VOICES OF HEALTH CARE WORKERS:
EXPERIENCE OF BEING ON AN INTERDISCIPLINARY TEAM
IN HOSPICE PALLIATIVE CARE

by

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Abstract

Having a model of interdisciplinary teamwork is an important part of clinical practice in hospice palliative care. It plays an integral role in providing patient care by multi-disciplines of healthcare professionals who are required to address the intricate needs of patients at the end of life. Yet, the nature of participating in an interdisciplinary patient care team has not been fully understood in theory or clinical work. The purpose of this research was to generate an understanding of the experience of being on an interdisciplinary team in hospice palliative care through healthcare workers’ own voices, using a content analysis method in a qualitative research paradigm. A total of 11 healthcare professionals across medical and psychosocial disciplines participated in this study. Data were collected from semi-structured interviews with these participants and were analyzed for thematic contents. The following six themes regarding the nature and quality of working as a member of an interdisciplinary team emerged; (a) collaborative work, (b) quality of relationships, (c) communication, (d) team building activities, (e) personal qualities, and (f) institutional influence. A conceptual framework is proposed as an “integrative and multidimensional” model of an interdisciplinary team approach to hospice palliative care. The proposed model offers a holistic view of an interdisciplinary team approach. Implications for clinical practice and future research are discussed. Further, suggestions are offered in order to enrich the understanding of interdisciplinary teamwork, to enhance the quality of patient care, to support and advocate the well-being of healthcare workers, and to develop accountability for hospice palliative care programs.
Preface

This research was conducted upon the ethics approvals granted from the University of British Columbia Behavioural Research Ethics Board on October 16, 2009 (number H09-01893), and from the Fraser Health Research Ethics Board on September 18, 2009 (number FHREB 2009-060).
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Dedication

This research is dedicated to my parents, Hajime and Harumi Okubo.
Chapter 1

Introduction

1.1. Statement of the Problem

Hospice palliative care programs have been expanding to fulfill the demands of end of life care for the past 30 years in North America and other parts of the world (Blacker & Deveau, 2010; Wittenberg-Lyles, Parker Oliver, Demiris, & Regehr, 2010). Canada is one of many countries with increasing demands for hospice palliative care programs, due to an increase in the aging population and populations with chronic illness (Williams et al., 2010). Here in British Columbia, hospice programs have been growing rapidly in order to meet the need for the complex care of dying patients through creating new hospice palliative care programs in the last few decades (Bodell & Taylor, 2007). For example, the Fraser Health Authority (FHA), where I work as a music therapist, has been developing their hospice program since 2001. The FHA has implemented eight programs within the region in the last 11 years. The development of hospice palliative care programs has faced a number of challenges, due to the complex needs of dying patients and as a result of being a new field in the healthcare system (Hiatt, Stelle, Mulsow, & Pearson Scott, 2007; Richie, 1987). In hospice palliative care, working within an interdisciplinary team is one of the main challenges (Resse & Sontag, 2001; Wittenberg-Lyles & Parker Oliver, 2007) that healthcare workers face on a daily basis in their clinical practice. Although many researchers have recognized various issues around interdisciplinary teams, the problems experienced by interdisciplinary team members have not been extensively investigated (O’Connor, Fisher, & Guilfoyle, 2006; Resse & Sontag, 2001; Wittenberg-Lyles & Parker Oliver, 2007).

Based on the hospice philosophy of holistic care for patients and their family, hospice
palliative care programs embrace interdisciplinary teamwork to accommodate the intricate needs of dying patients and their families (Bodell & Taylor, 2007; Head, 2002; Wittenberg-Lyles & Parker Oliver, 2007). Thus, a model of interdisciplinary teams fills an important role in hospice palliative care programs in order to provide care for the complex issues of patients with terminal illnesses. The interdisciplinary team is a group of people from different disciplines, who work together with the dying patient and his or her family to develop and implement a care plan. The team members interact and work together towards common care goals for the patient and their family, which an individual member of the team cannot achieve alone. That is, interdisciplinary teamwork requires a collaborative effort through an interpersonal process (Parker Oliver & Peck, 2006).

Head (2002) illustrates the importance of acknowledging the strengths and challenges of working in interdisciplinary settings. Without knowing both what the interdisciplinary team’s strengths and weaknesses are, the interdisciplinary team’s patient care cannot be successfully delivered. For example, one of the strengths of a successful interdisciplinary team is the power of collaboration in their effort to meet the dying patients’ physical and psychosocial needs (Wittenberg-Lyles & Parker Oliver, 2007). Conversely, various challenges such as interpersonal conflict and shared roles exist in developing successful collaborative work within the interdisciplinary team (Resse & Sontag, 2001; Wittenberg-Lyles & Parker Oliver, 2007). For example, unsuccessful interdisciplinary team members who have difficulties working with their interdisciplinary team collaboratively may develop a sense of incompetence in their work. However, research on the clinical practice of the interdisciplinary team has not yet been extensive. Healthcare workers have been working within their interdisciplinary teams blindly, without knowing what to expect or how they should work within the interdisciplinary team to
provide better patient care and fulfill patient needs through their teamwork.

Research on the clinical practice of these interdisciplinary teams, such as the collaborative communication within the team, is needed to understand and improve their effectiveness (Kirk, Kirk, Kuziemsky, & Wagar, 2010; Wittenberg-Lyles, Parker Oliver, & Demiris, 2010; Wittenberg-Lyles & Parker Oliver, 2007). O’Connor, Fisher, and Guilfoyle (2006) argued that studies of interdisciplinary teams in hospice palliative care are based only on theoretical assumptions. That is, clinical practice of interdisciplinary teams has never been studied beyond rhetoric. To move beyond rhetorical assumptions, research based on actual clinical practice, at both individual and systemic levels, is needed to better understand interdisciplinary teams in hospice palliative care units. From the study by social workers Monroe and DeLoach (2004), qualitative research about the interdisciplinary team model is needed to better understand the issues and concerns surrounding hospice social workers. In addition to Monroe and DeLoach’s comments, DeLoach (2003) states that qualitative research will help us to explore interdisciplinary teams in hospice palliative care, and will facilitate improvement of work environments and the job satisfaction of healthcare workers.

Qualitative research, which inquires about the experiences of the healthcare workers, is needed to understand both the strengths and the areas of improvement necessary for interdisciplinary teamwork in a clinical practice. In addition to the limited research on the clinical practice of interdisciplinary teams, other studies, based on multi-disciplines are lacking. Most studies of the interdisciplinary team model are based on a single discipline such as nursing or social work (McCallin, 2001). To understand the full picture of their teamwork, cross-disciplinary research is necessary. Hence, both qualitative research and the investigation of healthcare workers in multi-disciplinary settings are needed to understand the whole picture of
the interdisciplinary team in clinical practice. Furthermore, past research (Hall & Weaver, 2001; Parker Oliver, Wittenberg-Lyles, & Day, 2007) has highlighted the importance of providing education for interdisciplinary team members both before they enter the work force and throughout their career. The subject of the interdisciplinary team or how to work within an interdisciplinary team is not part of the curriculum of hospice palliative care degree or diploma programs, nor is it a part of continuing education within the hospice workplace (Cohen Fineberg, Wenger, & Forrow, 2004). Research and education for interdisciplinary teamwork is key to developing a productive and collaborative interdisciplinary team to better serve patients and their families in hospice programs (Weissman, Quill, & Block, 2011; Resse & Sontag, 2001).

We, as healthcare workers, have been working among interdisciplinary teams without formal training about how to work within these interdisciplinary teams to best address the patient’s complex needs in hospice palliative care (Cohen Fineberg et al., 2004). We do not have a complete knowledge of what is foundational for best practice in interdisciplinary teamwork, in the clinical settings of hospice palliative care. Before we can develop best practices in clinical settings and educational programs regarding the interdisciplinary teams, we need to understand their nature and their function through the experiences of working within the interdisciplinary team. By understanding the nature of the interdisciplinary team through clinical experience, we can then understand how interdisciplinary teams can be run more effectively to provide optimal care for dying patients and their families. Therefore, holistic qualitative research—that includes participants from across disciplines—is needed to understand the core issues and concerns for working within the interdisciplinary team, and to develop an educational program to train healthcare workers to be effective team members in hospice
palliative care settings. This research is a holistic exploration of the experience of the interdisciplinary team, which was investigated using a qualitative methodology: content analysis. The themes of the interdisciplinary team that emerge through content analysis may contribute to generating new knowledge of clinical practice and education to enhance hospice palliative care.

1.2. The Purpose of the Research

The interdisciplinary team influences the care received by patients and their families (Cherlin et al., 2010; Hall & Weaver, 2001; Parker Oliver et al., 2007). To provide high quality care for patients and their families, understanding the role and the issues of the interdisciplinary team is essential. As stated earlier in this paper, the nature of the clinical practice of the interdisciplinary team in hospice palliative care has not yet been fully researched. Without an understanding of the interdisciplinary team and developing structured education to work effectively within the interdisciplinary team, healthcare workers will find it challenging to maximize care for patients and their families. The purpose of this qualitative research is to understand the strengths and challenges associated with interdisciplinary teams by understanding the experiences of healthcare workers in hospice palliative care units.

1.3. Definitions

Here are the definitions of two main key concepts that are necessary to be clarified: (a) hospice palliative, care and (b) interdisciplinary team.

1.3.1. Hospice Palliative Care

The following definition of the hospice palliative care, taken from the British Columbia Hospice Palliative Care Association (2008), encompasses holistic care for the dying person and his or her family:
The combination of active and compassionate therapies intended to comfort and support individuals and families who are living with a life-threatening illness. During periods of illness and bereavement, hospice palliative care may be combined with therapies aimed at reducing or curing illness, or it may be the total focus of care. Hospice palliative care strives to meet, through patient-directed supportive interventions, the physical, social and spiritual needs of patients and families, with sensitivity to their personal, cultural and religious beliefs.

1.3.2. Interdisciplinary Team

Although some researchers have expressed that interdisciplinary and multidisciplinary are synonymous (Sommer, Silagy, & Rose, 1992), interdisciplinary teams and multidisciplinary teams will be distinguished by different concepts and definitions in this thesis, as supported by other research in this field (Lavin et al., 2001; Lindeke & Block, 1998). A multidisciplinary team is defined as “the sequential provision of discipline specific healthcare by multiple providers” (Lindeke & Block, 1998, p.213), while an interdisciplinary team requires further collaboration with other disciplines such as “coordination, joint decision making, communication, shared responsibility, and shared authority” (Lindeke & Block, 1998, p.213).

Another difference between the concepts is that multidisciplinary teams do not require face to face meetings with other disciplines, but interdisciplinary care involves meetings and shared responsibilities (Lavin et al., 2001). To further illustrate the differences between multi-disciplinary and interdisciplinary teams, I would like to use an analogy from the field of sports. A multi-disciplinary team is like an individual sport—for example: running. All players run towards achieving a common goal, but they do not need to communicate or share any responsibility. An interdisciplinary team is like a group sport—for example: soccer or rugby.
They share a common goal to achieve or win a game, like runners, but the players in the team need to communicate, understand each other’s role, share responsibilities, and support each other throughout the game. Furthermore, interdisciplinary teamwork for hospice palliative care embraces the hospice philosophy of care, which is holistic care for the patients and their families (Reese & Sontag, 2001). The definition of an interdisciplinary team for this research, which is integrated from referencing different literature (Lavin et al., 2001; Lindeke & Block, 1998; Parker Oliver & Peck, 2006), is as follows:

The interdisciplinary team in hospice palliative care programs embraces the collaborative teamwork by multiple disciplines, which includes medical and psychosocial professionals. The interdisciplinary team shares the leadership, responsibility, and decision making process for the care of patients and their families in order to provide holistic care to fulfill the needs of dying patients and their families at the end of life.

The following list is an illustration of various healthcare professionals in a typical interdisciplinary team of hospice palliative care. All the healthcare workers listed here work together to provide care and improve the quality of life for the patients and their families.

<table>
<thead>
<tr>
<th>Management</th>
<th>Medical Team</th>
<th>Psychosocial Team</th>
<th>Other services</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Program director</td>
<td>(a) Patient care coordinator</td>
<td>(a) Social worker/counselor</td>
<td>(a) Unit clerk</td>
</tr>
<tr>
<td>(b) Program manager</td>
<td>(b) Palliative physician</td>
<td>(b) Spiritual care coordinator</td>
<td>(b) Program clerk</td>
</tr>
<tr>
<td></td>
<td>(c) Pharmacist</td>
<td>(c) Occupational therapist</td>
<td>(c) Housekeeping</td>
</tr>
<tr>
<td></td>
<td>(d) Nurse (registered nurse or licensed practical nurse)</td>
<td>(d) Music therapist</td>
<td>(d) Dietician/food services</td>
</tr>
<tr>
<td></td>
<td>(e) Clinical resource nurse</td>
<td>(e) Volunteer coordinator</td>
<td>(e) Volunteers</td>
</tr>
<tr>
<td></td>
<td>(f) Clinical nurse specialist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
All the healthcare workers listed above work together to provide care and quality of life for the patients and their families.

1.4. Delimitation of the Study

This research included interviews from 11 participants working on interdisciplinary teams. These participants were drawn from multiple healthcare professions, from both medical and psychosocial teams, and from several hospice palliative care programs under the FHA. This study is based on a subjective view of the experience of the participants (Cozby, 2001). Therefore, the findings of this research may not be generalized due to the small sample size and ideographic nature (Cozby, 2001; Thomas & Harden, 2008). Through investigating the actual clinical experiences of healthcare workers, this research aimed to generate new knowledge of interdisciplinary teams in hospice palliative care settings.

1.5. Justification of the Study

This research is relevant to the field of counselling psychology for two reasons. Firstly, counsellors are part of interdisciplinary teams in hospice palliative care. They provide individual, family, and group therapy for patients and their families, as well as grief counselling for families after a patient dies (Kirk & MacManus, 2002; Pace, Burke, & Glass, 2006; Thompson, Rose, Wainwright, Mattar, & Scanlan, 2001). In addition, the counsellors provide support for team members (Thompson et al., 2001). Therefore, this research hopes to cultivate counsellors' knowledge of interdisciplinary teams in hospice palliative care, to enhance their clinical practice as team members and to support others within the interdisciplinary team. The second reason this research contributes to the field of counselling psychology is that interpersonal processes are an important aspect of the interdisciplinary team (Parker Oliver & Peck, 2006). Because counsellors possess knowledge and skills of interpersonal processes, a
counsellor’s perspective might cultivate knowledge in other interdisciplinary team members. Thus, researching interdisciplinary teams in hospice palliative care is an appropriate subject for the field of counselling.

1.6. The Research Question

This research was aimed at understanding how each healthcare worker experiences working within an interdisciplinary team on a day-to-day basis. To understand the nature of the interdisciplinary team, it is essential to understand healthcare workers’ clinical experiences. This research was conducted to explore the experiences of interdisciplinary teams, beyond theoretical assumptions.

To inquire about the experiences of interdisciplinary team members, the following primary question was explored: “What is the experience of being on an interdisciplinary team in hospice palliative care?” Through this research, the experiences of healthcare workers in the interdisciplinary team in hospice palliative care were examined in depth to bring new knowledge to the field.
Chapter 2
Literature Review

2.1. Introduction

The need for qualitative research investigating the interdisciplinary team in hospice palliative care was discussed in the previous section of this paper. The core question of this research to fulfill the purpose of the study is: “What is the experience of being on an interdisciplinary team in hospice palliative care?” Therefore, this study focuses on the clinical experience of healthcare workers who are on interdisciplinary teams. This section will explore several subjects, such as a brief history and philosophy of hospice palliative care, the history of interdisciplinary teams, and several topics from previous studies on the interdisciplinary team in hospice palliative care settings.

