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An Ethnographic Study of Interprofessional Collaboration in Palliative Care

by

Erin Christine Forsyth

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

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Abstract

Background: The concept of the modern palliative care movement was initially developed by Cecily Saunders. She believed that the complex emotional, physical, and spiritual needs of dying patients and their families were best met by a team of professionals working together rather than a sole practitioner. Today local, national, and international definitions of palliative care remain grounded in the philosophy established by Saunders, where care is most effectively delivered by an interprofessional team working in a collaborative manner to support patient and family centred goals.

Research Aim: The purpose of this study was to better understand the differences in interprofessional collaboration between palliative care teams in different clinical settings. The research questions were: 1) Do palliative care providers believe interprofessional collaboration is important? and 2) What are the contextual factors that act as either facilitators or barriers to the implementation of interprofessional collaboration in practice?

Methods: A qualitative ethnographic methodology was used to understand the factors impacting interprofessional collaboration in three separate teams providing palliative care in different settings in a city in Western Canada. Data were collected and analyzed using Carspecken's five step process for ethnographic research. Participant observation and focus groups were conducted with interprofessional team members responsible for providing direct care for palliative care patients/families.

Findings: Five themes emerged from the data: Interprofessional Collaboration: A Central Tenet of Palliative Care; Interprofessional Communication: The Single Most Important

Ingredient for Effective Interprofessional Collaboration; Professional Hierarchy Impacts Interprofessional Collaboration; Role Understanding and Valuing Others; and Facilitators and Barriers to Team Function.

Discussion: Findings from this study can be used to better understand how individual, professional, and organizational culture impacts teamwork in the delivery of palliative care and supports opportunities for understanding and mitigating the barriers to interprofessional collaboration in palliative care settings. The structure and values of the team impact interprofessional collaboration: how communication is enacted; how the hierarchy of the team influences who is viewed as having the ultimate authority over care; and how role understanding and valuing others drives interactions with other members of the team.

Keywords: palliative, palliative care, interprofessional, interdisciplinary, multidisciplinary, collaboration, team, and teamwork

Preface

This thesis is an original, unpublished, independent work by the author, E. Forsyth. The research reported in Chapters 4 – 5 was covered by Ethics Certificate number REB16-0475, issued by the University of Calgary Conjoint Health Ethics Board for the project "A Critical Ethnographic Study of Interprofessional Collaboration in Palliative Care" on October 19, 2016.

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I am deeply grateful to the teams who participated in this study for their willingness to share their experiences and insights. While each of your teams were unique in their own ways, you held the common thread of dedication to providing the best possible hospice and end-of-life care. You are inspirational in the way you care for not just your patients but for each other. You all represent the very best of excellence in healthcare and I feel privileged to have had the opportunity to learn from you.

Thank you to my family. To my husband Ron for his endless patience and support – you have been there for me throughout this entire process, and I have always known that youve had my back no matter what path I decided to go down. To my mom for her countless hours of proof reading and childcare – you have gone far above and beyond what any adult child should ever expect from a parent. To my dad for believing in me and for showering me with love and pride. Finally, thank you to my girls Abby and Sophie, I cannot even begin to tell you how grateful I am to be your mom and how much joy you bring to my life. I know that you have sacrificed in having to share my time and attention while I have been busy with school, but I hope that in the end I have been able to show you that you can do anything you set your mind to and that "you can do hard things".

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Chapter One: Introduction

The concept of the modern palliative care movement was initially developed by Cecily Saunders in the 1960s (Canadian Hospice Palliative Care Association [CHPCA], 2002). Saunders identified that there was inadequate support for individuals dying of terminal illness within the Western medical system and responded by constructing an approach to care focused on optimizing quality of life and relieving the suffering of patients and their families. Trained as a nurse, social worker, and physician, Saunders embodied an interprofessional approach to care that led her to view each patient as a holistic being. She believed that the complex emotional, physical, and spiritual needs of dying patients and their families were best met by a team of professionals working together rather than a sole practitioner (Clark, 2007; Saunders, 2001). Today local, national, and international definitions of palliative care remain grounded in the philosophy established by Saunders. Both the World Health Organization [WHO] (2020) and the CHPCA (2013) describe palliative care as an approach that aims to relieve suffering and provide support to maximize the physical, emotional, and spiritual wellness of individuals and families living with a life-threatening illness; noting that care is most effectively delivered by an interprofessional team working in a collaborative manner to support patient and family centred goals.

Problem Statement

While interprofessional collaboration is widely recognized as being an essential component in the delivery of palliative care, it is also an area where a theory practice gap has been identified (Parker Oliver et al., 2006; Parker Oliver et al., 2007; Reese & Sontag, 2001; Speck, 2006; Wittenberg-Lyles et al., 2007). In my experience as a nurse

working for over 20 years in a variety of palliative care environments, I have found that the tenets of valuing life while normalizing the dying process; enhancing quality of life for patients and their families; preventing and relieving suffering; and providing holistic care to address the total physical, emotional, and spiritual needs associated with dying are accepted as guiding principles for care. However, even though an interprofessional team approach is an important concept in the palliative philosophy, I have witnessed considerable differences in the form and function of palliative teams in practice. In short, some teams are better than others which may be due to several individual and/or organizational variables which either promote or create challenges to interprofessional collaboration. Additionally, other variables in teams such as resources, member composition, abilities, and scope of practice of team members all impact the functionality of teams. This presents a concern as it is believed that a lack of interprofessional collaboration decreases the ability of healthcare providers to deliver optimal patient and family centred care and may also limit professional growth and satisfaction for members of the healthcare team (Carter et al., 2019; Hall et al., 2012; Speck, 2006; WHO, 2010).

Research Questions and Statement of Purpose

I conducted a qualitative research study to explore the culture and lived experiences of three separate teams providing palliative care in different settings in the same Western Canadian city. The goal of the study was to better understand the discrepancies in interprofessional collaboration between palliative care teams in different clinical settings. The primary research question was "*do palliative care providers believe interprofessional collaboration is important?*" and the secondary question was "*what are the contextual factors that act as either facilitators or barriers to the implementation of*

interprofessional collaboration in practice?". The intent of the research was to better understand of how individual, professional, and organizational culture impact teamwork in the delivery of palliative care.

Research Design

To help answer these questions, I conducted a research study utilizing an ethnographic methodology. Data were generated through direct observations of 3 palliative care teams practicing in different clinical settings, 4 focus groups (comprised of a total of 28 healthcare providers), and 1 individual interview with one healthcare provider representing a variety of professional disciplines from each of the participating teams. Data were collected and analysed using Carspecken's (1996) five step process for ethnographic research which included *compilation of the primary record*, *preliminary reconstructive analysis*, *data generation through dialogue*, *describing system relations*, and *application of system relations to explain findings*.

Researcher Assumptions

In 2001, I was a 4th year undergraduate student nearing the completion of my Bachelor of Science in Nursing. Despite having had the opportunity to experience practicums in a variety of clinical environments, I was still feeling uncertain as to where I would want to work when I finished school – that all changed when I started my final practicum on the palliative care unit at one of the local hospitals. I finally felt like I had "found my way home". I loved everything about my experience on the palliative unit from the shift in focus away from illness to quality of living, to the way that patients and families were fully engaged as partners in their care and encouraged to make decisions that were right for them. However, what impacted me the most, was the way the

healthcare team worked together. This was the first time I had the opportunity to witness individuals from a wide variety of professional disciplines really working together to achieve goals that they established with the patient, family, and each other. Communication took place through regularly scheduled team rounds and face to face discussions rather than just reading notes left for each other in the chart or quick phone calls that felt rushed and as if they were an inconvenience to people who were "too busy" to take the time to really listen and explore what was happening for the patient and their co-workers. There were leaders on the team, however these individuals were recognized by their personal attributes and contributions to the team instead of just assuming a leadership title as a result of professional designation. I was inspired and motivated by the individuals working on that unit and knew that was the type of environment I wanted to work in.

One of my first jobs as a Registered Nurse (RN) was on a tertiary level palliative care unit. My experience there was much like that of my practicum. The team worked together, met regularly to discuss their patients, depended on each other's support and opinions, and looked to the best person to address the patient's needs – regardless of disciplinary background. Patients were supported by the team as a whole and team members were also supported to expand their professional knowledge and learn from each other. After two similarly positive experiences, I naively began to believe that this was how the healthcare team worked in all palliative care settings.

After 4 years on the tertiary palliative care unit, I moved to a position in a different setting in the same hospital. I was still working as an RN and my job description was still to provide support to patients and families requiring palliative care. However, in

functioning in a consultant team model, rather than being surrounded by a supportive team working together toward the same goal I was typically the only healthcare professional working with the patient from a palliative care perspective. Communication was often challenging and dominated by chart notes or messages left with various members of the nursing staff to pass along to individuals from other disciplines who were also working with the patient. Goals were inconsistent and patients often received mixed messages regarding their care, the options available to them, and information about what was happening in the bigger picture regarding their health. Unfortunately, this often meant that the patient did not receive the benefits of a well-coordinated team approach to help them achieve their goals and, at worst, the patient's voice was lost altogether in the shuffle. As a professional, I missed the opportunity for regular meetings with the other disciplines to work together to find innovative solutions to what were often very complex problems.

Cecily Saunders introduced us to the term "total suffering" to help describe the experience of dying patients and the physical, emotional, social, and spiritual suffering they faced (Saunders, 1996). While some people assume that physical symptoms are the most important focus of care, what Saunders found was that the lived human experience is much more complex than that. Based on my experience working as a palliative care nurse, I agree that physical symptom needs are only one part of the equation and not necessarily the most important point of focus for the patient. For example, a single mother who was dying conveyed that her biggest source of suffering came from the uncertainty of who would care for her 9-year-old daughter after she was gone. The patient had pain and other physical symptoms but that was not what she wanted help

with. Until there was a plan in place for her daughter, nothing else mattered to her. Her ability to come up with a plan for her daughter's future care was greatly impeded by her physical symptoms and the functional limitations that she was experiencing as a result of her advanced illness. That *suffering* was so much more than physical pain and required a team approach to alleviate it. It was clear to me that everybody including the nurses, physicians, social worker, and youth counsellor had an important part to play and no one discipline would be effective without the combined support and interventions from the other healthcare providers.

It is my bias that better outcomes are achieved in environments where a collaborative interprofessional approach is employed rather than care delivered in a multidisciplinary, or single discipline manner. I also believe that I experience a higher level of professional growth and satisfaction when I work in settings where there is more opportunity for collaboration with people from other disciplines. However, I am one nurse (cultural member) among an entire cultural group of palliative care professionals, and it may be that my own knowledge is based on taken for granted truths. This leads me to wonder whether other palliative care professionals feel interprofessional teamwork is as important as theory would have us believe, and if so, what are the contextual factors limiting the implementation of this approach in their work settings.

Rationale and Significance

It is my belief that changes in practice and policy may help to ensure all palliative care teams have equal opportunity for collaborative practice regardless of clinical setting. Research can help motivate change by creating buy-in from front line healthcare

professionals delivering care as well as policy makers and leaders responsible for allocation of the resources necessary to implement and sustain such changes.

Key Terms and Definitions

In reviewing the literature surrounding interprofessional palliative care teams, it is apparent that a number of key concepts and related terms exist that need to be defined. This includes a number of terms frequently used interchangeably in reference to interprofessional teamwork; these terms are multidisciplinary, interdisciplinary, and interprofessional. While some authors use these words synonymously, others assign each their own definition. Other terms that require consideration are interprofessional collaboration, and patient and family centered care. It is also necessary to identify the framework being used to describe interprofessional collaboration. Creating a common understanding of the language being used is important so that providers have an idea of what they are expected to achieve.

Multidisciplinary Team

Parker Oliver et al. (2005) defined multidisciplinary teams as "groups of various practitioners coming together to report on what they are each planning with a specific patient, working side by side but not necessarily together" (p. 279). Essentially, in multidisciplinary teams, professionals from various disciplines work in silos and interact through parallel communication primarily via chart documentation.

Interdisciplinary Team

Interdisciplinary teams are comprised of healthcare providers from a variety of disciplines who work together on a routine basis on a specific clinical unit or program

with the goal of delivering patient and family centered care (Reid Ponte, et al., 2010). “In an interdisciplinary team, members willingly share responsibility for providing care or services to patients” (Hanson & Carter, 2014, p.302).

Interprofessional Team

Interprofessional teams are made up of individuals from various health care disciplines who work together toward patient and family centred goals. Interprofessional teams are non-hierarchical, have shared decision making, and the members divide work by skill and experience rather than disciplinary role. Interprofessional communication and collaboration are key elements for successful interprofessional team working (Virani, 2012). Interprofessional teams differ from interdisciplinary teams, in their attempt to diminish traditional disciplinary boundaries and allow for new and creative approaches to achieving successful outcomes (Hanson & Carter, 2014).

Patient and Family Centred Care

Patient and family centred care is a partnership between a team of healthcare providers and a patient where the patient retains control of decision making and is an active participant in his/her care. With this approach, a plan of care is developed that is consistent with the patient’s self-determined goals, while drawing on the skills and knowledge of the professional care providers (Canadian Interprofessional Health Collaborative [CIHC], 2010). Furthermore, both the patient and their family are considered to be the unit of care (College and Association of Registered Nurses of Alberta [CARNA], 2011; Saunders, 1978). The concept of patient and family centred care is a guiding principle for both palliative care (CHPCA, 2013) and interprofessional collaboration (CIHC, 2010).

Interprofessional Collaboration

The CIHC defined interprofessional collaboration as "a partnership between a team of health providers and a client in a participatory, collaborative, and coordinated approach to shared decision-making around health and social issues" (CIHC, 2010, p. 24). The use of the word professional can be somewhat misleading in this context, as the term interprofessional collaboration encompasses non-professional and informal caregivers such as unregulated healthcare providers, community volunteers, and the patient and family.

Many healthcare providers believe that they are practicing collaboratively simply because they work together with other practitioners. In reality, they may simply be working in a multidisciplinary or interdisciplinary model where each individual has agreed to use their own skills to achieve a common goal. Interprofessional collaboration is not only about agreement and communication, but rather creation and synergy. "Collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care" (WHO, 2010, p.7). It involves individuals with complementary skills interacting to create a shared understanding that none had previously possessed or could have come to on their own (Bruner, 1991).

It is increasingly promoted in all areas of healthcare that the use of interprofessional collaboration, rather than the more traditional multidisciplinary or interdisciplinary approaches, can lead to better outcomes for patients, families, and members of the health care team (Carter et al., 2019; CIHC, 2010; College of Registered Nurses of Alberta, 2023; Hall et al., 2007; Lawrie & Lloyd-Williams, 2006; WHO,

2010). Due to the high degree of conflation of the terms interdisciplinary and interprofessional in the existing literature, for the purposes of this research, these terms were used interchangeably in my search strategy and analysis of the literature unless a clear distinction was provided in the primary document. In discussing my findings, the term interprofessional is used unless providing a direct quote that originally stated otherwise.

Framework for Interprofessional Collaboration

Just as there are a number of terms used to describe the concept of interprofessional collaboration in the literature, there are also a number of models and competency frameworks available to guide its use in practice (Sutter et al., 2009). The two frameworks most commonly identified in my review of the literature relating to collaborative practice in palliative care were the National Interprofessional Competency Framework (CIHC, 2010) and the Model for Interdisciplinary Collaboration (Bronstein, 2003). The CIHC (2010) framework for interprofessional collaboration identifies interprofessional communication, patient-centered care, role clarification, team functioning, collaborative leadership, and interprofessional conflict resolution as the six competency domains for effective interprofessional teamwork. While some domains are flexible and may not be applicable to all teams, patient-centred care and interprofessional communication are relevant in all care settings and support the other four domains. Bronstein's (2003) Model for Interdisciplinary Collaboration is comprised of five core components including interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process. Professional role, structural

characteristics, history of collaboration, and personal characteristics are identified as the primary influences on collaboration.

Bronstein's model is the one most commonly referenced in the existing body of evidence examining interprofessional collaboration in palliative care. It was developed from a social work perspective using a combination of multidisciplinary theory of collaboration, services integration, role theory, and ecological systems theory (Bronstein, 2003). This model has been extensively cited in the work of key researchers in the field of interprofessional collaboration in palliative care (Baldwin et al., 2011; Parker Oliver et al., 2006; Parker Oliver et al., 2007; Wittenberg-Lyles et al., 2007; Wittenberg-Lyles et al., 2010). However, the CIHC (2010) framework has advantages over Bronstein's model. The CIHC framework has fewer components and thoroughly describes each competency, versus Bronstein's framework which is more complex and not as easily understood. The language used in the CIHC framework is also more congruent with the language used in the CHPCA Model to Guide Hospice Palliative Care (2002, 2013) and the national Accreditation Canada standards for hospice, palliative, and end-of-life services (Qmentum Program, 2018). The CIHC framework is also promoted by the provincial health authority which the three participating study sites herein are accountable to. It is for these reasons that I have chosen the CIHC framework as my working model for the competencies required for interprofessional collaboration. Recently, (since the time when data collection for this thesis occurred), there has been the development of a new Interprofessional Palliative Care Competency Framework (2023) developed. This document will be alluded to in the final chapter of the thesis.

Outline of Chapters

In the second chapter of this thesis, I present a review of the literature regarding interprofessional collaboration in palliative care teams. In the third chapter I provide a description of how the study was designed and conducted, including an overview of the methodology employed to generate and analyze the data as well as the theoretical lens used to interpret the findings. The research setting, sample, and recruitment measures are described. Details are presented regarding measures that were taken to ensure validity and rigor throughout the research process. Ethical considerations are also discussed. In the fourth chapter of this thesis, I describe the cultural landscape of the three teams that participated in the study to help the reader understand how the culture of each of the teams was driven by the context of their setting. Descriptions of the teams and their environments are provided based on the data generated through observations and artifacts collected from each site. While all three of the observed teams had some commonalities in addition to their shared mandate of providing palliative care to adult inpatients, each team also had its own unique culture resulting from their individual purpose, vision, physical environment, and social structure.

Thematic findings are discussed in the fifth chapter. While there were many differences between the three separate sites recruited for the study, there were also many findings that were generalizable across teams. In this chapter I describe the five primary themes that emerged from the data including: Interprofessional Collaboration: A Central Tenet of Palliative Care; Interprofessional Communication: The Single Most Important Ingredient in Effective Interprofessional Collaboration; The Impact of Professional

Hierarchy on Interprofessional Collaboration; Role Understanding and Valuing Others; and Facilitators and Barriers to Team Function.

In the final chapter, I discuss the themes from chapter five in relation to the literature and how they relate to the systems that influence palliative care teams in their ability to achieve interprofessional collaboration in their clinical practice. I identify implications for further research, study strengths and limitations, and a summary that explores areas for continued growth and change to facilitate interprofessional collaboration in palliative care teams.

Summary

Interprofessional collaboration is widely accepted as a core tenet of palliative care, however this is an area where a theory practice gap often exists. It is believed that effective collaboration leads to improved patient and family centred care as well as improved professional satisfaction for the healthcare providers involved. A qualitative study was conducted with three palliative care teams to help understand the values of the healthcare professionals in regard to interprofessional collaboration and to explore the cultural and contextual barriers and facilitators to effective teamwork in their practice settings. Key terms were reviewed, and an explanation was provided of the framework that was used to help understand what best practices around interprofessional teamwork should look like in practice.

Chapter Two: Literature Review

A narrative literature review was undertaken to explore the existing body of evidence related to the problem of inconsistent interprofessional collaboration in palliative care teams. The intent was to assess the strengths and weaknesses within the knowledge base of interprofessional teams in palliative care, critically reflect on what exists, and ground the research in the existing knowledge (Bloomberg & Volpe, 2019). With limited research to address this problem, it was important to obtain a better understanding of interprofessional practice in palliative care to inform the design and development of the research study.

Beginning the literature review, I was seeking to understand the breadth of the issue, population, and review purpose. A list was generated to identify key words to be searched. This list included combinations of the terms; *palliative, palliative care, interprofessional, interdisciplinary, multidisciplinary, collaboration, team, and teamwork*. Although interprofessional teams exist in many palliative care settings, I narrowed the literature search to focus on teams in acute care and hospice as these were the teams I was studying. The electronic data bases MEDLINE, CINAHL, ProQuest, and PsychInfo were searched using the identified terms and limiting results to peer reviewed articles, with abstract available, in the English language, and published between 2003 and 2014. I chose these data bases as they capture the disciplines of palliative care practitioners who are a part of the interprofessional teams in this study. The CHPCA website was also searched for policy statements, frameworks, and reports with information relating to interprofessional teamwork. The Qmentum Program (2012) hospice, palliative and end-of-life accreditation standards was retrieved from my personal

library and later replaced by the updated Qmentum Program (2018) standards. A subsequent literature review was completed in March of 2023 to bridge the time between the original literature review and the completion of the research. A search of Google Scholar using the same key phrases (palliative, palliative care, interprofessional, interdisciplinary, collaboration, team, and teamwork) as in the initial review, within the time frame of 2015 and 2023 was undertaken.

A combined total of 574 results were returned using the search strategy outlined above. After eliminating duplicate results, articles were scanned by title and abstract for their design and for relevance to collaboration within palliative care environments. Articles were considered to be relevant if they referred to team structure, function, and professional members' perceptions of intra-team collaboration in the provision of palliative care. Articles were excluded if they did not examine team process, did not incorporate the perspective of formal members of the palliative care team, did not involve specialized palliative care teams, examined inter-team collaboration between the palliative care teams and other services, involved pediatric populations, or focussed on interprofessional education rather than interprofessional collaboration in clinical practice. All conceptual papers and editorial pieces were excluded, and only primary studies or policy documents and frameworks that addressed interprofessional collaboration in palliative care were included for review. As a result of this process a total 18 articles were retrieved in full text and analyzed. I first organized and compared sources by creating broader subgroups based on document type, team settings, and professional roles. Next, I extracted the data from the articles to focus and organize it into a systematic framework for analysis according to the purpose, research design, care setting, findings,

and relevance. The extracted data was compiled into a matrix to compare the data including the population, methodology, results, strengths, and weaknesses of the study. Analysis of the results revealed the key themes of standards and expectations for interprofessional collaboration in palliative care, variations in the quality of collaboration in practice, and significance of professional discipline in collaboration.

Standards for Interprofessional Collaboration in Palliative Care

First, I started with reviewing six key policy documents and frameworks in regard to standards for interprofessional collaboration in palliative care. These documents included the WHO (2020) Palliative Care, the CHPCA (2002) Model Guide to Hospice Palliative Care Based on National Principles and Norms of Practice, the British Columbia Ministry of Health (2013) Provincial Framework for End-of-Life Care Action Plan for British Columbia, the Health Canada (2018) Framework on palliative care in Canada, the CARNA (2011) hospice palliative care position statement, and the Qmentum Program (2018) standards for hospice, palliative, and end-of-life services for Accreditation Canada. There was consensus between all of the documents regarding the need for interprofessional collaboration within the palliative care team. All clearly indicated that "palliative care is most effectively provided by interdisciplinary care teams" (CHPCA, 2002, p.22), and that "collaboration and effective communication among care providers are essential for quality care" (CARNA, 2011, p.2). The Qmentum Program (2018) indicated that it was a *high priority standard* for the interdisciplinary team to communicate regularly to provide collaborative care in terms of services, roles, and responsibilities. The language of "the team" was used throughout the entire Qmentum Program document for the vast majority of the accreditation standards.

