' level of trust and relationship development are key determinants of how they handle stress and conflict [21]. Medical interactions, like those in transplant clinics and selection conferences, are generally terse, business-like, and stripped of social conversation [24] hindering interpersonal connection and relationship formation. For various reasons, medical teamwork is generally difficult for teams to address [25] and tribalism is common and detrimental in healthcare [26]. Physicians, who may view themselves atop a hierarchical structure, can be unaware of team problems [27,28]. Medical and psychosocial disciplines have idiosyncratic culture and psychology, conceptualize and prioritize teamwork differently, and possess varying personal and collective capacities for the reflection and vulnerability requisite for IPT [24].

Strong feelings, unchecked, may bias any clinician favorably or unfavorably, skew team policies, obfuscate nuance, intensify team discussions, and complicate collaboration. Stewardship of precious donor organs is a unique transplant role which can heighten clinician emotion during clinical care and decision-making. Many healthcare professionals

have their own mental health and substance use disorders [29–32] that impact their own decision making and care delivery. Table 1 summarizes potential IPT barriers and depicts them in fictional scenarios.

2. Recommendations for improving transplant psychosocial IPT

The nature of transplant IPT means personal wellness must be a priority. In-service mental health (MH) seminars and facilitated process groups are formal ways that transplant clinicians can get support at work in addition to employee psychiatric resources. There are many other informal ways psychosocial clinicians contribute to broader mental health awareness and a healthy transplant center culture through workday social interactions, professionalism, and participation in committees and quality improvement initiatives.

High-quality team interpersonal relationships stabilize a transplant team during difficult discussions, disagreements, and bad outcomes. Durable relationships of this quality, however, are unlikely to form spontaneously or easily, particularly among diverse specialties; they require cultivation, investment, and vulnerability. Good will fosters the flexibility, creativity, and innovation that transplant psychosocial work requires. The necessary problem-solving for inevitable team conflict is comprised of agreed-upon rules and resolution procedures, avoiding blame, maintaining neutrality and objectivity, ensuring all voices are heard, and establishing an open culture of questioning [21]. Transplant psychosocial clinicians must also construct and maintain alliances with non-transplant and unaffiliated community psychiatric colleagues since transplant centers cannot provide sufficient MH and substance use disorder (SUD) care on their own.

Intuitively, team co-location enhances IPT [16,24]. Transplant psychosocial clinicians should work in close proximity to one another during normal clinical operations and, if possible, near transplant medicine and surgery colleagues. Elements of constructive team togetherness include optimally-configured physical space, consistent interaction, and shared communication methods [16].

Clinicians working in a psychosocial team must agree upon well-defined roles and responsibilities which is uniquely important as expertise and scopes-of-practice overlap [33]. Physicians and nurses have overlapping roles yet errors still occur [1,6]. Overlap among transplant psychosocial clinicians is similarly high but will not guarantee adequate coordination or patient care. Task redundancy may lead to confusion or frustration.

Regular multidisciplinary meetings are the main communication strategy of any interprofessional team; their absence leads to communication breakdown, poorer patient care, and workflow delays [24]. Transplant psychosocial meeting frequency and format should be agreed upon with all members regularly attending. Such regular, face to face (in-person or virtual) communication about psychosocial matters is likely more reliable and efficient than written synchronous (electronic messaging) and asynchronous (chart notes, email) formats. Team members most qualified and willing should be designated psychosocial care coordinators who collate and manage data and lead team meetings. For teams whose patients have higher levels of baseline psychosocial complexity and require

intensive treatment planning (i.e. liver teams), a transplant psychosocial care manager may be a full-time position. Such care managers are crucial “go-betweens” but should not be teams’ sole communication channels [24]. Social work may be best equipped for this role [34]. Physicians, while often clinically and legally accountable for patient care, may not be well equipped for IPT logistics [35].

Psychosocial work requires careful data and population management given the large patient cohorts constantly moving through phases of transplant care over long periods of time. While general transplant coordinators are tasked with this responsibility for the broader team, they may not be available to curate and respond to detailed psychosocial information hence the utility of a psychosocial care manager. Dashboards are a helpful way to collate and review medical and psychosocial data stored within transplant databases and electronic medical records. Transplant patients are frequently treated in multiple health systems including by outside MH and SUD providers making such record review all the more crucial and challenging. (MH and SUD data are protected and appropriate patient releases of information should be obtained early.) Dashboards must be regularly updated to maximize usefulness. Their thorough review during team meetings can yield coordinated and effective team interventions as clinical needs emerge. Such interventions may include a prompt clinic visit (face-to-face or virtual) or, given the wide geographic dispersal of transplant populations and variable technology comfort levels, phone calls. Phone calls can be invaluable “soft touches” between clinical encounters where support is rendered, treatment plans adjusted, and psychometric scores updated to track symptom severity and resolution. Expansion of telemedicine during Covid-19 is likely to ensure more transplant patients can be followed virtually.

