SECOND EDITION

The Interprofessional Health Care Team

Leadership and Development

Donna Weiss, PhD, OTR/L, FAOTA
Emeritus Faculty
Occupational Therapy Program
Department of Rehabilitation Sciences
College of Public Health, Temple University, Philadelphia, PA

Felice J. Tilin, PhD
Program Director and Professor
Organization Development and Leadership Programs
Saint Joseph's University, Philadelphia, PA
Lecturer
University of Pennsylvania
Penn CLO Executive Doctoral Program
President
GroupWorks Consulting, LLC
www.groupworksglobal.com

Marlene J. Morgan, EdD, OTR/L
Associate Professor
Department of Occupational Therapy
The University of Scranton, Scranton, PA

JONES & BARTLETT
LEARNING

World Headquarters
Jones & Bartlett Learning
5 Wall Street
Burlington, MA 01803
978-443-5000
info@jblearning.com
www.jblearning.com

Jones & Bartlett Learning books and products are available through most bookstores and online booksellers. To contact Jones & Bartlett Learning directly, call 800-832-0034, fax 978-443-8000, or visit our website, www.jblearning.com.

Substantial discounts on bulk quantities of Jones & Bartlett Learning publications are available to corporations, professional associations, and other qualified organizations. For details and specific discount information, contact the special sales department at Jones & Bartlett Learning via the above contact information or send an email to specialsales@jblearning.com.

Production Credits

VP, Executive Publisher: David D. Cella
Publisher: Cathy L. Esperti
Editorial Assistant: Carter McAllister
Production Editor: Kristen Rogers
Director of Marketing: Andrea DeFronzo
VP, Manufacturing and Inventory Control: Therese Connell
Composition: Cenveo® Publisher Services
Cover Design: Kristin E. Parker
Associate Director of Rights & Media: Joanna Lundeen
Rights & Media Specialist: Jamey O'Quinn
Media Development Editor: Troy Liston
Cover Image: © **TO COME**
Printing and Binding: Edwards Brothers Malloy
Cover Printing: Edwards Brothers Malloy

Library of Congress Cataloging-in-Publication Data

Names: Weiss, Donna (Donna F.), author. | Tilin, Felice J., author. | Morgan, Marlene J., author.
Title: The interprofessional health care team : leadership and development / Donna Weiss, Felice Tilin, Marlene J. Morgan.
Description: Second edition. | Burlington, MA : Jones & Bartlett Learning, [2018] | Includes bibliographical references and index.
Identifiers: LCCN 2016028393 | ISBN 9781284112009 (pbk.)
Subjects: | MESH: Patient Care Team--organization & administration | Leadership
Classification: LCC RA971 | NLM W 84.8 | DDC 610.68--dc23
LC record available at https://lccn.loc.gov/2016028393

6048

Printed in the United States of America
20 19 18 17 16 10 9 8 7 6 5 4 3 2 1

Dedication

To my husband, Leigh, for his optimism, energy, and love; and my granddaughter, Madeline Paige Broome, for her wide-eyed wonder.

— Donna Weiss

To my spouse, Trudi Sippola, for all of her unwavering support; and to my loving parents, Sonya Tilin and in memory of my father Edward Tilin, who both taught me that developing relationships is the secret to a happy and healthy life.

— Felice J. Tilin

To the memory of my parents, Al and Alice Morgan. What more can I say?

— Marlene J. Morgan

Contents

Preface

Afaf Meleis, PhD, FAAN, DrPS (hon)
Margaret Bond Simon
Dean of the University
of Pennsylvania School of Nursing

Quality health care requires teamwork. Putting individuals together to teach across disciplines or to provide health care never guarantees the creation of a team with the synergy needed for a shared vision, an agreed-upon mission, and a system of collaboration. To form productive and efficient teams requires a knowledge base, the use of best practices, interprofessional leadership, and individuals who are well prepared to be collaborative and effective members of the team.

It has become apparent, as evidenced in many policy reports and through much research, that teamwork is the hallmark of positive outcomes for the health and well-being of patients, families, and communities. Collaboration and partnership are equally as important and must be forged within and between organizations to advance well-being and enable institutions to function at their full capacities. However, it also has become apparent through many thoughtful dialogues and reports such as *Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World*, written by the independent Lancet Commission on Education of Health Professionals for the 21st Century, and *The Initiative on the Future of Nursing*, authored by the Institute of Medicine Committee on behalf of the Robert Wood Johnson Foundation, that partnership, collaboration, and the formation of teams requires a paradigm shift in educational

programs as well as in institutional function (Bhutta et al., 2010; Institutes of Medicine, 2011).