While the need for a collaborative team of professionals was clear, what was not as clearly defined was, *which* professionals should comprise the palliative care team. There was a common indication that the team should include "people with different roles and from various disciplines" but there was not a consistent indication of which disciplines should be represented. The Qmentum Program (2018), British Columbia Ministry of Health (2013), CARNA (2011), Health Canada (2018), and CHPCA (2002) documents did provide some recommendations as to specific disciplines that *could* be included on the team, but all stated that the composition of the team would vary depending on the needs of the patient and the resources available to the palliative care program. Five of the documents recommended that the team include physicians, nurses, and volunteers; three indicated that social workers, psychologists, and spiritual care providers could be potential team members; with two suggesting dieticians, occupational therapists, physical therapists, and bereavement support workers; and one document referred to the inclusion of child-life specialists, recreational therapists, pharmacists, interpreters, speech language pathologists, and support workers. As noted in the CHPCA document, it is important to have consistency within the membership of the group in order to maintain good relationships. While allowing flexibility in team composition based on local context and available resources, the inconsistency in the recommended professional disciplines that should be represented on the palliative care team creates difficulties for program organizers to ensure the proper human resources are available. As a result, it is difficult to advocate for the creation of a committed team if you aren't sure who would be best suited to be part of the team.

Variations in Collaboration in Practice

Various quantitative, mixed methods, and qualitative studies have been undertaken to measure perceptions of collaboration among members of palliative care teams (Day, 2012; Kirk, et al., 2010; Klarare, et al., 2013; Parker et al., 2006; Wittenberg-Lyles et al., 2007; Wittenberg-Lyles et al., 2010). Three of these studies found that perceptions and acts of interprofessional collaboration were inconsistent within teams (Day, 2012; Kirk et al., 2010; Wittenberg-Lyles et al., 2010). Another three found that there were variations in the quantity and quality of interprofessional collaboration when comparing teams to each other (Klarare et al., 2013; Parker Oliver et al., 2006; Wittenberg-Lyles et al., 2007).

The study by Wittenberg-Lyles et al. (2010) used a mixed methodology design incorporating observations of 62 videotaped team meetings and the results of a validated self-report questionnaire (the Modified Index of Interdisciplinary Collaboration [MIIC]). The MIIC is a 42-item survey tool that uses a five-point Likert scale of rating perceptions of collaboration among palliative care team members; with a score of 1 indicating highly perceived collaborative practice and 5 indicating problematic collaborative practice. The aim of the study was to explore the perception of collaboration among hospice team members as compared to observable collaborative practice in team meetings. Twenty palliative care professionals including nurses, social workers, chaplains, physicians, volunteers, health care aides, medical students, and an executive director completed the MIIC. These professionals represented two separate teams within the same service program. Overall, team members rated their perceptions of cooperative work with colleagues from other disciplines as being very high (mean score of 1.27 with a standard

deviation of 0.47). When the videotaped team meetings were analyzed, of the 43 team discussions that focussed on patient care, 19 did not include any interprofessional collaboration. In summarizing the study results, the authors proposed that "team member perceptions of interdependence and flexibility were much higher than enacted collaborative practices" (Wittenberg-Lyles, et al., 2010, p. 271).

Day (2012) conducted a grounded theory study that included one year of clinical interprofessional team observations to compare the results of semi-structured interviews to gather professionals' self-reported perceptions of interprofessional collaboration and observations in the practice setting. She found that team members reported collaborative communication but had difficulty transferring that communication into collaborative acts. "Communication occurred regularly while collaboration occurred occasionally" and "team members' intentions to collaborate on pain palliation rarely translated into collaborative actions" (Day, 2012, p.68).

Kirk et al. (2010) conducted a study using a survey comprised of 12 open ended questions and 27 close-ended questions to collect both qualitative and quantitative data from 138 health care providers working in a variety of palliative care settings on Vancouver Island. The aim of the study was to identify barriers to communication for professionals working in palliative care teams. The authors reported that, "Communication within the interdisciplinary teams was the most frequent source of frustration and difficulty reported. Respondents identified interpersonal as well as interdisciplinary barriers to effective communication" (Kirk et al., 2010, p.62). Additionally, it was found that interprofessional collaboration was inhibited when individuals did not trust the competence of other professionals on the team. "A significant

concern expressed by respondents was difficulty in communicating with health care providers perceived to be unskilled in palliative care" (Kirk et al., 2010, p.66). Overall, while participants strongly agreed with the importance of interprofessional teamwork and identified themselves as being members of interprofessional teams, they felt that interprofessional collaboration existed more in theory than in reality.

A study by Parker Oliver et al. (2006) used the MIIC to collect quantitative data to determine if there were variances in perceptions of collaboration within and between hospice programs. Data were gathered from 95 palliative care professionals from five hospice programs in four different states. While there was no significant difference in the perception of collaboration between the professionals within the hospices, one-way analysis of variance (ANOVA) of the responses from between the various hospices demonstrated "statistically significant differences on the mean total instrument score and on three of four subscales . . . these variances indicate significant differences in perceptions of collaboration between hospice programs" (Parker Oliver et al., 2006, p.279). Unfortunately, this study was limited by the lack of observations to confirm self-reported levels of perceived collaboration to acts of collaboration in practice within the palliative care teams. This leads to the question as to whether there were inconsistencies between perceived levels of collaboration and actual collaboration in practice within the teams in this study as was found in other studies.

In a study by Wittenberg-Lyles et al. (2007) a semi-structured phone survey was used to collect information from a purposive sample of physicians, nurses, patient care coordinators, social workers, volunteer coordinators, and health care aides from 191 palliative care agencies across the United States (US). The purpose of their study was to

learn more about common practices related to interprofessional practice and team meetings in palliative care organizations. The results revealed that there were variations in the programs' team meetings related to structural characteristics, frequency, and number of participants involved. The authors also noted that not all programs who participated were meeting the standards set out in the US federal guidelines regarding the requirements for palliative care programs to provide care in an interdisciplinary team format.

Klarare et al. (2013) conducted 15 semi-structured interviews with palliative care nurses, physicians, social workers, and paramedical staff. Content analysis was used to explore team interaction among palliative care professionals providing specialized palliative care services in Sweden. "Competence, communication, and organization (were) the three main themes in the results of this study" (Klarare et al., 2013, p.1066). Teams found collaboration to be difficult and indicated that "focussed efforts on role clarification, leadership style, and development of interprofessional competence would increase odds for effective collaboration" (Klarare et al., 2013, p.1067).

It is apparent in all the studies presented, that the concept of interprofessional teamwork is inconsistently translated into the practice setting. In some teams the professionals involved were more likely to collaborate with various team members based on their levels of trust and communication. In other teams, the professionals believed that they were practicing in a very collaborative manner, but their observed practice did not match their self-perceived levels of collaboration. Most palliative care professionals found that there were personal, professional, and/or organizational resource barriers that made it difficult to consistently practice in a collaborative manner. The findings from

these studies add to the evidence that some palliative care teams practice in a more collaborative fashion than others.

Significance of Professional Discipline

The theme of disciplinary differences in the approach to professional collaboration was present in several studies (Day, 2012; Klarare et al., 2013; O'Connor & Fisher, 2011; Parker-Oliver et al., 2005; Parker Oliver & Peck, 2006; Parker Oliver, et al., 2010; Pype et al., 2013). Many of the studies reviewed had a large focus on the influence of nurses, physicians, and social workers regarding interprofessional collaboration in palliative care teams (Day, 2012; Klarare, 2013; Parker Oliver & Peck, 2006; Parker Oliver et al., 2010; Pype et al., 2013). The fact that these studies were all conducted by either nurses, physicians, and social workers led me to wonder if there was some bias (intentional or unintentional) which led the authors to focus on members of their own professional disciplines and if a wider representation from a variety of disciplines would have been found if there were less homogeneity in the disciplinary backgrounds of the authors.

While some studies provided evidence that nurses, physicians, or social workers contributed to increased interprofessional collaboration within palliative care teams, others suggested that individuals from these disciplines created barriers to collaboration. However, there was not a clear indication that any one discipline influenced the process of interprofessional collaboration in a consistently positive or negative way.

Studies by Parker Oliver et al. (2010) and Pype et al. (2013) focussed on the role of the physician and their perspectives regarding interprofessional collaboration within palliative care teams. Parker Oliver et al. (2010) conducted a descriptive study to explore

the perceptions of 17 hospice medical directors regarding interprofessional collaboration. "Physicians, as traditional leaders of health care teams in a medical model, are not always trained in this collaborative model." (Parker Oliver et al., 2010, p. 537). However, the *ability to work as part of a team* was one of the key themes that emerged from the data in this study and it was recognized that "collaboration among staff from different backgrounds is a fundamental part of hospice practice" (Parker Oliver et al., 2010, p.540). The physicians in this study "clearly articulated the philosophy of collaboration and gave specific experiences supporting their respect for their interdisciplinary colleagues" (Parker Oliver et al., 2010, p. 543). While it is not explicitly stated, it is implicitly suggested that hospice medical directors are formal leaders who positively contribute to interprofessional collaboration within their teams. Conversely, a grounded theory study by Pype et al. (2013) explored the perspectives and preferences of general practitioners (GPs) toward interprofessional collaboration with palliative care teams and found that the willingness of the GPs to collaborate was inconsistent and highly dependent on their perceived levels of competence of the other care providers. While some GPs "were not restrictive and valued the involvement of all caregivers, some regarded the current organization of palliative home care as unnecessarily complicated and stated a preference to deliver 'care as usual' on their own" (Pype et al., 2013, p. 315). The physicians in this study expressed support for interprofessional collaboration; however, they were more guarded than the hospice medical directors and felt that familiarity with the competence of other team members was an important requirement for successful collaboration.

A mixed methods study by Wittenberg-Lyles et al. (2010) found that nurses and physicians were the team members most likely to promote collaborative actions during interprofessional team meetings; “Nurses enacted the most interdisciplinary collaboration (57.1%), followed by Medical Directors (20.4%)” (Wittenberg-Lyles et al., 2010, p. 266). Less than ¼ of all collaborative communication within the observed team interactions were from social workers, chaplains, volunteer coordinators, bereavement coordinators, and aides. This demonstrated the tendency for higher levels of collaboration from nurses and doctors, and less collaborative interaction from team members from other disciplines. The gaps in collaborative contributions between members of specific disciplines may be related to a lack of clarity of providers own roles and their understanding of the roles of others within the team. “Role ambiguity can result in the absence of collaboration in interdisciplinary team meetings as well as create gaps in the contributions among team members.” (Wittenberg-Lyles et al., 2010, p.272). Day (2012) observed that nurses and physicians did not always communicate in a way that demonstrated value for team members from other professional disciplines. In her observations of interprofessional team rounds on a day when some team members had not yet arrived, Day noted the nurse leading interprofessional rounds to say “well, we can go on without the social worker and chaplain”. This reinforced the culture of disciplinary hierarchies within the team with nurses and physicians comprising the core of the team and other members merely playing adjunct roles (Day, 2012).

Several studies focused specifically on the roles of social workers within interprofessional palliative care teams (O’Connor & Fisher, 2011; Parker Oliver et al., 2005; Parker Oliver et al., 2006). Parker Oliver et al. (2005) used the MIIC instrument to

measure 77 hospice social workers' perceptions of interprofessional collaboration in relation to their other team members. The results of the study indicated that social workers were highly collaborative, that they had a very positive perception of interprofessional collaboration, and no barriers to collaborative teamwork were identified (Parker Oliver et al., 2005). However, the study by O'Connor and Fisher (2011) found social workers' perceptions of disciplinary role blurring created barriers to interprofessional collaboration. In this qualitative study, O'Connor and Fisher conducted semi-structured interviews with seven palliative care professionals from three different sites. Participants included two nurses, a palliative care physician, a psychiatrist, a social worker, counsellor, and an occupational therapist. The aim of this study was to explore team members' perceptions and experiences of team dynamics using a social constructivist paradigm. They specifically investigated the role overlap that occurs between professionals from different disciplines on an interprofessional team. While nurses and physicians supported the blurring of role boundaries, professionals with a traditionally psychosocial role such as social workers found the overlap to be a negative outcome of interprofessional working. As the authors concluded, "The blurring of role boundaries and the provision of psychosocial care by members of the team was perceived as being positive by non-specialist psychosocial team members and as unsatisfactory, frustrating, and even potentially harmful by specialist psychosocial team members" (O'Connor & Fisher, 2011, p.194). This can create barriers to interprofessional collaboration as team members develop a sense of "turf protection" in their attempt to retain power within the team by maintaining control over the areas that they have

expertise in and minimizing the knowledge of other professionals (O'Connor & Fisher, 2011).

While not addressed specifically in any of the reviewed studies, the question of team leadership was an underlying issue across numerous studies. This is an important issue, as the CIHC (2010) promotes a flexible leadership style and suggests that leadership should be situational and based on matching the skills of the various team members to the specific needs of each situation. Some of the participants in the study by Klarare et al. (2013) supported this type of flexible leadership and stated that the professional discipline was not important, but rather personal skills and attributes should determine leadership. However, other participants in the same study felt that the team should be led by a physician. While there was not consensus on who should lead the team, it was agreed that the formal leader should be responsible for creating an atmosphere supportive of interprofessional collaboration. Day (2012) found that many participants reported the social worker to be the leader in interprofessional team rounds; however, her observations revealed that it was the physician who led the team. It seems that the traditional hierarchy of the medical model that places the physician as the team leader is also adopted in practice by some palliative care teams – even when the team believes they are using flexible leadership.

Professional cultures specific to various disciplines, traditional professional hierarchies, and role protection can all create barriers to interprofessional collaboration. It is therefore important to consider team composition when considering interprofessional collaboration. "Looking at different proportions of the professions could radically change teams from a medical framework to embrace other dimensions" (Klarare et al., 2013,

p.1068). Additionally, it is necessary to ensure role clarity and good interprofessional team function to achieve effective interprofessional teamwork (CIHC, 2010).

Summary

I conducted a narrative review to gain a broad understanding of interprofessional teams in palliative care. Three themes that arose in the data from the articles were standards and expectations for interprofessional collaboration in palliative care, variations in the quality of collaboration in practice, and significance of professional discipline in collaboration. It is evident that while palliative care providers support interprofessional collaboration in theory, it is frequently an area that could use improvement in practice. Given the results of the evidence reviewed and considering the CIHC (2010) framework for interprofessional collaboration, it is critical to consider interprofessional communication, role clarification, team function, interprofessional conflict resolution, and collaborative leadership and the impact of these on patient and family centered care when exploring ways to enhance interprofessional collaboration in palliative care teams. Further research is still needed to consider how the composition of palliative care teams influences interprofessional collaboration in a variety of care settings including acute care and hospice. It is likely that the disciplinary mix will influence the culture of the team, and the ways that professionals work together in providing palliative care. It may seem logical to assume that an increased representation of individuals from a variety of disciplines will increase the quality of interprofessional collaboration within a palliative care team. However, that may not be the case as it is unclear whether individuals from specific professional backgrounds are more or less likely to create barriers or facilitate the process of interprofessional collaboration. As well, further understanding of an ideal

composition of interprofessional teams is limited. Before policy development or other team initiatives can occur, an increased understanding of the way that personal, professional, and organizational culture impacts the perceptions of team members could provide insights into the best ways to support change to enhance interprofessional collaboration in palliative care teams. Therefore, I conducted an ethnographic study focusing on understanding the culture of interprofessional teams and collaboration in palliative care.

Chapter 3: Methods

The goal of this study was to better understand the perspectives of healthcare providers regarding interprofessional collaboration in the provision of palliative care. The primary research questions were: "*Do palliative care providers believe interprofessional collaboration is important?*" and "*What are the contextual factors that act as either facilitators or barriers to the implementation of interprofessional collaboration in practice?*". In this chapter I will discuss the immersive process in which I engaged to ensure meaningful data were obtained and analyzed, including discussions around the methodology employed to generate and analyze the data, as well as the theoretical lens used to interpret the findings. The research setting, sample, and recruitment measures are described. Details are presented regarding measures that were taken to ensure validity and rigor throughout the research process. Study limitations and ethical considerations are also discussed.

Purpose and Research Questions

I used an ethnographic methodology employing Carspecken's (1996) five step process to answer the above research question. I sought to explore a greater understanding of interprofessional collaboration in palliative care from the perspectives of healthcare providers who practice in the field every day. This offered emic knowledge of the complex challenges they faced as teams and allowed me as a researcher gain a holistic picture of the culture of palliative care in the natural setting.

Ethnography

Ethnography is a research methodology concerned with understanding the behaviours, beliefs, and functional patterns of cultural groups (Atkinson & Hammersley,

1994). Ethnographers focus on a wide range of cultural aspects including language use, rituals, ceremonies, relationships, and artifacts. A culture can be a society, a community, or a group of individuals with something in common. This may include people who work in a specific care setting or provide a certain specialty of care. In the case of this study the culture being examined was that of healthcare providers working in the specialty area of palliative care.

There are different types of ethnographies with varying philosophical underpinnings. However, regardless of the style of ethnography used, there are fundamental characteristics that apply across traditions. These characteristics include the researcher as instrument (researchers explore and analyze culture through interviews, observations, cultural data, and artifacts), they are the tool that listens, feels, and observes the people and the context. Fieldwork (researchers conduct fieldwork within the cultural scene), in the natural setting or place where humans connect. Cyclical data collection and analysis (data collected in the field leads to further questions about the culture that are taken up in interviews). A focus on culture (the goal of ethnography is to understand the cultural meanings of the group being studied), a relational process occurring between people. The culture in ethnography may be a society, community subculture, or an organization. Ethnographers are culturally immersed (researchers embed themselves within the culture being studied to collect data through interviews, observations, and review of artifacts). This emersion allows researchers to understand relevant behaviors within the context of the culture. Finally, reflexivity is a reflexive process that recognizes the influence that a researcher brings to the research process. Researchers openly acknowledge and disclose themselves in their research, seeking to understand their part in

it, or influence on it (Madden, 2010). Ethnography requires researchers to conduct fieldwork for an extended period so that they may become immersed in the culture of the study to the extent that they can understand an insider's perspective or *emic* view. This can be done through observation and active participation within the cultural group being studied. As research is collected and analyzed, it leads to further questions about the culture. This in turn leads to more interviews and observations, thus a continuous cycle of data collection and analysis occurs. While collecting data from the emic view, the researcher also maintains an outsider's or *etic* view which allows for interpretation. This can present challenges for ethnographic researchers as they become aware of the balance between immersing themselves as participants within a culture, their research role of objective observer, and the way that their presence within a culture alters it.

Focused Ethnography

When nurses decide if they will use ethnography to study a culture, a parallel consideration will be whether they conduct a "micro or macro" ethnographic study. Focused ethnography, also known as micro-ethnography, is a practical methodology for nurse researchers to use to investigate "fields specific to contemporary society which are socially and culturally highly differentiated and fragmented" (Knoblauch, 2005, p. 1) such as nursing. This involves the study of a specific phenomenon or issue within a specific context in a sub-culture of a larger societal group, like the phenomenon of interprofessional collaborative practice within the context of a palliative care setting (Cruz & Higginbottom, 2013; Higginbottom et al., 2013; Knoblauch, 2005; Roper & Shapira, 2000). While focused ethnography shares some similarities with conventional

ethnography such as fieldwork, in-depth data collection, and analysis, there are a few key differences.

With most types of ethnography, the researcher enters the field as a stranger and must take time to learn the culture to gain the insider's perspective. The researcher is most influenced by their etic perspective throughout the research process, which may inhibit their understanding of the culture under study (Hammersley & Atkinson, 2007; Roper & Shapira, 2000; Ybema et al., 2012). A trademark of focused ethnography is a shared background between the researcher and participants (Cruz & Higginbottom, 2013; Higginbottom et al., 2013; Knoblauch, 2005; Wall, 2015). With a shared background, researchers are able to easily access and understand nuanced aspects of the culture that an outside researcher may overlook (Cruz & Higginbottom, 2013; Higginbottom et al., 2013; Knoblauch, 2005; Roper & Shapira, 2000).

Other differences include shorter, purposeful field visits, focus groups, data analysis member checking, entering the field prepared with a specific research question, and focusing on a small group or sub-culture (Cruz & Higginbottom, 2013; Hammersley, 2006; Higginbottom et al., 2013; Roper & Shapira, 2000; Wall, 2015). Focused ethnography offers a pragmatic approach to nursing research, and the results often have practical application within the clinical setting (Higginbottom et al., 2013; Scott & Pollock, 2008). Detailed descriptions of these groups and unit culture can provide rich data that gives insight into the meaning nurses give to their behaviours. When nurses choose to conduct ethnographic research studies, usually they have decided there is some shared cultural knowledge to which they would like to understand (Streubert & Rinaldi Carpenter, 2011). The way they understand is by making cultural inferences which are

the observer's (researcher's) conclusions based on what they have seen or heard while studying the culture. According to Spradley (1980), ethnographers generally use three types of information to generate cultural inferences: cultural behavior (what people do), cultural artifacts (the things people make and use), and speech messages (what people say).

A significant part of culture is not often readily available (tacit knowledge). This consists of information members of a culture know, but do not often express directly. In this study, the researcher was exploring interprofessional collaborative practice within palliative care teams as a subset of a larger healthcare system. The intent was to explore the impact of the system on the culture of interprofessional collaboration within the participating teams. To do this, the researcher employed Carspecken's (1996) five step method for ethnographic analysis:

1. Compilation of the primary record - initial data collection through passive observation.
2. Researcher interpretation through preliminary reconstructive analysis – the primary record is analyzed for subjective and normative themes that are consistently present.
3. Dialogical (emic) data generation through dialogue – focus group discussions and interviews to elicit the emic view.
4. Describing system relations to broader context – systems analysis between sites/cultures (discovery)
5. Application of system relations to explain findings – analysis of relationships identified in step four and how they relate to broader social, political, and

organizational factors within society. The analysis in step five helps to makes sense of the findings in steps one through four.

Setting and Sample

Setting

The research setting encompassed three separate teams providing palliative care at different locations in the same large Western Canadian city. The teams worked in the following settings: a small freestanding residential hospice ("Hospice House"), a tertiary level palliative care unit in an acute care hospital ("Palliative Unit"), and a palliative consult team at a large acute care hospital ("Consult Team"). These teams were selected because they have the shared mission of providing palliative and end-of-life care to individuals and families in inpatient settings, however the structures and the environments in which they work are very different. The differences between the three settings are described in detail in the following chapter. By recruiting three teams, all providing palliative care but in different settings, factors such as social, environmental, and organizational contexts could be explored. Having worked in a professional capacity with each of the teams at some point or other over the past 20 years, I came to this research as an insider. Thus, I was aware that there was a high degree of variation in the way that each of the participating teams engaged in interprofessional collaboration. In observations and focus groups I attempted to see each team from an etic view to allow myself to collect data regarding the distinct and shared cultures of the teams with a new lens, and challenge my own pre-existing biases in the analysis of the data while unpacking the social and cultural influences impacting collaborative practice.