Efficient transfer of psychosocial data to the broader transplant team is a crucial art, likely best done face-to-face (in-person or virtual). Non-psychosocial team members may not be receptive to exhaustive psychosocial descriptions; selection conferences have time constraints and must run efficiently. Optimal psychosocial verbal presentations are given by one team member who succinctly reports only crucial clinical findings, uses predictable format and style, models de-stigmatized language and attitudes, and offers clear impressions and recommendations.

IPT is less likely to be widely adopted without the buy-in and promotion by transplant leadership. Just as pilots are hired as much for their teamwork aptitudes as their technical abilities [25], principles of IPT should be prioritized in transplant recruitment and hiring processes. Psychosocial clinicians should be involved in transplant hiring proceedings alongside medical and surgical colleagues. IPT metrics may be useful in tracking individual and team performance [35].

Interprofessional medical education programs are feasible and improve clinician competencies in leadership, initiative management, teamwork, patient centeredness, population management, and systems thinking [36]. Similar results have been found among MH professionals [37,38]. Within a psychosocial team, regular cross-training among social workers, psychologists, and psychiatrists will expand knowledge bases and broaden paradigms about transplant patients and families. Observing and critiquing teammates’

interviews can allow clinicians to garner feedback, improve technique, and disseminate skillsets. Robust MH and SUD lectures should be part of transplant medicine and transplant surgery curricula. Consultation-liaison psychiatry fellows should regularly rotate in transplant.Addiction medicine and addiction psychiatry fellows should rotate on transplant teams with prominent SUD. Psychology graduate students, interns, and post-doctoral fellows working in transplant settings could receive unique education with a complex patient population in addition to gaining valuable interprofessional skills.

In the airline industry, effective flight deck crews allocate one-third of their communication to discussing errors and environmental threats; poor performing teams only use 5% [25]. Poor psychosocial outcomes should be regularly presented and discussed by psychosocial personnel and, ideally, alongside medical and surgical colleagues in transplant morbidity and mortality conferences. This not only addresses psychosocial matters programmatically, further integrating them into a center's consciousness and culture, but also provides ongoing team education. Table 2 summarizes recommendations for optimizing psychosocial IPT and provides implementation examples.

3. Conclusions

Just as it has been shown to be a factor in safety and quality elsewhere in industry and medicine, IPT is foundational to optimizing and maintaining quality psychosocial work in transplant. Psychosocial clinicians, along with medical and surgical colleagues, must intentionally cultivate and maintain strong personal relationships, reliable and open communication methods, conflict resolution strategies, and shared professional goals to succeed in their challenging work.

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Table 1

Potential barriers to transplant psychosocial interprofessional teamwork.

Barrier	Definition	Fictional clinical scenarios
Clinician stress	Individual or collective emotional strain resulting from various challenges inherent to organ transplantation	A transplant social worker is discussing his ongoing concerns about an acutely ill patient's depression and treatment adherence. He is often pressured from physician colleagues to endorse candidates who are otherwise favorable medical and surgical candidates. When a physician asks a clarifying question, the social worker loses his temper. A transplant pulmonologist has had several patients die in the past year. She perceives that psychosocial colleagues are unduly prolonging her patients' transplant courses and begins to reduce her correspondence and referrals to them.
Weak relationships and poor trust	Interpersonal disconnection among individuals or groups arising from past events or neglected team building	A transplant psychologist and psychiatrist, with little in common personally, fundamentally disagree on the nature and treatment of psychopathology. They rarely collaborate on patient care and communicate only via email and chart correspondence. Psychosocial clinicians endorse a candidate whose severe mood disorder was in remission at transplant evaluation. The patient attempts suicide soon after transplant. Team members often reference the suicide attempt in subsequent selection conferences even when the cases at hand bear little resemblance to the tragedy.
Disparate professional cultures and tribalism	Interpersonal incongruences originating from dissimilar training backgrounds and clinical identities	Transplant psychologists have not been able to improve collaboration with social work colleagues. When they voice their concerns to transplant leadership about impact on patient care, the surgeon chuckles about the "drama." Transplant psychiatry and psychology monopolize psychosocial team discussions and treatment planning focusing on psychopathology to the exclusion of other theories and paradigms which their social work colleagues expertly understand and use.
Traditional hierarchies	Real or perceived rankings in power and influence among transplant specialties	A transplant psychiatrist perceives that he is not as esteemed as other physicians on the team. He reacts by elaborating his case presentations during selection conferences to include overly inclusive detail, literature references, and obscure jargon. A transplant psychologist voices concern to his psychiatrist colleague about possible side effects from a medication she recently initiated in a patient they share. The psychiatrist bristles at a perceived slight and dismisses feedback from a "non-medical" colleague.
Clinician bias and strong emotions	Prejudice for or against certain people or groups based on one' s personal psychological traits or past experiences	A transplant social worker is a fierce advocate for SUD patients after years of work in a residential treatment facility and a sister and mother both in recovery. She regularly insists the team should list candidates whose SUD risk profiles concern other team members and exceed the team' s resources. For years, a senior transplant hepatologist has cared for numerous challenging patients who resume drinking after transplant, many with dire outcomes. Out of frustration and a belief that SUD treatment is futile, he does not attend meetings led by psychosocial colleagues where team policies regarding transplanting SUD patients are being reevaluated and potentially liberalized.
Subjectivity of psychosocial data	Psychosocial problems are rarely bound by concrete technical parameters interpretable to a few team members which invites inaccurate speculation and inefficient dispute	During selection conferences, the training and expertise of medicine and surgery yield efficient and accurate interpretation of patient laboratory and imaging data with little input or dispute from other disciplines. Conversely, psychosocial clinician expertise and time spent with patients are not deemed sufficient to interpret psychosocial data and make recommendations. Hearing psychosocial presentations for the first time, medicine and surgery alter or override psychosocial recommendations without providing additional clinical data or literature support.