Paradigm shifts occur through deliberate and systematic dialogues and debates. Productive dialogues and debates depend on knowledge of a field, willing participants, environments that promote such dialogues, diversity of opinions, respect of different voices, and trust in the value and principles that promote partnership and collaboration. Whether this paradigm shift is needed for crossing the boundaries of professions and developing interprofessional education, moving the silos of different disciplines toward interdisciplinarity, or the ethos of independence toward interdependence, it fundamentally depends upon and requires the use of a well-organized and comprehensive evidence-based knowledge foundation and tools for implementation.

This book provides the much-needed knowledge base for developing a relational leadership style that promotes interdisciplinarity, interprofessionalism, and productive teamwork. It describes possibilities and options, theories, exercises, rich references, and stimulating questions that will inspire both novices and experts to think differently about their roles and styles as leaders or members of a team. I venture to suggest that this book will become a very important resource that will lead to more constructive actions for the development of a collaborative culture. The authors provide many tools to empower readers and facilitate the fostering of productive teamwork. It is an inspiring book with easily operational principles. My gratitude goes out to the authors for having the wisdom, knowledge, and experience to invest in writing this book. As teaching faculty members, students, clinicians, leaders, and managers read it and discuss its ideas, they will be as grateful to the authors as I have been after reviewing and using its content. It is written for many audiences and to achieve many goals all centered on best practices to attain quality care, particularly during this time of reinventing and transforming health care.

References

Bhutta, Z. A., Chen, L., Cohen, J., Crisp, N., Evans, T., Fineberg, H., . . . Zurayk, H. (2010). Education of health professionals for the 21st century: A global independent commission. *The Lancet, 375*(9721), 1137–1138.

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: The National Academies Press.

Acknowledgments

Our individual contributions to this book are products of the innumerable relationships that we have been fortunate enough to enjoy over the course of our professional and personal lives. Through our collaboration on this book, we have been edified and transformed by the experiences of each other. We share the deepest gratitude for the thought, guidance, and support that we have received from the following people:

To mentors: Annie McKee, Susan A. Wheelan, and Sherene Zolno, who generously shared their scholarship and fostered our learning.

To colleagues, teachers, clients, friends, and family for sharing their stories and wisdom: Rebecca Austill-Clausen, Stephen Berg, Marco Bertola, Joanne Broder Summerson, Tracy Christopherson, Luis Constantino, Claire Conway, Wanda Cooper, Laurie Cousart, Vincent Curren, Dan Drake, Mario DiCioccio, Peter Doukas, Tim Fox, Kevin Hook, Francis Johnston, Emily Keshner, Moya Kinnealey, John Kirby, Robin Kurilko, Delores Mason, Afaf Meleis, Karen Nichols, Linda Paolini, Prem Rawat, Debra Pellegrino, Melanie Rothschild, Carol L. Savrin, Stephen Scardina, Lana Schuette, Kathryn Shaffer, Judith Shamian, Carole Simon, Mary Sinnott, Beth Sippola, Rob Sippola, Trudi Sippola, David M. Smith, Eileen Sullivan-Marx, Bruce Theriault, Kelsey Tilin, Sam Tilin, Beulah Trey, and Sue Carol Verrillo.

To the team at Jones & Bartlett Learning who patiently provided support, advice, and encouragement throughout the publication process: Cathy Esperti, Carter Cathleen McAlister, Sean Fabery, Grace Richards, Kristen Rogers, Alianna Ortu, and Laura Almozara. Special thanks are extended to Felice's colleagues at St. Joseph's University who provided the time and encouragement to complete this book: Karin Botto, Jeanne Brady, Sabrina DeTurk, William Madges, Robert Palestini, Becky Rice, Erin Schwing, and Wendy Thruman.

Finally, we acknowledge all learners—whether they are students, teachers, leaders, or group members—and their active engagement in asking questions and trying on new ways of thinking, being, and doing.

About the Authors

Donna Weiss, PhD, OTR/L, FAOTA, is a coach, trainer, and facilitator in the areas of interpersonal communication, group dynamics, and leadership in health care.