Gaining Entry

I began the process of entering the field and recruiting participants after receiving approval from the Conjoint Health Research Ethics Board (CHREB) as well as the Alberta Health Services Administrative approval for each of the involved agencies.

For all three teams, I began by reaching out to the formal leaders/managers by email or through in-person meetings to ensure they were supportive of this research happening in their settings. During initial contact I shared my research proposal, explained my research goals, plans for recruitment, and outlined how I hoped to go about observations and focus groups. All team leaders were supportive of me proceeding.

After meeting with the leaders, study information was provided to the larger teams to create awareness and begin the recruitment process. Recruitment was done in a variety of ways. Posters were sent out to the email distribution lists for each of the settings and hard copies were posted at the work sites. The posters introduced the research project and provided contact information so that interested individuals could reach out to me for more details and/or to sign up for focus group participation (see Appendix A). Emails were also distributed to all the teams providing more fulsome information regarding the purpose of the study, methodology, inclusion criteria, and an invitation to participate. The Director of Care at Hospice House and the Manager of the Palliative Unit opted to send the study information out via email to all their teams themselves. For the Consult Team, the Manager and Medical Director asked that I send an email to all members of their larger service at four separate acute care sites to determine which team had the most interest in participating. The specific Consult Team

site that was selected had a positive response for interest in participation from 100% of their team members.

Short in-person information sessions were also offered at each setting. These information sessions provided me with the opportunity to introduce the study to the team members, describe the research goals in further detail, and answer questions. For the Palliative Unit, I provided information sessions at varying times on three separate days to ensure that as many people as possible had the opportunity to attend. I presented one in-person information session to the Consult Team during team rounds. An information session was also offered to the team at Hospice House; however, the Director of Care declined my offer as she felt the other recruitment materials were sufficient.

Participants

The sample included a mix of professionals from the various disciplines represented at each of the settings. Participants were selected for their potential to provide good representation of the culture, team processes, and dynamics in their unique work settings.

To be eligible to participate in focus groups, participants had to be healthcare providers employed in a part time or full-time capacity with one or more of the identified teams and regularly involved in activities related to the delivery of patient care. Transient members such as casual staff, locum physicians, and partnering teams were present during observations (step 1: compilation of the primary record) but were excluded from participation in focus groups and interviews (step 3: data generation through dialogue). The decision to exclude transient staff from step 3 was made because they were not as likely to have the same perspective and insights into the nuances of team function as

individuals who worked with the teams on a regular basis. While the voices of patients and family members would have had the potential to add rich insight into the effectiveness of interprofessional collaboration in the identified teams, the scope of this study was limited to healthcare providers.

Data Collection

Data were collected through direct observations of healthcare providers interacting with each other, field notes, questionnaires (for demographic information), focus groups, individual interviews, and informal conversations with key informants. Each team was observed on multiple occasions between the hours of 0700 – 1600; no observations took place in the evenings or at night as the majority of the interprofessional team members were only present during regular daytime hours. All teams also participated in focus groups.

Building the Primary Record: Observations

During step one, observations were conducted with the teams during formal and informal interactions in their work environments. I used this time to observe and compile detailed field notes in all three settings. Each team was observed on two separate occasions for 4 – 6 hours at a time. Data collected during observations included descriptions of the physical environments, group interactions in situations such as shift report, the organization of daily work routines, debriefing of challenging patient interactions, and team rounds. Observations were limited to interactions and behaviours of healthcare providers, no patients/families or members of the public were observed.

Field notes were taken during observations in step one and step three to ensure that details were accurately captured and assisted in the reconstruction of cultural

interprofessional teamwork actions and how meaning was constituted during interactions that I observed of the team members. These field notes were recorded in two separate journals. The first journal was thick descriptions of observed activities and interactions. These thick descriptions became my primary record from step one and were later typed out and used for coding and expanded analysis. The second journal served as my field journal of descriptions that were observed away from the primary events but helped to provide context and reflection to the entries in the primary record.

Dialogical Data Generation Through Focus Groups and Interviews

As per the third stage of Carspecken's (1996) ethnography framework, focus group discussions were conducted with participants from the observed teams. Focus groups allowed for a dialogical approach to gain an emic or "insiders" position with respect to the culture. The purpose of the focus groups was to discuss the observations gathered in the first phase of data collection and to provide further insight to ensure reflexivity. These discussions illuminated practical understandings where explanations could be provided and spontaneous responses as a quick and effective way of evaluating my fieldnotes and promoting dialogue between the team members. Each focus group was 1 hour long, during which time the participants were asked to discuss their views regarding collaborative practice within their teams and in palliative care in general. Participants were also asked questions to explore their beliefs regarding the barriers and facilitators for interprofessional collaboration. Each team had their own focus group session which was limited to participants from their own settings. All participants were also offered the opportunity to meet with me for a 1:1 interview if they were not available to participate in their designated focus group or if they were uncomfortable sharing in a

group setting. In total three large focus groups were conducted (one with each team), one small group with two participants who could not attend the larger session with their group, and one 1:1 interview was conducted with an individual who was not able to attend their team's focus group session.

Focus group participants from each setting represented the full mix of healthcare disciplines employed with their teams. Hospice House had 8 individuals who participated: one health care aide (HCA), four RNs (two staff nurses, one Director of Clinical Care, and one Clinical Nurse Educator), one spiritual health practitioner (SHP), one physician, and one volunteer services coordinator. The Palliative Unit had 12 participants: four RNs (two staff nurses, one nurse manager, and one transition services nurse), three physicians, one SHP, one social worker, one pharmacist, one recreation therapist, and one registered dietician. The Consult Team had 8 participants: four physicians, and four RNs (three clinical nurse specialists and one palliative nurse instructor).

As a measure to ensure that rigour was maintained, a leader and an observer were present to conduct the focus groups. As the more experienced researcher, my supervisor led the focus groups while I maintained the observer role and recorded field notes. I conducted the 1:1 interview on my own. Informed, signed consent was obtained from all participants prior to conducting focus groups and interviews. All focus groups began with the same broad initial question "*Is interprofessional teamwork a necessary element for providing palliative care; or is it possible for a single health care provider to do an effective job?*". The remaining questions were formulated based on the data gathered during observations as well questions arising from the application of the CIHC

framework and team development theory (see focus group questions in Appendix C). All focus groups and interviews used the same guiding questions to get a further sense of the commonalities and differences between teams. The focus groups and interviews were audio recorded and the recordings were provided to a hired transcriptionist to be transcribed verbatim. I subsequently reviewed the transcripts while relistening to recorded interviews to confirm context and accuracy from language cues. The anonymity of participants was then further protected by the removal of all personal identifiers from the transcripts and the use of generic pseudonyms or participant labels.

All focus group and interview participants completed a short questionnaire (Appendix D) to provide demographic information to help me understand any potential relationships between personal history, work experience, professional role, and their responses to the focus group questions.

System Analysis

The data collected and analyzed in stages 1 – 3 were then linked to broader sociopolitical aspects and corresponded to Stages 4 and 5 moving between the emic and etic perspective (Carspecken, 1996). The goal of Stage 4 was to discover system relationships between the site groups and then in stage 5 to consider the findings more broadly in relation to literature of other research (discussion chapter).

Ethnographic data analysis is an inductive process that begins while still in the research field; material and information is categorised into themes and abstract concepts through the researcher's reflexive process (Roper & Shapira, 2000). The data generated during observations (fieldnotes) and focus groups underwent a first level of analysis where all transcripts were read individually to generate new meaningful constructions.

Firstly, fieldnotes that involved thick description made during observation were collated in a journal and were used to describe the cultural landscape (Chapter 4) and used as data to compare to focus groups and eventual thematic findings (Chapter 5). By reading each focus group transcript in its entirety, initial hunches were developed, and memos were written as they emerged. Additionally, constant comparative analysis, as initially described in grounded theory by Glaser and Strauss (1967), offered an iterative approach throughout data collection, coding, and analysis of findings congruent with Carspecken's (1996) discussion of analysis, whereby I actively compared and searched for commonalities and differences across teams. This inductive approach initially reduced data into categories or themes helping me to identify patterns for further interpretation in relation to the context I observed in observation. I became fully immersed in the data as I read and re-read individual transcripts while making notes of beginning ideas and thoughts in the margins and in my reflexive journal. Coding was used to label (assign) and more importantly, organize data extracts according to their key meaning to help with analysis. I organized these codes in a notebook divided into multiple sections that helped me to label and group similar data. Through the process of constant comparative analysis, codes were then reduced and organized using a colour-coded legend to organize the findings from all sources of data (transcripts, fieldnotes, and observations) in their respective domains. This organization of codes allowed the codes to tell a story about the data, thereby helping conceptualize relationships and initial reflections.

A second level of data analysis occurred where I transferred codes to a table and inputted quotes that offered rich insight. This approach encouraged findings to occur that identified recurrent patterns across groups that emerged and resulted in key themes (see

Appendix E). At this phase of analysis, the themes were compared to the CIHC framework and team development theory to help structure the presentation of findings. Finally, an attempt was made to interpret and provide discussion around the social and organizational factors impacting the roles, relationships, and power balances within the teams. My focused lens and previous practice knowledge about the different interprofessional team roles necessitated reflexivity throughout the research process.

Trustworthiness and Rigor

Carspecken's model "does not guarantee the findings of 'facts' that match absolutely what one may want to find" (Carspecken, 1996, p.6). Acknowledging biases and remaining open to other perspectives is an important part of focused ethnographic research. I agree with the notion that truth as we accept it is shaped by societal, political, and organizational factors that we are often unaware of. I was aware of the importance of continually examining my own assumptions while attempting to understand the emic perspective of the study participants. Reflexive journaling and discussions with my supervisor assisted me to gain insights into my own biases and truth claims during data analysis. This was particularly important given my previous experience with each of the teams on a personal/professional level and beliefs that I held regarding some of the individual team members' lack of collaboration in their day-to-day practice. Discussing observations of these individuals and how they worked within their teams helped me to see how organizational and environmental factors were potentially impacting the ways in which they were interacting with their colleagues. While personality and individual beliefs likely played some role, these behaviours were also influenced by external factors such as space allocation and team structure.

Procedures for member checks were incorporated throughout the research. These measures included consistency checks between observed actions and verbal statements by participants, consistency between verbal and non-verbal communication during focus groups/interviews, and member checks with participants to review data analysis and reconstruction. Member checks were conducted by engaging in informal discussion with the participants during the initial phases of data analysis to further validate and clarify the emic view and ensure my interpretations were consistent with their lived experiences. An example of this was a conversation I had with an RN on my second day of observations where she confirmed my observation of professional hierarchy and the perception of the physician as the ultimate authority from my previous day of observations with their team.

Rigor is essential for qualitative research and Carspecken (1996) adopted the validation criteria used by Lincoln et al. (1985) for assessing rigor and establishing trustworthiness (credibility, transferability, dependability, and confirmability). The detailed information about the context, background data and findings combined with purposeful sampling strategy enhanced the transferability of "context relevant findings" that can be applicable to broader contexts while remaining their content-specific richness (Bloomberg & Volpe, 2019). The use of thick descriptions and presenting discrepant findings within team members offered additional credibility of the work.

Member checking was also incorporated throughout the data collection and analysis to enhance study credibility and confirmability. As per stage 3 in Carspecken's approach (1996), researcher notes were clarified with the participants to fully explore their descriptions. When disagreements arose, these were noted for further analysis. Additionally, I participated in conversations with my supervisor to ensure accuracy of

data throughout the collection and analysis phase and to check my conclusions. Triangulation of several data sources (observation, fieldnotes, and focus groups) obtained from a variety of members of the interprofessional teams, as well as the perspectives of my supervisor and committee members offered transparency and safeguarded the trustworthiness of the study and strengthened the credibility, confirmability, and dependability of this focused ethnographic study.

Ethical Considerations

This study was given approval by the Conjoint Health Research Ethics Board (CHREB) and operational approval by the research administration team in Alberta Health Services. Informed consent was obtained from all participants prior to focus groups and interviews. Consent information was provided in writing and verbally reviewed. All participants were also informed that they could revoke consent and cease participation at any time.

While this study was conducted in a large urban centre, the palliative care service in the city is comprised of a relatively small group of professionals. As a result of working within the palliative care community for many years, I have personal and professional relationships with individuals on each of the involved teams. While this provided the opportunity for me to gain entry quite easily, it also presented some risk for perceived coercion to participate. In the effort to minimize this risk, I emphasized during recruitment that there would be no consequences for refusing to take part and also no personal benefit or favour that would be gained for those who did choose to participate. Efforts were also made to eliminate any confusion between my role as an employee within the palliative care community, and my role as a graduate student conducting

research with the University. To ensure differentiation between my role as an employee and a researcher, I provided each team with advance written notification of the times that I would be present at their work sites as an observer. This notification was posted in areas where all team members could see it for two weeks prior to observations. I also emphasized to the team members at all three sites that data collection would only occur during times that I had scheduled in advance for research purposes and would never occur during times when I was present as an employee.

All data generated including field notes, focus group and interview transcripts, and questionnaire responses have remained confidential. Participants were identified by pseudonyms in the writing of this thesis.

Individual interviews were offered to all participants in addition to focus group participation. This provided participants with an alternative option if they were not able to attend on the date of the focus group and provided the opportunity to speak in a setting that would allow for confidentiality and anonymity if they were not comfortable in a group setting.

Justification of Methodological Approach

As previously stated, the goal of a focused ethnographic study is to create awareness and knowledge of a particular groups' culture. Any implications for practice will ultimately need to be adopted from within the cultural group experiencing the problem as they become aware of the factors limiting collaborative practice and look for way to create change (Freemen & Vasconcelos, 2010). This reinforces the importance of studying the theory practice gap from the viewpoint of those affected by the phenomena, while simultaneously maintaining an etic perspective to attempt to identify influential

elements that may or may not have been readily apparent to the participating healthcare professionals. This was an excellent methodology for me to be able to explore the culture, beliefs, and the contextual challenges experienced by the teams involved in this study.

Summary

Ethnography is a research methodology concerned with understanding the behaviours, beliefs, and functional patterns of cultural groups. Focused ethnography applies the fundamental characteristics of ethnography while exploring the knowledge of a focused cultural group. By employing a focused lens of the culture in a larger system, in the analysis of the findings I was better able to explore elements that influence interprofessional collaboration in palliative care teams. The aim of a focused ethnographic study is to generate data that will create understanding and a potential to mitigate challenges in the culture; this is congruent with the aim of this research, which was to better understand cultural impacts on interprofessional collaboration in palliative care settings where challenges to collaborative practice exist.

Chapter Four: The Cultural Landscape of The Teams and Their Environments

Introduction

The purpose of this chapter is to describe the cultural landscape of the three teams that participated in the study – *Hospice House*, *Palliative Unit*, and *Consult Team*. Descriptions of the teams and their environments are provided based on the data generated through direct observations and artifacts such as job descriptions, communication guidelines, and mission statements collected from each site. As stated by Bloomberg & Volpe, "discussion of the setting serves to situate your study within a context" (2012, p.150). While all three of the observed teams had some commonalities in addition to their shared mandate of providing palliative care to adult inpatients, each team also had its own unique culture resulting from their individual purpose, vision, physical environment, and social structure. This chapter will provide the background to help the reader understand how the culture of each of the participating palliative care teams was driven by their practice setting.

While I have attempted to provide a rich and accurate portrayal of the teams as I encountered them, it is important to note that teams are ever changing as people leave and new members are introduced. For example, each of the teams that participated in this study have had changes in their formal leadership since the time of observations. The descriptions provided below are therefore derived from the data that I collected at the time of observations. While I was an "insider" as a frequent collaborator with each of the teams within my regular work, I attempted to interpret the data through an etic lens as an "outsider" during observations at each of the settings. Discussion of the teams' culture in

relation to interprofessional collaboration and further incorporation of the emic perspectives of the various team members will be presented in chapter five.

Mandates, Missions, and Visions

Hospice House

Hospice House was a seven-bed residential hospice which provided inpatient end of life care for adult cancer patients in their final days to short months of life. Hospice House was owned and operated by a local not-for-profit organization and was one of seven hospices in the area contracted by the provincial health authority. Referrals for admission were made by members of the palliative consult service, tertiary palliative care unit, or palliative home care program. Admissions to Hospice House were coordinated through a central access program which managed the admissions to all seven of the local hospices.

The mission, vision, and values for Hospice House were posted in multiple locations around the premises. The mission of the organization was “to help families and individuals achieve support, hope, and well-being through compassionate end-of-life and bereavement care” (Mission Statement, 2022). The organization’s vision was “to be an innovative leader for compassionate, holistic, family-centred end-of-life and bereavement care”. The core values identified by the organization were “compassion, dignity, empathy, equality, ethical practice, family-centred care, high quality service, inclusiveness, integrity, and respectfulness”.

Palliative Unit

Palliative Unit was an inpatient acute care unit with the mandate to assess and manage complex palliative symptom issues for adult patients with the goal to discharge

to an appropriate care setting when resolved. Criteria for admission to the Palliative Unit included severe symptom control issues such as pain, dyspnea, delirium, or nausea arising in a palliative context that were unable to be managed at the patient's current site of care; procedural/technical requirements such as epidural or intrathecal analgesia or inpatient methadone rotation for difficult pain; and/or palliative symptom control issues combined with complex family or psychosocial and spiritual issues requiring multifaceted team involvement.

The Palliative Unit did not have their own specific mission and vision statements, rather they followed the direction set out by the provincial health authority whose mission was "to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans" (Alberta Health Services, 2022). Their vision was "Healthy Albertans. Healthy Communities. Together." (Alberta Health Services, 2022). The five core organizational values of the provincial health authority were compassion, accountability, respect, excellence, and safety (Alberta Health Services, 2022). The mission, vision, and core value statements were not visibly posted anywhere on the Palliative Unit; however, they were clearly identified on the health authority's webpage and all staff were required to review them as part of their orientation and annual education.

Consult Team

The Consult Team provided support for adult patients, families, and healthcare teams on a variety of units throughout a large acute care facility with the goal of assisting the attending teams to manage the palliative symptoms related to the patients' life-threatening disease. This included assessment and management of patients' physical

symptoms such as pain, delirium, nausea, anxiety, and dyspnea; assessment and management of emotional and spiritual distress; education for patients and families regarding expected disease progression and care needed at the end of life; suggestions for receiving the best possible end-of-life care and support for families faced with the loss of a loved one; help with advance care planning conversations; and help with exploring care options for receiving palliative care services including moving to different care settings such as a hospice. Unlike Hospice House and the Palliative Unit overall care for the patient, medical responsibility, and decision making were not managed by the Consult Team but instead continued to be managed by the attending medical team on the units throughout the hospital where patients were admitted.

The Consult Team's vision and mission were not posted in their work areas; however, they was stored electronically on the shared computer drive that all team members had access to. The formal leaders of the team were easily able to provide me with this document and spoke to the fact that the vision and mission were developed specifically for their program in addition to the vision, mission, and values of the provincial health authority (as described for the Palliative Unit) which also applied to them. The mission of the Consult Team was "to provide sustainable, quality advance care planning, palliative and hospice care, and grief support to adults across the service area through interprofessional collaborative practice, education, and research". Their vision was for "all adults in the service area to have access to excellent sustainable integrated advance care planning, palliative and hospice care, and bereavement support".

Physical Environment and Atmosphere

Hospice House

Hospice House was a large three-story house that was renovated to be used as a healthcare facility yet still maintained a welcoming, homelike, non-institutional feel. Located in the heart of an affluent residential neighbourhood, Hospice House appeared from the outside to look like many of the nearby homes. The environmental atmosphere of Hospice House was home-like, inviting, comforting, and the team showed obvious pride in their environment as they provided the researcher with a tour of their facility. In keeping with the homelike atmosphere, the team typically referred to it as "the house" rather than "the hospice".

When entering the building through the front door, I walked through a beautifully landscaped yard with big trees, flower gardens, and planter boxes with giant tulips in full bloom. Upon entering the house, I found myself in a grand foyer dominated by a spiral staircase and a tastefully decorated reception desk manned by a friendly volunteer who greeted me with a smile and politely asked me to sign the visitor logbook. The smells of bacon and homemade soup wafted down the hall from the kitchen.

The house was decorated throughout with beautiful artwork and comfortable furniture. There were several rooms near the reception area including the Volunteer Services Manager's office, the House Manager's office, a small meeting room, a large meeting room/storage area, a laundry/housekeeping room, and a small room with storage lockers for use by the physicians and volunteers. Down the hall was a dining room which was dominated by large family style dining table with 12 chairs around it, a breakfast bar, and a wall-to-wall window overlooking the beautiful front yard. The dining room was not

typically used for patients to eat meals as the patients at Hospice House were in advanced stages of their illness and often bedbound. Instead, this room was used for meetings such as weekly interprofessional team rounds and staff education activities. The remainder of the first floor included the large kitchen where all patient meals were prepared on site, public bathrooms, a large storage room, maintenance rooms, and a staircase leading up to the second floor.

The house was built into a hill as a front walk out whereby the back-entrance entered on the second floor. When coming in through the back door I found a large foyer with comfortable benches to sit on and an elevator that led up to the patient care area on the third floor. The second floor was home to offices for the Spiritual Health Practitioner (SHP), Director of Clinical Care (DCC), Clinical Nurse Educator (CNE), Medical Director, and Administrative Assistant. There was also a spare office which was frequently accessed by the Executive Director (ED), Operations Director, and Attending physicians. All of the offices were within a few steps of one another. There were other staff areas on the second floor including a private staff room with a couch, chair, coffee table, and a window that looked out into the back yard that staff/physicians/volunteers could access as a quiet space to use for their breaks.

There were several common spaces on the second floor that were available for patients, families, and staff to use including multiple comfortable living room spaces, a chapel, the memory lamp area, and a guest room. Although Hospice House was not affiliated with any specified religious organization, the chapel was a beautiful room with dramatic floor-to-ceiling stained-glass windows that invited spiritual reflection and provided a peaceful space for patients, families, and members of the care team to quietly

sit and reflect in whatever way was individually meaningful to them. The living room spaces were large, comfortable rooms with overstuffed couches and chairs. One room had a fireplace, piano, dining table, fridge, microwave, toaster, kettle, and sink that created a welcoming environment for patients/families, including the healthcare team to use for breaks, with staff reporting that sometimes patients or visiting families would have their meals alongside the staff in this room. The memory lamp area housed many of the items that were used in rituals practiced by the Hospice House team at the time of patient death. These rituals included a tiffany style lamp that was lit and remained on for 24 hours after a patient death, and a "dignity quilt" that had been sewn by a group of staff members and volunteers and was placed outside of patients' rooms when a death occurred and then covered the patient's body when they were taken down the elevator and out of the hospice to the awaiting funeral home vehicle. In the middle of the second floor was the spiral staircase that led down to the reception area on the first floor, or up to the nursing station and patient care area on the third floor.