2.2. History and Philosophy of Hospice Palliative Care

The history of hospice palliative care began with the intention to provide care for the pilgrims who were dying from terminal illnesses in the fifth century (Bishop et al., 2000). The hospice was a place of refuge and rest for pilgrims at their lives’ end. The word hospice originated from the Latin word *hospes*, meaning a host and a guest. The early foundational hospices created the hospice philosophy, which is as follows: the hospice is a place to promote “the care of the whole person” (Bishop et al., 2000, p.137) and to address “the needs of the body, mind, and spirit.”

The modern hospice movement was started by a physician, Dr. Dame Cicely Saunders (Bishop et al., 2000; Parker Oliver, Bronstein, & Kurzejeski, 2005). Dr. Saunders had a unique educational and professional background, having been a social worker, nurse, and physician, which influenced the foundation of modern hospice programs. She carried on the hospice’s
philosophy of holistic care, but Dr. Saunders did not believe that a single discipline could accommodate all of the patient’s and their family’s physical, financial, spiritual and psychosocial needs. As such, she introduced the concept of interdisciplinary teams into the hospice palliative care setting. She established a hospice program at St. Christopher’s Hospice in London, England, in 1967.

Dr. Saunders’s teachings influenced the establishment of hospices in North America (Bishop et al., 2000), where palliative care programs embrace the hospice philosophy—which is the total care of the patient and their family—as well as the inclusion of an interdisciplinary team to manage complex end-of-life needs. In 1973, the Royal Hospital in Montreal opened the first hospice for palliative care in Canada based on St. Christopher’s Hospice model (Billings, 1998; Bishop et al., 2000).

2.3. **Interdisciplinary Teams for Hospice Palliative Care Programs**

The foundation of hospice palliative care is to address the intricate needs of the whole person at the end of life. Because of this intricacy, high-quality patient care can best be achieved through an interdisciplinary team model (Billings, 1998; Bishop et al., 2000; Crawford & Price, 2003; Demiris, Washington, Doorenbos, Parker Oliver, & Wittenberg-Lyles, 2008; Parker Oliver et al., 2005). This section describes the history, conceptual framework, education, and other related issues regarding the interdisciplinary team in hospice palliative care setting.

2.3.1. **Brief History of Interdisciplinary Teams**

The interdisciplinary team in hospice palliative care is rooted in the hospice philosophy dating back to the fifth century (Bishop et al., 2000). However, in general, the history of the interdisciplinary team is newer than the history of hospice palliative care. In modern times, the
interdisciplinary team model was introduced after World War II (Coopman, 2001). The concept of the interdisciplinary team was influenced by two factors: the human relations movement and the Japanese business management model (post World War II). Business teams in the United States recognized that interdisciplinary teams could enhance productivity and profit, through collaborative work for complex productions. As a result, the interdisciplinary team has become a central part of the post-modern business world.

The concept of the interdisciplinary team in the healthcare services was borrowed from the business world (MacCallin, 2001). The interdisciplinary team was introduced to healthcare services for a number of reasons: (a) each discipline became highly specialized in one area, and a single discipline could not provide care for a patient alone; (b) the team-based organization is believed to be more effective, efficient, and adaptive; and (c) the team-based approach embraces a philosophy for the holistic care of the person, which applies to the hospice philosophy of care (Coopman, 2001). Hospice palliative care naturally established the involvement of the interdisciplinary team to address the complex care needs of people at the end of life. To better understand the interdisciplinary team, the next question to be explored is: What are the core concepts of the interdisciplinary team within the healthcare system?

2.3.2. Conceptual Framework of Interdisciplinary Team in Hospice Palliative Care

In the first chapter, the interdisciplinary team in hospice palliative care was described as a team that works collaboratively. How can collaborative teamwork be achieved? Without understanding the concept of successful collaborative teamwork, we cannot identify and solve the issues relating to less successful teamwork. Collaborative teamwork is the interpersonal process of working towards a common goal (Parker Oliver & Peck, 2006). How can an interdisciplinary teamwork together towards a common goal, through the interpersonal process?
To answer this question, Bronstein (2003) has developed a model or a conceptual framework of interdisciplinary collaboration, which is based on role theory and ecological systems theory. The interdisciplinary collaboration model includes five components which will be explained below: interdependence; newly created professional activities; flexibility; collective ownership of goals; and reflection on process.

**Interdependence**

Interdependence means professionals from different disciplines working together towards common goals and tasks, which can only be achieved through teamwork. Interdependence also includes team activities such as spending time together formally or informally. Some examples of this are: having a meeting for the care plan; assessing a patient together; writing a report to the team; and showing respect for others.

**Newly Created Professional Activities**

Newly created professional activities refer to synergetic actions, programs, and structures, which maximize the abilities and expertise of each discipline. Newly created professional activities achieve goals which one discipline or person could not complete alone. One example is a nurse working with a music therapist to manage pain through both medical care and musical relaxation techniques. Creating new activities helps build teamwork and develops a sense of achievement within the team.

**Flexibility**

Flexibility is adaptability with changing situations or conditions to creatively achieve a common goal. Flexibility may cause a blurring of the professional roles, but it should be permitted to an appropriate extent. The team members help each other towards interdependence by sharing responsibility and developing flexibility.
Collective Ownership

Collective ownership of goals refers to the shared responsibility of processes towards a common goal. This includes not only taking one’s individual responsibility as a team member seriously, but also to provide support to all team members through the entire process of working together.

Reflection on Process

Reflection on process encourages team members to focus on not only the outcome, but also on the process of working together, which requires making a commitment to self-evaluation and mutual feedback.

These five components together are the construct for collaborative teamwork. Bronstein’s model is a conceptual framework based on theory, not from actual clinical work (Bronstein, 2003; Wittenberg-Lyles & Parker Oliver, 2007). Bronstein (2003), who developed this model, expressed the need for applying it to clinical work. Does this conceptual framework really reflect the clinical practice of successful interdisciplinary teamwork in hospice palliative care? Do the healthcare workers who are working in collaborative teams in hospice palliative care units experience all five of these concepts? Wittenberg-Lyles and Parker Oliver (2007) addressed these two questions through a mixed methods study with qualitative observation by ethnography and administering the Modified Index of Interdisciplinary Collaboration (MIIC), which is a measure based on Bronstein’s concept of collaborative interdisciplinary teams. They concluded that several changes needed to be made in both the conceptual framework and the MIIC. They recommended developing the areas of communication and individual and group reflective processes further. The examination of the conceptual framework for collaborative interdisciplinary teams is limited. Further studies are
needed to develop a theoretical framework which reflects actual clinical practice in hospice palliative care.

2.3.3. Major Problems of the Interdisciplinary Team in Hospice Palliative Care

The concept of an effective interdisciplinary team was discussed in the previous section. Even though the interdisciplinary team approach is valued by healthcare professionals, it is also a source of stress and frustration for them (Bruce & Boston, 2008). Six common challenges faced by those working in interdisciplinary teams in hospice palliative care settings are: role blurring; different values and paradigms; communication; unequal share of responsibilities; power differentials; and personal conflicts (Reese & Sontag, 2001; Vachon, 1987).

Each issue will be discussed in the following pages to further illustrate the everyday challenges of interdisciplinary team members face in their practice.

Role Blurring

Role blurring is defined as the overlapping roles with other disciplines (Reese & Sontag, 2001). The issue of role blurring has existed in interdisciplinary teams since their inception (Vachon, 1999). In early days, professionals and volunteers shared their roles. Currently, role blurring can still be seen among professionals even in specialized fields such as social work, and spiritual care/chaplain. Healthcare professionals are struggling to distinguish each other’s boundaries (Hall, 2005; Meier & Beresford, 2008a; Wittenberg-Lyles, Parker Oliver, Demiris, Baldwin, & Regehr, 2008). For example, a physician or a nurse identifies the psychological or spiritual needs of the patient, and then he or she might address these needs without reaching out to other psychosocial team members. Vachon (1987) proclaims that “hospice roles are frequently ill defined” (p.86), although the workers’ desire in the hospice palliative care units is to be helpful to the patients and their families. Healthcare workers try to
do as much as they possibly can to help dying patients and their families, but these desires can further contribute to role blurring. The roles of each discipline are not clear in the hospice palliative care setting, and team members may assume the roles of other workers (Blacker & Deveau, 2010; Hall, 2005); therefore, as a consequence of these unclear roles, the interdisciplinary team may fail to achieve a strong collaboration in their teamwork (Wittenberg-Lyles et al., 2010).

Differences in Professional Values and Paradigms

Interdisciplinary teams consistently face the challenge of integrating different professional values (Lindeke & Block, 1998). The differing values and priorities across disciplines can cause conflicts in the assessment, and the care plan, for a patient. For example, a physician may emphasize on beneficence, but a nurse may focus on the autonomy of patients and their families. The difference in paradigms also creates conflicts within the interdisciplinary team. For example, a physician may use a patho-physiological paradigm, while a social worker may value an individualistic paradigm. These differences can block collaborative work in the interdisciplinary team. Differences in professional values have often been internalized and not shared openly among the team members because the values are engrained during educational training, and the team members rarely have opportunities to discuss their values with other team members in clinical settings (Hall, 2005). To overcome differences between professional values and paradigms, all disciplines would benefit from sharing their core values with all team members.

Communication

Communication is one of the stressors within interdisciplinary teams (Dean, 1998; Vachon, 1987). The participants in a study (Vachon, 1999) on job stress expressed more
difficulties with communication within the system, and the interdisciplinary team, than with patients and their families. Furthermore, the primary source of job stress among palliative care nurses is not the stress from on-going loss and grief (Dean, 1998), but stress of communicating within the team and with patients and their families. In another study (DiTullio & McDonald, 1999), 55.3% of hospice worker participants expressed inadequate communication, such as lack of planning and unclear work guidelines, as the major source of stress in the workplace. A lack of proper communication among the interdisciplinary team causes stress for its team members (DiTullio & McDonald, 1999; Kirk et al., 2010). Street and Blackford (2001) expressed the need for a common language which all the interdisciplinary team members understand, in order to communicate more effectively for patient care.

Furthermore, research about communication across multiple disciplines by the interdisciplinary team in hospice palliative care has rarely been studied (Kirk et al., 2010). The current studies have concentrated on communication during interdisciplinary team meetings (Demiris et al., 2008; Wittenberg-Lyles et al., 2010; Wittenberg-Lyles et al., 2009). Research on communication in interdisciplinary team meetings provided evidence for a lack of formal protocols for the sharing of information, and a lack of shared discussion time among the interdisciplinary team (Kirk et al., 2010; Wittenberg-Lyles, Parker Oliver, Demiris, Baldwin, & Regehr, 2008). More attention should be paid to communication among the interdisciplinary team members because it influences and determines the patient’s quality of care (Wittenberg-Lyles et al., 2009).

**Unequal Share of Responsibilities**

Ideally, the collaborative interdisciplinary team shares responsibilities equally (Bronstein, 2003; Lavin et al., 2001). However, the reality is that the responsibilities of the
team are not all equal (Eagle & de Vries, 2005; Meier & Beresford, 2008b). In their ethnographic study, Eagle and de Vries (2005) found that the members of the psychosocial care team have less involvement in the decision making and admission processes, compared to members of the medical team. Furthermore, psychosocial information is identified as extra or additional information to the interdisciplinary team, rather than being seen as an essential aspect of the care plan (DeFord, 2003). Most of the interdisciplinary team meetings focus on the biomedical information of the patient.

**Power Differential**

The study by Coopman (2001) showed that the interdisciplinary team members in hospice palliative care do not share power equality, which is related to having authorities to make decisions and take responsibility for the patient care. Power struggles among team members cause conflicts at both the professional and the personal level (Vachon, 1987). For example, power struggles between physicians and nurses are particularly common in the hospice palliative care setting (Kirk et al., 2010). The healthcare professionals who are working on the interdisciplinary team tend to view other disciplines negatively, as having less expertise, or as being less co-operative.

In another study, Hall (2005) claims that physicians often dominate the group because they are trained to take charge of a situation. A team which is dominated by a physician tends to follow a more medical model, rather than a more holistic model. In one study (DeFord, 2003), where the interdisciplinary team was led by a non-medical professional, the patient was viewed in a more holistic way. Thus, sharing leadership and decision-making roles in the interdisciplinary team facilitates collaboration and improves the quality of care for patients and for their families.
Personal Conflicts

Personal conflicts are also common in the interdisciplinary team setting (Parker Oliver & Peck, 2006). Of the team members interviewed, 70% expressed that they had dealt with personal conflicts. A lack of flexibility seems to be one of the key sources of personal conflict when working together. In the study of job stress of hospice workers (Vachon, 1987), personal conflicts in the workplace were caused by scapegoating, rivalry, power struggles, hostility, separation anxiety, and inadequacy.

There are many complex issues around the effective functioning of the interdisciplinary team in hospice palliative care. These interpersonal issues may be due to a lack of guidelines for working within the interdisciplinary team (Cohen Fineberg et al., 2004), when the team members are expected to work collaboratively without any formal education or training in this area. Education may be the key to solving these interpersonal conflict issues.

2.3.4. Education

The concept of ongoing education for interdisciplinary teams in the healthcare system has been receiving increased international attention (Lavin et al., 2001). Because the interdisciplinary team model began as a grass-roots movement to address the complex needs of patients (Hall & Weaver, 2001), there has been little to no focus on training professionals to work collaboratively with other healthcare professionals (Cohen Fineberg et al., 2004). In hospice palliative care setting, it is essential to understand the roles of other disciplines. The education healthcare practitioners receive tends to be isolated within each discipline, or highly specialized. It does not serve to foster an understanding of other disciplines or the development of mutual respect for other disciplines. Weissman et al. (2011) suggest that medical students should have training in teamwork to understand the roles of other disciplines in
order to learn how to facilitate comprehensive care for palliative patients. Research by Cohen Fineberg et al. (2004) was conducted to evaluate the interdisciplinary education program for social work students and medical students. The results showed the benefit education provided on how to work within an interdisciplinary team. It helped develop the understanding of professional roles between both medical and social work students. Both sets of students expressed that they appreciated learning from each other and gained new knowledge and perspective from one another. These studies show support for the importance of education so that the interdisciplinary team can work together effectively. Currently, universities are feeling the pressure to educate interdisciplinary teams, due to the demand for effective team players within the healthcare system (Hall & Weaver, 2001). This area of education is still new, and further studies surrounding the education of interdisciplinary teams is necessary to develop a structure for formal training of healthcare professionals.

2.4. Summary of the Literature Review

For interdisciplinary team members, teamwork is an intuitive process (Rafferty, Ball, & Aiken, 2001), which makes it challenging to understand or evaluate its function, process, and outcome. Not one area of the interdisciplinary team has been researched extensively, even though most healthcare workers within the interdisciplinary team experience various challenges (Bruce & Boston, 2008; Reese & Sontag, 2001; Vachon, 1987). Further studies of the interdisciplinary team are needed. This research may add to the knowledge of interdisciplinary teamwork by exploring the experience of interdisciplinary team members working in the hospice setting.
Chapter 3

Methodology

3.1. Paradigm: Qualitative Research and Social Constructionism

Qualitative research encourages researchers to question their own assumptions and biases, and to explore their participants’ experiences (Creswell, 2007; Merrick, 1999). It facilitates understanding of the subjective world. Qualitative research inquiry can provide a framework to discover and to ascribe meanings of experience by individuals and groups. Morrow (2007) states that qualitative research is the best approach to understand one’s meaning of experiences. Therefore, the qualitative research method is most suitable for investigating the research question of this study: “What is the experience of being on an interdisciplinary team in hospice palliative care?”

