Comprehensive Exam Definitional Essay: Area 2

Interdisciplinarity and Interdisciplinary Health Care Teams

Objective

The objective of this definitional essay is to explore the notion of interdisciplinarity (and by extension, disciplinarity) with particular emphasis on collaborative teamwork in the health care milieu. This reading will inform my doctoral research into interdisciplinarity in the North American health care context.

Interdisciplinary Health Care Teams

Interdisciplinary health care teams, or IHCTs (Drinka & Clark, 2000), have become a regular feature in the health care landscape. This has been in response to several factors, including a restructuring in the delivery of care (especially primary health care reform) that aimed to increase efficiency and reduce costs, the increased specialization in the medical and allied health professions, the increasing complexity and chronicity of presenting health problems, and the move toward more patient-focused care (Greenwell, 1995; Stewart et al. 2003), all of which called for greater collaboration and communication across the disciplines and health professions.

Many terms are used to refer to collaborative work in health care, including *interdisciplinary*, *multidisciplinary*, *cross-disciplinary*, *transdisciplinary*, *interprofessional*, and *multiprofessional* (Klein, 1990; Lynch, 2006; McCallin, 2001; Moran; 2002; Poole & Real, 2003; Shalinsky, 1989; see also Casto et al., 1994; Soothill, Mackay, & Webb, 1995; Wenger, 1998). These terms are used differently and even sometimes interchangeably by those who provide health care, as well as by those who study them, to describe a variety of collaborative work that runs the gamut from the juxtaposition of two or more disciplines in an additive approach to care to a blurring of disciplinary boundaries in teamwork. While the goal here is not to problematize the definitions of these terms, it is important to be mindful of how the terms are used.

Some of the notions behind the impetus for more collaborative care include a desire for a more "holistic" approach, which Klein (1990) explains derives from a unity-of-knowledge ideal: The

interdisciplinary collaboration (Bennington, 1999; McCallin, 2001): In theory at least, when members of an interdisciplinary team work together, there is an exchange of sorts—what Moran (2002) calls an *interaction*—that leaves neither party unchanged. Indeed, this transformation, blurring of disciplinary boundaries, or what is sometimes called synergies, is often held up as an ideal, a holy grail of sorts, which some (Klein 1990; Moran, 2002) claim is rarely achieved.

While this might be the case, there has still been considerable research on interdisciplinary health care teams, or IHCTs (Drinka & Clark, 2000). Some authors offer models of how IHCTs ought to be conceptualized (Casto et al, 1994; Drinka & Clark, 2000; Shalinsky, 1989). Empirically, IHCTs are studied and explained in a variety of ways. Some of the common themes in the literature include:

- *the importance and difficulty of communication* (e.g., Alvarez & Coiera, 2006; Lingard, Espin, Whyte, Regehr, Baker, et al, 2004; Long, 1996; Poole & Real, 2003);
- *clarity of team member roles and identities* (Lingard, Reznick, DeVito, & Espin, 2002; Leipzig, 2002; Long, 1996; Poulton & West, 1999);
- *status, power, and hierarchy* (e.g., Cott, 1997; DiPalma, 2004; Klein, 2005; Long, 1996; O'Donnell & Derry, 2005);
- *leadership* (Drinka & Clark, 2000; O'Donnell & Derry, 2005; Sinclair, 1992);
- *collective action and decision-making* (Lanceley, Savage, Menon, & Jacobs, 2007; Leigzig, Hyer, Wallenstein, Vezina, Fairchild, et al., 2002; McCallin, 2001);
- and the need for *more interdisciplinary training in education programs* (Beattie, 1995; Hall & Weaver, 2001; Lingard, Reznick, Espin Regehr, & DeVito, 2002; Lynch, 2006; Sievers & Wolf, 2006).