The third floor of the house was the patient care area containing seven private rooms. The nursing station was located midway down the hallway between the first three and last four patient rooms. The nursing station was closed off from the hallway with a large sliding glass door which allowed for the care team to be able to have private conversations while still being visible to patients/families passing by and enabling staff to see what was happening in the hall. Although it was only a small space, the nursing station was the hub of the action for the care team. All team members who were present during observations began their day in the nursing station and returned there between tasks. It was this area that was used for charting upon a long counter with three rolling

chairs pulled up to it. In the middle of the counter was a telephone for staff use, above the counter was a row of cupboards full of binders and reference materials, and on the far end was a lone computer. The phone was frequently in use as the nursing staff made and received phone calls with families and other members of the healthcare team; the computer was not used at all during my observations and did not even have the power turned on. When I asked the team what the computer was for the response was that it was there in case any of the staff needed to look up resources such as policies and procedures on the organizational shared drive or research anything on the internet, however throughout my observations all members of the team consistently used the binders and paper copies of resources rather than utilizing the computer.

Behind the charting counter was another row of cupboards which held the patient charts, a printer/fax machine, and rows of drawers holding office equipment and supplies. Behind the wall with the charts was a small medication room that was locked and could only be accessed by the RNs. Beside the counter with the charts there was a fourth chair that was unofficially reserved for the volunteers to sit in. Although there was only seating for four in the nursing station there were occasionally more people in the area – with the seats usually being provided to the nursing staff and volunteers with others finding space where they could. For example, during shift handover in the morning the on-coming and out-going RNs sat in chairs beside each other and shared a binder with patient information. The oncoming HCA sat to the side of the RN with their own binder. The DCC stood behind the RNs by the charts leaving the fourth chair available for the volunteer.

Palliative Unit

The Palliative Unit was located on the 4th floor of a large acute care facility and the environment was like that of most busy acute care medical units. There were some unique welcoming touches designed to provide comfort to the patients and their families and help to soften the clinical atmosphere such as a chalkboard in one of the hallways covered with poetry and messages of hope written in colourful chalk, a beautiful silver bowl full of wrapped candy for people to help themselves to, and a shelf with a bowl full of rocks painted with inspirational messages. At the far end of the unit was a large sunroom with multiple comfortable chairs and coffee tables, floor to ceiling windows with a beautiful view of a river, a piano, and a bread machine that filled the unit with the welcoming smell of fresh baked bread once a week. However, despite the efforts to create a gentler environment, the overall impression of the unit remained sterile and clinical. Computers dominated the shared charting areas and hallways, reflecting the technology driven atmosphere of the unit. Although it appeared to be a comfortable space for the team to work it did not have the homelike feeling or "pride of ownership" that was observed at Hospice House.

Entry to the unit was through fire doors from a concrete staircase or by coming up on one of the large, frequently crowded elevators that also serviced the other floors of the hospital. The reception area of the unit was dominated by charting areas and the nursing station where the unit clerk and charge nurse sat beside each other – each had their own phone and their own computers that they were logged into and appeared to be actively working on every time I came onto the unit. Nobody looked up when I came onto the unit, but they did smile and greet me warmly when I went up to the desk and said hello.

The reception desk extended in a horseshoe shape in front of the unit clerk and charge nurse's spots with an extra chair, computer station, and phone available for any staff members to sit down and use. A white board with the names of all the on-call physicians was posted on the wall next to the charge nurse and a bulletin board with names and numbers of physicians and other key contacts were posted next to the unit clerk. There was a large printer behind the reception desk and another computer on top of the desk with a high stool and telephone that served as an extra workstation for any staff who came onto the unit who needed to use it. During my observations this workstation was always turned on and in use, reinforcing the busy and technologically driven clinical atmosphere. Sometimes it was used by the Palliative Unit nurses and physicians but more often it was used by other staff members who worked elsewhere in the hospital but who were not necessarily part of the Palliative Unit team such as porters, lab technicians, and other physicians/consultants who were passing by. There was a feeling of "busyness" with many people coming and going on the unit but not necessarily communicating with each other or being there for a common goal. A large room adjacent to the reception desk housed the medication preparation area, controlled substance cupboard, and four clean supply carts. While the room was technically open to all staff it was mainly accessed by the unit RNs when preparing medications and retrieving supplies, and by non-unit specific staff who came to restock the supply carts.

Across from the reception desk was the charting area which was a large open area filled with eight computers in two long rows along counters and a large rolling rack which held the patients' charts. Staff used this space when charting in the paper charts and in the electronic medical record (EMR). This was also the area where shift

handover/shift report took place as the out-going RNs typed their report into the EMR and then the on-coming RNs read their report on the computers.

Behind the nursing station there was a short hallway leading to four offices and a large conference room. The first office was the "allied health office" with three dedicated workspaces that each had a computer and phone but no privacy. This space was shared by the Medical Director, the pharmacist, and the recreation therapist. The unit manager (nursing manager) used the second office which was a large private space with a desk, computer, phone, and round table with chairs for meetings. There was also a second desk with a computer and phone that her supervisor would use when she was working on the unit as she split her time between the Palliative Unit and another nursing unit in the same hospital. The third office was another large space and was used by the CNE – like the other team members, they had a desk with a computer and phone but also had a second table that could be used for meetings and/or a teaching space. The CNE shared their office with the unit admin support clerk who had their own small workstation in the corner of the room. The fourth office, the "physicians' office", was a small room with a wrap-around table set up with four workstations each with their own computer and one shared phone line – this office was shared by the attending physicians on the Palliative Unit (other than the Medical Director) and any medical students/residents who were working on the unit. The remaining team members such as the social worker (SW), registered dietician (RD), transition services nurse, physiotherapist (PT), occupational therapist (OT), and SHP did not have offices or dedicated workspaces on the unit.

The nursing station seemed to be an important physical space on the Palliative Unit but was not the same hub of activity as was seen at Hospice House. Instead of there being

one key spot where all team members would gather, the nursing station, charting area, physicians' office, and allied health office all appeared to be important areas of ongoing team activity with people coming and going from each of the spaces. The area most likely to be identified as a "hub" on the Palliative Unit appeared to be the charting area as there were typically several different team members using that space at any given time. Some of them would speak/interact with each other, while others worked independently on their computers sitting near one another but not necessarily interacting with each other. There was also a sense that there was no dedicated ownership of space in the charting area, whereby when one person finished on a computer and left to provide patient care/attend to another task they would log off the computer leaving the space free to be used by any of the other healthcare providers on the unit. While this was a highly functional area that created space for a large number of people to be able to find a space to work at any given time, the lack of individually dedicated workspaces also created an atmosphere of a transient space that was used by all but belonged to none.

Further down the hall, past the offices, was a large conference room dominated by a rectangular table with fourteen chairs around it. One end of the room had a screen and projector for video conferencing with families and other healthcare providers, while the other end of the room had a ledge and a large window that overlooked the hospital grounds with distant views of a river. This room was used for the team's large interprofessional team rounds on Thursday mornings, a variety of nursing and medical educational activities, and miscellaneous meetings.

Across from the nursing station was a second conference room with glass doors and a frosted glass wall. This room held another large rectangular conference table with 12

chairs around it. This space was used for rounds with the nurses and physicians on all days except Thursdays (when the larger team rounds occurred), shift report between the charge nurses, education, and sometimes for staff breaks. In addition to the conference table, there was a small workstation with a telephone and a computer for staff to use. Bulletin boards were posted inside the conference room with education updates and information for the nursing staff.

Mounted on the wall outside of the conference room, readily visible to all staff and public, was a very large white board with "care hubs" written on it. All patients on the unit were assigned by room/bed number to one of three care hubs with two RNs and one HCA per hub. The first names of the RNs and HCAs in each care hub were written on the white board so that all staff and visitors entering the unit were easily able to identify the nursing team assigned to each room.

The patient rooms were located down 3 wings/hallways that stretched out from the nursing station in a spoke-like manor. The hallways were tidy and clinical with a spattering of medical equipment such as mobile carts for taking vital signs and computers on wheels with attached medication carts that the nurses would take into the patient rooms when recording assessments and giving medications. There were also wall mounted computers located midway down each hallway – these computers were for staff to access the EMR and were not accessible to patients/visitors.

The first hallway had a clean storage room for medical supplies and equipment. Next to the storage room was a kitchen which was reserved for patient use. In an attempt to create a more welcoming atmosphere for patients and families, the patients' kitchen was better equipped than those typically found on most other units in the same hospital as it

had a full-size fridge, oven with stove top, microwave, and toaster. Once a week a volunteer would use the oven to bake cookies and then deliver the fresh cookies to patients, visitors, and staff. Two of the hallways also had private "family rooms" each with a comfortable couch, two chairs, and a coffee table. These spaces were available for patients and families to access for family meetings or to use as a quiet space to have some privacy.

Aside from the offices described above, there were no designated staff rooms or spaces for the healthcare professionals to take breaks as a team on the Palliative Unit. This appeared to limit the potential for team members from the various disciplinary backgrounds to spend time informally interacting and building community during their breaks. While many of the physician and allied health team members went to the staff cafeteria together, most of the nurses chose to spend their breaks in a staff room that was off the unit but still close enough that they could quickly return to the patient care area if they were needed,

Consult Team

The Consult Team worked in a much more complex and dynamic environment than Hospice House or the Palliative Unit. Unlike Hospice House or the Palliative Unit, there was no identifiable central hub where all members of the team would gather or where most of their activities would occur, except for team rounds which occurred in one of the conference rooms on the Palliative Unit. Clinically, the team was dispersed throughout a large acute care hospital on many different medical and surgical units, intensive care units, and emergency department. Their designated office spaces were in two separate suites in a smaller auxiliary building adjacent to the hospital that had

historically been used as a nurses' residence which had been retrofitted, in a somewhat misshaped manner, into offices. It was approximately a five-to-ten-minute walk to get from the Consult Team's office spaces to the main hospital where the patient visits/consults were conducted, making the opportunity to congregate back in the team's office space during breaks throughout the day inconvenient. Some of the physician members of the team frequently made use of a physicians' lounge located within a private space of the main hospital – this space was geographically much closer to the units where their clinical work was conducted and therefore easier to access throughout the day, however it was not accessible to the non-physician professionals on the team. Separate areas created a feel of separation within the team, almost as if they were nomads without a true home roaming from unit to unit for their patient interactions, borrowing space on the Palliative Unit for team rounds, and team members using different spaces in different buildings to start and end their days.

The Consult Team manager, Medical Director, and six secretaries/administrative support staff had offices located in one suite of the building behind the main hospital. When entering the office there was an open reception area where three of the secretaries sat at their own desks, each with their own computer and phone and personal items decorating their workspaces. To the right of the reception area was a small office with a big window and two desks that were shared by the Medical Director for the program and another physician who oversaw the medical teaching/residency activities for the team. Next to the Medical Director's office was a larger office with two big desks and a six-drawer filing cabinet, this space was shared by two administrative assistants.

The nurse and physician consultants had a designated shared office space located in the suite directly adjacent to the managers and administrative support team. The main part of their suite was furnished with eight workstations housing individual computers. Three workstations faced a large window that spanned the entire wall and overlooked a grassy space with views of a river – these spots were used by three of the nurses. The remaining five workstations faced the walls, three of these spaces were used by the one remaining nurse and two of the physicians, the other two spaces were drop-down workstations used by casual/relief staff and students. Three of the four nurses had personal items such as photos set out at their workstations, with the remaining nurse and the two physicians not personalizing their desk in any way.

The office space also had a small kitchen area with a fridge, microwave, toaster, and coffee maker. A round table with chairs was between the kitchenette and the desk area, however I did not observe any staff members using that space for meals or breaks. Instead, they each sat at their desks and ate in front of their computers, sometimes continuing to work while they ate while at the same time chatting and visiting with their colleagues. There was also a small room adjacent to the main office area furnished with modular furniture organized to make two couches, two chairs, two small coffee tables with large white pads on them to allow for note taking, a few folding chairs, a telephone, and a wall mounted TV with a laptop connected. This room was typically used for in-person team rounds on Monday mornings and various committee meetings.

The remaining Consult Team physicians did not routinely use the workstations in the designated office space and instead started and ended their days in the physicians' lounge located in the main hospital building. The physicians' lounge was located down a

main hallway and accessed through an unmarked door that required a swipe card which was only provided to medical staff. The nurses were permitted to be in the lounge if they were accompanied by a physician, however they could not enter the space on their own. Once inside, the lounge was reminiscent of a café with several modular couches and chairs and approximately a dozen round tables with chairs around them. Most tables were occupied by small groups or individual physicians either having meetings or sitting by themselves having coffee. There was a small coffee shop that sold hot and cold beverages as well as light snacks such as toast and muffins. The lounge also had two computer stations that were available for the physicians to use as needed, a locker area, and two private rooms that could be reserved to be used as workspaces.

The nurses and physicians spent very little time in their office areas as most of their time was spent travelling from unit-to-unit consulting on patients throughout the hospital. They also routinely used the conference room on the Palliative Unit once per week for team rounds and the physicians from the Consult Team frequently dropped into the Palliative Unit to use the computers in the charting area to work when they were not on other units doing consults as it was more convenient than trundling back to the consult offices and allowed them to intermingle with their palliative physician colleagues on the unit. In terms of the remaining members of the consult team, the nurses and one of the physicians would usually return to their designated office space for lunch, with the remaining two physicians eating on their own in the cafeteria or elsewhere.

Team Structure

Each team was made up of a different combination of professional disciplines which are described in greater detail below. An important part of observations was

determining who the core professionals were on each team and how they went about their work including observing their roles on the teams, when they worked, and the geographical proximity in which their work occurred in relation to one another. This data was collected via both participant observation and by inquiring with members of the care team directly in focus groups.

Hospice House

When study participants were asked directly who the members of the care team were, the consistent answer was that everybody who worked and volunteered in the house contributed in some way to patient care and was therefore a critical member of the team. During the time of my field observations, I observed a total of 53 staff and physicians in regular full time, part time, or casual employment at Hospice House: with typically anywhere from 2 to 12 team members in the house at a time. In total, the team was comprised of 11 casual, and 6 part time RNs; 6 casual, 6 part time, and 1 full time HCAs; 1 part time SHP; a full time DCC who was also an RN; a part time CNE who was also an RN; a full time administrative assistant who was also an HCA; a Medical Director who also worked with the group of four regular attending physicians; 2 locum physicians; a full time House Manager; a full time Volunteer Services Manager; 2 casual, 2 part time, and 1 full time housekeepers; 2 casual, 2 part time, and 1 full time cook; and a part time maintenance man. Additional team members included a palliative physician consultant and a pharmacist who both worked off site but attended rounds. The Executive Director and the Director of Operations had offices located at another location but used the shared office space at Hospice House to work approximately once per week. While everyone that I met during observations and focus groups at Hospice House identified their team as

consisting of those listed above, for the purpose of this study, observations were limited to the RNs, HCAs, SHP, physicians (including Medical Director and palliative consultant), DCC, CNE, pharmacist, and the Volunteer Services Manager as they were the members who provided direct clinical care and/or participated in their weekly interprofessional team rounds.

There were also many on-site volunteers at Hospice House that the staff identified as being part of the interprofessional team but were not included in the total team numbers. While the role of the volunteers in the interprofessional team is invaluable, the purpose of this study was to focus on the collaboration between members of the paid staff and physicians comprising the team, and volunteers were therefore excluded from this study.

Palliative Unit

The Palliative Unit identified themselves as having 95 team members which was by far the largest of the teams observed. When asked who made up their team, formal leaders stated that the team was comprised of 23 casual, 25 part time, and 13 full time RNs; 11 casual, 7 part time, and 8 full time HCAs; 1 casual, 3 part time, and 1 full time unit clerks; 1 full time admin assistant; 12 part time physicians (including the Medical Director); 1 full time SW; 1 part time RD; 1 part time psychologist; 1 full time OT; 1 full time PT; 2 part time pharmacists; 1 part time recreational therapist; 1 full time transition services RN; 2 full time Nursing Managers who were also RNs; 1 part time CNE who was also an RN; and 1 part time SHP. During my observations, the Palliative Unit staff and physicians did not identify individuals such as housekeeping, maintenance, dietary/kitchen staff, and volunteers as part of their team.

Consult Team

Like the complexity of their physical environment, the Consult Team also had the most complex social structure of the three participating teams. Not only did they interact within their own team, but as consultants, they also individually interacted and inserted themselves into the attending teams that they were providing consultative support to on various hospital units.

The nurses and physicians on the Consult Team identified themselves as a team of 16 which was made up of 7 nurse consultants and 9 physician consultants. Of these individuals, 4 physicians and 4 nurses were regular members of the team in either permanent full time or part time positions while the remaining 8 were casual/relief staff. Some of the nurses were masters prepared clinical nurse specialists (CNSs), the others were non-masters prepared nurse consultants (palliative nurse instructors). Many team members of the Consult Team also referred to a SHP who was not officially employed by or assigned to their team but was a valued informal collaborator and somebody who frequently joined their weekly team rounds and occasionally provided spiritual support to consult patients.

While the nurse and physician consultants did not readily identify management, formal leaders, or admin support as members of their team, the Consult Team did have a Nursing Manager who was an OT, a Medical Director, and multiple secretaries/admin support staff. The Consult Team managers were not present during any of the clinical observations or focus groups conducted with this team. Members of the formal leadership and management team were however very responsive and supportive to emails from the researcher with requests for artifacts and team documents.

Communication

Each team had mechanisms for both formal and informal communication between the various team members. Some communication mechanisms differed between teams and some, such as weekly interprofessional team rounds, were consistent across locations. It appeared that some communication methods enhanced the teams' abilities to work collaboratively while other communication methods seemed to impede collaborative practice.

Hospice House

During my observations at Hospice House, communication took place on a regular basis through both formal and informal processes. Formal communication took place throughout the day at designated times and places including shift report between the on-coming and out-going RNs and HCAs, written communication and documentation of assessments in the patients' charts, phone calls from the RNs to the physicians to provide clinical updates and receive medical orders when the physicians were on call but not physically on site, faxes to the pharmacist with medication orders and faxes received by the nurses from the pharmacist with medication administration records that the pharmacy generated for them, weekly interprofessional team rounds, and weekly email updates to the clinical team from the DCC. Informal communication happened throughout the day as team members from all disciplines actively worked together to provide hands on patient care, talked to each other about work-related topics as well as sharing about their personal lives while working together in the nursing station and while taking breaks together in the living room space on the second floor.

Computers were not used in the clinical area as Hospice House did not have an EMR, instead team members documented the clinical care of patients through written communication in the paper chart for every patient. This meant that team members would have to wait for one-another if needing to access a chart that somebody else was using. It also meant that all team members could easily see what one another was writing about each patient which often led to impromptu verbal conversations based on what they were writing/reading in the chart. In my observations, the paper chart functioned as the written record of what was already discussed informally between the RNs, HCAs, and physicians. Individual patient care plans were created for each patient and kept in a binder at the nursing station. The care plans were written documents that were created by the HCAs, RNs, and DCC based on their assessments and conversations with the patients, families, and other members of the interprofessional team. Care plans were accessible to all members of the clinical team and were reviewed daily by the nursing staff and updated by the DCC weekly at the interprofessional team rounds. Any significant changes to a patient's care plan were flagged by the DCC for verbal discussion among the team at weekly rounds.

A verbal handover was provided by the RN at each shift change to report on the condition of each of the seven patients to the on-coming team members. Since some of the nursing staff had staggered start times, verbal report occurred four times per day when the RNs and HCAs changed shifts at 0730, 0830, 1500, and 1930 and was also repeated as needed throughout the day when other team members came to the nursing station and required an update regarding any of the patients/families. During observations, report was provided to the RNs, HCAs, DCC, SHP, and sometimes to the

physicians (either in person or by phone). Verbal report was guided by notes written by the RNs in the shift report binder which was a three-ring binder divided into sections for each of the seven patients. The RNs followed a template to write down pertinent updates/changes/important information from their twelve-hour shift and then used that information to guide their verbal shift report. The information was kept in the binder for the entirety of the patients stay and was readily available for any team member to access to refer to the current or historical shift updates.

While the physicians were only required to be physically on-site at Hospice House three days per week, they remained on-call 24 hours/day and were readily accessible to the rest of the interprofessional team if clinical support was required for their assigned patients. During observations, phone calls from the RNs to the physicians occurred regularly throughout the day. Sometimes the phone calls were to request orders, other times the RNs would call just to "keep the physician in the loop" by providing information and updates regarding pertinent changes with the patients/families.

On my first day of observations the night RN was giving report to the day RN and telling her about a patient who had been significantly declining overnight and who appeared to be within hours of death. The patient's family was very attentive to her changing condition and concerned about the noisy respirations that they were hearing ("death rattle"/rhonchi which is quite commonly experienced near end of life). The family wanted medications to be given for what they were perceiving to be a distressing symptom. The night RN was a young nurse who, according to the DCC, was "saying all of the right things to the family" regarding their concerns and the best management for the patient, however the family remained very distressed. While the on-coming staff all

reassured the night RN that she had done and said everything right, they also gave her the advice that she should call the physician whenever situations arise where a family is distressed. While the RN continued to provide verbal report to the other RN and HCA, the DCC sent a text message to the attending physician to advise her of the distressed family. The physician called within minutes and spoke directly to the day RN who then gave the phone to the night RN. The night RN gave the physician a verbal report of the night and received orders from the physician for a new medication to trial to help decrease the patient's rhonchi. The physician also said that she would come by the house later to see the family. While the RN was expressing feelings of distress because she could not help the family to feel reassured on her own overnight, the message that the team gave to the young night RN is that "you are never alone, and you can always call on your team for help", which served as a poignant example of the communication style and team approach that I witnessed while conducting participant observation at Hospice House.

Weekly interprofessional team rounds were another key mode of communication that I observed amongst the entire team. Rounds took place in the dining room and were attended by the RN on duty, the DCC, the Medical Director, all attending physicians, the volunteer services manager, the pharmacist, the palliative physician consultant, the SHP, and the CNE. When I asked why the HCAs did not attend rounds the DCC explained that while they would like to have the HCAs present, they were needed on the patient care floor to ensure somebody was readily available to respond to the patients while the other team members were in rounds. There was also a second RN working who did not attend

rounds so that they could also remain close at hand in the patient care area to provide any needed clinical care along with the HCA.