This research embraces the social constructionist worldview, which is based on the belief of that “individuals develop subjective meanings of their experiences—meanings directed towards certain objects or things” (Creswell, 2009, p.8). In other words, knowledge or meaning is co-constructed by each individual’s subjective social reality (Haverkamp & Young, 2007). The focus of this research is to understand the experience of each research participant, who is working on an interdisciplinary team in the hospice palliative care setting. Individual semi-structured interviews were the data source for this research because they “are widely used by healthcare researchers to co-create meaning with interviewees by reconstructing perceptions of events and experiences related to health and healthcare delivery” (DiCicco-Bloom & Crabtree, 2006, p. 316). Therefore, the data collected through semi-structured interviews will allow the researcher to inquire into the experience of being on an interdisciplinary team in hospice palliative care, and it will generate subjective meanings of one’s experience through the
paradigm of the social constructionism.

3.2. Method: Content Analysis

To understand the experience of being on an interdisciplinary team, content analysis was selected as a method of data analysis for this research. Content analysis embraces two different traditions (DiCicco-Bloom & Crabtree, 2006). One is the linguistic tradition, which is an objective analysis of texts, and the other is the sociological tradition, which is interested in understanding human experiences through one’s use of language. This research is guided primarily by the latter tradition. Vieny (1983) states that “content analysis is based on the assumption that the language in which people choose to express themselves contains information about the nature of their psychological states” (p.542). Content analysis makes inquiries into texts or transcripts of research participants’ interviews. The research participants’ own words or voices are reflected by the emergent themes discovered through the content analysis. This is a useful method to understand research the realities or perceptions of research participants’ experiences through their own language. Unlike other research methods which are theory based, content analysis has only one assumption—that one’s choice of language embraces information about the nature of their experience (Schilling, 2006; Viney, 1983). Thus, content analysis can be used to investigate the nature of one’s experience directly without having various preconceptions, which are based on a particular perspective of theory or methodology.

The content analysis research process provides an opportunity to inquire into both subjective and objective perspectives (Granheim & Lundman, 2004; Schilling, 2006; Viney, 1983). Content analysis was developed to analyze the contents of communication both systematically and quantitatively. More recently, content analysis has evolved to interpret
latent content or meaning in the texts. Hence, a rigorous process through content analysis can be completed to understand the research participants’ voices of their experiences both subjectively and objectively.

Furthermore, content analysis will cultivate “an open and honest relationship between researchers and research participants” (Viney, 1983, p.559). The mutual relationship is essential for in-depth semi-structured interviews (DiCicco-Bloom & Crabtree, 2006). The open and honest relationship influences the quality of interviews, the primary data source for this research.

This research aims to understand one’s experience of working in an interdisciplinary team in hospice palliative care. Therefore, this research is an explanatory study, which is based on the experience of individuals who are a part of an interdisciplinary team rather than based on theories or hypotheses. In order to examine one’s experience, this research utilizes the inductive process, which allows for examining texts or one’s voice closely, through content analysis (Braun & Clarke, 2006; Elo & Kyngäs, 2007; Marying, 2000; White & Marsh, 2006).

In conclusion, content analysis is an appropriate method by which to understand the nature of the experience of being on an interdisciplinary team without any particular theoretical lens or as exploratory research. Exploring the experience of working in an interdisciplinary team through content analysis may help us gain an understanding of the function of the interdisciplinary team in clinical work settings.

3.3. Role of the Researcher

Creswell (2007) states that the researcher is a key instrument for qualitative research. In qualitative research, the researcher is the person who collects data, observes behaviour, interviews participants, and interprets data. From the view of social constructionism, meanings
of a phenomenon or a research question are co-constructed through multiple realities by participants and the researcher (Marrow, 2007). The researcher’s subjective view and values are embraced in qualitative research. In this research, I am an instrument in interviewing participants, transcribing, analyzing, and synthesizing the data. Even though the subjectivity of the researcher is valued in the social constructivist worldview, the researcher needs to be aware and to be able to distinguish differences between the participants’ realities, and the researcher’s own perceptions (Morrow, 2007; Yeh & Inman, 2007). Qualitative researchers need to be aware of their own biases and perceptions on an on-going basis, through journaling and self-reflexivity.

I worked in several hospice palliative care programs as a music therapist from 2000 to 2011, and each program had an interdisciplinary team that was unique in its composition and dynamics. My experience as an interdisciplinary team member in the hospice palliative care units has influenced my understanding of the experience of others in this research. Through this research, I was aware of my biases as a result of my clinical experience. I applied bracketing, journaling, and self-reflexivity to have a fresh perspective into the participants’ subjective experience throughout this research.

3.4. Data and Data Collection

The main data source for this study was semi-structured individual interviews, as previously mentioned. Recruitment started after the ethics review from the University of British Columbia (UBC; cf. Appendix A) and the FHA (cf. Appendix B). The participants were selected by criterion sampling. In attempts to recruit participants, I advertised this study through sending the Invitation Letter and Consent Form (cf. Appendix A) to several hospice palliative care programs within the FHA. The criteria for participants were as follows:
Inclusion

- Employed as a regular full- or part-time worker at a hospice palliative care program, which included either acute palliative care programs or residential hospice programs in the FHA.

- Employed in either a medical or non-medical/psychosocial discipline.

- Employed at the same site more than one year.

Exclusion:

- Employees at the hospice residence in the Langley Memorial Hospital, where I was employed.

- Employees whom I have known either professionally or personally.

- Employees at home care hospice programs, because they are usually operated by a physician and nurses and rarely include other disciplines.

- Employees who are casual workers.

A total of 11 participants were recruited. Although one participant did not meet the above criteria (this participant had a shorter work experience than preferred), I included that participant’s interview in this research data because her interview touched on, and helped clarify, notions included in the research results. The reason I utilized the data from this participant will be explained further, when I describe the results of this study in a later chapter. Table 1, includes a list of demographic information of the 11 participants.

Because community of hospice palliative care programs in the FHA is relatively small, I have only included general information in Table 1, to protect participant confidentiality. The occupations of the participants represented multiple disciplines from both the medical and the
psychosocial teams: two patient care coordinators; one clinical resource nurse; two practical licensed nurses; one physician; one music therapist; two spiritual care coordinators; one social worker; and one volunteer coordinator. To respect their confidentiality, participants are identified by pseudonyms. Furthermore, I omitted each participant’s occupation to minimize identifying factors.

Table 1. Demographic Information of the Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Work Experience in Hospice</th>
<th>Work Experience in Healthcare</th>
<th>Medical team or Psychosocial Team</th>
<th>Full Time or Part Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anna</td>
<td>2 years</td>
<td>20+ years</td>
<td>Psychosocial</td>
<td>Part time</td>
</tr>
<tr>
<td>Becky</td>
<td>7 years</td>
<td>20+ years</td>
<td>Psychosocial</td>
<td>Full time</td>
</tr>
<tr>
<td>Connie</td>
<td>4.5 years</td>
<td>20+ years</td>
<td>Medical</td>
<td>Full time</td>
</tr>
<tr>
<td>Deb</td>
<td>3.5 years</td>
<td>17 years</td>
<td>Medical</td>
<td>Part time</td>
</tr>
<tr>
<td>Elaine</td>
<td>5 months</td>
<td>20+ years</td>
<td>Medical</td>
<td>Full time</td>
</tr>
<tr>
<td>Fiona</td>
<td>3 years</td>
<td>20+ years</td>
<td>Medical</td>
<td>Full time</td>
</tr>
<tr>
<td>Gerri</td>
<td>4 years</td>
<td>4 years</td>
<td>Psychosocial</td>
<td>Part time</td>
</tr>
<tr>
<td>Hanna</td>
<td>5 years</td>
<td>7 years</td>
<td>Psychosocial</td>
<td>Part time</td>
</tr>
<tr>
<td>Isabella</td>
<td>1.5 years</td>
<td>1.5 years</td>
<td>Psychosocial</td>
<td>Part time</td>
</tr>
<tr>
<td>Jane</td>
<td>5 years</td>
<td>20+ years</td>
<td>Medical</td>
<td>Full time</td>
</tr>
<tr>
<td>Kate</td>
<td>4 years</td>
<td>7 years</td>
<td>Medical</td>
<td>Full time</td>
</tr>
</tbody>
</table>

The interviews were conducted face to face, for about one hour. The participants were provided with informed consents [cf. Appendix A and B]. The interviews were audio and video recorded. The interview format was semi-structured [cf. Appendix C. Interview Protocol]. The reason for choosing a semi-structured interview was because this method of interview “attempts to understand themes of the lived everyday world from subject’s own perspectives” (Kvale & Brinkmann, 2008, p.27). The semi-structured interview can help elicit participants’ lived experience and their own unique meanings of these experiences. Therefore, the semi-structured interview will help to answer the research question through the perspective of social constructionism.
Each interview was conducted in either a quiet room or a meeting room, on the unit where the participants worked. Each interview was transcribed following the interview, and the transcripts were analyzed using content analysis. The audiotapes and transcripts are stored in a secure location, to protect participant confidentiality.

3.5. Process of Data Analysis & Synthesis

This research was guided by the five steps which were adapted from various qualitative content analysis procedures (Braun & Clarke, 2006; Elo & Kyngäs, 2007; Granehim, & Lundman, 2003; Marying, 2000; Saldaña, 2009; Schilling, 2006; Strijbos, Martens, Prins, & Jochems, 2005; Thomas & Harden, 2009; White & Marsh, 2006). The following data analysis process was created to rigorously investigate the research question, and to make sure the research analysis had valid authenticity and trustworthiness.

Step 1: Transcribing Data

All 11 interviews with the research participants were transcribed, verbatim, from the audio data.

Step 2: First Coding

As a researcher, I read all 11 interview transcripts by thinking through the research question, or by identifying which texts or phrases related to the research question. The subject responses were coded for each interview. Relevant content was extracted and gathered in a list. Then, shorter descriptions of the texts or codes were created. Statements that were not answered or not related to the research question were deleted. I read and coded each transcript numerous times to ensure the reliability of the coding process.

Step 3: Identifying and Defining Initial Themes

After the initial coding, coded data from each transcript were interpreted and categorized
by like and oppositional constructs. Through categorization, the constructs or themes emerged. I repeated this categorization process numerous times in order to assure the reliability of the coding process. I completed an additional coding based on the themes and sub-themes which were drawn from the first two interviews, and then made a few revisions to the themes and the sub-themes. After this revision, the definitions and illustrations of the themes and sub-themes were created. This list of definitions and illustrations were subjected to a peer review by a counsellor with master’s degree, and then an expert review by a palliative care bereavement counsellor with a doctoral degree. With agreement from the peer review and the expert review, I moved to the next step of the analysis.

**Step 4: Second Coding and Finalizing Emerged Themes**

I proceeded with the second coding for all texts by using the definitions of the themes from the first coding, and then returning to the original interview transcripts to determine whether these identified themes and sub-themes represent the meaning of the participant’s experience. After this process, peer review was conducted. I selected five of the 11 interviews, and provided the data from these to a peer reviewer to check the validity of my coding. One segment (30 minutes) was from the interview with Connie; two segments (five minutes each) were from the beginning of the interviews with Anna and Fiona, and two segments (five minutes each) were from the end of the interviews with Gerri and Jane. The agreement rate between coders was 96.9%.

To finalize the emergent themes, I then requested an expert review. The expert agreed that the final themes and sub-themes were valid.

Finally, member checking was administrated. By e-mail, I sent a summary of their first three major themes to each participant, along with the transcript of their full interviews. Member
checking occurred one-and-a half years after the interviews were conducted. Of the 11 participants, 10 responded to the member checking (one participant did not reply to e-mails or phone calls). The agreement rate from the participants was 100%. All of the agreement rates, and the verification of the coding process and the member checking, exceeded the recommended threshold of 80% as determined by Strijbos et al. (2005) for determining authenticity of the data analysis.

**Step 5: Concluding Analyses and Synthesis**

In reviewing the process of data analysis from this study, I identified six themes and 29 sub-themes. I revisited and reflected on the relationships among those themes—from raw data to coded transcriptions of both the first and second coding—to better understand participants’ experience in interdisciplinary teams in hospice palliative care. During the reflection period, interrelations of the themes were examined by comparing raw data to coded data. Through investigating the interrelations among the themes, a synthesis emerged. Another peer review and expert review were held to validate the researcher’s interpretation and synthesis of the research data. Both reviewers agreed with the researcher’s interpretation and synthesis. In addition to those reviews, another expert review by a social worker, who has been working at hospice palliative care for over ten years, was held to validate the research synthesis. Her feedback was utilized for the synthesis of the findings. The interpretation of the themes, and the synthesis of the data analysis, will be revealed in the next chapter.

**3.6. Authenticity and Trustworthiness**

Every researcher should ensure rigorous research validation for their qualitative research (Humble, 2009). Creswell (2007) recommends that researchers have more than two validation strategies to strengthen the authenticity and trustworthiness of qualitative studies. This
research included four validation strategies: (1) bracketing; (2) peer review; (3) expert review; and (4) member checking of the participants. The awareness of bracketing facilitates the researcher having a fresh perspective every time he or she analyzes the data. Bracketing was considered every time I revisited the research data. As mentioned in the previous section, ongoing peer review and expert review were conducted to increase the credibility of the results. Regular peer review was held throughout the coding process. Member checking was completed at the end of the coding process as illustrated in the data analysis section.

Although validation of authenticity and trustworthiness of the content analysis is a challenge due to the naturalistic paradigm of the content analysis (Hsihe, & Shannon, 2005), this research was designed to overcome those challenges by utilizing the above mentioned various validation strategies.

3.7. Ethical Issues

One major ethical consideration in this study was avoiding dual relationships. I worked at the hospice residence at Langley Memorial Hospital (LMH) from September 2005 to August 2011. I have built professional and personal relationships with co-workers at LMH. Therefore, I excluded those who knew me personally from this research (cf. 3.4. Data and Data Collection).

Another ethical consideration was participants’ confidentiality. Confidentiality was discussed with each participant when I addressed the issues of informed consent. Verbal and written informed consent forms were given to participants at the beginning of each interview. Throughout the research process, the participants’ identities have been kept confidential. As mentioned in the section on data and data collection, I revealed only general information about participants, and used pseudonyms. To protect male workers' confidentiality, I did not reveal
the gender of participants, because there are a limited number of male healthcare workers in the hospice palliative care programs in FHA. To describe the research data in a way to protect confidentiality, I used gender neutral language, and feminine pronouns and pseudonyms to identify all participants.
Chapter 4

Results

4.1. Overview of the Research Results

“What is the experience of being on an interdisciplinary team in hospice palliative care?”

This research was conducted to explore this question, and attempted to discover the core elements of the interdisciplinary team and to gain a further understanding of healthcare workers' experiences. All 11 research participants brought up their unique experiences in their interviews. Through content analysis of the transcripts, some commonalities were found in the themes in the participants’ experiences. Six themes emerged from the interviews of the 11 participants. Each theme included several supporting sub-themes. These themes and their sub-themes are explained in the following section. Before I discuss each theme in depth, I will supply an overview of the results.

4.1.1. Summary of Six Themes and 29 Sub-themes

Content analysis resulted in six themes and 29 sub-themes as shown in Figure 1 (cf. Figure 1. Summary of Six Themes and 29 Sub-themes), which provides an overview of the results with a hierarchy of the themes and their sub-themes. The six themes were supported by majority of the participants’ interview content. A total of 29 sub-themes emerged from the participants’ transcripts, in addition to the six themes. These sub-themes provided a meaningful understanding of the content found in the six primary themes generated from the participants’ interviews.