Felice J. Tilin, PhD, is an organization development consultant, facilitator, executive coach, and educator with multinational, private and nonprofit businesses, and healthcare organizations in the United States, Canada, Europe, Africa, and Asia.

Marlene J. Morgan, EdD, OTR/L, has extensive experience in clinical and academic leadership positions and her research interests include interprofessional education for health professionals.

Reviewers

Patrick C. Auth, PhD, PA-C
Chair
Physician Assistant Department
Drexel University
Philadelphia, PA

Linda C. Caplis, MS, RT(R)
Clinical Assistant Professor
Towson University
Towson, MD

Joy Doll, OTD
Assistant Professor
Director
Post-Professional OTD Program
Creighton University
Omaha, NE

Cristina Dumitrescu, MS, OTR/L
Associate Director and Assistant Professor
Academic Fieldwork Coordinator
Mercy College
Dobbs Ferry, NY

Deborah Giedosh, EdD, MS-Ned, MS, BSN, RN
Director of Nursing
Alaska Career College
Anchorage, AK

Margaret Gillingham, MS
Lecturer
University of Baltimore
Baltimore, MD

Jason Glowczewski, PharmD, MBA
Manager of Pharmacy and Oncology
University Hospitals Geauga Medical Center
Chardon, OH
Affiliate Assistant Professor of Pharmacy Practice
Findlay University
Findlay, OH

Lauren R. Goodloe, PhD, RN, NEA-BC
Director of Medical and Geriatric Nursing
Administrative Director for Research
Assistant Dean for Clinical Operations
Virginia Commonwealth University School of Nursing
Richmond, VA

Deborah A. Greenawald, PhD, RN, CNE
Associate Professor
Alvernia University
Reading, PA

Jaime S. Greene, MS, EMT-B
President/CEO
Safety Associates, Inc.
Greenacres, FL

Tina Gunaldo, PT, DTP, MHS
Instructor
Louisiana State University Health Sciences Center
New Orleans, LA

Wilton Kennedy, MMS, DHSc, PA-C
Director of Clinical Education
Jefferson College of Health Sciences
Roanoke, VA

Judi Schack-Dugre, PT, DPT, MBA
Instructor
University of Central Florida
Orlando, FL

Introduction: Interprofessional Leadership in the Healthcare Environment

Learning Objectives

1. Understand the interprofessional healthcare team as a broadly inclusionary concept.
2. Describe how an interprofessional orientation can enhance patient care.
3. Explain the importance of relationship-centered care to patient outcomes.
4. Understand the concept of members as leaders.

Human beings are social by nature and bond together in families, small groups, and tribes. As we attempt to navigate from childhood through adulthood, our behaviors tend to mirror those of our family groups, peer groups, and professional groups. As we mature, our sense of self is created in part by our interactions with and feedback from these groups. Over the millennia, interaction with a variety of other people has been necessary to fulfill primary needs like love and affection but also to accomplish the work inherent to community building and survival. With the evolution of societies from the Stone Age through the Information Age, the complexity of the challenges that individuals and organizations

face has increased, as well as the need for well-functioning, diverse groups that can meet those challenges. Solving complex problems requires diverse information sets that are not the purview of a single person or a single profession. This is true in all modern endeavors but most apparent in the healthcare industry.

The concept of health incorporates a complex and holistic system where biological, psychological, physical, socioeconomic, cultural, and environmental factors function as interconnected and interacting determinants of one another. Rowe (2003) has noted that health issues are characteristically broad and complex and are most appropriately examined from an interdisciplinary perspective. Reports from the Pew Health Professions Commission (1998), the Institute of Medicine (2001, 2002, 2003), and the World Health Organization (2010) have repeatedly supported the notion that educational programs for health professionals can only be considered complete if they include experiences working in interprofessional teams. The literature regarding higher education is replete with references to research, as well as interdisciplinary, interprofessional, and integrative studies. External funding sources for research identify evidence of interprofessional collaboration as a key criterion for grant eligibility (Bray, Adamson, & Mason, 2007; García & Roblin, 2008; Palincsar, 2007). Evidence of interprofessionalteam experiences is included in the accreditation standards for many health professional education programs with the expectation that health professionals will be educated with an interprofessional orientation and will develop an ability to leverage the power of teams to solve complex problems (Frenk et al., 2010; Interprofessional Education Collaborative Expert Panel, 2011; NIH, 2008; Royeen, Jensen, & Harvan, 2009).