All team members who attended rounds sat around the dining room table that was set with fresh fruit, baking, fresh coffee, and tea. Rounds began with the DCC calling the room to order by chiming a singing bowl which everybody responded to by quickly quieting themselves and coming to attention around the table. During my first day of observing rounds the DCC asked if the team could do a round of introductions and invited me to go first. After the introductions were complete the RN began by introducing the first patient. Each patient was discussed in turn with the RN starting the discussion by sharing an update and recent clinical assessment scores, followed by physician input, and information interjected by the other team members. Despite the heavy topics that were being discussed, such as reflections of patients who were "working through the fear of dying", there was a pervasive feeling of levity and laughter among the team. Dialogue appeared to flow easily between the team members whereby they seemed to read each other well and anticipate each other's needs without having to use words.

The team used the time during rounds to ask questions and talk about their concerns and support each other. Rounds also provided a safe place for the various professionals to express their own vulnerabilities and uncertainties without fear of judgement from other members of the team. One example of this occurred when one of the attending physicians asked the palliative consultant a question about a physical change (skin rash) that one of her patients was experiencing that the physician was having difficulty managing, to which the palliative consultant responded that she was also uncertain as to what to do. The rash was not causing the patient physical discomfort,

but it was causing distress for the patient and family to look at and the physician was feeling helpless due to her inability to resolve it but the discussion at rounds let her know she was not alone in her feeling of helplessness. Another example occurred when the discussion focussed on a patient whose family was struggling with their grief and overwhelming sadness, which in turn was creating a lot of distress for the patient who was feeling overwhelmed by their family members emotions. The various team members shared how they did not know how to best support the patient's family who really wanted to be present with the patient 24 hours/day, while also trying to protect the patient's needs and help them to feel less overwhelmed. In response to the discussion around this case, the SHP stated, "I just feel so powerless" and other members of the team showed their agreement by nodding their heads. The physician responded by acknowledging the distress that the team was expressing and validating that it was an emotionally hard situation by saying, "this is very difficult and lots of teamwork (has been) required on this one, so thank you for that". There was no rush to anybody's sharing. Everybody was given time to speak, they appeared to be heard and respected for the information they shared as well as for the vulnerabilities and uncertainties that they acknowledged. After the seventh patient was finished being discussed the DCC chimed the singing bowl again to signal an end of the formal discussion.

Palliative Unit

As was observed at Hospice House, examples of formal and informal communication between team members were observed throughout the day at the Palliative Unit. There were designated times and modes for formal communication including nursing shift report, verbal handover between the nurse clinician and the

oncoming charge nurse, care hub huddles, and daily interprofessional team rounds. Formal communication was observed as a combination between verbal communication and written communication via chart documentation and entries typed into the EMR.

Clinical communication in patient charts happened in two separate ways. The RNs, HCAs, and allied health professionals such as the RD, SHP, pharmacist, and SW documented by typing all assessments, recommendations, and progress notes into the EMR. The physicians accessed the EMR to enter medical orders but documented their assessments and progress notes in the paper chart. While all team members were expected to review the daily charting and progress notes from the other disciplines in both the EMR and paper chart this did not appear to happen routinely unless somebody had specific information that they were looking for.

Shift report was conducted three times a day when the nursing shifts changed. Report was typed into a basic template in the EMR by the out-going RN and then the on-coming RN would read the information in the EMR, check the white board with the care hubs written on it to see who they were working with, and then ask the out-going RN any questions that were not fully covered in the handover that they had read in the EMR. This was a relatively new practice from the previous routine of the RNs giving each other a verbal shift report. When I asked one of the RNs what they thought of the new process they responded that it was now “more work for us” as it required typing information into the computer, reading it, and then still usually having some verbal handover to clarify outstanding questions.

Shift handover between the nurse clinician and the oncoming charge nurse occurred mostly in the form of a verbal report in the front conference room. During an

observation of this handover, the unit clerk joined the two RNs for the report with the three of them sitting close to each other around the conference table. The two RNs (nurse clinician and on-coming charge nurse) appeared to be engaged in conversation regarding updates and relaying the needs for each of the patients on the unit. The unit clerk lapsed in and out of the conversation, frequently looking around the room and appearing to lose interest in the conversation while the RNs spoke to each other.

Informal communication between team members was observed at times and seemed most likely to occur when individuals found themselves sitting in close proximity to each other in the charting area, or when they had a clinical question regarding a shared patient. An example of this occurred when the RD was working in the charting area where one of the RNs and physicians were discussing the potential for needing to start one of the patients on total parenteral nutrition (TPN). The RD was able to interject regarding some of the requirements and clinical considerations of starting TPN, while the nurse brought forward implications for the patient's long-term goals and plan of going home with limited supports, and the physician was able to share his perspective on the overall medical management. At other times, opportunities for verbal communication between team members did not appear to happen as organically and needed to be more intentionally sought out. During an observation of shift change, one of the RNs had a question about the plan of care for a patient he was taking over. In order to find the information he needed he first had to track down the out-going RN who had entered the typed shift report to ask if the physician had provided any guidance around the matter – the out-going RN responded that she did not know the answer as she had not seen the physician at all during her shift. The oncoming RN then had to walk over to the

physicians' office to find the attending MD to seek clarification; after he spoke to the physician, he returned to the charting area so that he could read the remainder of the shift report that was entered in the EMR. The on-coming RN was ultimately able to gather all the information that he required; however, the process was cumbersome and would likely have been much easier if their routines and processes had been set up for face-to-face interactions and verbal communication.

As noted earlier, the RNs and HCAs on the Palliative Unit were assigned to designated care hubs for their shift and the patients on the unit were divided between those care hubs. Care hub huddles took place amongst the RNs and HCAs at the beginning of their shift and at designated intervals throughout their day. The huddles were intentionally designed opportunities for the RNs and HCAs to verbally communicate and plan for patient care related activities such as what type of assistance their assigned patients needed for personal care, ambulating, and preparations for tests and procedures. Information discussed during care hub huddles was much more specific to the moment of care than the information in the typed shift handover summary in the EMR. For example, one interaction that I observed during a care hub huddle was between an RN and an HCA planning how they were going to physically move their shared patient. They came up with a plan together based on the information provided in the shift report in combination with the information that was written on the white board beside the patient's bed. While the planning was done collaboratively between the two of them, they did not engage any other members of the team in the discussion, nor did they ask the patient or his family what his transfer requirements/abilities were. Care hub huddles were also a time for the RNs and HCAs to plan how they would coordinate with each other for

activities such as breaks and reporting during interprofessional rounds throughout their shifts.

A recurring observation on the Palliative Unit was the reliance on computer-based communication by all healthcare providers. Frequently staff members were found interacting with computers rather than with their colleagues. Multiple situations were observed when the use of the electronic charting system appeared to impede interprofessional collaboration as people were focused on their computer screens rather than engaging in any type of dialogue with the other team members working beside them. At one point I observed the RD working at a computer reading information from the EMR, two consulting physicians sitting side by side working on separate computers, three RNs individually working at their own computer stations reading reports from the out-going shift, and one of the attending physicians who left the charting area to use a computer in the physician's office as all of the workstations in the charting area were in use. Everyone was working on separate computers with no interpersonal interactions. During this time, it was noted that some of these individuals were in fact reading and entering information simultaneously on the same patients, without conversing with one another. My impression was that even though there were multiple healthcare providers sitting near each other in a small space, they were siloed with their computer rather than engaging with their colleagues. It appeared that the electronic charting system was creating a culture of multidisciplinary interactions through disparate technological means, even though the healthcare providers were literally sitting right beside each other and should have had ample opportunity for collaborative interaction with dialogue and shared problem solving. It also appeared to be creating a culture with at least some staff where

they felt more comfortable interacting with their computers than they did with their colleagues.

Like Hospice House, the Palliative Unit also used interprofessional team rounds as an important measure for team communication for the planning, delivery, and evaluation of patient care. The team on the Palliative Unit met daily Monday through Friday for rounds. On Monday, Tuesday, Wednesday, and Friday rounds were with the RNs, nurse clinician, SW, and physicians in the front conference room and comprised of a quick discussion of each patient's last 24 hrs, being appropriately referred to as "short rounds". Thursday rounds took place in the back-conference room and lasted for an hour and a half and included a review of all patients. The team referred to these rounds as "big rounds" as this was their weekly opportunity to review the overall care needs and plan for each of the patients. Thursday morning rounds included more members of the interprofessional team – RNs, nurse clinician, OT, PT, SW, RD, recreational therapist, pharmacist, attending physicians (including the Medical Director), psychologist, SHP, and transition services RN. During these rounds, the RNs took turns coming into the room to discuss the patients assigned to their particular care hubs while the other RNs on the unit provided clinical coverage for their assigned patients. The HCAs did not attend rounds. When I asked one of the RNs if the HCAs ever attended her answer was, "They are not included because they are just task focused. Information should be provided on a need-to-know basis for information privacy. They do not need the information in rounds for their jobs." This and other examples of what could be interpreted as professional hierarchy that potentially impacted feelings of power and worth for the various individuals within the team will be further explored in Chapter 5.

While observation of rounds on the Palliative Unit provided many excellent examples of interprofessional collaboration, observations also revealed situations of role overlap and how blurred roles and responsibilities could lead to tension within the team. It appeared that these tensions were more likely to occur with individuals who were potentially less familiar with the roles and ways in which the other professionals contributed to the care of the patients. In one observation a new medical resident stated during rounds that a patient had been waitlisted for hospice. The SW appeared surprised/taken aback as it was typically his role to discuss the logistics of hospice with patients and enter their information into the referral system once the decision was made to pursue transfer. After the medical resident was done speaking, the SW asked, "Did I waitlist the patient?". The attending physician who was working with the resident responded, "No, we did it the other day". This example demonstrated some of the risk that is associated with role overlap in interprofessional teams and will be explored further in Chapter 5. Without the verbal discussion that occurred between the physicians and the SW at rounds it was likely that the SW would have approached the patient and their family to explore the topic of hospice which could have led to confusion for the patient and ultimately impeded effective collaboration between the involved healthcare providers.

Rounds also gave opportunities for team members to verbally share observations that may otherwise have seemed unimportant but did in fact lend context, insight, and spark conversation about what might be happening in the patient's bigger picture. When discussing one patient, the recreational therapist (RT) noted that the patient had expressed interest in joining one of the recreational therapy programs that had been offered earlier

in the week but ultimately had not attended. This was not information that was communicated anywhere else (such as the EMR) and could easily have remained unknown to the other members of the team. However, when the attending physician heard the RT share this piece of information she responded, “no, I get what you’re saying, she (the patient) says one thing but acts differently . . . a lot of what’s happened in the last 12 hours doesn’t seem in line with her goals”. The action of the team discussing the nuances of their various interactions with the patient appeared to provide opportunity for greater understanding of changes that were happening with the patient’s current goals versus what she had previously identified as being important to her. Pieces of information that may have seemed irrelevant or unimportant on their own were combined to create insight into the bigger picture – like the larger picture of a puzzle coming together as each team member contributed their various pieces.

Consult Team

Communication among the Consult Team took place mainly through formal processes including email handovers, in-person team rounds twice per week, and conference calls. Informal communication happened less frequently as team members did not necessarily see each other during their day-to-day clinical work and they did not all make use of the designated team office space to start and end their days.

The Consult Team did not have a set time for a daily shift report where one set of caregivers would handover to the next in the way that was observed at Hospice House and the Palliative Unit. Instead, their team operated Monday – Friday from 0800 – 1700 with all team members starting and ending at essentially the same time and everyone providing ongoing consultation to their own assigned caseload of patients. The

exceptions to this were handover communications provided by part time staff when they finished their schedule of workdays or individuals who were going to be away for vacation/other reasons and required the patients on their caseload to be reassigned to other members of the Consult Team. These handovers were sent to the entire team via email with the intent that the team would work together to determine which nurse or physician would be assigned to take over care. A template existed to provide structure for the email handovers; however, while it was regularly used by the nurses, only a couple of the physicians utilized the email template resulting in inconsistencies in the way that clinical information was shared amongst the team. Additionally, while handover emails were supposed to be read each day by all team members who were working, during my field observations it appeared that the nurses were the ones who took ownership for reviewing the handovers and communicating the information to the physicians (usually by phone).

The Consult Team met on Monday and Wednesday mornings for rounds. Rounds on Monday mornings took place in the small meeting room at their designated office area. These rounds consisted of one of the nurses reading aloud the list of patients with current referrals to the Consult Team to ensure that each patient had either a nurse or physician assigned to them and that there was a plan in place for coverage for any team members who were not working. Any email handovers that had been received that morning from staff who were not working and needed to have their patients reassigned were also reviewed at that time. When reading through the list, each patient was reviewed very briefly by identifying their name, gender, location in the hospital, diagnosis/chief concern, and general plan of care. The team did not spend much time discussing the

patients' condition during these rounds unless a specific need was brought up by the team member assigned to them. Monday morning rounds were attended in person by all of the nurses, the physicians, and any students/residents working with the team.

On Wednesday morning the nurses, physicians, and any students met in the front conference room on the Palliative Unit for their interprofessional team rounds. They were often joined by a SHP who did not formally belong to the Consult Team but had an interest in palliative care and frequently provided consultation for patients with psychosocial/spiritual care needs. The Wednesday morning rounds usually began with a short reading or poem to promote contemplative practice. The team explained to me that this was a relatively new practice for them that had only been adopted since the SHP started joining them for rounds in the recent months. On the day that I observed in their Wednesday morning rounds the SHP provider was not there so one of the nurses offered to share an excerpt from an editorial she had read earlier that morning. After the reading was finished, the team took turns bringing forward patient cases that they wanted to discuss with the team. As such, not every patient was discussed, just cases where the assigned nurse or physician believed input from the rest of the team would be beneficial. There was no particular format to rounds as each member of the team took turns presenting patients, with other team members providing input when they had something to contribute. The presentation of patients was equally distributed between nurses and physicians except for one physician who chose not to present any patients for review. These free-flowing discussions, involving discussing fifteen patients, took place over the course of two hours.

On the days when they did not have rounds, the members of the Consult Team began their day with a short conference call with the nurses at the designated office space and the physicians calling in from remote locations (often the physicians' lounge). The intent of these calls was not to review or have collaborative discussions regarding the care of the patients they were following, but rather to ensure that all patients with active referrals to their team were assigned to somebody who was working that day. During these calls the team would read through the names of all patients on the consult list, identify and reassign any patients who they had received an email handover for, and ensure a plan was in place for coverage for all patients.

The lack of daily in-person contacts between the nurses and physicians limited their opportunities for informal interactions. As a result, the Consult Team did not routinely share interprofessional communication regarding to the patients they were following. Collaboration in regard to clinical situations only appeared to occur between those who did utilize the shared workspace (either between the nurses and the lone physician in the designated office or amongst the physicians who gathered together in the physicians' lounge) or in cases when an individual raised a clinical scenario for discussion during their Wednesday morning interprofessional team rounds.

Summary

All three of the participating teams were unified in their shared mandate to deliver holistic palliative care to adult inpatients living with a life limiting illness. However, the intent of their interventions and the way that their care was delivered varied from team to team. Hospice House was the attending team for patients in their final days to weeks of life. The Palliative Unit was the attending team for patients in crisis with the goal of

discharge either home or to hospice where they would eventually die. The Consult Team provided support and assisted with the plan of care for palliative patients admitted to various units throughout their acute care facility in a consultive role, in partnership with the primary care team on these units.

The environmental atmosphere of Hospice House was cozy, comfortable, and welcoming. The team had stable membership and high levels of staff retention, with minimal turnover. Most members of the interprofessional team appeared to know each other well and had a noticeable level of comfort with one another. During observations, individuals from all professional disciplines were friendly toward each other and appeared to respect each other not only as professionals but also as people. Team members worked near one another by virtue of the small size of the "house" which seemed to facilitate a communal bond. Communication happened between all members of the healthcare team on a regular basis both formally through activities such as shift handover and rounds, and informally when sitting together in the family room during their breaks.

In contrast, the atmosphere of the Palliative Unit was not as relaxed and "homey" as that of Hospice House. While there were attempts to soften the clinical environment, it ultimately retained the atmosphere of a busy acute care medical unit with the various healthcare providers functioning alongside of one another but not necessarily in an interprofessional manner. As the biggest team among the three sites, it was not surprising that the Palliative Unit also had the most frequent changes to who was present due to the large number of part time staff and varying work rotations. While there were some individuals who were consistently present on a full-time basis, many members of the

team reported that there were frequent changes to which nurses and physicians were working from day-to-day or week-to-week. The size of the team, fluctuations in who was working each day, and influence of how shared workspaces were configured did seem to create a feeling of "sub-teams" within the larger team. Specifically, there appeared to be a nursing team which consisted of the RNs and HCAs; a physician team; a charge nurse/unit clerk team; and then another team comprised of allied health professionals including the SHP, SW, pharmacist, RT, OT, PT, and RD. Communication between team members was respectful and friendly but was ultimately less face-to-face/conversational and more facilitated through technology. Almost all communication between professionals seemed to occur through the multidisciplinary notes within the EMR other than the communication during care hub huddles and team rounds.

Unlike Hospice House or the Palliative Unit, the Consult Team did not have a shared space that served as a central hub for all members of the team. While the members of the Consult Team appeared to hold professional respect and a general kind regard for one another, they seemed to lack the sense of community that was observed at Hospice House and (to a lesser degree) on the Palliative Unit. The lack of communal bond appeared to be in large part due to the limited interactions between the nurses and the physicians. While a shared workspace was available, many of the physicians opted to use an alternate location which meant the nurses started and ended their day from the designated team office space while many of the physicians were at the physicians' lounge in a different area of the hospital. This was exacerbated by the fact that they were not collocated for their clinical work as they spent majority of their days independently travelling throughout the hospital to see their assigned patients rather than all working on

one designated unit. The nurses and the physicians who used the shared office space at various times of the day did appear to have a stronger social connection with one another than those who seemed to function largely in isolation.

The fact that many of the physicians from the Consult Team chose to utilize the physicians' lounge to start and end their day also appeared to contribute to feelings of hierarchy within the team as this space was not readily accessible to the non-physician team members. This created a physical and a social environment that facilitated collegial relationship with other individuals from the same discipline rather than interprofessional relationships within their entire team. Even though the Consult Team had the fewest members of the participating teams, their team membership appeared fragmented which was likely due in large part to the lack of daily physical interaction between team members and the resulting limited and opportunities for interprofessional collaboration between the nurses and physicians.

Chapter 5: Findings

Introduction

The intent of data collection was to gain a deeper understanding of healthcare providers perspective regarding interprofessional collaboration in the provision of palliative care. Specifically, the aim was to answer the questions "do healthcare providers believe teamwork is an important component in the delivery of palliative care?" and "what makes teamwork work?" in various hospice/palliative care settings. Utilizing both observation and focus groups with Hospice House, Palliative Unit, and Consult Team staff several themes emerged regarding interprofessional collaboration. Although differences existed between the three separate sites, there were also many findings that were consistent across teams. In this chapter I will describe the five primary themes and subthemes (See Table 1) that emerged from the data namely: Interprofessional Collaboration: A Central Tenet of Palliative Care; Interprofessional Communication: The Single Most Important Ingredient in Effective Interprofessional Collaboration; The Impact of Professional Hierarchy on Interprofessional Collaboration; Role Understanding and Valuing Others; and Facilitators and Barriers to Team Function. Each of the themes and subthemes are described in detail below and are substantiated by salient quotes from research participants (using pseudonyms) to reflect both the overarching sentiments of the group, as well as incidents of individual differences. I will also describe the characteristics of the participants.

Table 1: Themes and Subthemes

Theme	Subthemes
Interprofessional Collaboration: A Central Tenet of Palliative Care	Collaboration is necessary, valued, and needs to be interprofessional Interprofessional practice enhances one's critical reflection on practice Collaboration is significant in theory, but inconsistent in practice
Interprofessional Communication: The Single Most Important Ingredient in Effective Interprofessional Collaboration.	In person conversation increases efficiency while preventing misunderstandings and mixed messages A shared space creates opportunities for informal conversation
The Impact of Professional Hierarchy on Interprofessional Collaborations	The hidden and unspoken culture of professional hierarchy Physicians remain the lead and "ultimate authority."
Role Understanding and Valuing Others	Role overlap: A balancing act Role clarity among all: Necessary for smooth functioning and offering of palliative interventions Mutual respect and trust: Maintaining healthy relationships
Facilitators and Barriers to Team Function	Does size matter: Or is it a matter of perception? Continuity of personnel: A common team concern

Participant Characteristics

A total of 28 healthcare providers comprised the sample. The total numbers of participants were Hospice House N=8, Palliative Unit N=12, Consult Team N=8. A breakdown by discipline at each site was provided in the methodology chapter. Participants' time of practice in palliative care ranged from 1 – 35 years and time working in their current settings ranged from 1 – 25 years.

Interprofessional Collaboration: A Central Tenet of Palliative Care

In understanding interprofessional collaboration in palliative care teams it was important from the onset for me as a researcher to consider the cultural context within each team and how this related to their perceived value of interprofessional collaboration. I was therefore curious to know if interprofessional collaboration mattered to some teams more than others and whether there was a difference in the observed importance of collaboration among individuals from different professional disciplines. The responses from the various healthcare providers to the question "do you think teamwork is important?" was overwhelmingly "yes". Regardless of their practice setting or disciplinary background, participants from all settings (Hospice House, Palliative Unit and Consult Team), felt strongly as exemplified in their responses below, that effective teamwork led to better palliative care. As one nurse from Consult Team stated, "More eyes, more ears and more brains are better" (Nurse Randy). A nurse from Hospice House stated, "I think it's invaluable, absolutely invaluable because in end-of-life there's so many things that the patients and families feel. I couldn't possibly feel like I could provide all, cover all of their needs myself." (Nurse Hannah). In the same vein one allied

health provider from Palliative Unit noted that, “I think it’s imperative. I mean, I think the premise of palliative care is teamwork and I think all of the disciplines have something to contribute to an individual’s experience.” (Allied Health Provider Terry), while a team manager from Hospice House summated, “I think everybody brings different skill sets and that’s what makes us work well together. Nobody can be all things to all people.” (Manager Molly).

Collaboration is Necessary, Valued, and Needs to be Interprofessional

According to participants, caring for patients and families living with life limiting illness presents many complex issues, many of which are not physical symptoms that can be fixed with a medication or technical intervention. Physician Ben from the Consult Team noted, “It takes a village to raise a child, but it takes a team to manage a palliative patient.” In saying this, he was referring to the notion that to address total suffering that traverses the physical, social, emotional, and spiritual domains, healthcare providers must work together as community of skilled and caring people to optimally respond to the humanity and holistic needs of their patients. As eloquently embodied in the words of Palliative Unit Allied Health Provider Greg, interprofessional palliative care teams meet the many needs of their patients through their collective expertise. He stated, “the philosophy of palliative care is that you are looking at things from a holistic perspective and you need an interdisciplinary team that can touch on different aspects of total suffering. It’s extremely important in palliative care.” This sentiment was also echoed by Hospice House HCA Lauren, “I think teamwork is of the utmost importance. I can’t even imagine a single person providing all of the different areas that need to be covered within palliative care”.