Table 2 outlines the “Response Rate from the Participants’ Interviews Using Content Analysis.” A few sub-themes did not have high response rates from the participants’ interview contents. I consulted one of the expert reviewers about such low response rates in some of the
Figure 1: Summary of Six Themes and 29 Sub-Themes

1. Collaborative Work
   - 1a. Common Goal of Striving for Holistic Care
   - 1b. Sharing Responsibilities for Patient Care
   - 1c. Expertise
   - 1d. Multiple Perspectives
   - 1e. Leadership

2. Quality of Relationships
   - 2a. Mutual Respect and Trust
   - 2b. Professional Acknowledgment
   - 2c. Psychosocial Support
   - 2d. Belonging and Connection
   - 2e. Egalitarianism
   - 2g. Personal Relationships

3. Communication
   - 3a. Mode of Communication
   - 3b. Form of Communication
   - 3c. Timing of Communication
   - 3d. Recipients of Information Sharing
   - 3e. Content of Shared Information

4. Team Building Activities
   - 4a. Education
   - 4b. Social Events
   - 4c. Ongoing Team Review
   - 4d. Formal Debriefing

5. Personal Qualities
   - 5a. Depth and Richness of Life and Work Experience
   - 5b. Affinity for Working within a Interdisciplinary Team

6. Institutional Influence
   - 6a. Management/Administration
   - 6b. Budgetary Factors
   - 6c. Policies and Regulations
   - 6d. Available Work Hours
   - 6e. Size of the Team
   - 6f. Medical or Psychosocial Team
   - 6g. Nurse as a Subgroup
Table 2. Response Rate from the Participants’ Interviews Using Content Analysis

<table>
<thead>
<tr>
<th>Section</th>
<th>Response Rate (Number of Participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Collaborative Work</strong></td>
<td></td>
</tr>
<tr>
<td>1a. Common Goal of Striving for Holistic Care</td>
<td>9</td>
</tr>
<tr>
<td>1b. Sharing Responsibilities for Patient Care</td>
<td>11</td>
</tr>
<tr>
<td>1c. Expertise</td>
<td>9</td>
</tr>
<tr>
<td>1d. Multiple Perspectives</td>
<td>10</td>
</tr>
<tr>
<td>1e. Leadership</td>
<td>7</td>
</tr>
<tr>
<td><strong>2. Quality of Relationships</strong></td>
<td></td>
</tr>
<tr>
<td>2a. Mutual Respect and Trust</td>
<td>9</td>
</tr>
<tr>
<td>2b. Professional Acknowledgement</td>
<td>8</td>
</tr>
<tr>
<td>2c. Psychosocial Support</td>
<td>11</td>
</tr>
<tr>
<td>2d. Belonging and Connection</td>
<td>7</td>
</tr>
<tr>
<td>2e. Egalitarianism</td>
<td>9</td>
</tr>
<tr>
<td>2f. Continuity</td>
<td>8</td>
</tr>
<tr>
<td>2g. Personal Relationships</td>
<td>7</td>
</tr>
<tr>
<td><strong>3. Communication</strong></td>
<td></td>
</tr>
<tr>
<td>3a. Mode of Communication</td>
<td>9</td>
</tr>
<tr>
<td>3b. Form of Communication</td>
<td>9</td>
</tr>
<tr>
<td>3c. Timing of Communication</td>
<td>4</td>
</tr>
<tr>
<td>3d. Recipients of Information Sharing</td>
<td>7</td>
</tr>
<tr>
<td>3f. Content of Shared Information</td>
<td>10</td>
</tr>
<tr>
<td><strong>4. Team Building Activities</strong></td>
<td></td>
</tr>
<tr>
<td>4a. Education</td>
<td>7</td>
</tr>
<tr>
<td>4b. Social Events</td>
<td>5</td>
</tr>
<tr>
<td>4c. On-going Team Review</td>
<td>2</td>
</tr>
<tr>
<td>4d. Formal Debriefing</td>
<td>5</td>
</tr>
<tr>
<td><strong>5. Personal Qualities</strong></td>
<td></td>
</tr>
<tr>
<td>5a. Depth and Richness of Life and Work Experience</td>
<td>6</td>
</tr>
<tr>
<td>5b. Affinity for Working within an Interdisciplinary Team</td>
<td>9</td>
</tr>
<tr>
<td><strong>6. Institutional Influence</strong></td>
<td></td>
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sub-themes, and explored whether I should have included these sub-themes as the findings of this research. She recommended including these sub-themes to provide a more holistic view of the research results. With her recommendation and based on my clinical experience, these sub-themes were considered to have relationships to the understanding of the experience of working in interdisciplinary teams, which affect the quality of teamwork and give depth to the meaning of interdisciplinary teams. Furthermore, this study is qualitative, which allows us to understand the meaning of one’s experience (Morrow, 2007). These sub-themes reflected each participant’s unique experience of working within the interdisciplinary team. As a result, embracing these sub-themes enriched the holistic understanding of the research participants’ experience of working in interdisciplinary teams in hospice palliative care.

4.1.2. Definitions and Illustrations of Six Themes and 29 Sub-Themes

Based on participants’ interviews, these definitions of the themes and their sub-themes were created to elaborate the meaning of each participant’s experience. To support these definitions through interview content, one interview quote was provided in each category.

**Theme 1. Collaborative Work**

Collaborative work refers to an interdisciplinary team that works jointly, shares common goals, responsibilities, expertise, and leadership within the interdisciplinary team.

**Theme 1. Collaborative Work: Sub-Theme 1a. Common Goal of Striving for Holistic Care**

Common goal of striving for holistic care means that an interdisciplinary team embraces a common goal which based on the holistic care model and palliative care philosophy, which treats a whole person, or commits to the total care of the person’s mind, body and spirit.

*An illustrative example of a participant response:*

… because the number one thing I do all the time is, we never forget that, the number
one reason the team is here for, is the patient and their loved ones, if we forget that then we’ve lost the reason for being here… (Becky)

Theme 1. Collaborative Work: Sub-Theme 1b. Sharing Responsibilities for Patient Care

Sharing responsibilities for patient care means that an interdisciplinary team shares responsibilities of their patient care with other interdisciplinary team members, or the interdisciplinary team members work above and beyond one’s own discipline to fulfill the patient’s needs.

An illustrative example of a participant response

… because you are working as a team, send that person in to do a little bit more than their specialty, and they’ll (team members) actually start to clear all the issues.

(Connie)

Theme 1. Collaborative Work: Sub-Theme 1c. Expertise

Expertise means each interdisciplinary team member applying one’s expert knowledge and skills from their discipline to patient care. For example: expert knowledge and skills in areas such as spiritual care, music therapy, counselling, and medical expertise.

An illustrative example of a participant response:

…we all learn from each other, because everybody’s got their own background, and own specialty… (Deb)

Theme 1. Collaborative Work: Sub-Theme 1d. Multiple Perspectives

Multiple perspectives refers to various perspectives that interdisciplinary team members have from different disciplines and a variety of viewpoints from which they exchange and share one’s own opinion and knowledge with other interdisciplinary team members.
An illustrative example of a participant response:

I guess one of the other special things about the hospice palliative care team is the number of different disciplines, or the number of different people, and how we really did embrace that sense that the patient and family are at the center of the care, because lots of team, lots of other disciplines… (Hanna)

Theme 1. Collaborative work: Sub-theme 1f. Leadership

Leadership refers to an interdisciplinary team member or a leader of the interdisciplinary team who facilitates the cohesiveness of the team.

An illustrative example of a participant response:

…they have a really strong PCC (patient care coordinator), who helps kind of direct everything … (Elaine)

Theme 2. Quality of Relationships

Quality of relationships refers to the nature of the relationships with other interdisciplinary team members.

Theme 2. Quality of Relationships: Sub-Theme 2a. Mutual Respect and Trust

Mutual respect and trust infers that the interdisciplinary team members reciprocate respect and trust, and/or enhance esteem and loyalty towards one another.

An illustrative example of a participant response:

… the biggest strength is the trust between the co-workers, trust in the volunteers, trust in your PCC, that you can count on each other, for whatever, trust your doctor, you know you can phone them at any time, trust, biggest thing in team, and that encompasses so many other things… (Fiona)
Theme 2. Quality of Relationships: Sub-Theme 2b. Professional Acknowledgement

Professional acknowledgement means that the interdisciplinary team members provide or receive positive acknowledgement towards one’s professional contribution and achievements.

An illustrative example of a participant response:

I want to feel validated in my position, and I do just feel like I’m contributing just as much as everyone else. (Gerri)

Theme 2. Quality of Relationships: Sub-Theme 2c. Psychosocial Support

Psychosocial support means that the interdisciplinary team members encourage or show empathy towards other team members, or provide feedback, help or comfort to them.

An illustrative example of a participant response:

I think professionally strengths there, but also the support for one another…

(Connie).

Theme 2. Quality of Relationships: Sub-Theme 2d. Belonging and Connection

Belonging and connection are experiences that the interdisciplinary team members develop. It is a feeling of being part of an interdisciplinary team.

An illustrative example of a participant response:

…and it’s a team that I’m proud to be associated with, it is a good feeling to belong to it… (Connie)

Theme 2. Quality of Relationships: Sub-Theme 2e. Egalitarianism

Egalitarianism means the idea that individual interdisciplinary team members wield an equal level of power, right, and responsibility.

An illustrative example of a participant response:

I don’t personally believe in a layered team… (Jane)
Theme 2. Quality of Relationships: Sub-Theme 2f. Continuity

Continuity refers to continued relationships among members of a team.

An illustrative example of a participant response:

I think it evolves by working with that person over time… (Fiona)

Theme 2. Quality of relationships: Sub-Theme 2g. Personal Relationships

Personal relationships refers to friendships and a sense of personal connection among interdisciplinary team members.

An illustrative example of a participant response:

I do notice there’s a good sense of friendship, but there is bonding that happens in the team, so it doesn’t just feel we are just working… (Gerri)

Theme 3. Communication

Communication refers to a process by which an interdisciplinary team shares information among its team members.

Theme 3. Communication: Sub-Theme 3a. Mode of Communication

Mode of communication means that the way information is provided to team members.

For example, verbal or written communication.

An illustrative example of a participant response:

I think verbal communication is good on this team, I think we are good, like if I need to sit down and talk with someone, we’ll sit and talk, but actual written, note taking is a challenge to get everybody’s input, and then use that information to do better care, I think that is challenging. (Gerri)

Theme 3. Communication: Sub-Theme 3b. Form of Communication

Form of communication refers to a form of presenting information to other
interdisciplinary team members such as rounds, team meetings, referrals and charting.

An illustrative example of a participant response:

…everybody in rounds appreciates everybody else’s opinion that’s why we get rounds, we throw the problems on the table, and everybody brainstorms, because everybody comes up with the something different, sometimes the simplest thing you can’t… (Deb)

Theme 3. Communication: Sub-Theme 3c. Timing of Communication

Timing of communication means the timing or time period where information is shared with other interdisciplinary team members.

An illustrative example of a participant response:

I guess, it’s part of just not having a lot of spare time, so you don’t take the time to walk with the team member over what happened, you just get right in there.

(Connie)

Theme 3. Communication: Sub-Theme 3d. Recipients of Information Sharing

The sub-theme of recipients of information sharing means the members of the interdisciplinary team who receive and address information.

An illustrative example of a participant response:

…but making the team aware, even if you don’t think, that they particularly got the answer, they may do, just say this is a concern to nursing, any input that you have, to the pharmacist, to the social worker, all the team members, let’s try to bring the team in, and make sure that they know the whole picture, so that we are not missing any issues, any knowledge… (Connie)
Theme 3. Communication: Sub-theme 3e. Content of Shared Information

Content of shared information refers to the content or subject matter of information shared among interdisciplinary team members, such as family issues, spiritual issues, or personal disclosure.

An illustrative example of a participant response:

In a way, it’s kind of odd, there is something awkward about. I do offer, I do offer insight. Sometimes people, my experience is sometime staff members are not ready that the emotional level, and I have to prepare myself for, in some ways I get little anxious, and I shouldn’t be anxious, but I am little anxious in what I’m going to present because I don’t want, I resist being so clinical, I resist being the clinical counsellor sort that profession, anyway maybe I should be more professional. I think I am professional, but there’s something about the presentation of matters that might be really important for the team, or it might be really important for me to express that I know the family members, the dynamic of the family, on that level. (Anna)

Theme 4. Team Building Activities

Team building activities means activities which are intended to enhance the relatedness and cohesiveness of the interdisciplinary team.

Theme 4. Team Building Activities: Sub-Themes 4a. Education

Education refers to training, instructions, and a facilitated learning process intended to enhance knowledge and skill for interdisciplinary team members. For example, attending conference or workshop.

An illustrative example of a participant response:

I guess the other big one and I haven’t thought about it until just now, it’s the
education, the ongoing education… (Connie)

**Theme 4. Team Building Activities: Sub-Themes 4b. Social Events**

Social events means a social gathering without any professional obligation of the interdisciplinary team such as an outing, party, or celebration.

*An illustrative example of a participant response:*

Personally I’d like to be able to know that staff is going to get together two or three times a year for a staff party or something, I’d like that. Then, we see each other in a different light, and we see each other as a human in a certain way… (Anna)

**Theme 4. Team Building Activities: Sub-themes 4c. On-going Team Review**

On-going team review means that the interdisciplinary team regularly reviews the team goals, and identifies and evaluates the strengths and challenges of the team.

*An illustrative example of a participant response:*

…once a year or every six months, to do just a team review, how things are going, what is your sense of what do you think when you come in and give you report, and that, what you are not feeling…(Jane)

**Theme 4. Team Building Activities: Sub-Themes 4d. Formal Debriefing**

Formal debriefing is when the interdisciplinary team members gather to reflect, and share one’s thoughts and concerns about the residents who passed away, with other team members in a formal team setting.

*An illustrative example of a participant response:*

They do for anything really traumatic that happened in the unit, they do a debriefing, they will do it with us, talking about feelings surrounding that event, or whatever. (Kate)
Theme 5. Personal Qualities

Personal qualities mean one’s personal experience and character while working within the interdisciplinary team work environment.

Theme 5. Personal Qualities: Sub-Theme 5a. Depth and Richness of Life and Work Experience

Depth and richness of life and work experience refers to one’s past personal and professional experience related to hospice palliative care and/or working on an interdisciplinary team.

An illustrative example of a participant response:

I think a lot of our team members are, which is a part of the reason maybe our team works so well together, a lot of our team members started out elsewhere, I mean I started [at another job] all through [school], so when you are able to not only see things from different people’s perspectives… (Deb)

Theme 5. Personal Qualities: Sub-Theme 5b. Affinity for Working within an Interdisciplinary Team

Affinity for working within an interdisciplinary team means one’s suitability to work within an interdisciplinary team.

An illustrative example of a participant response:

I think so, yes, it doesn’t flow naturally all the time, some people get the team, and for some people it’s a struggle… (Connie)

Theme 6. Institutional influence

Institutional influence refers to factors which influence the interdisciplinary team through its institutional organization.
Theme 6. Institutional influence: Sub-theme 6a. Management/Administration

Management/administration refers to the influences from the health authority upper management or administration on the interdisciplinary team of the hospice palliative care program.

An illustrative example of a participant response:

I think the bigger system from the director down, they are really committed to it, and they have a lot of passion about it, about hospice palliative care... (Hanna)

Theme 6. Institutional Influence: Sub-theme 6b. Budgetary Factors

Budgetary factors means the financial support issues for the interdisciplinary team of the hospice palliative care program, as dictated by the health authority.