In addition, a variety of methodological approaches have been employed, including *ethnography* (Ellingson, 2003; Lingard, Reznick, Espin et al., 2002; Lingard et al., 2005); *social network*

2005; Housley, 2006),

and *focus groups* (Lingard, Reznick, DeVito et al., 2002).

Lacuna

Given these recurring themes in the literature, communication would seem to be a key to understanding what happens on these teams—how they function and why. However, most of the empirical literature treats communication as information exchange or as a given (some exceptions are Ellingson, 2003; Lingard, Reznick, Espin et al., 2002). Communication *is* about information exchange, but it is also *constitutive* of the health care teams themselves, and language, interaction, and interpretation are crucial factors to team members communicating with each other. With this in mind, I propose the following contributors to a theoretical framework that foregrounds and problematizes communication on interdisciplinary teams.

Theoretical contributions

Critical link between language and disciplinarity: Foucault describes the link between disciplinarity, knowledge/power, and discourse. Specifically, he writes that a discipline's discourse delineates the boundaries of what is sayable and knowable, from that discipline's point of view. In other words, discourse informs the disciplinary epistemology and ontology, determining what is endogenous and, by extension, exogenous to a given discipline (see also Smelser, 2004). This notion is helpful for understanding disciplinary differences and conflict between members on interdisciplinary and multidisciplinary health care teams. Relatedly, the link between knowledge and power can be observed playing out in multi- and interdisciplinary teams with regard to status, hierarchy, and decision-making.

Interpretation: How disciplinary members interpret the language and concepts used by their team members, and how they themselves use them, will be informed by their disciplinary socialization. Several theorists are useful in this regard. First, Bourdieu's notions of *field* and *habitus* (Benson & Neveu, 2005; Bourdieu, 2005) are informative at a macro level. We can think of disciplines as fields, each with its continuum of social, economic, and cultural capital, which have significance within the discipline and also with the broader social context. The notion of habitus helps to explain the socialization or indoctrination of disciplinary members: The [illegible] both shape it and are shaped by it.

Wenger's (1998) notion of [illegible] shapes identity, shared meanings, and shared ways of doing things. Each discipline can be thought of as a community of practice. However, disciplines are not the only communities of practice; a health care organization, a hospital ward, and even an IHCT can each constitute a community of practice. On an IHCT, the team member is both ambassador of his or her own disciplinary community of practice *as well as* participant of the IHCT community of practice (among others). Like Bourdieu's overlapping and conflicting *fields*, Wenger's description is of nested and overlapping communities of practice as constituting an actor's social world. (Drinka and Clark, 2000, talk about disciplines as *cultures*, which echoes the notions of habitus and CoP with regard to disciplinary members' socialization.) Other useful concepts from Wenger are that of *broker*—someone who spans different communities of practice (a concept that comes from social network analysis)—and that of *boundary object*—artifacts, documents, terms, concepts, and other forms of reification around which CoPs can organize their interconnections (see Hall, Stevens, & Torralba, 2005, who credit Bowker and Star for this concept; see also Journet, 1993, on boundary rhetoric; and Lingard, Schryer, Garwood, & Spafford, 2003, on learning sanctioned ways of talking).

Interaction: Finally, Goffman's (1959; 1997) social theories are useful for examining IHCTs at the micro level for a number of reasons. To begin with, his emphasis on the interaction order and situational properties gives us the imperative to look at team interactions to get at situated interdisciplinarity. Secondly, his dramaturgical theory of interaction gives us the notions of *role*, *performance*, *backstage* and *frontstage*; team members perform their disciplinary roles, following the scripts for different kinds of team meeting ritual performances. Thirdly, his work on framing and frame analysis offers insights as to how individuals attend to and make sense of "what's going on here."

Conclusion

Proponents of an interdisciplinary approach to health care sing its merits, while its detractors bemoan the added costs of time and funding they claim this approach implies. There seems to be agreement across the board, however, that evaluating interdisciplinarity on health care teams is [illegible] and interactional dynamics of IHCTs, we might

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