Participants felt that teamwork was necessary but that the composition of teams and their ability to work together varied based on location and service model. Many of the participants shared the belief that teamwork did not require all healthcare members to be specialized in palliative care, rather what was essential was for palliative care specialists to work with non-palliative healthcare professionals to establish effective collaboration based on the individual patient's needs. As Physician Sam and Nurse Randy from Consult Team discussed the importance of teamwork with one another they said, "Yes (teamwork) is necessary, it [palliative care] can't be done solo." (Nurse Randy) and "Part of the definition of palliative care is teamwork and collaboration. And whether it's a collaboration between fellow palliative care practitioners or other people from the healthcare team, it doesn't necessarily matter. But there has to be somebody else involved." (Physician Sam). Overall, participants felt that teamwork occurs through various channels that includes palliative teams working together with others with the ultimate goal of working to meet the patients' needs.

Physician Mark from Consult Team was the only participant who expressed that while he believed that teamwork was preferred, he did not believe it was necessarily essential to the delivery of care, "It [providing palliative care as a lone clinician] can be done, it's not the most effective way, but if that's all you've got, I think it's important that people know that that's valuable." Even though they worked on the same team, Physician Sam disagreed with Physician Mark's sentiment that a lone provider could effectively deliver palliative care, "A single person may *think* they're doing a good job, but it won't be satisfactory. Palliative care as we look at it has to be collaborative, integrated, and of course interprofessional." While some differences existed among

participants in terms of how essential they felt teamwork was to palliative care, the vast majority of study participants felt that it was not simply an option or a preference, but a necessity.

Interprofessional Practice Enhances One's Critical Reflection on Practice

Not only did the participants acknowledge the importance of interprofessional collaboration for the delivery of high-quality care to their patients, they also felt that collaborative practice helped to enhance their professional skills and abilities as a result. Nurse Jill from Consult Team spoke of the importance of collaboration with her colleagues in aiding her ability to critically reflect on and provide guidance to her practice.

> *. . . to have colleagues that you feel comfortable sharing with can sometimes, not sometimes, it always allows you to have a bigger perspective . . . I think that, especially doing this kind of work, it's really important to have colleagues that you can feel comfortable enough to say, 'you know what, I think I've lost perspective' or 'I'm seeing this, am I completely off base?*

Nurse Lisa from Consult Team also expressed the importance of being able to collaborate with the members of her team as a way of problem solving difficult clinical situations and improving her personal practice, ". . . at the end of the day I can come back to the office or in rounds I can say 'ok, this is what I'm experiencing, what are your thoughts? Do you have any other suggestions?' Getting that input from different places helps inform me to provide better care." This was not just a sentiment expressed by the nurses, participants from other disciplinary backgrounds also felt that they had increased professional growth when they had opportunities to collaborate with their colleagues.

Physician Lynn from Palliative Unit stated, “I feel like I do a better job, what I’m able to provide patients and families is better, because of what I’ve learned from other team members.” Similarly, SHP Jerry from Palliative Unit felt that collaboration with other members of the healthcare team could lead to increased confidence in situations where professionals were feeling uncertain or lacking confidence.

> There are sometimes situations that arise that (we) don’t know how to deal with or aren’t comfortable dealing with. And I think when people are in that state of uncertainty or un-assuredness, that’s when people start to second guess themselves. They start to lose confidence in themselves and then that affects performance . . . I think when people feel that they have somebody else that they can talk to, rely on, that they can ask questions of or know that somebody has their back in essence, then in helps restore that sense of self confidence.

Collaboration is Significant in Theory, but Inconsistent in Practice

The inherent nature of interprofessional collaboration was apparent during clinical observations and focus groups with each of the three teams; however, the way in which interprofessional collaboration ensued in practice was different from site to site. This speaks to the significance that the cultural context plays on teamwork in palliative care. In all cases, the various healthcare providers referred to other members of the team and the importance of their role even when they were not present. There were times during the observations where I noted that the absence of some team members seemed to hold as much impact as their presence; not because they were not valued when they were there, but because their contributions were so noticeably missed when they were absent. For example, one morning during observations with Consult Team, Nurse Jill mentioned that

the SHP Kim, would not be at rounds that day and shared that she, "really noticed the difference when she wasn't there." This led to a discussion amongst the group of nurses that were present regarding the specific contributions that the SHP made to their team and the positive changes she had implemented over the past few months to the flow and culture of team rounds. Notably, SHP Kim had initiated doing a reading at the beginning of rounds as a contemplative exercise and as a way of setting the tone for the subsequent meeting. In discussing the contributions that the SHP brought to the group as well as the void they were feeling with Kim's absence that day, the conversation expanded to discussing the role of the SHP on a broader level within the palliative care team and the importance of spiritual support particularly for patients and families who were "struggling with feeling unprepared for what is coming." When the remainder of team arrived at rounds, SHP Kim's absence was also commented on by Physician Mark – not in a critical way, but in a manner that echoed the sentiments voiced by the nurses earlier. The adage "absence makes the heart grow fonder" went through my mind as I could see the impact of the missing team member in the way that the other team members referred to her that day.

Although all teams stated that they felt teamwork was essential, there were some apparent contradictions between what was shared verbally in the focus groups and what was witnessed in some of the observations. One of the most glaring examples of this was that while HCAs were attested as full team members in the focus groups, in practice the HCAs were not included in rounds at any of the locations. Nurse Mary's from Palliative Unit commented that HCAs did not need to attend rounds because they did not need to know the information that was discussed, "They are just task focused . . . They do not

need the information in rounds for their jobs." At Hospice House, Manager Andrea stated that they would ideally like to have the HCAs at rounds but could not spare them from the patient care floor. While providing adequate coverage for patient care is essential, it should be noted that they had created room in their budget to have an extra nurse present so that the primary RN could leave the patient care area for rounds while having the extra nurse available to respond to patient needs – raising the question as to why this same resource allocation could not be provided for the HCAs on the team? Perhaps even more striking was the fact that the Consult Team did not have any HCAs on their team, and, in my observations, they never interacted with the HCAs from the primary teams that they were providing consultative support to raising questions about their membership within the interprofessional team.

Another example of incongruence between what was spoken by the various team members and what was observed in practice occurred when team members from different disciplines attested to working in an interprofessional fashion but in practice they seemed to be working in isolation, despite being in close proximity to one another and even, at times, simultaneously entering notes on the same patient. One such instance (noted in my field notes) occurred while I was observing Physician Eileen from Consult Team, who upon arriving on the unit, immediately began reviewing the patient's paper chart and EMR to make herself aware of any updates/changes since her last visit. While she was reviewing the charts, one of the medical residents (Physician Raj) working with the team also arrived on the unit to see a different patient. Dr. Eileen and Dr. Raj greeted one another but neither checked in with the nurses or any other unit staff to say hello or let them know who they were there to see or to receive a verbal update on the patient's

status. When she finished her chart review, Dr. Eileen went to see the patient in his room and while I was unable to join her on any of the direct patient interactions during my observations, I was able to spend time observing the nursing staff who were unaware that Dr. Eileen was on the unit. While Dr. Eileen was with the patient, I overheard two of the nurses discussing the pain medications for the patient that Dr. Eileen was seeing, with both nurses expressing concerns that the medication did not seem to be working well enough and their hope that the physician would come by to reassess. Neither of the nurses were aware that Dr. Eileen was currently on the unit seeing the patient nor were they aware that Dr. Raj was a resident working with the palliative care team and could therefore help address their concern. Dr. Raj was sitting beside me and could presumably hear the nurses talking; however, he did not speak up to introduce himself nor did he tell the nurses that Dr. Eileen was in the patient's room. When Dr. Eileen returned to the charting area, she immediately went to the computer to enter new orders into the EMR, completely unaware of some of the medical issues that the nurses had been discussing. Instead, she commented that she would need to speak to the charge nurse to discuss home care services for the patient but did not actually go to speak to any of the nurses, leaving the unit after making some progress notes in the paper chart and entering orders into the EMR. Throughout her entire time on the unit neither she, Dr. Raj, nor the nurses who were in the area around the nursing station made any attempts to discuss the patient with one another. While none of the healthcare providers being observed commented or even seemed aware of it, as an observer this appeared to be a lost opportunity for collaboration and for potential improvements in patient care.

Interprofessional Communication: The Single Most Important Ingredient in Effective Interprofessional Collaboration

According to participants from all sites, communication was the most essential element to successful interprofessional collaboration. Participants also identified that ineffective communication/communication challenges had the potential to create the biggest barriers to effective teamwork. During a focus group discussion Dr. Ben from Consult Team stated, "I think that so many problems happen because of a lack of communication . . . I just can't emphasize enough how important I see communication." This was a consistent theme throughout each of the focus group discussions as many participants identified "open, honest communication" as one of the most important requirements for effective interprofessional collaboration. As Nurse Randy from Consult team noted communication was considered by participants as the single most important aspect of interprofessional teamwork, "I'm going to go down into the nitty gritty of it, it's communication." Nurse Beth from Palliative Unit stated, "When people see how people communicate, they see how we work together as a team. There is an expectation that you have that communication with each other". There were countless other examples noted during participant observation (noted in my field notes) where effective interprofessional communication either improved outcomes or ineffective communication created barriers to practice.

In Person Communication Increases Efficiency while Preventing Misunderstandings and Mixed Messages

The example previously described between Dr. Eileen, Dr. Raj, and the nurses highlighted how patient care was negatively impacted and healthcare provider time was

less efficient because the various professionals did not take the time to talk to each other when they were together on the unit. While Dr. Eileen did leave progress notes in the patient's chart and entered orders into the EMR that were accessible by team members, if she, Dr. Raj, or the nurses had made an effort to have a conversation with one another they could have addressed the nurses' concerns about the patient's pain management in a timely manner and would have avoided having the nurses page/make phone calls to connect with Dr. Eileen later in the day in order to rectify the situation. Although he was not referring to the specific scenario with Dr. Eileen and Dr. Raj, during one of the focus group sessions, Dr. Ben used a similar situation as a case example to speak about the importance of in-person conversation vs. written communications with team members in general. He shared that his routine to ensure interprofessional communication occurred was to "always touch base with the charge and bedside nurse and simply ask, 'do you have any concerns today that you want me to look into?" In his experience, this simple communication technique led to better care for the patients and increased collaboration with the other members of the team.

Another poignant example of the importance of interprofessional communication was observed while Nurse Randy and Nurse Lisa from Consult Team debriefed their experience of a family meeting where all attending healthcare providers were together with the patient and family. The patient and family had previously been told by some members of the team that the patient's condition was deteriorating, and that the family should be making plans accordingly, which seemingly contradicted a note in the chart indicating that the attending physician had told the family that the patient "appeared to be improving." Nurse Lisa described how this conflicting information had led to

understandable frustration and confusion for the patient and their family as well as frustration on the part of many of the healthcare providers involved who had not discussed the patient's case but rather relied solely on written communication in the patient's chart. Participants shared how this caused them to feel like the patients care team was working in opposing directions, with the patient and family being caught in the middle. Many of the healthcare providers voiced that an in-person family meeting could have provided the opportunity for the various members of the team to communicate and offer consistent messaging through dialogue. A family meeting would also have provided an opportunity to offer consistent information to the patient and family which may have prevented the damage that had been caused by the mixed messages that had been given.

The sense that teamwork facilitated consistent messaging among team members and patients and families was underscored at a separate focus group discussion. During this focus group, Physician Lynn from Palliative Unit highlighted a situation involving Nurse Randy and Nurse Lisa that demonstrated the importance of face-to-face communication in mitigating mixed messages. In describing these incidences, Dr. Lynn summated that there seemed to be "too many cooks in the kitchen" whereby team members were not communicating effectively among themselves and in doing so, providing patients and families with mixed messages.

> Feedback from a family was that a real barrier was that the other team members or professionals involved didn't know what was going on and people were kind of working in silos . . . I think it gives a very different experience when they all see we're communicating, and we all have an understanding of the goals and are working together towards that common goal.

A Shared Space Creates Opportunities for Informal Conversation

Another subtheme was the belief amongst participants that working in close proximity to other team members, such as in shared offices, facilitated opportunities for informal communication and as a result greater teamwork. As Physician Lynn from Palliative Unit stated, "I really appreciate sharing an office because I think it does allow for more, not just team building, but better patient care. Like I love that I can turn around and go 'Hey what do we do with this?". Likewise, Nurse Lisa and Nurse Jill from Consult Team also spoke about the benefits of a shared workspace in facilitating communication amongst team members. They acknowledged that formal communication such as rounds and handover could take place regardless of where people started and ended their days, however when it came to informal communication, they felt it was much more likely to occur between the team members who spent more time in close proximity to one another. Nurse Jill spoke of efforts that had been made with the Consult Team to create a space where all members of their team would be able to congregate in a shared office with multiple workstations, a small kitchenette, and a side room with comfortable seating and technology designed to accommodate group working sessions. However, while some team members had made use of the shared space, a number of the physicians on the team chose not to utilize the space which negatively impacted the sense of teamwork among a number of participants. As Nurse Jill noted,

> One of the things that was made in an effort to support the collaboration of the team was we created a work environment where all of us could be together. It has not worked out the way that it was anticipated. Some of the team, including some

of the physicians, start the day with us and we just spend more time chatting with them because they are physically present.

When teams were not co-located in the same space, participants felt that informal face-to-face communication was diminished, causing them to rely on written communication such as chart notes, texts, and emails. These methods of written communication, while helpful, did not seem to be as effective as in-person informal and formal conversations, and at times seemed to create additional barriers to effective interprofessional communication.

> It's overwhelming. The number of emails, the number of pages that come through, it can be absolutely overwhelming . . . I mean I know it's the way we do it and we are all very accustomed to it, but it, it's just overwhelming the volume of communication and I think sometimes within our team communication then gets lost (Nurse Jill).

The Impact of Professional Hierarchy on Interprofessional Collaboration

Participants in this study identified that while teamwork is espoused in contemporary healthcare, in practice they felt inequalities and divisions exist and even abound including how the practice setting is designed and the system is structured. While all three of the participating teams expressed the importance of the contributions of all team members and the equal value of all professions, it was obvious that professional hierarchy was present.

The Hidden and Unspoken Culture of Professional Hierarchy

In some settings this was more overtly present than in others, however even in the settings where the hierarchy was more covert, it still emerged as an underlying theme.

During observations (as recorded in field notes), the notion of hierarchy was occasionally voiced amongst members of the same professional discipline (i.e., nurses talking to one another) but it was more typically an unspoken aspect of the teams' cultures and not something that was overtly discussed. Rather, it seemed that ingrained in each team culture were hidden ways of functioning within the local professional hierarchy, with varying degrees of acceptance or resistance amongst team members. For some teams, this hidden hierarchy created an unspoken tension between disciplines, created subgroups, and seemed to detract from the team's ability to work in a fully collaborative manner. Nurse Lisa spoke about her desire for change as well as her reluctance to address the fact that many of the physicians opted to use a private lounge as their daily workspace rather than utilizing the shared space that was available to their team, making them less accessible to other members of the team and being cloistered in a segregated space.

> I think it's, it's often, it sort of comes out you know, 'is this a hill I'm willing to die on?'. The answer is often 'no'. So, it just ends up just sort of staying, being that sort of low-level kid of mumble, grumble. You know, 'this is the way it is'. Yes, it would be nice if we could meet in the same place, and all be at the same office every morning and that would help if we had rounds every day in person rather than always over the phone. But you know, that's the way it is. We've tried to fix it; it's not really been fixable and so again this is not a hill I'm willing to die on. So, then it just ends up staying.

Physicians Remain the Lead and "Ultimate Authority"

While some team members sought to dismantle professional hierarchy, others appeared to accept it and felt that there wasn't any perceived negative impact to

professional hierarchy. In the focus group with the team from Palliative Unit, Allied Health Provider Ian stated, “Well there’s gotta’ be some hierarchy. I think it’s a pretty open easy-going atmosphere around here, but at the end of the day the Attending is the Attending but they’re not dictating, they’re not telling us how to run the show per se”. Likewise, Nurse Beth acknowledged the assumption that ultimately the physicians were “in charge” of the healthcare team and did not appear to find this problematic or overly distressing, “I think definitely the leader is the physician. There are certain places that are changing where the physician is on the team where he or she isn’t necessarily the one who is leading but I think in acute care it’s definitely the physicians.”

While patients and families were not included in this study, multiple participants expressed that patients and families ascribed to the belief that the physicians were in charge or the most important members of the healthcare team. Regardless of how the team members viewed the power balance, professional contributions, and leadership of the individuals from various disciplines, there were times when these cultural beliefs held by the patients/families that the physician’s opinion was paramount overrode the teams’ own beliefs about interprofessional teamwork. When asked about this, HCA Lauren from Hospice House responded, “I think to the patients the physician is always the ultimate resource. I think patients and families would definitely identify physicians as the key player.” Nurse Jill from Consult Team also agreed that the cultural perceptions of many people in our society led them to believe that the physicians were ultimately the team members that they should be looking to and placing the most trust in. “I think it speaks to the age of the population of people that we see . . . we see a lot of patients who say, ‘what does the doctor say?’”

While many focus group participants acknowledged that professional hierarchy did exist within their teams and that patients and families felt that physicians were seen as "in charge" or the ultimate authorities on the various teams, there were some team members that disagreed. For example, Physician Lily from Hospice House, upon hearing this, was noticeably uncomfortable and responded, "I certainly don't feel like that. You know, we're (the physicians) taking care of some aspects of the care and we're giving input to other aspects of the care . . . everybody shares responsibility." Physician Lynn from Palliative Unit also agreed that there were aspects to the care when the physician was the leader but felt that the leadership was flexible and dynamic in response to the specific needs of the patient.

> It's true the physician is responsible for the overall care, but I would always feel like there were significant portions of people's care that is not, I would not have the expertise and I would look to the leaders of those areas to help inform the care and I would follow their care plan because it's their expertise.

Aside from the Medical Directors, it is important to note that the physicians within this study did not actually hold positions of formal leadership within any of the teams. Yet despite having no formal authority, they were clearly perceived as leaders by the other healthcare providers and by patients/families, whether the physicians were aware of it or not.

Role Understanding and Valuing Others

Participants in this study discussed many instances in all of the focus groups where their colleagues' actions and unique contributions impressed upon them that interprofessional collaboration brought value to their work and more holistic care to

patients. Study participants also acknowledged that in interprofessional teams there are many situations where role overlap occurs, noting that it is therefore important for team members to understand their individual roles and the roles of their colleagues within the team so that they can consider the best approach for supporting patients and families.

Role Overlap: A Balancing Act

During focus groups, the concept of role overlap was discussed by participants from all three of the teams. While many participants found role overlap beneficial, others found it to be detrimental to collaborative practice.

Physician Lynn from Palliative Unit spoke of the benefits that occurred when team members work together with a degree of overlap in their roles,

> I love role overlap. We look at how we can work together and then tap into each other's skill sets and then sometimes we'll go see patients together. And then one of us might step out . . . but we try to do things together as a team and kind of learn from each other.

Other participants communicated that while an overlap of skills and professional knowledge between the various disciplines can be a positive thing, it can also cause tension and concern, causing people to question "whose role is it?" It was for this reason that many participants felt it was imperative that team members understood their own roles and were aware of areas of potential overlap within the interprofessional team in order to avoid negative interpersonal team dynamics. As Allied Health Provider Greg from Palliative Unit explained,

> I think that if each of the team members know what role we're all playing then it goes more smoothly. But when there's situations where roles aren't understood or there's cross over and there's confusion then things don't go as smoothly.

Study participants expressed that there were many times where nurses' and physicians' roles overlapped when conducting physical assessments and when having conversations regarding disease process and expected trajectories with patients. However, nurses and physicians agreed that different clinical scenarios will call for enhanced medical input while other situations require a greater emphasis on nursing assessment and care delivery. It was discussed by multiple participants that on many occasions different team members had performed duties or had conversations with patients that could have been done by another team member, a further recognition of the reality and necessity of role overlap in high functioning interprofessional palliative care teams.

Role Clarity Among All: Necessary for Smooth Functioning and Offering of Palliative Interventions

Participants discussed the importance of being familiar with their own role and the roles of their colleagues in order to understand the unique contributions that are brought forth by each team member from their disciplinary perspective. During a focus group session Nurse Randy from Consult team spoke of the importance of role understanding. She reflected that not only was it important for team members to understand one another's roles, but they must also communicate their roles to the patients and families to avoid potential confusion.

> Role confusion can definitely lead to confusion for patients and families. Because they're the ones who need to know who is doing what for them . . . yeah, it

> certainly can be confusing for them and they're the ones who are at the centre of it. So that's why clarifying roles at the beginning is really important.

In the focus group from Palliative Unit, an example of the importance of role clarification and recognition of the specialized skills of specific team members occurred when participants were describing patients/families that required psychosocial support. While participants acknowledged that psychosocial support falls within the scope of many healthcare providers in palliative care, it was agreed that SHPs and SWs have the advanced knowledge and skills required to respond when complex or tertiary level psychosocial/emotional/spiritual concerns arise, as is the case in many palliative care settings. In discussing the complex issue of role overlap in relation to psychosocial care, it was explained that it was not only an issue between non-specialized providers (MDs, RNs, HCAs) and specialized psychosocial providers (SHP, SW), but between SWs and SHPs themselves with each approach resulting in different clinical outcomes. SHP Jerry spoke about the importance of recognizing this overlap and the importance in understanding the differences between SHPs and SWs:

> From my perspective, social work and spiritual care will often overlap in terms of handling grief situations. All of us can do that but then there are some distinctions between each of those roles as well. We can all address the similar thing but we're doing it in very different ways and ultimately with different goals or objectives or purposes in mind.

Participants from Consult Team expressed that having conversations with their colleagues, with themselves, and management to clarify their understanding of the roles of the various professionals on their team was key to healthy teamwork and

interprofessional collaboration. “Recognizing your own skill set [is important] too. So, if I know that I’m not very good at whatever is needed, then I’ll say ‘ok, well this person is better at that maybe he should do it” (Nurse Randy). Unfortunately, participants acknowledged that this does not always happen as some roles are not fully understood by the other healthcare providers on the team which creates further challenges for collaborative practice. Nurse Jill felt that in her setting that there was often a lack of understanding of other team members’ full scope of practice and role overlap, “As nurses, I do sometimes think that our role is understood to be narrower than it actually is… I think it’s a little bit fraught. A little bit difficult.” (Nurse Jill). In contrast, at Hospice House, Nurse Karen felt that everyone had a very clear understanding of their various roles and the way that each contributed to care. She did however acknowledge that the level of role understanding on their team was better than she had experienced in other settings, and she felt that it contributed in a positive way to interprofessional collaboration.