An illustrative example of a participant response:

…it is about the team, but some of it is also about motivating factors such as budget. You have to almost show your effectiveness to the team that you are needed as part of the team that does not come from within these team members, it doesn’t come really from there, but it is always is sitting in the back particularly, because of our fiscal restraints right now, so we are all feeling that now. (Isabella)

Theme 6. Institutional Influence: Sub-theme 6c. Policies and Regulations

Policies and regulations refers to guidelines and rules for the interdisciplinary team of the hospice palliative program by the health authority.

An illustrative example of a participant response:

… so the frustration sometimes is that, feeling that dominant thing, seeing these incredible people in the system, nurses, physicians, everybody, trying to hold a higher philosophy, but the system is hitting them, the health authority changes to the
privacy act, just information to the volunteers that kind of thing, they are cracking down in a way, they don’t realize there’re impacting the quality of care in the specific programs that we have. (Becky)

**Theme 6. Institutional Influence: Sub-Theme 6d. Available Work Hours**

Available work hours refers to the work hours of each healthcare professional in the interdisciplinary team. For examples: shift work (day or evening), full-time, part-time, and casual.

*An illustrative example of a participant response:*

I think it comes down to not having that daily presence, I think that would be better, if we had all the team members there every day, I think that is certainly a challenge.

(Connie)

**Theme 6. Institutional Influence: Sub-Theme 6e. Size of the Team**

Size of the team refers to the number of members on an interdisciplinary team.

*An illustrative example of a participant response:*

Probably scaling back a little bit, but we, just with the size of the team, even for now, in my head I think there are other hospices that have only one physician for the entire unit, when we have seven, so you are trying to deal with different doctors and different ideas, and this and that, and then you are dealing with casuals, then it becomes a little bit frustrating, but if you only had the one, just kind of minimizing your team, right? Would make it a little bit easier? (Kate)

**Theme 6. Institutional Influence: Sub-Theme 6f. Medical or Psychosocial Team**

Medical or psychosocial team refers to two disciplines within an interdisciplinary team, either medical or psychosocial.
An illustrative example of a participant response:

… the people coming in from the medical team, aren’t always given the true training to be with the dying, to understand the full dimensional on a human level, and I would really love to see more of that… (Becky)

Theme 6. Institutional Influence: Sub-Theme 6g. Nurse as a Subgroup

Nurse as a subgroup refers to a nursing team as a unit of a subgroup in an interdisciplinary team.

An illustrative example of a participant response:

…it is very nice to see you got this small team of social workers and therapists and pharmacists, it’s that huge circle of nursing that’s got to be added into that mix and they are on their own, and they will do whatever they think needs doing to fix in the middle of the night when there’s nobody else available. (Connie)

The overview of the six themes and 29 sub-themes from the content analysis was discussed above. In the following section, the details of the six themes and 29 sub-themes by the healthcare worker’s voices will be discussed in depth.

4.2. Healthcare Worker’s Experience of Working in Interdisciplinary Teams in Hospice Palliative Care: Six themes and 29 Sub-Themes

Eleven healthcare workers were interviewed about their experience of working in interdisciplinary teams in hospice palliative care units. Each voice represented a unique experience and through content analysis, six core themes and 29 sub-themes emerged. In this section, their voices will be shared to reflect the core elements of working on an interdisciplinary team in hospice palliative care.
4.2.1. Theme 1. Collaborative Work

All 11 participants shared their experiences of working together towards common goals, which were based on hospice palliative care philosophy, and complementing patient care with each other’s expertise. Anna and Becky described the strengths of their interdisciplinary teams as “complementary”, in their interviews. I was puzzled about what these participants meant by “complementary” in the context of interdisciplinary teams. Through content analysis, the concept of a complementary role in interdisciplinary teams became clearer. The concept of a complementary role in interdisciplinary teams is about working together and sharing responsibilities for patient care, in a collaborative manner. Thus, I titled this first theme as “collaborative work.” Collaborative work embraces five main sub-themes: (a) common goal of striving for holistic care; (b) sharing responsibilities for patient care; (c) expertise; (d) multiple perspectives; and (e) leadership. In the following section, the details of these five themes will be discussed.

Theme 1. Collaborative Work: Sub-Theme 1a. Common Goal of Striving for Holistic Care

The primary goal for care in hospice palliative care is addressing all of the needs of dying patients (Billings, 1998; Bishop et al., 2000; Crawford & Price, 2003; Demiris, Washington, Doorenbos, Parker Oliver, & Wittenberg-Lyles, 2008; Parker Oliver et al., 2005). It became very clear from the interviews that the central goal of care was meeting the patient’s needs in a holistic manner. For example, Elaine stated:

Best quality of the team? I think they [are] all patient focused, everything is, ... they are very much the patient is the centre, everything is centered around the patients, everybody works to achieve the goals of the patients, and like I really see that happening, it’s not what staff wants or it is about what the patients want, I do see that
happening.

Likewise, Becky described the importance of patient-centered care as being: “... because the number one thing I do all the time is we never forget that the number one team is here for, is the patient and their loved one, then we’ve lost the reason for being here…”

Jane expressed her belief that the medical model did not fit into hospice palliative care, and could not meet the complexity of the patient’s needs. She said: “I know [that] I can’t do everything, I mean I can’t, I could not do it all, I certainly could not do a good job, the holistic approach is really important.”

From the results of the content analysis, it was clear that sharing the common goal of striving for holistic care was important. Some participants, especially from a psychosocial team, expressed that sometimes this common goal of striving for holistic care was forgotten, or overshadowed by the medical model. Gerri expressed: “I do find as I said before it is very medically centered, so if there’s some sort of an issues we are having to deal with medical things.” Becky expressed fears that the medical model would take over hospice palliative care philosophy, and she wanted to remind her team members of the importance of embracing holistic care for the patients.

In the study by DiTuilo and MacDonald (1999), participants expressed that embracing a unique hospice philosophy was the top reason for “what makes hospice different.” Similar to DiTuilo and MacDonald’s research, the participants in this research also supported the view that common goal of striving for holistic care was the foundation of the interdisciplinary team and necessary in order to support the patient’s end of life and fulfill patient needs.

**Theme 1. Collaborative Work: Sub-Theme 1b. Sharing Responsibilities for Patient Care**

As mentioned above, it was a challenge to describe complementary roles in
interdisciplinary teams. This, in turn, made it a challenge to determine how to best analyze the research data. Three sub-themes, “1b. sharing responsibilities for patient care,” “1c. expertise,” and “1d. multiple perspectives,” explain how the interdisciplinary team in hospice palliative care is complementary, or working collaboratively together as a team, in order to provide holistic care to patients.

Sharing responsibilities for patient care means working together, in a cooperative manner, within an interdisciplinary team. All participants expressed that they helped each other out in the interdisciplinary team. Connie elaborated about the sharing of responsibilities for patient care:

I think that’s where the strength because in my concept of interdisciplinary is you don’t just divide the work out, and say, that’s the social worker will do this and the nurse will do that, you are looking at all the care issues…

Then, she added these details about the expectation of shared responsibilities within the interdisciplinary team: “…you’re not expected that anybody taken on everything that you are as a team, you’re sharing out the stresses, the burdens, the complexities…”

Connie expressed that it was important to know that the team was there in support of all members, to seek help from each other, and to utilize help from other team members to meet the patient’s needs rather dealing with issues by themselves, especially in the case of nurses. Deb expressed that sharing responsibilities for patients’ care enhanced rapport among team members, including volunteer team members. Fiona described how she could ask volunteers to help her out to share patient care in her interdisciplinary team: “… between the volunteers, they are wonderful, we have a really good group, I said, “Mrs. so and so, she is by herself… but I don’t want to leave her alone, could you go sit with her?”
All the participants stated that interdisciplinary team members should embrace sharing responsibilities for patient care. However, several participants noted that there were challenges in putting this into practice. One main issue with the sharing of responsibilities for patient care was in the overlap of professional roles. By sharing responsibilities for patient care, it is hard to identify who is responsible for individual tasks, and the potential exists for team members to become territorial about their work. Isabella stated: “Yeah, the lines are blurred, weakness comes when lines are blurred, and then they’re treading in areas like I would never dream of treading in an area…” Becky acknowledged the overlap of work among the team members: “…there’s areas that overlap, so that’s a bit of dance sometimes.” Several people stated the need for role clarification. Jane said: “I think it is really important to have clearly defined roles.”

Current literature supports the importance and difficulties of sharing work within a team (Dean, 1998; Parker Oliver, Wittenberg-Lyle, Day, 2007; van Staa, Visser, & van der Zouwe, 2000). Sharing responsibilities for patient care is central to the hospice palliative care program, and while it fosters support for team members it can also be a source of stress and frustration. Gerri shared information about her role in the team:

It is a very quiet role, I don’t speak up very much, I’m thinking of rounds, but what is my role? That’s interesting, I’m thinking there’s my perspective of my role, and there is what I think their perspective of me is, so if I’m thinking of me, let me see, what is my role on the team? My role in care, can I think of it that way? Because it’s interesting, I’ve never really looked at it, or thought about that I mean I think about my role, but I don’t think specifically, about it...

Gerri openly expressed that she had never thought about what her role in her team was, which
led me to consider how many people have clear knowledge of their role within the interdisciplinary team. As mentioned in chapter 1, healthcare workers are practising the interdisciplinary team model without education or guidelines specific to working in interdisciplinary teams in hospice palliative care settings (Cohen Fineberg at al., 2004).

Therefore, it is important to have strict guidelines for shared responsibilities for patient care, which should outline such topics as the team members’ ability to divide and share responsibilities for care, and clearly defining roles for individual team members. Clarifying roles would increase team members’ understanding of his or her role in the interdisciplinary team, and might serve to enhance the quality of patient care through a strengthening of teamwork.

**Theme 1. Collaborative Work: Sub-Theme 1c. Expertise**

A primary role of the interdisciplinary team is the sharing of responsibilities for patient care, which was discussed in the previous section. It was also implied from the research results that the participants honoured each other’s expertise and ability to provide appropriate patient care. Hanna expressed that her expertise was valued more in hospice palliative care than in other units she had worked in. She reported that the interdisciplinary team members in hospice palliative care sought her expertise: “I do feel that my field of expertise, like the psychosocial issues are valued, and my input is sought, by the doctors and the nurses, and other people…” As Hanna expressed, her expertise was valued by her interdisciplinary team because it allowed her to address intricate issues. However, some participants said that it was hard to understand their role or expertise. Because of the complexity of the dying patient’s needs, different disciplines have their own goals and objectives (Peck, 2006a), which strengthen the quality of care for the patients by having specialists’ expertise, but as the same time, having
goals and objectives by each disciplines makes hard to understand each other’s role or expertise, and the unique role of each discipline should be clarified within the team, in order to maximize each member’s effectiveness in providing care. Deb acknowledged the need to understand the roles of other disciplines in the team: “If you don’t understand their disciplines, or why they are there, and you are never using them, then it is kind of pointless for them to be there, if you are underestimating them…” These issues of not understanding each other’s expertise, as raised by Deb, were related to sharing responsibilities for patient care, or issues surrounding ambiguous roles or boundaries among team members. Isabella shared her concerns about sharing work and advocating on behalf of her own expertise:

When the nurses take on too much of [my job], that is not their area of expertise, not that they can’t do a portion of it, they can, but some of the conversations that I have with patients…

She was concerned about the reduction in the quality of patient care by not utilizing her services.

It is valuable to understand each other’s expertise and roles, with regards to what a particular team member can provide to the patient by using his or her own special training and knowledge. Higgins (as cited in Meier & Beresford, 2008a) proclaims that social workers need to advocate for their expertise and what they can contribute to patients and the team, from their area of specialized training. Once again, clarifying roles and educating team members on areas of expertise is necessary in the effective development of interdisciplinary teams.

Several participants expressed a perception of a lack of range in expertise within their hospice palliative care programs. Kate acknowledged that she would like to have more music therapy, art therapy, or other alternative therapies for her patients. Some participants (Connie,
Deb, Hanna, Jane and Kate) felt that there was a lack of expertise in spiritual care, as a result of partial or full cuts to spiritual care in hospice palliative care programs in the Fraser Health Authority. Deb acknowledged how devastating the loss of spiritual care had been for both patients and the interdisciplinary team:

…the other thing I’d like to bring back is, … our team is really suffering from our loss of our spiritual care, so that was a big blow to our team, because she was a valuable team member...

She spoke further about the loss of expertise from her spiritual coordinator:

… I think it was a big change, because now staff is expected to fill in, it just increases your workload too, and I think it’s something that we relied on her so much, that none of us were real great at it necessarily, because it was always “oh this’ll be a good patient for [her].”

Lack of expertise, especially with spiritual care, influenced the patient care in Deb’s interdisciplinary team. It was clear from the participants' voices that more psychosocial areas of expertise were needed in the hospice palliative care programs.

Theme 1. Collaborative Work: Sub-Theme 1d. Multiple Perspectives

Most of the participants in this study insisted that having multiple professional perspectives is one of the strengths in the interdisciplinary team model. Combining different perspectives means better care for patients, and promotes learning between team members.

Hanna elaborated about multiple perspectives:

I think the patient wins when there’s more, because there’s lots of different ideas that can come out, and lots of different perspectives, and so we can look at the patient and family situation from a lot of different angles...
Similar to Hanna, Kate expressed:

I think that having so many disciplines on board, you are given a stronger backbone to find that solution to whatever is going on, whether it be with the patient, a unit issue, whatever, you’ve got a lot of more, like a lot more heads in there...

With regards to multiple perspectives, Gerri said: “One thing I really appreciate is hearing the other team member’s perspectives on their care of the patients.”

Multiple perspectives allowed team members to see from each other’s viewpoint. The culmination of multiple perspectives might facilitate solutions to patient care issues. Deb stated that: “... everybody in rounds appreciates everybody else’s opinion that’s why we get rounds, we throw the problems on the table, and everybody brainstorms, because everybody comes up with the something different.”

Also, multiple perspectives could provide learning opportunities for other team members about his or her patients. Jane expressed:

I think that valuable because… You learn from [having multiple perspectives], and I learn from that, I value… I love it when [the spiritual coordinator] speaks about [our patients], because I am not there when she is talking about people’s spiritual needs, and she will bring up some things from time to time in the rounds, that give us some insight into what’s going on with that person, afraid of dying, things I don’t know anything about that, we don’t discuss those things.

Similar to Jane’s discussion, Deb noted that:

Resources are everywhere, more people you can have, pick their brain, the better, look at them as a great resource, every team member bring something different, and you can always learn something from somebody else, that’s my biggest thing about having the
Many participants expressed that they learned from each other by having multiple perspectives represented. Even though the majority of participants believed that sharing multiple perspectives was a positive experience, they also acknowledged it is a source of stress. Hanna found that having so many perspectives could be overwhelming: “Sometimes it’s easier, sometimes harder, because there’s more people to spread the work out to, so you don’t feel quite so overwhelmed…” Likewise, Deb described the challenges of multiple perspectives:

... obviously the benefit of the team is the same as the challenges, you have a lot of input, so some people have different ideas, … three people have different ideas, and how do you choose between them, and sort of talking it out, and sometimes personality dynamics, when you are dealing with large people, sometimes making a decision in a large group, when there’s varying opinion, it is a lot of harder than three or four people, making a decision amongst three or four people a lot of easier than making decision when there’s twelve people in the room, …

As discussed above, multiple perspectives might include both positive and negative influences to the interdisciplinary team. It will be interesting to consider what will be key factors in enhancing the positive attributes of multiple perspectives, or what cultivates multiple perspectives in the interdisciplinary team in hospice palliative care.

