Vancouver Coastal Health

Spiritual Care and Multifaith Services
Spirited Leadership – Humanizing Encounters
Compassion | Curiosity | Collaboration

# The Inter-Professional Pie Model

## An Alternative to Pyramidal Approaches

## Introduction

In order to undertake the laudable cause of describing the relationship and value of different professions in an age of inter-professionalism within healthcare, writers have sometimes taken recourse to a pyramidal model of specialization wherein the near tip of the pyramid symbolizes the portion of professional distinction that delineates one profession from the next. Such models see the distinction of each profession as based in selective tasks or highly expert functions. In such models, professions may be presented as overlapping with each other for as much as 80% of function. Such models sometimes use the term generic to describe the majority functions of a professional.

Some professionals, however find pyramidal models inadequate inasmuch as they do not account for a more fundamental distinction in approach between professions that permeates all tasks. For these professionals few, if any, tasks are considered truly generic. Often it has been difficult for persons of this dissenting persuasion to articulate an alternative paradigm despite being frustrated with a model, that they find reductionist and lacking in its ability to express what is most core to their professional being. Professionals of this persuasion say that although a task performed by two different professions may look the same on a surface level, the experience for the patient is indeed different upon closer examination. Further, they believe that this often leads to different results. This brief analysis seeks to address these concerns by providing an alternative to the pyramidal model.

## The Pie Model

In the Pie model, shown on the affiliated diagram, the hierarchy of tasks and function that the pyramidal approach depends upon for distinguishing a profession, is replaced by each discipline's distinct professional orientation, which if space permitted would include a description of each profession's philosophical approach, clinical focus, and their preferred competency processes.

The Pie model of inter-professional care delivery begins with recognizing the education and training of each profession as rooted in a particular distinct approach, unique to their discipline rather than simply training for a collection of tasks at various levels of expertise. It considers the distinct approach of each profession to colour everything they do. It sees that which makes a profession distinct, not as simply expert tasks added to otherwise generic inter-professional functions, but instead, as something core to everything that profession does. It considers such things as the ethos and orientation of each profession, its philosophical understandings of patient care, and its distinct processes, as those things that best indicate a profession's distinct identity. It sees these factors as functioning at all times and infusing patient care with

the qualities of the profession. These qualities are not interchangeable with colleagues in other professions even when there exists significant overlap between neighboring disciplines. When professions overlap, it does not mean that they are essentially the same or able to do each other's work, because even the same task when done by each of them, is performed in distinctly different ways. It may be that the pyramidal specialization model works to describe the relationship between specialists within one profession such a physicians who share an enormous amount of common education but the model lacks in describing the differences and therefore the relationship between professions.

For example, a spiritual care practitioner may initiate a conversation about family dynamics, with a patient for equally good reasons, as a social worker. However, the process will be different in each case, despite the fact that both are discussing the same topic. Both dialogues will have value, precisely because each is following their respective education and training as separate albeit related disciplines. The distinct professional orientation of each profession, which includes a philosophical approach, clinical focus as well as preferred competency processes will lead to different aspects of the family dynamic being explored due to a variance in clinical focus. In addition to a difference in focus, their respective ways of being present with the patient will be different due to differences in philosophical orientation. Finally, their preferred dialogical processes will vary according to their distinctly different training. As a result, the patient will have a different experience of each profession and the outcomes will also be different. Indeed when spiritual care practitioners try to duplicate social workers or vice versa the results are never as good as when they remain in their respective roles. Each hears different things, each asks different questions and each relates from a different orientation or stance.