Members of interprofessional healthcare teams have multiple reporting relationships and value systems. Finding themselves working in increasingly complex organizational and political structures. The competitive healthcare market presents professionals with a variety of leadership challenges—not the least of which is learning to leverage the power of interdisciplinarity. Drinka and Clark (2000) define an interdisciplinary healthcare team (IHCT) as "a group of individuals with diverse training and backgrounds who work together as an identified unit or system" (p. 6). Disciplinary expertise is maximized when members of the IHCT can routinely employ strong relational skills and effectively coordinate their work with others. Relational coordination in the form of high-quality communication, mutual positive regard, trust, and active

engagement are associated with a stronger collective identity, reduction in status differential, increased ability to respond to pressures with resilience, job satisfaction, and retention of staff. Most importantly, organizations that institutionalize the consistent communication strategies associated with relationship-centered organizations are high performing and profitable, and have low employee turnover, better clinical outcomes, a reduction in length of stay, and enhanced patient-perceived quality care (Gittell, 2009; Suchman, Sluyter, & Williamson, 2011; Uhlig & Raboin, 2015).

The trend toward specialization in the health professions may lead to a less inclusionary interpretation of Drinka and Clark's definition of interdisciplinarity. It may be interpreted as the inclusion of persons who have the same basic training but have a specialty. For instance, some people may consider an internist, gynecologist, and a physiatrist to be an interdisciplinary team. The term *interprofessional* connotes a broader perspective and may include persons who have professional licensure or certification in nursing, occupational therapy, physical therapy, speech and language pathology, social work, and other health-related professions in addition to physicians (Hammick, Freeth, Copperman, & Goodsman, 2009). In literature and in practice, the terms are often used interchangeably.

Health care evolved from a hierarchical process dominated by physicians to an inclusionary team of professionals that was broadened to include patients and caregivers. The conceptual shift regarding the focus of health care occurred in tandem with the recognition of health care as a complex system of relationships. Neither term—*interdisciplinary* nor *interprofessional*—reflects the importance of the patient and other important constituencies/contexts in the achievement of good patient outcomes. The more cogent term seems to be *relationship-centered*. The notion of relationship-centered healthcare teams reaches beyond the traditional core of physicians, nurses, and therapists, and incorporates all the constituencies who impact patient outcomes. It implies that the construction of healthcare teams is unique to the individual patient needs. The breakdown of traditional professional boundaries is necessary to meet the challenge of providing quality and cost-effective health care that is accessible to increasing populations (Grant & Finocchio, 1995). Skills in team building, team membership, and the understanding of the group dynamics are foundational and indispensable for the next generation of healthcare leaders.

Whether teams are called interdisciplinary, interprofessional, or relationship centered, each member of the healthcare team needs to ask these important questions:

- Who needs to be involved in order for the best patient outcomes to be achieved?
- How can we work together to achieve those outcomes efficiently and effectively?
- What is my unique professional and personal contribution to the team?
- How can I facilitate the optimum functioning of the team and the best client outcomes?

The full potential of the interprofessional healthcare team is realized when each member assumes a leadership stance. The member as a leader recognizes the power of his/her unique professional expertise and personal qualities. He/she accepts the responsibility of actively contributing relationship-centered, safe, effective, and quality health services. The designated leader is responsible for drawing out the leadership stance in all team members by modeling self-awareness, self-regulation, empathy, and positive communication and encouraging these behaviors in others (Boyatzis & McKee, 2005). Leaders who are successful in facilitating a proactive leadership stance throughout their teams realize that their own perspective is incomplete and recognize the value of engaging the wisdom and power of the collective. In doing so, they create sustainable, relationship-centered, and highly productive team cultures that are creatively resilient in the face of change and thrive over time (Uhlig & Raboin, 2015).

Leadership in the interprofessional healthcare team means that both the designated leader and members must be willing to share the responsibilities of team leadership and be cognizant of group dynamics in order to work with widely diverse skills, values, and interests (Lee, 2010). Appropriately addressing these issues requires strong leadership that has a broad and integrative perspective. Leadership should be embraced by a cadre of professionals who leverage their own disciplinary knowledge base and integrate it with those of other related disciplines in order to develop advanced understanding and competence in patient-centered and relationship-centered practice. The accountability for this type of leadership is shared by health professionals at all organizational levels who engage in research, teaching, health administration, and health policy development, as well as direct patient care (Boucher, 2016).