Theme 1. Collaborative Work: Sub-theme 1e. Leadership

The majority of the participants expressed the importance of leadership during their interviews. Leadership in hospice palliative care means having one person who guides an interdisciplinary team to deliver quality patient care (Peck, 2006b). Due to the structure of the interdisciplinary team in hospice palliative care programs in the Fraser Health Authority (FHA),
the participants identified this leadership role as the Patient Care Coordinator (PCC), who facilitates the care of the patients with the interdisciplinary team. Elaine stated that her team had “a really strong PCC, who helps [to] direct everything.” Similar to Elaine, Fiona expressed that her PCC assisted her and provides on-going support for her and her team. It was clear that the PCC or leadership role was a vital component of the interdisciplinary team when the interdisciplinary team was facing a lack of leadership, or absence of the PCC. Deb, Gerri, Hanna, Isabella, and Jane experienced a lack of leadership, and explained how the PCC or leadership role is important to the interdisciplinary team. Deb illustrated:

... just because the staff didn’t have support for so long, that everything, just you can go along for so long and everything just crashes, it was a challenge to start with just because the staff felt unsupported, and they were really reluctant to ask some stuff, or come up with stuff right off the bat, kind of thing…

She added clarification on how the lack of leadership affected her team:

I think kind of go without support for so long, and the PCC was here, when it first open was amazing, she was hard to replace anyhow, so when she left, and then there was big void, it was definitely tough, I think that was a big …., they were all wonderful nurses, and I worked with them as a nurse, so it was a shock for me, I had been off for six months, and I came back, “Oh my Gosh, what happened here, it’s like they were a whole different group of people,” same people, but they were all just burnt out, they were overworked…

A lack of leadership created burn out among the nurses due to excessive workload and lack of support. Isabella expressed similar concern about what a lack of leadership does to the interdisciplinary team:
.. we are missing a PCC, a big piece of the team is missing a PCC. That presents tons of challenges. I think it is been way too long without a PCC, and so there are boundaries that are constantly being crossed because if there is no leader, someone is going to step up to be a leader, and I don’t think that person really fully understands the role of a PCC, and it's just crossing boundaries all the time, I shouldn’t say a person, it is one of the challenges right now. We need to be able to, because we are missing a major component of the team.

Isabella’s interdisciplinary team suffered when leadership was absent, and it raised issues of boundaries among team members. Gerri also commented: “It is with changes and stuff, people don’t know what is going on, it is tough.”

Participants expressed the opinion that interdisciplinary teams do not function well without leadership. Jane described what kind of personal qualities were needed for the leadership role or PCC:

Someone who can be able to pick up on, first of all someone who is approachable, so people can go that person, and somebody who is just, approachable, smart, fair, and has good people skills, good conflict resolution skills, because what really is going to disrupt the team is there is conflict amongst the team members, that’s really key, so you need somebody who’s gonna take that on, and help solve it, they have to be seen as approachable and fair, and have good conflict resolution skills, good people, good people business…

As Jane noted, leadership requires high interpersonal skills. Peck (2006b) states that a good team leader needs to have sensitivity and understands the needs of his or her team members. He or she needs to have good communication skills to address issues among the team members.
Healthcare workers’ voices emphasized that leadership was an essential component to the interdisciplinary team to provide support to team members and to facilitate a smooth process of providing patient care. Furthermore, the quality of leadership is important as it influences each team member’s well-being and the dynamics of the interdisciplinary team (Peck, 2006b). It is important that future research attempts to better understand what kind of unique qualities of leadership enhance strong teamwork and the quality of patient care.

4.2.2. Theme 2. Quality of Relationships

In the study by DeLoach and Monroe (2004), one of the top reasons for job satisfaction among hospice palliative care workers is having positive relationship with other team members in an interdisciplinary team. The importance of having positive relationships among the interdisciplinary team members was also significant in their research. Quality of relationships included seven sub-themes: (a) mutual respect and trust; (b) professional acknowledgment; (c) psychosocial support; (d) belonging and connection; (e) egalitarianism; (f) continuity; and (g) personal relationships. These seven sub-themes illustrate the various elements that are needed to have high quality relationships within an interdisciplinary team in hospice palliative care settings.

Theme 2. Quality of Relationships: Sub-Theme 2a. Mutual Respect and Trust

Many study participants stated that mutual respect and trust are the foundations of relationships among interdisciplinary team members. Deb expressed: “If I pick one thing to describe our entire team, I say respect, that is what it’s about.”

Mutual respect and trust was core elements necessary for developing and maintaining the quality of relationships in Deb's interdisciplinary team. Fiona believed that mutual respect
and trust built supportive relationships: “... the biggest strength is the trust in the co-workers, trust in the volunteers, trust in your PCC, that you can count on each other… trust, biggest thing in team, and that encompasses so many other things.”

Becky suggested that mutual respect and trust are key to fostering strong working relationships:

... any deep relationship starts with trust, and I know that just from life experience ... so you know you learn in life, that to have a true relationship, and have true communication, trust is the key, and if trust is broken, then the relationship breaks down.

Others expressed similar responses, supporting the importance of mutual respect and trust in their interdisciplinary teams. Gerri explained that mutual respect and trust provided an understanding for working with other disciplines: “... but they also really respect the other the members in the team, I’m obviously on the psychosocial sides of things, I find they respect what I do, and they are interested in what I do...” Other participants made similar comments that mutual respect and trust become a bridge among different disciplines, for example: doctors showed respect to nurses; and nurses showed trust in spiritual care coordinators without questioning or doubting other people’s abilities to care for patients. Based on the participants’ experiences, mutual respect and trust were necessary to work with people who had different backgrounds and training. Without mutual respect and trust, relationships might not flourish in the interdisciplinary team.

**Theme 2. Quality of Relationships: Sub-Theme 2b. Professional Acknowledgement**

Professional acknowledgement was another characteristic of quality of relationships, based on the healthcare worker’s voices. Becky, Fiona and Hanna stated that they received professional acknowledgement about their work, from other interdisciplinary team members.
Becky remarked: “... in fact they told me time and again, it’s very hard do their work without [me], and there’s such a strong compliment …” Illustrating another example of professional acknowledgement, Hanna discussed how other people valued her work: “... the psychosocial issues are valued, and my input is sought, by the doctors and the nurses, and other people, so I do feel like a valued part of the team …”

It is interesting to note that four of the participants identified a lack of and need for providing and receiving professional acknowledgement in their interdisciplinary team. Gerri expressed that she did not have much professional acknowledgement from other team members: “I want to feel validated in my position, and I do just feel like I’m contributing just as much as everyone else …” Gerri communicated her honest reflection of the lack of professional acknowledgement from her team members. She further explained that:

I feel I need to always defend why I am here and what I do, and put it out there whenever I can, and that just comes from me, maybe feeling they don’t know really what I do, or they don’t think I deserve to be here as much as everyone else...

Hanna had similar concerns of a lack of professional acknowledgement in her position. A total of four out of five team members that address the psychosocial aspects of patient care felt a lack of professional acknowledgement, but none from the medical team expressed a similar absence in their roles. From the interviewed healthcare workers’ experience, psychosocial team members tend to feel less valued or validated in their professional work within their interdisciplinary team.

Anna, Connie, and Deb expressed a need for professional acknowledgement in their interdisciplinary team. Deb described:

I think I would like to see more sort of staff recognition, like whether it would be at
rounds, so and so really benefit from this, so the people all actually feel appreciated, because we all take each other for granted, like that fact that my pharmacist knows everything, and sometimes you take that for granted, you just forget, to sort of say thank you or whatever...

The participants’ ideas surrounding professional acknowledgement was echoed in the research by Dean (1998). Dean stated that giving positive acknowledgement to other team members relates to job satisfaction in interdisciplinary teams, and suggests providing team members some form of appreciation to develop staff support. I can relate to the participants well, as professional acknowledgement from my team members was very important to me, in my own practice. It made it feel like my work was valued, not only by patients but also by my team members. Through hearing my team members’ professional acknowledgement, I felt supported by the team and developed a confidence about my ability to provide for patient needs. Recognition by other team members supported me especially when I was faced with difficult situations, or when I felt helpless in my work with patients as a music therapist. Moreover, professional acknowledgement helped me to cope with loss and grief by having a positive acknowledgement from the team members, which will remain with me forever.

Therefore, professional acknowledgement might be an important part of working within an interdisciplinary team to develop professional and personal support, and to enrich quality relationships among team members.

**Theme 2. Quality of Relationships: Sub-Theme 2c. Psychosocial Support**

All participants expressed that they had support from their team members, but it was hard for me to pin-point what *support* meant to each participant. This might be due to pragmatic confusion as a result of my lack of interviewing skills in hindsight. I should have
asked more reflective questions about what support means to participants during interviews. Another reason why it was difficult to define support was because support has a range of meanings. Gathering from participant interview responses, to them support included not only emotional support (venting their emotional stress to other team members), but it also covered other psychosocial aspects from simply making tea for the team members, to hearing each other vent their challenges, or to receiving mentorship from another team member. Therefore, I’ve chosen to call this sub-theme “psychosocial support.”

The participants expressed that they need psychosocial support because hospice palliative care deals with a significant amount of sadness. Elaine commented:

... this can be a very very sad place, if you allow it, this can be an emotional, draining place, if you allow, and it will do both at some point in time, but if you have a team member, that you know, you can say “Oh, you know what happened?”

A few participants used to describe psychosocial support as “leaning on” each other. As an additional example, Kate elaborated that:

... we have situations that too incredibly difficult, and we have each other to lean on, and you can cry in front of peers here. You can talk about things you might not be able to deal with elsewhere, it’s just such a wonderful feeling to know that. And we all go through it, especially in this line of work. It’s a good thing.

Kate’s words illustrate the uniqueness of the interdisciplinary team in hospice palliative care. The uniqueness being that team members not only focus on work responsibilities but also rely on psychosocial support from one another. Anna stated that psychosocial support helped contribute to a sense of well-being for her and her team members: “... because that I want to see people having the supports they need when I work hard to get the support that I need to stay
Connie described importance of psychosocial support:

I get a lot of support, [a co-worker], so good, I get a lot of support from [another co-worker], who is a part of the team, I don’t see her all the time, but yeah I know I can go to those people, but they are probably my main support, I can run things by them, and it’s a safe place to say, I’m miserable about this, or I don’t know about that, and I get that support, very much, I wouldn’t come, if I don’t feel supported, I think it is vital...

In addition, Connie expressed the importance of nurturing and providing on-going psychosocial support to her team: “... the team needs to be nurtured the whole time, we can easily fall apart, if we don’t look after each other, and work together.”

Thus, psychosocial support is essential for interdisciplinary teams to work well together. Through the participants’ experience, psychosocial support is an indispensable part of quality of relationships in the interdisciplinary team.

**Theme 2. Quality of Relationships: Sub-Theme 2d. Belonging and Connection**

Some participants described a sense of belonging and connection in the team as being important. Four participants, Becky, Connie, Fiona and Kate, expressed that they feel like a part of their team, and that they are proud to be in their team. Connie stated: “... it’s a team that I’m proud to be associated with, it is a good feeling to belong to it...” She illustrated why it was important to have a feeling of belonging and connection in the interdisciplinary team:

I think just by having that team, and knowing that you are not alone with an issue, it’s always about the people you work with, if you work good people, then you don’t mind going to work, however challenging it is.

Fiona expressed that a sense of belonging and connection includes the extended team
members, such as house keepers and volunteers: “... even the cleaning staff, our cleaning staff is very very much a part of the whole thing..., like I said, the volunteers, same thing, you really can interact each other, it’s great.”

On the other hand, three participants, Anna, Gerri, and Hanna expressed that they were feeling isolated from their team or lacked of sense of belonging and connection. Gerri said:

I don’t feel involved, and that which is fine, that’s what is that about, so that’s just kind of challenging because I don’t feel like part of the team I guess, so I don’t feel like I’m part of that.

Similar to Gerri, Anna expressed these feelings: “… I’m only here two days a week has as me feeling like kind of like on the outside sometimes…” This lack of a sense of belonging and connection might be related to work hours. Three of the participants who felt a lack of a sense of belonging and connection are employed as part-time workers. Hanna told me that she felt a greater sense of belonging and connection when she worked as a full-time worker. Gerri expressed that she would like to feel a greater sense of belonging and connection with other team members: “That’s nice not to feel alone, I think in any job you want to feel some sense of togetherness, I think it makes your job easier to do…”

The issue of a lack of belonging and connection is discussed in the literature. Dean (1998) reports that some hospice healthcare workers experience a feeling of isolation or lack of belonging and connection, because they are working independently and do not have many opportunities for exchange with other team members. Connie identified this challenge of a lack of belonging and connection in her team, as well. She stated: “So that’s a challenge, just making everybody aware, that they are part of a team, and we are in there together.”

In summary, Connie believed that it is a challenge to develop a sense of belonging and
connection to all of the team members. However, it is necessary for interdisciplinary team members to have a sense of belonging, especially giving the challenges of working with dying patients.

**Theme 2. Quality of Relationships: Sub-Theme 2e. Egalitarianism**

In my literature review, the issue of a power differential in the interdisciplinary team in hospice palliative care was discussed (Coompan, 2001; Kirk et al., 2010; Vachon, 1987). Participant interviews yielded information that supported the necessity of egalitarianism and how it helped the team work together. In contrast, a lack of egalitarianism was a challenge in the team, in some instances.

Many participants believed that they had egalitarianism among their teams. Fiona communicated about her positive experience: “... now it is a great experience for me, because now I’m interacting with doctors and pharmacy and family, that was I never allowed to do before, so it’s great...” She continued to elaborate on that uniqueness of egalitarianism in the interdisciplinary team:

... so when you go to a doctor, ... and we interact with each other, like we are a team, where you don’t get the same feedback, if you are in acute care, here they totally respect your opinion, and they value your opinion...

Her opinion was equally respected as a team member, similar to how the opinion of her team’s physician would be viewed. Deb proclaimed: “I believe every team member is equally important, if you had to say pick one member of the team that’s no longer able to come to rounds...” She believed that everyone has their own place in the team.

On the other hand, the issues of power differentials or a lack of egalitarianism still existed in the interdisciplinary team in the participants’ interviews. One of the participants, a
physician, whom I will not identify in order to protect her confidentiality, expressed that she was forced to take a leadership role, when she started her hospice program, because of an antiquated hierarchy in the healthcare system. She elaborated:

... but I do think when I started here, my sense was that there was a hierarchy, perceived as hierarchy, I didn’t like it, I didn’t want it, but it was a given from some of the nursing staff, but they saw me in that role, so it was uncomfortable for me, …

Another issue of a lack of egalitarianism between Registered Nurses (RN) and Licensed Practical Nurses (LPN) were discussed in the interview with Jane:

As an example, I have heard now and again, LPN and RN roles are, I know that sometimes the LPNs over the five years have felt not valued at times by the RNs, some of them, and there is, I don’t know how that kind of stuff, how they resolve it, can we as a team help with that? Or should we as team help with that?

This issue, surrounding a lack of egalitarianism, can be attributed to not just medical teams, but also to psychosocial teams when working with medical professionals. The psychosocial team members feel inferior to the rest of the team. Isabella expressed: “My comment with regards to concern is when the staff or when the rounds seems to go too fast or someone seems to minimize some of the psychosocial issues.” Several psychosocial team member participants, Anna, Becky, Gerri and Isabella, were feeling a lack of egalitarianism on their teams. I will discuss this issue between medical and psychosocial team members in the section of institutional influence theme later.