> I think this team has a really good understanding of what everybody does and where our roles overlap. Other places that I’ve worked do not have that to the same extent and I think it’s detrimental to patient care because people work more in a silo and there’s no knowing what other people do and where you need to say ‘Oh, I’ll have Joe come see you’ or ‘Oh, I’ll have Jill come see you’ instead of trying to go forth and say things that maybe aren’t correct and then it’s a lot of backtracking for other people. So, I find that doesn’t happen a lot here because we all really know what other people do and what their role is in the team. (Nurse Karen)

Mutual Respect and Trust: Maintaining Healthy Relationships

In the focus groups with all participating teams, the values of respect and trust were raised multiple times by members of the various disciplines as important factors to seeing the value that all team members bring. This was felt to not only make the work environment more pleasant but also contributed to a sense of healthy team functioning. As one participant from Consult Team stated, "Understanding the roles and what skill sets people bring is important but then there's also that mutual respect too, mutual respect and trust so you can trust your team members are going to be doing the job needed of them." (Nurse Randy). Likewise, SHP Dale from Hospice House identified that respect was a key factor in helping to ensure team members maintained healthy relationships with one another even when there were differences in the ways they were approaching various clinical scenarios or differences in opinions on the right course of action, "[the most important thing is] respect for others – it is ok to disagree, but you must maintain respect." Physician Eileen from Consult Team and Physician Jade from Palliative Unit both identified "collegial respect" and "respect for one another in all situations" when asked to consider the critical elements of interprofessional collaboration within their teams. Physician Jade elaborated that the trust and respect that the team members held for one another led to a sense of "shared vulnerability and shared humanity" that marked a difference in the way the professionals on their team collaborated with one another versus her experiences working in non-palliative settings in the same hospital. Likewise, SHP Jerry from Palliative Unit stated that "value of other" and the "equality" that was perceived in the contributions of all of the various team members was a key to the successful collaboration experienced in their team.

Facilitators and Barriers to Team Function

The final theme that emerged from the participant observation and focus group data were barriers and facilitators related to team function. Specifically, the size of the team, the workplace environment, and the consistency (or inconsistency) of membership all appeared to impact the ways that the teams functioned which in turn effected interprofessional collaboration, in both positive and negative ways.

Does Size Matter: Or is it a Matter of Perception?

During the focus group sessions, participants from Hospice House and Consult Team identified that the size of the team made a difference in team function and that they felt that interprofessional collaboration was easier to achieve within smaller teams. While the members of the Consult Team all spoke to the importance of interprofessional collaboration for the delivery of high-quality patient care and the benefits it brought to their own professional practice, most participants felt that their team did struggle with consistently achieving this in their day-to-day practice. Nurse Jessica specifically identified that one of the challenges to team cohesion and function, was the large size of their team, noting that "Sometimes a smaller team feels more collaborative. So, I don't know if that's a dynamic of team size or our environment that are the factors playing into that." Physician Mark echoed this sentiment and explained that the Consult Team was very complex in its composition, creating difficulties in the way that they were able to work together, "You know, it's a large group of people, different personalities, different skill sets, different levels of comfort, and so I think that those are really big barriers." It is important to note, that in actuality the Consult Team was not the biggest of the participating groups. In fact, they had the smallest number of people formally working

with them. However, the complexity of the Consult Team's working environment and the way that they went about their work appeared to make their team feel bigger, more spread out, and less cohesive. In contrast, Nurse Karen and Manager Molly identified the Hospice House team as being very small, even though the number of people and representation of disciplines on their team was much larger than the Consult Team that Nurse Jessica and Physician Mark worked in. Nurse Karen and Manager Molly both attributed the sense of smallness within their team as a positive factor in their perceived ability to consistently work together in a collaborative fashion. "I think (size) is one thing that helps for teamwork, and I think we can do that here because we're so small and in a bigger organization that's not always possible." (Nurse Karen). Although both Nurse Karen and Nurse Jessica alluded to it, neither specifically identified whether it was the size of their environment/organization that effected their perception about the size of their team versus the number of staff members within the team; however, both agreed that working in 'small' teams made interprofessional collaboration easier.

Continuity of Personnel: A Common Team Concern

Both the Palliative Unit and the Consult Team had a number of people who worked part time or on a rotational basis where they would work for a number of days/weeks and then "switch out." Both teams identified that the lack of consistent full-time membership created challenges for team function and led to challenges in the continuity of care for patients. As Nurse Jessica from Consult Team stated, "I think being a mix of full time and part time definitely complicates things." Likewise, Nurse Beth from Palliative Unit spoke about the concerns that their team felt as a result of the lack of continuity in who was working from one day to the next.

> There's continuity issues. It's like, 'Well they're not here today, who is going to take over?' and 'They're back tomorrow, are they going to take over from two days ago?'. That's a challenge. I don't know how you get around it when you've got people coming and people going.

Although they worked in different settings, Physician Ben from Consult Team also found the lack of continuity on his team to be a concern and, like Nurse Beth, he was uncertain how this challenge could be overcome, "There are continuity issues, but you do the best you can right? Soldier on." (Physician Ben). Likewise, allied health provider Greg from Palliative Unit acknowledged that the lack of consistent presence of team members was one of the biggest issues facing the team. He noted that not only was this a concern for the healthcare professionals in their ability to effectively collaborate, but it was also a concern that patients and families had brought forward, "Yep, frustrating. That's some of the feedback that I've gotten [from patients and families]. More consistency, people who kind of work here regularly would be helpful for the team dynamics and the communication pieces."

Some participants voiced that staffing shortages and turnover were specific disruptors of team function, that they increasingly faced in their day-to-day patient care.

> I think it's also been hard over the past couple of years with all the changes that have happened with this team, especially amongst the (nursing) staff . . . you know, it was just sort of getting to that stable place where it's the same people who you sort of get more into the groove and rhythm of how that team works then there's lots of changing faces and different people. It been a challenge. (Nurse Lisa Consult Team)

Further, staffing shortages amongst the doctors in one of the teams meant that physicians from other locations would sometimes need to work with them to ensure that there was adequate clinical coverage. While these locum physicians had palliative expertise and were respected clinicians, the change in team composition created concern amongst the "regular team members." Nurse Mary from Palliative Unit spoke about the challenges that these situations presented.

> I think the changeover where one week there's a random physician here for a week . . . it's difficult to navigate that sometimes . . . if it's somebody who works infrequently, they may not be used to the way the team communicates and not familiar with some of the roles and that makes it very challenging.

Whether the frequent changes in who was present was due to fluctuating schedules, or new members being constantly added to the teams due to staffing shortages/staffing turnover, all participants agreed that disruptions in team membership made interprofessional collaboration harder to achieve. When there was consistent presence from the same people their teams were able to function at a higher level and as a result, they felt they were able to provide better consistency in their delivery of patient care.

Summary

All three teams that participated in this study were united in their shared mandate of providing palliative care to adults in inpatient settings. While there were differences in the way that care was delivered by each team, there were also many similarities. As a result of participant observation (field notes) and focus groups, five primary themes emerged: Interprofessional Collaboration: A Central Tenet of Palliative Care; Interprofessional Communication: The Single Most Important Ingredient in Effective

Interprofessional Collaboration; The Impact of Professional Hierarchy on Interprofessional Collaboration; Role Understanding and Valuing Others; and Facilitators and Barriers to Team Function.

In general, there was consensus among participants that interprofessional collaboration was an essential factor in the delivery of quality palliative care and that the total suffering that is commonly experienced by palliative patients is best managed when a team of healthcare providers from various disciplines work together to provide holistic support to the patient and family. However, even though participants from all teams identified that interprofessional collaboration was important and valued, all teams also acknowledged that they were vulnerable to the issues related to interprofessional communication, professional hierarchy, role clarity, and team function which could either facilitate or inhibit their ability to effectively collaborate in practice.

Chapter 6: Discussion

Interprofessional collaboration in palliative care is a complex, cultural process requiring the expertise and skills of a variety of healthcare providers from various disciplines to ensure the delivery of holistic patient care while improving system outcomes. The findings presented in the previous chapters provide direct insight into the culture of interprofessional collaboration from the perspectives of team members from three settings: Hospice House, Palliative Unit, and Consult Team where teamwork is central to their work. Through analysis of both participant observation and focus group data five themes emerged: Interprofessional Collaboration: A Central Tenet of Palliative Care; Interprofessional Communication: The Single Most Important Ingredient in Effective Interprofessional Collaboration; The Impact of Professional Hierarchy on Interprofessional Collaboration; Role Understanding and Valuing Others; and Facilitators and Barriers to Team Function. In addition to identifying the key factors associated with interprofessional palliative care, the study findings also provide description of cultural differences, strengths, and challenges within each team that underpin how interprofessional collaborative practice is enacted and valued. For example, the structure, composition, and values of the team influence how communication takes place; how the hierarchy of the team influences team function and patient care; and how role understanding and valuing others informs interactions with other members of the team. In the following section, additional nuances around interprofessional collaboration will be discussed, situating the study findings in the existing knowledge base. I will then offer a summary of the strengths and limitations of the study and provide recommendations for future research, practice, and education.

Interprofessional Collaboration: A Central Tenet of Palliative Care

Findings from this study highlight the value that palliative care professionals attribute to a collaborative interprofessional approach in providing holistic patient care. It was unequivocally endorsed that collaboration is necessary, valued, and needs to be interprofessional in order to meet the needs of patients and families and mitigate the suffering experienced at the end-of-life. When team members collaborate to share their expertise from a variety of disciplinary backgrounds, they create opportunities to harmonize care into a coordinated and coherent whole. According to Porter-O'Grady and Malloch (2007) at the core of patient centered care are strong relationships among members of the care team, the patient, and the organization. As was further attested to in the current study, these relationships provide linkages in the care network to share information, understand values and preferences, engage the family and the care team, and support respect. Conversely, this study affirms previous research that demonstrates that a lack of interprofessional collaboration can lead to patient dissatisfaction, poor clinical outcomes, and frustration for the professionals involved in the care (Carter et al., 2019).

In this study, participants shared that the contributions of different team members not only affected patient outcomes but also made team members reflect on their own practice as healthcare professionals. Within each of the teams in this study, it was readily apparent that each individual valued their fellow team members and acknowledged the positive effect that interprofessional collaboration brought them not only professionally, but personally. In a grounded theory study conducted by Taffurelli et al. (2021), it was revealed that collaborative practice created a "weaving of professional resources" which allowed healthcare providers to establish a place of mutual help and emotional balance

among team members. Furthermore, Carter et al. (2019) asserted that collaboration among individuals with different perspectives can result in personal and professional rewards of creativity and learning. As further evident in the current study, it seems that interprofessional collaboration functions as a source of strength for teams in the face of suffering, with the positive effects of interprofessional collaboration being shared learning, motivating each other, stress release, and mutual support.

The importance of interprofessional collaboration was supported in theory by all of the teams who participated in this study; however, inconsistencies were noted in the degree to which interprofessional collaboration actually occurred in practice. Participants attributed the variations in collaborative practice in their settings to a number of cultural, organizational, and professional influences which either served to facilitate or hinder effective teamwork. These factors included interprofessional communication, professional hierarchy, role understanding, and elements that contributed to team function. These findings align and solidify previous studies, that have identified challenges to the actualization of interprofessional collaboration in palliative care teams and healthcare teams in general. In the literature, these challenges have been ascribed to a number of factors such as the innate differences in the way that healthcare providers from different disciplinary backgrounds communicate, professional hierarchy, physical layout of workspaces, lack of role understanding, and lack prioritization and attendance at activities such as team rounds (Apker & Eggly, 2004; Dean et al., 2016; Garth et al., 2017).

Interprofessional Communication: The Single Most Important Ingredient in Effective Interprofessional Collaboration

Participants in this study continuously revealed that clear and consistent communication by all members of the interprofessional team was critical in helping patients and families cope with their diagnosis, fears, and suffering in a pivotal time in their life course. Nonetheless, participants also indicated that interprofessional communication could also be a source of great frustration and was sometimes difficult to effectively achieve in their interactions with one another due to a number of contextual and cultural factors. As noted by Carter et al. (2019), interprofessional collaboration requires a sophisticated level of communication to improve quality, minimize errors, and ultimately benefit patients. Healthcare professionals who wish to make a positive impact must be masters at communicating and connecting across networks, teams, and organizations.

The field of palliative care has identified communication a key priority because of the important role it plays in the delivery of quality care (Donesky et al., 2020). Studies have documented that effective communication by team members may help patients maintain a sense of control, aid in determining goals of care, find meaning in their lives, maintain hope, and ask for and receive relief when experiencing pain and other physical symptoms (NCP Guidelines, 2018). Yet, as participants noted in this study, communication is a doubled edged sword, with good communication among team members improving outcomes, and poor interprofessional communication contributing to negative outcomes (Junger et al., 2007).

While participants in this study viewed communication as a team as an opportunity to build relationships and provide information in a way that could positively impact patient care, they also noted times where ineffective communication between professionals led to increased suffering of family members. Herbert et al. (2009) discussed similar examples, where patients noted communication by the healthcare team initially seemed sparse, conflicted, and contradictory, with it only improving closer to the end of life. This is a concerning phenomenon that was echoed in this study as participants agreed that poor interprofessional communication can detrimentally impact patients across the care trajectory; this is particularly concerning when these failings occur when providing care in the final stages of a person's life.

In conducting participant observation in this study, a number of instances of parallel communication between healthcare professionals were revealed. Carter et al. (2019) described parallel communication as occurring when healthcare professionals interact with patients independently of the other clinicians involved in the patients' care. The various professionals may be addressing the same clinical problems; however, they document their interventions in separate areas of the patient's chart, and they do not talk directly with one another to share their assessments or collaborate on care. Examples of this were observed in this study when individuals communicated their findings and plans regarding patient care to the rest of the team through the EMR in place of verbal communication. During observations, it appeared that the cultural practice of written communication as the primary method for communicating with other members of the healthcare team actually created barriers to effective interprofessional communication. Missed opportunities for collaboration were observed as the basic communication

technique of speaking with one another in the moment gave way to the business of chart documentation. While this type of communication is common in contemporary healthcare settings, it is a cultural norm which needs to be addressed as it ultimately creates barriers to successful collaboration when multidisciplinary healthcare professionals interact solely within the patients' chart but not with each other, leading to an uncoordinated and fragmented approach to care.

Additional barriers to communication resulting from the lack of in-person interactions were prevalent throughout this study. It was apparent that teams whose space was structured in a manner where they were forced to work in close physical proximity with one another, had more opportunities for both formal and informal communication which resulted in improved interprofessional collaboration. Alvarez and Coiera (2005) found that healthcare providers not only preferred in-person communication, as opposed to communicating through chart notes or email, but felt that physical proximity was an important facilitator of in-person communication. In their ethnographic study involving observations and focus groups, Gum et al. (2012) discovered that the design of the physical environment in healthcare settings greatly influenced collaborative practice. Interprofessional communication was much more effective when healthcare settings were designed with a "hub" or common space where the various practitioners involved in care could gather to exchange information. As noted in the findings, the teams at both Hospice House and the Palliative Unit frequently congregated at the nursing station/charting area, which functioned as central hubs where the majority of the day-to-day conversations between members of the healthcare team occurred. Contrastingly, in-person communication was much more difficult for the Consult Team as some team members

chose not to utilize the designated office space and they did not have a shared clinical setting where all team members would congregate throughout the day. This led to fewer opportunities for interprofessional communication with the various members of the Consult Team, ultimately decreasing their capacity for interprofessional collaboration in their day-to-day work. This is an important factor to consider as the act of discussing clinical situations together, in detail and in-person, not only improves the care and outcomes for the patients but also strengthens the relationships between the members of the interprofessional team (Mahmood-Yousuf et al., 2008).

The Impact of Professional Hierarchy on Interprofessional Collaboration

Interprofessional collaboration is increasingly promoted in today's healthcare systems. Effective interprofessional collaboration is dependent on several factors including the philosophy of equal value and respect for the contribution of all team members irrespective of disciplinary background. Collaboration among healthcare providers from different disciplines is arguably one of the most difficult competencies to attain because it is mediated by social processes such as attitudinal and cultural factors that are ingrained in their professions and society. Tradition, role, and gender stereotypes have been identified as additional obstacles to collaboration (Rafferty et al., 2001). Safriet (1992) has suggested that the field of medicine staked out broad professional territory early on and historically considered any encroachment into their 'professional turf' by other clinicians, at any level, as unacceptable. The lingering stereotype of physicians leading the healthcare team with other healthcare providers as ancillary members, has permeated healthcare culture in the way that our systems, language, and day-to-day operations reinforce in both overt and discrete ways. As participants in this

study suggested, while physicians at times take a leadership role in patient care, leadership within high-functioning interprofessional palliative care teams reflects a shared leadership model, that was felt to enhance successful team collaboration and patient care.

Several participants acknowledged that the persisting view that the physicians' perspective is paramount by patients and families often led to the dismissal of information provided by other team members. A poignant example of this phenomena in this study was shared in the previous chapter in the form of a family disregarding information provided by a nurse, because the family felt that unless it came directly from the physician it was not reliable. In that example, the family had been reassured by the fact that the physician had been contacted and was coming to speak to them about their concern, however the RN expressed feelings of distress because she had not been able to help the family to feel reassured on her own. Her nursing colleagues attempted to provide comfort by assuring her "you are never alone, and you can always call on your team for help." While there was truth in that statement, they did not explicitly acknowledge or discuss the unspoken culture of professional hierarchy within the healthcare team and the impact that it had on the RN. The cultural belief that the physician was the ultimate authority in the healthcare team appeared to be at the root of the issue for this family who dismissed the information from the RN, in preference of hearing from the physician whom they felt was better equipped to address their concerns.

During focus groups, some of the physicians voiced their disagreement with the notion that there was a professional hierarchy within their teams and stated that they did not see themselves in positions of power. It is common for people in the positions of

power to be unaware of power imbalances because it does not negatively affect them or goes unnoticed. The physicians in this study may have believed that there was equal power among all healthcare providers on their teams because they had not encountered situations where their own unspoken authority and power had been challenged. However, it is likely that what they were experiencing at times where disagreements were occurring without their awareness, was faux collaboration rather than true interprofessional teamwork. Faux collaboration occurs when persons in a position of authority believe that they are being collaborative because those around them are agreeing with them, with this apparent cohesion being reflective of power differences within the team, in contrast to true interprofessional collaboration (Carter et al., 2019). In a mixed methods study exploring interprofessional collaboration between medical residents and nurses, Muller-Juge et al. (2013) also found instances of faux collaboration when nurses perceived their inputs were not being considered by the residents as a result of hierarchy, training, and culture. As others have also noted, the lack of recognition of existing hierarchy within healthcare teams is problematic and must be acknowledged in order for effective interprofessional collaboration to occur (Mahmood-Yousuf et al., 2008).

Role Understanding and Valuing Others

Interprofessional collaboration provides the opportunity for healthcare professionals to work alongside individuals from other disciplinary backgrounds who have specialized knowledge in areas that are different from our own. When these different but complimentary skills come together, it can create a synergistic effect where the whole is greater than the sum of the parts, resulting in a more holistic approach to teamwork and patient care. However, if all team members are not clearly aware of their

own role and those of the others on their team, role ambiguity and overlap may negatively influence team function and impede effective interprofessional collaboration (Crawford & Price, 2003; Klarare et al., 2013; O'Connor & Fisher, 2011). It is also essential that the clinicians from all of the various disciplines are valued and acknowledged as important members of the interprofessional team and recognized for the positive contributions that they make to patient care (Sutter et al., 2009; White-Williams & Shirey, 2021).

In this study there were findings from all team members which related to the importance of valuing others' contributions, expertise, and skill set and how this understanding was helpful in fostering teamwork. In a qualitative study conducted by Suter et al. (2009), findings similarly revealed that role understanding, and appreciation of others' roles were fundamental elements for effective interprofessional collaboration. When working in teams comprised of individuals from a variety of disciplinary backgrounds it is important that all team members understand the role and expected contributions from not only their own disciplinary lens, but also that of their colleagues' (White-Williams & Shirey, 2021). This requires team members to have familiarity with one another's professional limits and scope of practice; awareness and communication regarding their own personal skill set, knowledge, and limits; understanding when roles may overlap and how this will potentially enhance or hinder patient care; and respect for the knowledge and contributions of team members with skills different from their own. Lack of understanding of the role of individuals from other disciplinary backgrounds within the team can lead to duplication of interventions, underutilization of the specialized skills and knowledge of team members, perceived lack of respect, individuals

becoming protective of their professional scope, and ultimately resistance to collaboration (Sutter et al., 2009).

This study also affirmed that disciplinary diversity must be acknowledged, valued, and leveraged in interprofessional teams; requiring team members to understand the different traditions of knowledge, cognitive styles, and ways of perceiving that exist within their team. A number of participants in this study identified "respect for others" as a key element to interprofessional collaboration, which involves acknowledging and valuing the contributions of team members regardless of disciplinary background and the role they play within the team. In the focus groups, participants stated that all of the disciplines represented on their teams were essential members and that everyone had important roles in the delivery of patient centered care. However, while participants spoke of the value that they felt for the contributions of their colleagues, this was not consistently demonstrated during observations – the most glaring example of this was regarding the HCAs on the teams. While participants stated that the HCAs were full team members, in practice the HCAs did not appear to be valued to the same degree as the healthcare providers from other disciplinary backgrounds. HCAs were not included in rounds at Hospice House or the Palliative Unit and did not have any membership at all on the Consult Team (while HCAs were invited to participate in this study and were included in clinical observations, only 1 HCA chose to take part in the focus groups). This is particularly problematic as it leads to the exclusion of arguably one of the most important voices in the patient's care team as, in practice, the HCAs are the healthcare providers who have the most direct contact and spend the most time physically with the patient. In a grounded theory study exploring hospice team processes, Day (2012) also

found that while participants expressed respect for every discipline, observations revealed that some team members (including HCAs) appeared to be "adjunct" members whose input was not ascribed the same value as the physicians and the nurses. This in turn required the so-called adjunct team members to be more assertive than others in order to have their input included in team rounds and other discussions regarding patient care. Hall (2005) professed that embracing disciplinary diversity and the value that all members bring to interprofessional teams starts with dialogue regarding how individual disciplines identify their own value systems and roots underpinning their professional identity as a team member.

Facilitators and Barriers to Team Function

Achieving effective interprofessional collaboration can be challenging. A number of professional, sociocultural, organizational, and regulatory factors exist which can create facilitators or barriers to interprofessional collaboration. As was the case in the current study, many of the barriers to effective collaboration occur because of values, beliefs, and behaviors that have generally gone unchallenged in society and unaddressed in the organizations in which healthcare teams practice (Carter et al., 2019; Pavlova et al., 2023).

According to Meredith Belbin (2000), teams are distinguishable from groups based on a few key characteristics including size, selection of membership, flexible leadership, and a common purpose. When considering size, Speck (2009) asserts that teams are typically comprised of 12 people or less and that anything larger should be considered a group, which would then have different innate characteristics from a team. While participants in this study did not allude to a specific number when discussing the ideal

size of a team, the notion of size of team was identified in focus groups as a potential facilitator or barrier to effective teamwork. The team at Hospice House identified themselves as having a "small team" which they felt made team function easier, meanwhile the Consult Team identified themselves as having a "big team" which created challenges to team function. In reality, Hospice House had 52 people that they considered members of their team and the Consult Team had 16 members. This suggests that size, in reference to interprofessional teamwork, is dynamic and flexible, having far less to do with the actual size of the team and more to do with team cohesion with 'smaller teams' being perceived as being more effective and cohesive than 'larger teams'.