The challenge that faces health professionals is that while most health professionals work in interprofessional teams and recognize their value, the majority have been professionally acculturated into their respective professional guilds rather than seeing themselves as members of an interprofessional team. Until recently, professional training in most of the health disciplines did not emphasize collaboration, group decision-making, or shared leadership (Calhoun et al., 2008; Lee, 2010). The Institute of Medicine reported that a lack of effective collaboration among disciplines was most often identified as the cause of medical errors (Institute of Medicine, 1999, 2003). For example, a boy dies of a treatable infection or pain-reducing palliative care is withheld from a terminally ill patient for want of interprofessional collaboration (Dowd, 2012; Brown, 2012). On the other hand, effective interprofessional collaboration is linked to improved patient outcomes (Wheelan, Burchill, & Tilin, 2003). "It is becoming increasingly apparent the effort to produce high quality care is not hampered by lack of clinical expertise in the individual professions but rather by lack of appropriate knowledge and experience among these groups as to how to make these multidisciplinary teams work well" (Freshman, Rubino, & Chassiakos, 2010, p. 6).

As health systems increase in complexity, health professionals need to develop confidence in group problem solving, successful conflict management and resolution, efficient and effective information exchange, and boundary management (Gray, 2008; McKinlay, Gallagher, Gray, Wilson, & Pullon, 2015). These competencies are dependent upon an understanding of the stages of group development and what makes teams effective. An effective team shows high levels of reflectivity and self-management skill, the ability to develop and maintain reciprocal relationships, and the willingness to empower others (Goleman & Boyatzis, 2008). The most successful and productive healthcare teams are those in which the concept of the collective as leader is applied. This means that all members, regardless of status, are self-aware and committed to assuming leadership and responsibility for the continued development of the group.

This text is designed to help all health professionals realize their capacity for leadership and develop the knowledge, skills, and attitudes that are requisite to becoming a positive agent of change and growth in themselves, others, and their organizations.

This text is comprised of three parts: Teamwork and Group Development, Relationship-Centered Leadership, and Building and Sustaining Collaborative Interprofessional Teams. Each part is divided into

chapters that introduce theoretical concepts, provide case stories, and active teaching/learning experiences that are appropriate for in-class, online, or personal reflective learning environments.

Part I: Teamwork and Group Development introduces groups as complex systems and includes models of group dynamics, the developmental stages of groups, and how to optimize teamwork throughout the group life span. Activities provide practice in differentiating personal from group goals, analyzing the developmental levels of groups, and applying strategies that individual leaders/members can employ to foster and sustain highly functional teams.

Part II: Relationship-Centered Leadership provides a detailed discussion of leadership behaviors, emotional intelligence, and how self-awareness, self-management, and an understanding of positive psychology can facilitate team development and productivity. Activities will help the reader analyze competencies required for health professions leadership; analyze leadership behaviors in real-life situations; identify personal leadership characteristics, challenges, philosophy, and behaviors; and conceptualize strategies for successful personal and health professional leadership for members as well as leaders of healthcare teams.

Part III: Building and Sustaining Collaborative Interprofessional Teams focuses on spanning professional boundaries, facilitating the development of a team culture, and generative practices. Generative practices such as appreciative inquiry and positive communication can facilitate the development of affiliative environments and help sustain the productivity and effectiveness of relationship-centered healthcare teams. Real-world profiles provide examples of these concepts in action. Activities will focus on helping the student develop interpersonal sensitivity and attentiveness, utilize empathic communication strategies, provide and receive feedback, use positive influence to build trust, manage conflict, and leverage the creativity and energy inherent to diverse healthcare teams.

References

Boucher, N. A. (2016). Direct engagement with communities and interprofessional learning to factor culture into end-of-life health care delivery. *American Journal of Public Health. e-View Ahead of Print*. doi: 10.2105/AJPH.2016.303073

Boyatzis, R., & McKee, A. (2005). *Resonant leadership*. Boston, MA: Harvard Business School Press.

Bray, M., Adamson, B., & Mason, M. (Eds.). (2007). *Comparative education research: Approaches and methods*. Hong Kong, China: Comparative Education Research Centre.

Brown, T. (2012, July 15). The boy who wanted to fly. *New York Times*, pp. SR11.

