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EDITORIAL

Interdisciplinarity in Palliative Care: Difficult to Implement in Routine Practice?

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Palliative care has set the high standard of impeccable assessment and management of suffering in all four dimensions: physical, emotional social and spiritual. To do this one of the principles of palliative care states that an interdisciplinary team is needed. There is a recognition that inter and multidisciplinary teams have different characteristics and for palliative care, interdisciplinarity is wanted.

The multidisciplinary team is composed of individuals of several disciplines who work independently to do their assessments and interventions. In order to maximize the care offered to the patient, multidisciplinary teams need to have a formal way of communicating between various professionals in the team, like case reports or other structured way of communication. For busy health care settings this communication might be skipped and care for patient might be fragmented as a result.

In contrast interdisciplinary teams integrate separate disciplines into the consultation from assessment to diagnosis, care plans and intervention, all done jointly with the patient and the family members. The interaction and learning between disciplines are, as result, encouraged. More complex personalized and holistic care is provided for the patients and their families and this type of work environment enables growth of team members. For this type of teams to flourish a collaborative non-hierarchical team work approach needs to be put into practice with support and voice offered also to the quitter and less experienced members of the team and with well-defined and respectful communication within the team.

The palliative care team has to have in its composition in order to address physical, social, psycho-emotional and spiritual representatives of multiple disciplines: medical, nursing, social workers, therapist, priest/ spiritual counsellor, volunteers and many more.

For countries in central and eastern Europe where palliative care is not well established yet, and intense work is done to integrate it into routine health care, there might be, apart of financial reason, many more obstacles in properly implementing the palliative care philosophy with interdisciplinary work being a core principle.

Split between Medical and Social Care

Throughout Europe palliative care is recognized either as a medical specialty or a sub-specialty. This brings a recognition in the field, but is it really encouraging cooperation between social and medical services who, for palliative care patients, need to closely work together?

Many countries in Eastern and central Europe have separate ministries for social welfare and healthcare. As result independent and sometimes divergent guidelines and policies are issued concerning palliative care. For example, in Romania, hospice term is used differently for the social welfare and medical world, with different standards of accreditation of services, that put an extra pressure on the palliative care providers in terms of paperwork needed to show compliance.

Nursing as a self-standing discipline

Nurses' education at university level enables them to achieve a complex set of competencies in various field of patient care that ideally, they should implement autonomously in the practice. Some examples for palliative care competencies are empathic communication, communication in challenging situations, symptom assessment, terminal care and so on. Countries from Eastern and Central Europe have a strong hierarchical health care system with doctors placed on the top of the hierarchical leader. Teams are operating more vertical than horizontally and the competencies of nurses although taught in medical schools are not enacted in practice. Work routines are created in day-to-day practice where nurses serve more like doctor assistant. When palliative enters into the routine national health care system, this traditional way of work might become an unacknowledged barrier for smooth interdisciplinary work.

Consequences

In pioneering phase, models strongly adhering to palliative care principals are developed. The integration of this models in routine care is challenging regardless of all central regulated mechanism like quality management system with requirements of integrated nursing plans and intervention, psychological and spiritual care as the main barrier is at deeply rooted behaviours.