The lack of egalitarianism is an on-going issue, however Jane insisted on the importance of egalitarianism as a means for mutual respect among team members:

... my sense is, we all know how a team supposed to work, used to be idea of that,
and my idea of a team in healthcare is that all the members are equal, I don’t personally believe in a layered team, and that everybody’s input should be valued, and respected...

Based on the responses, the participants illustrated that the importance of and challenges surrounding egalitarianism must be identified within the interdisciplinary team in order to improve the quality of relationships among team members.

**Theme 2. Quality of Relationships: Sub-Theme 2f. Continuity**

Several participants expressed the significance of a continuity of membership in their interdisciplinary teams. Fiona stated:

I think it evolves by working with that person over a time, you just don’t, and as I was saying with the volunteers, you just don’t accept a new volunteer right off the back, “Oh I gonna do this, or I gonna let her do that, I don’t know her,” so she has to prove to me, or he has to prove to me, that I can trust them, as well as my co-worker is the same, it evolves as you work with them in time, hopefully those people will stay, so that you have this continuity.

Other participants (Becky, Deb, Gerri, and Hanna) expressed similar opinions to Fiona. Their relationships with other team members developed as a result of a continuity of team membership. Becky, Deb, and Isabella, described their difficulties with discontinuities due to lay-offs. Isabella stated that:

… it becomes a struggle in the team, we just recently, a team member was laid off, and all of us are looking at how are we going to cover what this person did, how we are going to be able to do that? And it distracts the team as a whole because all the sudden…

Becky also shared her thoughts about losing team members: “... we are starting to lose a few
people, in the coming weeks to other places, which is making my heart get tugged a bit.”

Without continuity in the interdisciplinary team, it is hard to provide holistic care for patients. A lack of continuity might be due to employee lay-offs, casual workers in the team, or to new workers being introduced into the interdisciplinary team. Fiona communicated about the challenges of having casual workers: “I think, challenge is like if we have casuals come in, I find casuals can be a challenge, because I don’t always know them.”

Deb discussed the difficulties of integrating a new team member to the interdisciplinary team:

I like to see because we got two new team member who have just come, so I think if I had my way, there might be better orientation for new team members, for one, and I think the whole coming up with a way to better, orientate especially the team members, the nurses are here all the time, so they all get orientated to each other real quick, but the other team members, that come, I’d like to come up with some better strategy to kind of welcome them...

Through working together for a long period of time and having continuity in the interdisciplinary team, the team develops trust and role clarity among its members (Peck, 2006a). Therefore, it stands to reason that new team members might have difficulties in joining the team.

The interdisciplinary team members need to face these challenges of continuity. However, Hanna believed that most of the interdisciplinary team members are committed to providing continuous care in the hospice palliative care setting:

...the immense commitment that people seem to have, it is not a job where people seem to just come and stay for a few months or a year, it’s a job, or a place,
people really want to be there...

The continuity of team members in the interdisciplinary team might reflect their commitment to hospice palliative care, and continuity could help to develop the quality of relationships among the interdisciplinary team members.

**Theme 2. Quality of Relationships: Sub-Theme 2g. Personal Relationships**

This sub-theme was added in the later stage of content analysis. Some of the contents of the participant interviews did not fit into other sub-themes, and I felt that another element of the “quality of relationships” was missing from the initial sub-themes. I compared interview contents, and found that intimate quality of relationships was part of the participants’ experience on their teams. For example, Kate stated:

That’s right it’s a real sense of family with us all. We just all know each other very well. It’s very comforting and just that sense of family, you are not scared to disappoint by saying something that maybe this person doesn’t want to hear.

Also, Gerri said: “I do notice there’s a good sense of friendship, but there is bonding that happens in the team...” Kate and Gerri experienced a sense of family or friendship among their team members. Another example is from Becky’s interview:

The physicians and the clinical nurse specialist actually come on their own time and present [people] sometimes, just to talk about the dying process, and you know, so there’s good rapport, even though we don’t do thing socially, they’re became friends too, because of the respect that we have, …

Personal relationships or a sense of family or friendship, which required close relationships, were part of the participants’ experience. These personal relationships among team members were unique part of the interdisciplinary team in hospice palliative care from my
clinical experience, as well. I have worked in interdisciplinary teams in the area of residential care, but have never experienced the kind of quality of personal relationships with other interdisciplinary teams like that of the teams in hospice palliative care settings. I felt like a part of a family in the interdisciplinary teams. I must wonder why personal relationships are so important to the interdisciplinary team in hospice palliative care. Gerri’s comment answered my question:

... this is hospice, it’s is a lot about emotion and it’s a lot about dealing with life, and dealing with death, so I think that brings people together too. Maybe that’s why the team works really well in here, because we are dealing with pretty heavy subject matter, and we are here for each other, and we all know that collectively...

In dealing with life and death every day in hospice palliative care settings, personal relationships might provide comfort and support among team members. Even though close personal relationships are needed in interdisciplinary teams, they still require healthy boundaries. Fiona insisted: “I guess a challenge on a personal, personal side, not so much with patients, but I think over the year, sometimes you are giving me way too much personal information, I don’t want to know all about your life...”

In hospice palliative care, healthcare workers provide care for patients, but their work is not only providing professional expertise, but also developing quality relationships with others. Becky posited: “I think interdisciplinary team rapport gets made more complex than it needs to, we analyze it too much, who should do what...” Becky’s point might be accurate, because so many healthcare professionals are involved on interdisciplinary teams that inter-relationships become very complex. However, it might help to better understand what kind of quality of relationship is needed in the interdisciplinary team in order to have a better rapport among team
4.2.3. Theme 3. Communication

“First and foremost, the communication here is unbelievable, key to anything, really.” Kate expressed, in her above statement, the importance of communication within the interdisciplinary team. All other participants also commented about the strengths and challenges of communication in their interdisciplinary teams, in their interviews. It is clear from the literature that communication is one of the challenges that interdisciplinary teams face (Dean, 1998; DiTullio & McDonald, 1999; Kirk et al., 2010; Vachon, 1987). It is also a challenge to identify a specific problem with communication in the interdisciplinary team.

Communication encompasses five sub-themes: (a) mode of communication; (b) form of communication; (c) timing of communication; (d) recipients of information sharing; and (e) content of shared information. These sub-themes, that were identified based on participant interviews, may provide some idea of where the challenging areas of communication are found, within the interdisciplinary team.

Theme 3. Communication: Sub-Theme 3a. Mode of Communication

Most of the participants recognized that verbal communication in their interdisciplinary team was sound, but they identified issues around written communication. Gerri illustrated the issue of written communication:

I’d like to see a better system for actually written communication, in terms of charting, and just communicating what is going on, because not everybody is here at the same time every day, so really the only time we all come together is in rounds, but even then it is only some of us and not all of the nurses are there, and so quite often there is gaps in the communication, just in terms of like day to day, what is going
on with patient A, B or C, so I would like there to be a better system for charting, not
everybody charts in the same place, and not everybody writes stuff, it’s just hard to
know what everybody else is doing, unless you actually sit down and have a chat with
them...

Connie expressed similar concerns to Gerri:

... by which I mean, either verbally letting someone know making sure you’re
documenting it the right time, and then actually reading the documentation because
you’ll have that doubling up that one of the team members say “OK, I was talking to
the patient, and I said this and that”, and somebody else will say I had that
conversation yesterday, but did you document, maybe they did, may be that person
didn’t read, or they didn’t document it...

As Gerri and Connie expressed above, it is important to pass on information in writing,
especially since each team member cannot always give a verbal report, such when nurses
change shifts. Gerri elaborated further on this issue:

I’m not here for the twelve hour shifts like nurses are, I’m not here five days a week,
so that is definitely my perspective on it, I kind of come in and I haven’t been here in
five days, I don’t know what’s happened in that five days, and it would be nice, if
there was a bit more.

In order to solve the problem of providing written information, one of the participants,
Deb, stated that her interdisciplinary team used electronic communication. She stated:

We find lots of information, we do a lot of communication through e-mail, so
everybody is on the same list, and everybody is on an e-mail, so even the simple little
thing, we just e-mail everybody, “just heads up a new patient in room [A],” then entire
team knows, “alright, that’s the one you e-mailed me about”, just so that everybody has the same information...

In her team, she expressed that communication through e-mail was working well. Street and Blackford (2001) stated that new information technologies, such as e-mail or voice mail, may increase the effectiveness of communication, especially with regards to the access to new resources. However, they warn that new information technology might not provide proper client records, as would formal documentation.

Documentation is an important factor for providing consistency and a quality of care for patients in hospice palliative care (Bergen-Jackson, et al., 2009). From the participants’ interviews, it was clear that their interdisciplinary teams faced challenges with documentation, and that there were no team guidelines with regards to handing over documented information to other team members. Standardized documentation is needed to improve communication among team members (Bergen-Jackson et al., 2009; Street & Blackford, 2001). Therefore, a lack of guidance on formal documentation might be causing difficulties in communication between interdisciplinary team members.

Theme 3. Communication: Sub-Theme 3b. Form of Communication

Various forms of communication were identified through participant interviews, such as rounds, team meetings, family meetings, charting, referral, and doctor’s boards. From participants’ interviews, it was evident that rounds, where all the disciplines get together to discuss care for patients, are the main form of communication. Anna stated:

It’s real honour to be a part of that (rounds). I don’t like to miss rounds to hear the PPS (Palliative Performance Scale) of the person, you know, in the short time I have been away to know how much, what’s been going on with them. It gives me
prioritization for who I should visit and who I plan on visiting, and what I can expect. The rounds provided her crucial information about her patients. Deb described what rounds mean for the interdisciplinary team:

... it’s more like a brainstorming session once a week, on how we can get the patient better care, so I think in the end, it’s the patients who benefit, it’s more like a brainstorming session once a week, on how we can get the patient better care, so I think in the end, it’s the patients who benefit...

She elaborated more about the purpose of rounds in her interview, later:

That’s the purpose of rounds, we are problem solving, and we are setting a goal for the patients, there is a problem with the patient, how do we get to that goal, what is the goal going to be for the next week until we meet next week, how did that work.

Based on this research, it appeared that rounds are an opportunity for the interdisciplinary team to share information and develop a care plan to work towards achieving patient's goals. Anna, Becky, and Gerri expressed their concern that psychosocial parts of care issues were sometimes ignored or were less valued in their rounds. Anna insisted:

I think what my most frustration is the speed that we have to go through rounds, even though it takes a long time, it’s seems so, like, sometimes, I’m afraid I don’t have the opportunity to share my opinion or my insight, so yeah, that’s one of toughest pieces, I think.

Later, she explained how the rounds usually proceeded:

... the nurse will speak first generally, the doctor and pharmacist will very often comment, or the doctor will give some insight into the background and she’ll also give some insight into what’s going to be, you know, offered as any treatment or
questions they have or there might be some pharmaceutical concerns and then the psychosocial.

She feels that she did not have enough time or space to share her information about the patient’s psychosocial needs. Echoing Anna, Becky commented:

…if I hear them a little getting too medical, sometimes in rounds, I’ll call them on it, and remind them of the humanity on the table, and their hearts, their head may be trying figure this out, but really all they need to do is to bring their heart into the situation, and listen to the depth of what is going on, and that simple act alone, can change something, instead of analyzing it too much.

This might be an issue how to process the rounds, or how to include everyone’s voices in the rounds. Jane expressed that historically, nurses were pressured to be the main person providing information about patients during rounds. They used to write a report about their patients for the rounds the night before, but her interdisciplinary team changed how they did the rounds to reduce the pressure on the nurses. She described the changes in how rounds were processed:

... so what we did was we re-structured our rounds, at least we tried to, and I think it is better, we don’t have a chair, it’s a rotating chair for rounds, and we have it so somebody, a different person takes a facilitator position every week, somebody else would take the recording position, so the same person is not having to fulfill those roles, the nurses do come in and talk about their patients, but we open up for everybody.

After the interview, Jane shared guidelines for rounds with me. She expressed that the guidelines made a difference in how the rounds were carried out by her interdisciplinary team.
Every member in her interdisciplinary team had an opportunity to assume the facilitator role, and each of them was provided equal opportunities to share their opinion.

Similar to these participants’ experiences, current literature shows there are communication issues, interpersonal conflicts (Larson, 2003), and competition among team members (Reese & Sontag, 2001) related to rounds. Recent studies (Baldwin, Wittenberg-Lyles, Parker Oliver, & Demiris, 2011; Demiris et al., 2008) recommend having a formal protocol and training for interpersonal communication skills required for team meetings.

Rounds in hospice palliative care are the main form of communication to provide better patient care in their programs. From the participants’ voices, rounds contain some challenges of communication among the interdisciplinary team members. Teams might need to have clearer guidelines and education on how to develop the rounds process in order to improve communication.

**Theme 3. Communication: Sub-Theme 3c. Timing of Communication**

Connie explained why the timing of communication is important in the interdisciplinary team in hospice palliative care:

… it’s partly because the onus is on you to keep communicating..., and I think with hospice a lot of our patients and families it’s in the moment, if they’re dared to come out with a concern, they need support there, not well there’ll be somebody in two days time.

In hospice palliative care, the patient’s condition might change quickly. Therefore, the team might need to address something right away to meet a patient's last wishes or needs. In order to support the patient’s imminent needs, the timing of communication needs to be considered. Connie also explained that the interdisciplinary team needs to communicate in a
timely manner, not depending on the timing of rounds only: “... once a week you get that opportunity at rounds, but if something happens the day after rounds, then it is a long time, you can’t rely on that one time, communication could be always better.”

It is important to communicate with other interdisciplinary team members on time because the patient might not have the same ability to do something a few days later, or might pass away while he or she is waiting for a last wish to be fulfilled. Anna expressed that she gets frustrated that she does not get referrals on time from other interdisciplinary team members:

... by being present I get the referral, and I don’t want to belittle them and say, but I say sometime why didn’t you page me, I came sooner, so upon seeing me, it’s the awkwardness of getting the referral at that time.

The timing of communication might be better if Anna’s team members paged her right away, when the need for psychosocial support for the patient first becomes apparent. The timing of communication is critical in hospice palliative care, especially when patients’ conditions may change rapidly (Bercovich & Adunsky, 2006). The interdisciplinary team needs to have timely or continuous information sharing with other team members to provide the best care for their patients.

**Theme 3. Communication: Sub-Theme 3d. Recipients of Information Sharing**

Gerri expressed that she and her team members did not receive as much information as the nurses, who spent more hours with patients: “the nursing staff passes things along, when they do the shift change, they pass it along, but I don’t get any of that, the rest of the team does not get either…” Similar to Gerri, Connie shared her concerns about the lack of information sharing among other team members:
Not sharing information, receiving information or giving it out, so see that as problem, then we are not giving the patient the sort of care we’d like to, because we are missing pieces of information, it is essential we all work as a team. As Connie stated above, it is important to share information with all of the interdisciplinary team members in order to provide holistic care for patients. Connie also expressed her concerns with nurses who tended to limit information to medical staff, and did not share with other interdisciplinary team members.

From the participants’ voices, it is clear that all of the team members should have access to all information, in order to work as an effective team. It is a source of frustration among interdisciplinary team members that they can’t know what all other team members have communicated with their patients (Kirk et al., 2010). As the participants in this research expressed, sharing information with all of the team members might be the key to effectively working together as an interdisciplinary team.