SUD, substance use disorder.

Table 2 –

Recommendations to Improve Transplant Psychosocial Interprofessional Teamwork.

Recommendation	Implementation examples
Clinician wellness	• Regular open-door process groups led by psychosocial team members for transplant personnel to share experiences, express emotion, and lend and receive support
	• Mental health awareness, crisis, and treatment resources readily discoverable
	• Recurring mental health seminars given by psychosocial team members
	• Psychosocial team members consistently offer support and friendship in their casual, personal interactions with other transplant team members
	• Frequent leadership reminders in newsletters and email correspondence about the importance of self-care and which destigmatize mental health treatment
Relationship building	• Regular formal and informal social opportunities offered to all transplant staff
	• Interprofessional transplant initiatives, committees, and research projects
	• Information packets sent to non-transplant community MH/SUD colleagues which introduce transplant team members, provide contact information, orient to the nuances of transplant mental health, warmly invite care coordination, and express gratitude for ongoing collaboration
	• Non-transplant colleagues invited to transplant center seminars and functions
Conflict resolution	• Time set aside during psychosocial team meetings where candid impressions about team function and decision-making are discussed
	• An open and questioning team culture is cultivated and maintained which invites good faith dissent
	• Regular reminders from team leadership about open channels of communication along with a commitment to discovering and resolving teamwork problems
Co-located workspace orientation	• Medical, surgical, and psychosocial offices arranged in close proximity facilitating personal and professional interactions
	• Transplant clinics scheduled and situated to maximize interprofessional overlap
Consensus role definition	• Division of psychosocial work is carefully discussed and agreed upon by psychiatry, psychology, and social work
	• Team members agree on and adhere to their roles during team meetings whose format, frequency, and length have also been jointly decided
Optimized team communication	• Cases are discussed thoroughly by psychosocial team members who polish a set of opinions and recommendations, presented in an agreed upon, succinct, standardized format to the broader team during selection conferences
	• Psychosocial clinicians politely correct stigma and bias among themselves and the broader team
Interprofessional data management	• The EMR dashboard functionality is customized to include psychometric scores (if collected), transplant dates, hospital admission and clinic visit data, and medical and toxicological lab values.
	• Psychosocial team notes and summaries are templated to maximize data uniformity, completeness, and easy team access
	• Signed recovery meeting attendance logs (i.e. AA, SMART recovery) and treatment summary letters from community providers are used to gauge MH and SUD treatment adherence and effectiveness
Team member performance and recruitment	• Formal anonymous feedback elicited from individual team members' coworkers, including their capacity for IPT with results discoverable to individual clinicians and their supervisors
	• Among other parameters, new transplant center faculty and staff recruits evaluated with regards to their proclivity for IPT
Interprofessional education	• Psychosocial topics presented alongside medical and surgical matters during morbidity and mortality conferences

Recommendation	Implementation examples
	• Transplant education materials and seminars include detailed psychosocial information
	• Psychosocial topics taught in transplant medicine and surgery trainee didactics and vice versa
	• Transplant psychosocial team members travel to surrounding mental health clinics teaching seminars which offer continuing education credits
	• Poor psychosocial outcomes are scrutinized and adjustments to workflows and skillsets are made
	• Team members periodically observe and give feedback on each other's interview skills
IPT tracking and quality improvement	• Metrics relevant to psychosocial IPT functionality: – validated teamwork rating scales – patient and clinician satisfaction data – rates of successful patient pre- and post-transplant MH and SUD treatment engagement – frequency of care coordination with community MH and SUD providers – time from evaluation to listing (particularly for MH and SUD patients) – patient no-show rates for transplant psychosocial visits – rates of patient de-listing for MH disorder or SUD worsening and recurrence – consistency of toxicology labs obtained
Future IPT research	• Transplant studies needed regarding impact of IPT on: – patient and team member satisfaction – psychosocial, quality of life, and medical outcomes – MH and SUD patient care access – cost efficiency

AA, Alcoholics Anonymous; EMR, electronic medical record; IPT, interprofessional teamwork; MH, mental health; SMART, self-management and recovery training; SUD, substance use disorder.