One could compare the situation to having tea with a wealthy Japanese family or a well-heeled English one. Both families will do a great job of hosting afternoon tea, as they both know tea well, according to their respective cultural traditions and have servants trained in tea service. However, the visitor will have a very different experience of teatime from start to finish. The difference lies not in one or two things but in the whole difference in orientation towards the serving and sharing of tea. The two are not different from each other simply because of specialization in a few tasks but for many reasons that infuse the 2 different approaches. As a result, the impact on the visitors will be different even if the tea served is from the same garden. The process of having tea may look very similar from a distance but upon closer examination many differences emerge. Even if one were to make the cups, the teapot, the setting and the language the same, the very act of pouring tea from the pot, the use of eye contact, the tone of voice and the form of body movement will vary. Do we not experience similar differences in the approach of a surgeon to pre-op conversations with a patient and pre-op conversation by a nurse or a social worker or a spiritual care practitioner? Indeed I know of occasions when complaints have been made when an SHP was said to have "sounded like a surgeon" even when the content was within spiritual care boundaries. If we can sense the difference between how a butler and a Geisha serve tea, then how much more should we expect years of education and training of healthcare professionals to make a difference in patient experience and outcomes?

Professions sometimes differ widely with respect to the content addressed, such as when a Spiritual Care Practitioner discusses transcendental experiences and a nurse discusses wound dressings. This is not just a difference in focus but a difference in subject competence. Seldom does the nurse venture deeply into discussing transcendental experience and seldom does a Spiritual Health practitioner discuss much about wound dressings. On other occasions however, each may discuss with the patient about anxiety related to an upcoming operation. Yet although both discuss anxiety with the same patient, there will be a distinction in both focus and approach between how the SHP and the nurse discuss anxiety over the operation.

While the 'task" of having a conversation about anxiety may be charted under the same heading each will address the patient's need from different perspectives, with different means and a different way of "being with". The SHP will likely be narratively and existentially oriented regardless of whatever practical strategy they may employ, while the nurse will likely be more practical, and explanatory no matter how sensitive

they are to the patient's story. The nurse is providing good nursing care and may lower the patient's anxiety through providing much needed bedside education and affirmation. Similarly, the spiritual care practitioner is providing good spiritual care when addressing the anxiety from an existential vantage point. The SHP is not providing nursing care anymore than the nurse is providing spiritual care. The nurse may be able to provide spiritual support but spiritual care is the work of the SHP just as nursing care is the role of the nurse. Indeed, I would argue, as would many, that without such boundaries, patients are at risk. In this example, we see how differences in approach are constantly at work even when addressing the same issue.

Professions do share such things as the core values of the organization for which they work and in this the overlap may be almost indistinguishable at the tip but the shape of each pie piece indicates that in the larger sections of the slice there is more distinction. This is in stark contrast to a pyramidal model in which distinction is only near the tip. By contrast, in the Pie model, the distinction is strongest in the widest section where the professional is engaged in processes infused with a unique approach, even when doing tasks similar to other disciplines.

It is important to note that all slices are part of the whole pie, which represents the holistic nature of care. Each piece is needed in order for healthcare to address the whole person. In this sense, distinction serves holism and communication is paramount precisely because of differences in approach. Each profession is critically important but at certain times, one may be more or less important than some other disciplines. An example may be found in how an SHP may have no role at all during resuscitation of a patient, except for family care, but when a patient is facing a decision whether or not to engage in rehab as a new start on life, the SHP's role may be the catalyst to all else.

Although this reflection was written primarily with Spiritual Care Practitioners in mind, we hope the Pie Model is helpful to professionals of all backgrounds seeking to promote inter-professionalism. We believe professionals are more likely to support inter-professionalism when they can visualize it without needing to explain it according to a form of inter-professional reductionism that tends to equate professions with the performance of task specificity rather than the distinct approaches to patient care in which they were educated. The Pie model undergirds the need for clear regular communication between professions precisely because of their individual distinct differences. The model recognizes that differences are often more nuanced and therefore less obvious on the surface.

As one renowned ICU internist once said, when professionals do not listen to patients and to one another, patients die. That's about as strong a rationale as one could ever argue. The corollary is that each profession needs to articulate its individual work with a patient in language that communicates those things that the team needs to know, but which are outside the perspective common to all team members. So, in those areas where our tasks overlap significantly, let's listen and speak with one another in a manner that does not assume that we necessarily know the same things. That way patient outcomes will be the best possible.

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