Additionally, findings from this study suggest that stability of membership and progression through the stages of team development are perhaps more salient contributors to successful team function than size of team. Tuckman proposed a model of team development which identified four stages that all teams must move through: forming, storming, norming, performing (Tuckman, 1965; Tuckman & Jensen, 1977). When new members are constantly introduced, teams cannot move past the first stage of team development as they are constantly returning to the "forming" stage. This concept is reinforced in the findings communicated by Alberto and Herth (2009) which state that a trusting and collaborative relationship develops over time and depends on recurring, meaningful interactions. Collaborative relationships may therefore be difficult to develop in organizations where there is a high staff turnover or frequent rotation of clinicians. The lack of consistent full-time membership and the resulting frequent changes to who was present on the team were challenges identified by participants from both the Consult Team and the Palliative Unit. Conversely, while the team at Hospice House was

theoretically more complex than the Consult Team and should have faced more challenges to team function due to the larger number of people they identified as being on their team, they seemed to be more advanced in the team development process as they appeared to be functioning at the performing level. This may be attributed to the fact that, while their team had more members, they also had more stability than the other teams and less turnover in who they were working with on a day-to-day basis.

Implications for Future Research

The use of focused ethnography for this research is indicative of the usefulness and practicality of the methodology in understanding the complexity and nuances of unit culture and the influence of culture on palliative care practice. The benefit of a shared background of the researcher helped participating team members feel comfortable in discussing their practice, experiences, and their perspectives. The team members were able to provide insights while critically reflecting on their practice, ultimately providing a comprehensive picture of working at their palliative care sites and reflecting on the nature of interprofessional practice. Focused ethnography is an accessible methodology that can be used by novice researchers to gain an understanding of the research process, and to conduct research within their own spheres of influence. This could lead to more healthcare providers conducting qualitative research within their own work settings and instigating change from within the culture.

Unit culture had a considerable influence in interprofessional teams' everyday practice and aided in the exploration of nuanced elements, such as communication practices, at each of the three sites. Communication in this study was impacted by a number of influencing factors including the architectural design of the practice setting.

While communication workshops, articles, and theory on improving team communication skills abound, research on and attention to the design of the physical space where teams function is just emerging. Further research is therefore needed on physical design of palliative care units to explore how space, specifically having team members located together, might facilitate improved interprofessional communication and collaboration.

While team composition was discussed during focus groups as a means of determining how each team viewed their own team's membership (who did they consider to be on the team), this study did not explore the question of which professional disciplines should optimally be represented on interprofessional palliative care teams. There is a paucity of evidence in the existing literature regarding recommendations or guidelines for disciplinary representation on palliative care teams. This is a topic that would be beneficial to explore in future research.

Implications for Practice and Education

Healthcare providersl from different disciplines in this study were experienced practitioners with varying scope of practice who would be considered palliative care specialists (practitioners focused on palliative care and consultation of complex patient and family needs). Thus, a discussion of implications for practice and education for findings of this study will propose suggestions that would speak to this level of experience and expertise. A few recommendations will be suggested that address communication, professional hierarchy, and cultural safety that may promote and enable interprofessional collaboration.

Communicating effectively is essential to the delivery of quality palliative care. Specific considerations for future studies should include organizational and physical

space structures (physical proximity) so identified face to face communication and information sharing can occur more frequently. Information technology at all levels (patient and family, service delivery, and system policy) should be further explored. These challenges must be addressed to safely deliver patient and family centered care and improve health care professionals' satisfaction with their everyday practice.

Professional hierarchy was identified in this study as posing issues for interprofessional collaboration, where some members revealed that their professional, personal, and ethical integrity was impacted to the point where equal value and respect for the contribution of all team members irrespective of disciplinary background was not maintained. There was disagreement by the physicians with the notion that professional hierarchy existed within their teams and that they did not see themselves in positions of power. This suggests the need for discussion within teams of "cultural safety", which requires that all team members acknowledge that we are all immersed in cultures and that there is a need for reflection on our own attitudes, beliefs, values, and assumptions. It requires recognition of the power differentials inherent in healthcare service delivery, and the need for open discussion to frequently address these inequities. Educational seminars, podcasts, and facilitated debriefs where system change within individual teams may be possible (Covenant Health Palliative Institute, 2023).

Study Strengths and Limitations

There were a number of notable strengths to this study. First, the study included 3 unique sites for participant observation, along with focus group data, providing an in-depth understanding of how the structure and composition of team members impacted how the teams function in theory and practice. There are very few ethnographic studies

that have focused on unit specific details, as was the case in this study, which are likely to have broad resonance with palliative care teams functioning across a variety of care settings. Fieldwork allowed the researcher to develop an understanding of social life, to not just reproduce, but to represent reality from the joint perspective of the participants and researcher. The flexibility in the chosen methods for this study helped create an accurate representation of the three units' clinical realities.

As is the case with any studies there are always limitations, including in this study. Although the observation was inherently useful occurring over a two-day period with each team, it would have been valuable to observe the teams over a longer period to determine if team dynamics changed when different staff members were working or as teams' comfortability with the presence of the researcher grew over time.

Second, the city in which this research was conducted has a very robust, integrated palliative care program which includes a large palliative consult service, palliative home care, a tertiary palliative care unit, and multiple residential hospices. This abundance of established palliative care services is atypical for most other urban centres, and certainly differs drastically from rural settings. The findings from this study therefore may not be applicable in other settings where palliative care teams such as those who participated in this study do not exist or are less robust.

It may have been beneficial to have had some patients and/or patient family members participate in this study, to determine their perspective on team functioning. This would have provided a unique perspective into the perception of effectiveness and necessity (or lack thereof) of interprofessional collaboration, as experienced from the recipients of the team's care. Including patients and family members perspectives would

be beneficial in future studies focused on how team effectiveness is experienced by those in their care. In a similar vein, as participation in this study was voluntary and influenced by participants self-interest in the topic, members of the team who felt segregated or underappreciated may have opted to not participate in this study. This may have been a particular factor in using focus groups as a form of data collection, as these potential participants and participating participants who may have held a differing view may have chosen not to enroll in the study or share a contrasting view in the presence of their other team members.

Finally, the study was limited by the fact that I am a novice researcher. All steps of the process were slowed by my lack of familiarity in conducting a research study. Similarly, my level of skill in conducting observations, writing field notes, analyzing the data, and writing the results was limited by lack of previous experience. However, this lack of experience was balanced with the dialogue and review by my supervisor and committee members, and the rigorous processes that occurred throughout the research process. Processes such as multiple forms of data collection, maintaining reflexivity throughout the research, and keeping an audit trail of the data during the process of analysis contributed to the overall integrity and credibility of the findings.

Conclusion

It is widely accepted that interprofessional collaboration is an essential component in the provision of high-quality palliative care. However, it is also acknowledged that interprofessional collaboration can be difficult to achieve in practice and is influenced by several contextual and cultural factors. The aim of this study was to better understand the differences in interprofessional collaboration between palliative care teams in different

clinical settings, to understand the perspectives of palliative care providers the importance of interprofessional collaboration in their work, and to identify facilitators and barriers to interprofessional collaboration in practice.

Using the methodology of focused ethnography, I gathered data to gain an insider's view on the culture of three separate teams providing palliative care in different settings. Through rich and descriptive detail, I described the cultural landscape of each of the teams and identified contextual various factors which influenced their team cultures'. Observations and focus groups with each of the teams led to findings that were categorized into five themes: Interprofessional Collaboration: A Central Tenet of Palliative Care; Interprofessional Communication: The Single Most Important Ingredient in Effective Interprofessional Collaboration; The Impact of Professional Hierarchy on Interprofessional Collaboration; Role Understanding and Valuing Others; and Facilitators and Barriers to Team Function.

Findings from this study can be used to better understand how individual, professional, and organizational culture impacts teamwork in the delivery of palliative care and supports opportunities for change to eliminate the barriers to consistent interprofessional collaboration in all palliative care settings. Interprofessional collaboration is influenced by the way that communication is enacted; how the hierarchy of the team influences team dynamics and patient care; how role understanding and valuing others drives interactions with other members of the team; and how factors such as physical space design and consistency of team membership influence team function. Further research is needed to determine how physical design of workspaces in palliative care settings can better support interprofessional collaboration; to assess and measure the

patient and family perspectives of interprofessional collaboration on care; and to explore the optimal membership of interprofessional palliative care teams in regard to which professional disciplines should be represented on the team and how continuity of membership is maintained in day to day practice through contributing factors such as full time equivalencies and working schedules.

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Appendix A

Recruitment Poster

UNIVERSITY OF CALGARY

ARE YOU A MEMBER OF A PALLIATIVE CARE TEAM?

DO YOU REGULARLY TAKE PART IN THE PLANNING OR DELIVERY OF PATIENT CARE?

A research study is underway to explore how healthcare providers work together to deliver palliative care

This study has been approved by the University of Calgary Conjoint Health Research Ethics Board REB 16-0475

IF YOU ARE A HEALTHCARE PROVIDER WORKING IN PALLIATIVE CARE YOU MAY BE ELIGIBLE TO PARTICPATE IN A 1 HOUR FOCUS GROUP SESSION TO SHARE YOUR EXPERIENCES AND OPINIONS REGARDING INTERPROFESSIONAL TEAMWORK

IF YOU AREINTERESTED IN PARTICIPATING, PLEASE CONTACT:

ERIN FORSYTH, RN, (MASTERS STUDENT)
ecforsyt@ucalgary.ca
403-874-4659

Appendix B

Consent Forms

UNIVERSITY OF CALGARY

FACULTY OF NURSING
2500 University Drive NW
Calgary, AB, Canada T2N 1N4
ucalgary.ca

Consent Form for Focus Group

TITLE: A Critical Ethnographic Study of Interprofessional Collaboration in Palliative Care

INVESTIGATORS:

Dr. Shelley Raffin Bouchal
University of Calgary, Faculty of Nursing
Associate Professor, Associate Dean (Graduate Programs)
(403) 220-6258

Erin Forsyth, RN, BScN, CHPCN(C) (Graduate Student)
University of Calgary, Faculty of Nursing
Master of Nursing Program
(403) 874-4659

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Teamwork among healthcare professionals is widely accepted as a key element of palliative care. The belief is that a team approach is the best way to support the wide range of needs that dying patients and their families experience. Research suggests that in addition to helping deliver optimal patient and family centred care, interprofessional collaboration may also promote professional growth and satisfaction for members of the healthcare team. This is however an area where a theory practice gap has been identified. Both clinical experience and a review of the existing literature reveal considerable differences between palliative care teams in practice; in short, some teams seem to work together better than others.

It is unknown if there are overarching consistencies in the beliefs of palliative care providers regarding interprofessional collaboration. This is an important question to consider when trying to understand

1. if people working in palliative care feel interprofessional teamwork is as important as theory would have us believe and
2. if the current inconsistencies in practice are worthy of efforts to attempt to create change

This study will involve observations of team members as they interact with one another (patient interactions will not be observed), focus groups, and one to one interviews with healthcare professionals working in a variety of palliative care settings. To be included in this study,

participants must work in palliative care and be regularly involved in activities related to planning and/ or delivering patient care. Transient team members such as casual staff may be present during observations. However, they will not be eligible to participate in focus groups/ interviews as they may not have the same understanding of team function as those who work with the team on a regular basis. While the perspective of patients and family members have the potential to add rich insight into the effectiveness of interprofessional collaboration in palliative care teams, the scope of this study will be limited to healthcare providers.

WHAT IS THE PURPOSE OF THE STUDY?

The intent of this study is to better understand team members' beliefs regarding interprofessional collaboration and the things that contribute to, or hinder, their ability to work together.

Our hope is that the information gained in this study will add to the understanding of best ways to support the delivery of palliative care across sectors.

WHAT WOULD I HAVE TO DO?

If you choose to participate in this study you will be asked to take part in an hour long focus group session. During the focus group, you will have the opportunity to discuss your views and beliefs regarding teamwork in palliative care in general, your perceptions of collaborative practice within your own team, and to explore your thoughts regarding potential barriers and facilitators for interprofessional collaboration. You will also be asked to provide some personal information such as your professional role on the team, how long you have worked in palliative care, and what other areas of healthcare you have worked in. The focus group discussion will be led by one of the researchers (Dr. Shelley Raffin Bouchal) and a second researcher (Erin Forsyth) will make notes and observations. The discussion will be audiotaped to ensure that there is an accurate record of the session.

You do not have to answer any questions you do not wish to answer and you may end your participation at any time. There will not be any negative consequences to you if you choose not to participate or if you choose to withdraw from this study. If you would like to participate in the study but do not feel comfortable sharing in the group setting, you will be offered the opportunity for a 1:1 interview with Erin Forsyth.

WHAT ARE THE RISKS?

Each participant will be assigned a fake name (pseudonym) which will be used in any written information, publication, or presentation of the study results; the name of your work place will also be changed. However, while measures will be taken to maintain your anonymity and confidentiality, it is not possible to guarantee complete anonymity. The palliative care service in Calgary is made up of a relatively small group of people and it is possible that some team identifiers will be recognized by others. It will also be impossible to protect your identity and responses from fellow focus group participants. This may cause feelings of distress if there are

participants who want to discuss information that is of a sensitive nature or that is related to challenges with interpersonal relationships within your team.

Should you experience distress during the focus group and believe you could benefit from support, Erin can refer you to a variety of counselling services. One example of such support is the AHS Employee Assistance Program.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study, there may or may not be a direct benefit to you.

The hope is that the information produced by this study will help to improved our understanding of ways to support interprofessional collaboration in palliative care teams in all work settings.

DO I HAVE TO PARTICIPATE?

No, you have no obligation to participate in this study; all participation is voluntary.

If you choose to withdraw after the focus group has begun, you will be free to leave and stop any further participation in the study. However, anything that you contributed during the focus group discussion (up to the point of your withdrawal) may still be included as removing your comments may not be possible without changing the meaning and context of the remainder of the focus group data.

You can withdraw from the study by:

- Contacting the Primary Investigator (Dr. Raffin Bouchal) or Graduate Student (Erin Forsyth) with your decision to withdraw;
- By not attending/ cancelling your participation in the focus group session;
- By stopping participation in the focus group discussion and advising the researcher that you cannot stay, wish to leave and/ or withdraw from this study.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid to participate in this study nor do you have to pay for anything.

WILL MY RECORDS BE KEPT PRIVATE?

Yes, your records will be kept private, only the research team will see the completed transcripts. The audio and transcribed recordings will be stored on a password protected computer with a firewall. The hard copy data such as master lists, and other research notes will be stored in a locked filing cabinet. All data will be erased from the computer when the study is complete and saved to a password protected flash drive which will be kept in a locked filing cabinet. Everything will be permanently deleted from the flash drive and all hard copy data files will be shredded five years after study completion.

UNIVERSITY OF CALGARY

FACULTY OF NURSING
2500 University Drive NW
Calgary, AB, Canada T2N 1N4
ucalgary.ca

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by the University of Calgary, Alberta Health Services, or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Shelley Raffin (403) 220-6258

Or

Erin Forsyth (403) 874-4659

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.
A signed copy of this consent form has been given to you to keep for your records and reference.

UNIVERSITY OF CALGARY

FACULTY OF NURSING
2500 University Drive NW
Calgary, AB, Canada T2N 1N4
ucalgary.ca

Consent Form for Interview

TITLE: A Critical Ethnographic Study of Interprofessional Collaboration in Palliative Care

INVESTIGATORS:

Dr. Shelley Raffin Bouchal
University of Calgary, Faculty of Nursing
Associate Professor, Associate Dean (Graduate Programs)
(403) 220-6258

Erin Forsyth, RN, BScN, CHPCN(C) (Graduate Student)
University of Calgary, Faculty of Nursing
Master of Nursing Program
(403) 874-4659

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

Teamwork among healthcare professionals is widely accepted as a key element of palliative care. The belief is that a team approach is the best way to support the wide range of needs that dying patients and their families experience. Research suggests that in addition to helping deliver optimal patient and family centred care, interprofessional collaboration may also promote professional growth and satisfaction for members of the healthcare team. This is however an area where a theory practice gap has been identified. Both clinical experience and a review of the existing literature reveal considerable differences between palliative care teams in practice; in short, some teams seem to work together better than others.

It is unknown if there are overarching consistencies in the beliefs of palliative care providers regarding interprofessional collaboration. This is an important question to consider when trying to understand

1. if people working in palliative care feel interprofessional teamwork is as important as theory would have us believe and
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This study will involve observations of team members as they interact with one another (patient interactions will not be observed), focus groups, and one to one interviews with healthcare professionals working in a variety of palliative care settings. To be included in this study

participants must work in palliative care and be regularly involved in activities related to planning and/ or delivering patient care. Transient team members such as casual staff may be present during observations. However, they will not be eligible to participate in focus groups/ interviews as they may not have the same understanding of team function as those who work with the team on a regular basis. While the perspective of patients and family members have the potential to add rich insight into the effectiveness of interprofessional collaboration in palliative care teams, the scope of this study will be limited to healthcare providers.

WHAT IS THE PURPOSE OF THE STUDY?

The intent of this study is to better understand team members' beliefs regarding interprofessional collaboration and the things that contribute to, or hinder, their ability to work together.

Our hope is that the information gained in this study will add to the understanding of best ways to support the delivery of palliative care across sectors.

WHAT WOULD I HAVE TO DO?

If you choose to participate, Erin Forsyth will meet with you for an interview. This interview will take approximately one hour to complete. It will be held at a mutually agreeable time at a location of your choice

During the interview, you will have the opportunity to discuss your views and beliefs regarding teamwork in palliative care in general, your perceptions of collaborative practice within your own team, and to explore your thoughts regarding potential barriers and facilitators for interprofessional collaboration. The session will be audiotaped and later transcribed (typed out word for word). You will also be asked to provide some personal information such as your professional role on the team, how long you have worked in palliative care, and what other areas of healthcare you have worked in.

You do not have to answer any questions you do not wish to answer and you may end your participation at any time. There will not be any negative consequences to you if you choose not to participate or if you choose to withdraw from this study.

WHAT ARE THE RISKS?

There is little risk to you in taking part in this study. You will be assigned a fake name (pseudonym) which will be used in any written information, publication, or presentation of the study results; the name of your work place will also be changed. While measures will be taken to maintain your anonymity and confidentiality, the palliative care service in Calgary is made up of a relatively small group of people and there is some risk that some team details will be recognized by others. Erin will make every effort to use quotations that do not reveal your identity.

Appendix C

Focus Group and Interview Questions

Interview Guiding Questions

- Tell me a little about yourself and how long you have been working in palliative care.
- Tell me about your current job and the team you work with.
- What are the various disciplines represented on this team? What roles do each of these individuals have on the team?
- Do you believe there are key members **required** to create an effective palliative care team? If yes, who would those members be (which professional disciplines)?
- Who are the formal and informal leaders on your team? How is leadership decided? Does leadership ever change?
- Do you think that team function impacts the effectiveness of care for clients and families? How so . . .
- Does interprofessional collaboration have any impact on the professionals providing care?
- Tell me about some of the ways that your team communicates with one another. Are there people who do not communicate with the rest of the team either because they either choose not to or because they do not have an opportunity (i.e. shift work)? What are some strategies that your team has tried to overcome communication challenges?
- Can you describe a time when there has been interprofessional conflict in your team? Were you able to address it? If yes, how did you go about addressing it? If no, why did you choose not to address it?
- What are some of the formal and informal activities you do to create teamwork in your setting?
- What makes teamwork hard?
- Are there things that have helped or that you think could help to improve teamwork?
- Describe a perfect palliative care team. Who would be involved? How would they organize their care?
- How important is teamwork in the provision of palliative care?

Appendix D

Participant Demographic Questions

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Demographic Questionnaire

Please complete the following demographic questions. This information is being collected to help the researchers understand the professional role and background of the study participants. This information will be kept confidential, any personal identifiers such as participant name and place of work will be changed prior to sharing the results in any publication or education sessions.

Participant Information

1) Please indicate your professional discipline:

NA/ PCA/ HCA	Occupational Therapist	Spiritual Care Provider
Physician	Physiotherapist	Social Worker
Pharmacist	Recreational Therapist	Registered Nurse
Volunteer Coordinator	Advance Practice Nurse	Licensed Practical Nurse

Other (please specify) _____

2) What is your role on this team (please check as many as apply)?

Manager	Palliative Consultant	Advance Practice Nurse
Attending Physician	Clinical Nurse Educator	Spiritual Care
Staff Nurse	Nurse Clinician	Social Work
Medical Director	Patient Rehabilitation	Volunteer Resources
Patient Personal Care	Other	

(please specify) _____

3) What is your age?

18 – 20	50 – 59	60 – 69
40 – 49		
70 or older	21 – 29	30 – 39

4) Gender:
male female

5) How long have you worked in health care?
less than 1 year | 1 – 5 years | 6 – 10 years
11 - 15 years | 16 – 20 years | 21 – 25 years
26 – 30 years | 31 – 35 years | 36 – 40 years
41 – 45 years | more than 45 years

6) How long have you worked in palliative care?
less than 1 year | 1 – 5 years | 6 – 10 years
11 - 15 years | 16 – 20 years | 21 – 25 years
26 – 30 years | 31 – 35 years | 36 – 40 years
more than 40 years

7) How long have you worked with this team/ in this location?
less than 1 year | 1 – 5 years | 6 – 10 years
11 - 15 years | 16 – 20 years | 21 – 25 years
26 – 30 years | 31 – 35 years | 36 – 40 years
more than 40 years

8) Have you had experience working with an interprofessional team prior to working in your current environment?
yes no

Appendix E

Example of How Codes Developed into Themes

Participant Quote from interviews	**Codes from Interviews**	**Fieldnotes**	**Potential themes**	**Main theme**
I think definitely the leader is the physician especially in acute care. The physician comes up with the plan and we just help carry it out. I think to the patient the physician is always the ultimate resource I would say ultimately, it's the doctor, because no matter what I'm doing if there is an issue, then I can say you know what our doctor is right here and I can get them to help.	The physician is always the ultimate resource Physician Dominance	I witnessed the staff discussing in handover how the family was not satisfied about the information given by the nurse and wanted to talk to "the Boss"	• Physicians Remain the Lead and Ultimate Authority	The Impact of Professional Hierarchy on Interprofessional Collaboration
I certainly don't feel like the physician is in charge. Everybody shares the responsibility, we don't own the responsibility.	No Hierarchy	I noted segregated spaces for the physicians in two of the teams in the acute care settings. This was not discussed but seemed to be taken for granted.	• The Hidden and Unspoken Culture of Professional Hierarchy	

I think it also speaks to the age of the population we see. We tend to see people who are steeped in that because that's how they grew up in the health care system. So they say what does the doctor say? I get cards that say to Dr. X and his team, and sometimes even more explicitly…your staff.	Doctor is the Leader		• Cultural Perception	