The Future of Pediatric Speech-Language Pathology in a More Collaborative World

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KEYWORDS

- Interprofessional practice • Interprofessional education
- Speech-language pathology • Networks • Teams

KEY POINTS

- Despite increasing emphasis on interprofessional practice, health care practitioners still primarily work in parallel rather than collaboratively and interdependently.
- Effective interprofessional practice depends not only on interpersonal determinants but also structural, regulatory, and governmental determinants that can be barriers or enablers to optimal collaboration.
- A major barrier to collaborative interprofessional practice is that care is often provided by different teams in different locations over time, a so-called network. Certain practitioners, including speech-language pathologists, are ideally positioned to bridge networks as boundary spanners, individuals who coordinate care across teams within a patient's network.
- To train practitioners to enhance interprofessional practice, students should receive interprofessional education as part of their professional programs. Practitioners need to engage in interprofessional continuing education relevant to their professional context, and leaders, researchers, and educators need to continue to refine models for a shared approach to practice.
- Done well, interprofessional practice can help health care practitioners reach their aspirations for higher quality, more equitable care.

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This issue of *Pediatrics Clinics of North America* focuses on interprofessional practice through the lens of speech-language pathology. Interprofessional practice, as defined by the World Health Organization,[1] is when: "multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, caregivers, and communities to deliver the highest quality of care across settings." The articles in this issue describe some successes in interprofessional practice, particularly for specific health conditions. However, they also highlight some of the challenges to optimal collaborative practice and identify some areas for future research and innovation in both education and care delivery.

THE LIMITATIONS OF TEAMWORK

Schreck and Golom[2] begin the issue with an overview of teamwork and interprofessional practice. In particular, they note several problems and challenges with the current state of teamwork in health care. First, they note that individuals often perceive more teamwork than truly exists. Rather than working in a collaborative fashion, groups of practitioners often work in parallel. Although they may perceive teamwork as they work in parallel with nearby colleagues, they do not realize the benefits of teamwork to themselves and their patients.

Drawing on the organizational development literature, they note 1 defining feature of teams is sharing a purpose and plan for work. In health care, the shared purpose is usually clear, improving the health of the patient. Yet, the plan for work is often not fully shared among team members. Critical questions teams in health care should be able to answer include

- How has each practitioner's plan for work evolved based on changes to the patient?
- How should that new individual plan interact with the updated plans of other health care practitioners?
- What expertise should be added to the new plan of care?
- What expertise should be subtracted in order to limit the complexity of the plan and the chance for error?

All of these questions are evidence of another defining feature of teamwork: interdependence. Team members embrace the reliance on each other, because it leads to a better overall outcome.

Why then is poor teamwork in health care implicated in so many problems and challenges faced by team members? Golom and Schreck provide some insight to this question. They note the ideal team size is between 5 and 6 members; team effectiveness decreases as the size of team increases beyond this range. Yet, the typical health care team is massive. A recent study looking at the number of health care practitioners involved in 2 months of cancer care for 100 patients showed the median team size was 117.[3] Not surprisingly, these teams are too large to be interdependent and to be able to develop a shared plan for work. Subsequent failures of desired interdependence then lead to poor outcomes.

How then should practitioners navigate these complex structures of work to best help patients, their families, and society? The remaining articles within this issue provide some hints on tackling these challenges.

NETWORKS AND BOUNDARY SPANNERS

First, health care practitioners should begin to think of health care as a network of teams. Although certain professional contexts have discrete teams with interdependence in

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