Calhoun, J., Dollett, L., Sinioris, M., Wainio, J., Butler, P. Griffith, J., & Warden, G. (2008). Development of an interprofessional competency model for healthcare leadership. *Journal of Healthcare Management, 53*(6), 360–374.

Dowd, M. (2012, July 15). Don't get sick in July. *New York Times*, pp. A20.

Drinka, T., & Clark, P. (2000). *Health care teamwork: Interdisciplinary practice and teaching*. Westport, CT: Auburn House.

Frenk, J., Chen, L. Bhutta, Z., Cohen, J., Crisp, N., & Zurayk, H. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. doi:10.1016/S0140-6736(10)61854-5

Freshman, B., Rubino, L., & Chassiako, Y. (2010). *Collaboration across the disciplines in health care*. Sudbury, MA: Jones and Bartlett Publishers.

García, L. M., & Roblin, N. P. (2008). Innovation, research and professional development in higher education: Learning from our own experience. *Teaching and Teacher Education, 24*(1), 104–116.

Gittell, J. (2009). *High performance healthcare: Using the power of relationships to achieve quality, efficiency and resilience*. New York, NY: McGraw-Hill.

Goleman, D., & Boyatzis, R. (2008). Social intelligence and the biology of leadership. *Harvard Business Review, 86*(9), 74–81.

Grant, R. W., & Finocchio, L. J.; California Primary Care Consortium Subcommittee on Interdisciplinary Collaboration. (1995). *Interdisciplinary collaborative teams in primary care: A model curriculum and resource guide*. San Francisco, CA: Pew Health Professions Commission.

Gray, B. (2008). Enhancing transdisciplinary research through collaborative leadership. *American Journal of Preventive Medicine, 35*(2S), s124–s132.

Hammick, M., Freeth, D. S., Copperman, J., & Goodsman, D. (2009). *Being interprofessional*. Malden, MA: Polity Press.

Institute of Medicine. (1999). *To err is human: Building a safer health system*. Washington, DC: The National Academies Press.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: The National Academies Press.

Institute of Medicine. (2002). *Who will keep the public healthy? Educating public health professionals for the 21st century*. Washington, DC: The National Academies Press.

Institute of Medicine. (2003). *Health professions education: A bridge to quality*. Washington, DC: The National Academies Press.

Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, DC: Interprofessional Education Collaborative.

Lee, T. (2010). Turning doctors into leaders. *Harvard Business Review*. Apr;88(4):50–58.

McKinlay, E. Gallagher, M. P., Gray, L., Wilson, C., Pullon, S. (2015). Sixteen months "from square one": The process of forming an interprofessional clinical teaching team. *Journal of Research in Interprofessional Practice and Education, 5*(2), http://www.jripe.org/index.php/journal/article/view/191/119.

Palincsar, A. (2007). Reflections on the special issue. *Educational Psychology Review, 19*(1), 85–89.

Pew Health Professions Commission. (1998). *Recreating health professional practice for a new century: The fourth report of the Pew Health Professions Commission*. San Francisco, CA: Pew Health Professions Commission.

Rowe, J. (2003). Approaching interdisciplinary research. In F. Kessel, P. Rosenfield, & N. Anderson (Eds.), *Expanding the boundaries of health and social science: Case studies in interdisciplinary innovation* (pp. 3–9). New York, NY: Oxford University Press.

Royeen, C., Jensen, G., & Harvan, R. (2009). *Leadership in inter-disciplinary health care education and practice*. Sudbury, MA: Jones and Bartlett Publishers.

Suchman, A., Sluyter, D., & Williamson, P. (2011). *Leading change in healthcare: Transforming organizations using complexity, positive psychology and relationship-centered care*. London, England: Radcliffe Publishing.

Uhlig, P., & Raboin, W. E. (2015). *Field guide to collaborative care: Implementing the future of healthcare*. Overland Park, KS: Oak Park Prairie Press.

Wheelan, S. A., Burchill, C. N., & Tilin, F. (2003). The link between teamwork and patients' outcomes in intensive care units. *American Journal of Critical Care, 12*, 527–534.

World Health Organization: Health Professions Network Nursing and Midwifery Office within the Department of Human Resources for Health. (2010). *Framework for action on interprofessional education & collaborative practice* (WHO/HRH/HPN/10.3). Geneva, Switzerland: World Health Organization. http://www.who.int/hrh/nursing_midwifery/en/