**Theme 3. Communication: Sub-Theme 3e. Content of Shared Information**

Based on participant interviews, the content of shared information was found as another significant area of communication within the interdisciplinary team. From the healthcare workers’ voices, the content of shared information included several elements such as the issue of the lack of sharing of psychosocial information, the ethical issues of disclosure to other interdisciplinary team members, and the need for sharing of personal stories among team members.

As I described above, Anna, Becky and Gerri felt that the content of psychosocial issues was less valued in their teams. Anna described the reason why some of the team members do not want to share psychosocial issues:
… my experience is sometime staff members are not ready that the emotional level, and I have to prepare myself for, in some ways I get little anxious, and I shouldn’t be anxious, but I am little anxious in what I’m going to present because I don’t want, I resist being so clinical...

The lack of sharing psychosocial content might be a common issue in hospice palliative care. Another study by Wittenberg-Lyles and her associates (2009) showed the same issue with regards to the lack of non-medical information sharing in interdisciplinary team meetings.

Anna and Kate expressed their concerns about confidentiality of patient information. In the interdisciplinary team, it is vital to share patient information among other team members, and to provide quality care to patients. However, how the patient’s information is disclosed is important, as well (Kirk et al., 2010; Wittenberg-Lyles et al., 2009). Anna stated that she feels her team members are not careful enough when disclosing patient information:

... nursing staff, sometimes I am afraid that something they find out for me might be disclosed somehow by, in a way that’s insensitive by nursing staff members, by saying well you know, I understand something that on my level should be... So here it’s not so much treated as confidential ...

Similar to Anna, Kate expressed feelings about the issue of confidentiality: “... you’ve got to be really careful about what you say, and about confidentiality, you have to be careful there, all and all I mean we are respectful of what we have to bring to the table.”

Since the content of information might include sensitive issues involving the patient’s personal life, the content of shared information needs to be addressed with sensitivity and respect when disclosing patient information within the interdisciplinary team. It is important to deal with the concerns about patient confidentiality that Anna and Kate have raised.
Another area that some of the participants discussed about the content of shared information was the need to share their personal stories. Isabella said that the interdisciplinary team needed to share personal stories in order to work as a team:

As a team, if we don’t know each other’s story, there comes better functioning as a team when you know each other’s story, when you know the values of an individual, never mind in the team, but individual, to have those kinds of thought out discussion, it’s better for the whole team, because you do a better job of functioning...

Anna also stated that listening to others’ stories was a part of her job:

... but I think it is really important to spend time with staff and to hear their stories and to hear what’s going on with them, and relationship to their patients, so that is a big piece of my work too.

Gerri expressed that she would like to know what other people’s challenges are, through listening to their stories: “I guess so, just to talk about challenges you have, or just talk about how things are going, and to have the whole team together for that, I would like to see more of that…”

The research participants stated that sharing personal stories or challenges, among the interdisciplinary team members, is important in order to work as a team. Some reasons for sharing their stories might be because healthcare workers in hospice palliative care deal with various challenging emotions, or they need to off-load their emotional and spiritual stress at both the individual- and team-level, to maintain their well-being (Peck, 2006a). Therefore, sharing one’s personal stories and challenges among the interdisciplinary team members might be beneficial for maintaining healthcare workers’ well-being through sharing self-reflection and receiving feedback and support.
Communication embraced five sub-themes, and each sub-theme raised some specific issues around communication. In order to solve those problems, education and training are needed to improve communication (Demiris et al., 2008; Kirk et al., 2010; Wittenberg-Lyle, et al., 2009), which relate to the next theme: team building activities.

4.2.4. Theme 4. Team Building Activities

Team building is needed to integrate knowledge and skills from multiple disciplines to provide holistic patient care (Payne, 2006). The participants in this research identified the need for team building activities to improve the cohesiveness in their teams. Team building activities contain four sub-themes: (a) education; (b) social events; (c) on-going team review; and (d) formal debriefing.

Theme 4. Team Building Activities: Sub-Theme 4a. Education

The need for education was mentioned in previous sections through other themes such as education to clarify roles or expertise (cf. 1b. sharing responsibilities for patient care and 1c. expertise), and education for communication (cf. 3. communication). The participants identified needs in those areas. Deb shared that:

... it’s education, if people don’t know what those people do, and the social worker is going, “Oh, I thought everything was `going great, no one ever phoned me over there,” she works different units right? It’s a total miscommunication, and they just thought she never showing up, and here nobody was ever making a referral, she works on a referral basis, and somewhere along the line, never ever get picked up…

Gerri expressed that she needs to provide more education about her role in the interdisciplinary team to other team members “To create more awareness for them what I do. I need to educate my team more, I’ve only done that once when I was started four years ago, I
haven’t done any more education.”

Therefore, education to clarify roles and communication is needed in the interdisciplinary team. Furthermore, Connie expressed the need for on-going education for the nursing team members:

I guess other big one and I haven’t thought about it until just now, it’s the education, the ongoing education, we have sessions twice a year, specifically for nursing, you got it’s the team that comes in, and will presents on a topic, usually we asked the nurses what they are interested in, so again you’ve got a team, physician, and the last one we had the physician, social worker came in, [a volunteer coordinator], a wide range, hopefully this time, we’ll get [a pharmacist], I think the ongoing education and then it’s specific to hospice, it’s given by team members that know the issues.

Anna, Becky, Gerri, and Hanna expressed the need to address psychosocial issues in education. Becky insisted on the necessity of more psychosocial training for the medical team:

“... the people coming in from the medical team, aren’t always given the true training to be with the dying, to understand the full dimensional on a human level, and I would really love to see more of that…”

Due to the complexity of the needs of patients towards the end of life, collaboration with other members of the interdisciplinary team is necessary (Reeves et al., 2009). Without collaborative work within the interdisciplinary team, the team will fail to provide a quality of care for patients. Reeves and his associates (2009) insist that education may enhance collaboration among the interdisciplinary team and the quality of care for patients. As the participants of this research shared, education of various aspects of care was needed to improve their teamwork.
**Theme 4. Team Building Activities: Sub-Theme 4b. Social Events:**

Five participants described social events in their interdisciplinary team as team building activities. Jane expressed her opinion on why her interdisciplinary team has social events:

... it doesn’t mean we have to be friends with one another on the outside, we need to have a lot of social, it doesn’t matter because we have all kinds of different personality here, but it’s for team building.

As Jane expressed above, social events are part of team building. Meier and Beresford (2008b) insist on having an off-site retreat or a social event to get to know each other in the interdisciplinary team, as a team building exercise. Gerri outlined the kind of social events her interdisciplinary team has:

... we have parties for people, and we buy presents for people, we have once a year a big picnic, and I feel that even that, and they even include the housekeeping staff and a lot of other things that we do, really that adds to, my work enjoyment, because then when I come to work, I respect what everyone does, and we kind of feel like we know each other.

She added her support for having more team building social events:

I think that would be really beneficial, I’ve only ever done one of those events (social events), where it was organized, and everyone came, and we did different activities, it was kind of a team building thing, I would like to see more of that because then it gives us, more of a chance to come together as a team, and to hear each other’s perspectives outside of this physical location.

Likewise, Anna stated that she wanted to know her team members outside of their work, through social events:
Personally I’d like to be able to know that staff is going to get together two or three times a year for a staff party or something, I’d like that. Then, we see each other in a different light, and we see each other as a human in a certain way, I think I’m that way most of the time at work, so then I also feel welcomed at work as someone who has the time to be able to sit with people, and bring a bright spot into the day.

From the participants’ voices, social events were needed as part of team building or getting to know each other on a personal level in the interdisciplinary team. Speck (2006a) insists that informal support among the team members outside of work strengthens the relationships in the team, and grows confidence and trust among one another at a personal level. Thus, social events might help to foster team support and to develop personal relationships among interdisciplinary team members.

**Theme 4. Team Building Activities: Sub-Theme 4c. On-GOing Team Review**

Although only two participants mentioned the need for on-going team review, it is an important part of amending the function of the interdisciplinary team. Jane criticized her interdisciplinary team’s lack of on-going team review:

I think you have to always work at, and getting at, it’s not static, the team members coming in, we have new volunteers, you have to always re-evaluate, I think for one thing, we probably don’t, I think one criticism I would have is, we probably should do more evaluation, of how things are going to this, that it should be at least a yearly things that’s done...

She expressed that a regular on-going team review is needed in her team. She expanded on what types of things she believed needed to be discussed in the team review:

... once a year or every six month, to do just a team review, how things are going,
what is your sense of, do you think when you come in and give you report, what that you are not feeling…

Similar to Jane, Isabella expressed the need of a systematic team review:

I think on a regular basis we kind walk around it, but we don’t sit down and actually really identify it, and maybe it was done at the very beginning, but I don’t know that it’s been done recently, and I think that when you’re talking about values, you have to come back to it. Where I used to work, we every year we’d come back and we’d do SWOT analysis, Strength, Weakness, Opportunity, and Threats, we would look at all of it, we would, every year, we would come back and we’d do that, we looked at our five year strategic plan as a team, and are each doing our piece in the team? And that’s the piece that’s missing up here because we don’t have the leadership. We are not looking as a team as: Do we have a five year plan?

She added that she felt her team was not improving their teamwork due to a lack of on-going team review:

... even to do just a simple SWOT analysis on a regular basis would be very beneficial, ..., and which is if you aren’t working towards something, you are going backwards, and I would say that is what’s happening this team right now.

Jane stated why on-going team review was needed in her team:

... we go ahead and start thinking about how we function as a team here, how do you think it’s going, what ways or which way we can improve it, or do you think it needs improvement...

On-going team review is needed to understand and improve the function of the team.

A lack of on-going team review is evident from the lack of coding in this category by the other
participants (cf. Table 2. Response Rate from the Participants’ Interviews Using Content Analysis). There was no formal on-going team review for any of the participants’ interdisciplinary teams. Related literature reflects the importance of on-going team review (Bainbridge, Brazil, Krueger, Ploeg, & Taniguchi, 2010; Bruce & Boston, 2008; Dean 1998; Dunlop & Hockley, 1998). Bruce and Boston (2008) insist that evaluation of the interdisciplinary team is required on a regular basis, in order to develop and improve collaboration within the team. Having a regular team review also helps to address the function of the team, including stress and conflict management (Dunlop & Hockley, 1998). On-going team review is needed to improve collaborative teamwork among the interdisciplinary team, which enhances the quality of patient care. As Jane and Isabella expressed above, the lack of on-going team review caused a lack of understanding of how the team could work collaboratively and refine the teamwork in their interdisciplinary team.

Thus, the implementation of a regular and systematic on-going team review might improve the quality of teamwork in the interdisciplinary teams, and thereby provide seamless interdisciplinary team care for patients towards the end of their life.

**Theme 4. Team Building Activities: Sub-Theme 4d. Formal Debriefing**

The uniqueness of working in an interdisciplinary team in hospice palliative care is that healthcare workers face on-going loss (Dean 1998). They need to support each other, and to have a place to confide in or share their loss and grief with other team members in order to deal with their stress. Some of the participants expressed that sharing stories about their patients with other interdisciplinary team members, which was previously described under the sub-theme, “3e. content of sharing information,” or debriefing with others helped them to connect as a team. Anna expressed:
... but I think it is really important to spend time with staff and to hear their stories and to hear what’s going on with them, and relationship to their patients, so that is a big piece of my work too...

Likewise, Isabella shared: “... if we don’t know each other’s story, there comes better functioning as a team when you know each other’s story, when you know the values of an individual, never mind in the team,…”

It is important to share one’s personal stories among the interdisciplinary team to understand what is going on with other team members, or to see what kind of challenges they are facing through their work. However, team members seemed to lack opportunities to share their stories or to have debriefing sessions as a team. Elaine commented: “I don’t know what they do around, I don’t even know what they do debriefing or around honouring people that have passed away, memorial type of thing, I don’t even know, I haven’t figure out…” Elaine had been working with her team for more than six months at the time of this interview, but she had never had an opportunity to debrief with her team.

Only Kate provided an example of formal debriefing from her team:

They do for anything really traumatic that happened in the unit, they do a debriefing, they will do with us, talking about feelings surrounding that event, or whatever. ... It is incident debriefing, so for example, we have patients who can potentially it’s called bleeding out, so it is very traumatizing to witness when that happens, and they take us into a room and debrief with us, so just talking about it, how it made you feel, just it getting out, and look anything how anybody else on team, when I talk about things, it helps, and of course, they always stress aside from work, when you go home, you really need to find that outlet that helps you.
For Kate, sharing her feelings and thoughts during the debriefing session helped her cope with a difficult situation. However, incident debriefings were provided only on an as needed basis in her team.

The following example is not a formal debriefing, but it relates to sharing loss and grief among the interdisciplinary team members by having a ritual in the team meeting. Deb mourned the loss of opportunities to share grief and loss issues with her team members:

... the last month of every rounds, we used to do like a healing session, where she (spiritual care coordinator) would bring a candle, and we do a memory for all the patients, the staff and she’d do a little blurb “and now it’s time to let them go”, we used to write off and read off each name, ding the little bell she had in memory, I’d like to see that brought back…

It was valuable experience to have the time to draw closure with the patients in Deb’s team.

Dean (1998) suggests providing regular debriefing sessions with a counsellor or a facilitator from outside the team, for staff support to address grief and loss and self-care. Johnson (as cited in Meier & Beresford, 2008b) elaborates that formal debriefing embraces three purposes in his interdisciplinary team: (1) enhance support to each other in the interdisciplinary team; (2) provide critical and informative feedback to each other; and (3) facilitating self-care. Formal debriefing is not only a place to share their stories, but also to improve their skills as clinicians through constructive feedback with each other, and to maintain their well-being through having an opportunity for self-reflection. Unfortunately, formal debriefing was not utilized in most of the participants’ interdisciplinary teams. However, the importance of sharing stories among the team members was discussed by some participants, as illustrated above.
I experienced the lack of opportunities for formal debriefing in several hospice palliative care programs in my clinical work. However, I had an opportunity to facilitate formal debriefing with my colleagues, a social worker and a spiritual care coordinator, on a regular basis in one of the hospices where I worked. I received positive feedback from the interdisciplinary team members when I provided formal debriefing. They expressed that formal debriefing brought them closure with their patients, and they felt closer to other team members by sharing their stories.

As Isabella stated, the interdisciplinary team might not function as a team without sharing one’s stories about working in hospice palliative care settings. By sharing loss and grief and stressful events with other interdisciplinary team members, having regular formal debriefings as a part of team building activities might be another potential area to bring the interdisciplinary team closer, and to improve the quality of care and well-being of healthcare professionals.

The importance of and the need for team building activities were evident through each sub-theme. One reason for the lack of team building activities might be due to a lack of funding, which was mentioned by Anna and Isabella. Anna acknowledged a cut back of team building activities:

... but I would like to see a collective collegiality, or gathering of, not that it’s recommended or something, but something that would be really good for people to come together in a workshop day, those things have happened I’ve known that in Fraser Health, maybe there’s been cutbacks on those, maybe yeah it has been, but they’re good those things are valuable to be able to build as interdisciplinary team and to stay grounded it in the values and the missions, the vision we have, I think more that
will be really good.

In addition to her comment above, she also expressed the importance of team building activities. Similar to Anna, many other participants understood the importance of team building activities. However, another reason that contributes to the lack of team building activities is a lack of interest in those team building activities (Anna, Isabella, and Jane).

Isabella illustrated the reason why people do not like team building activities:

... but lots of people don’t like team building, a lot of people don’t like the team building exercises, so they won’t come, because they don’t like going to a rope course and working together, they want to see something more concrete, but once you see something more concrete, then you can get together, and have team building exercises, that are based on the concrete goal, that you are working towards, and so it is interesting thing...

As Isabella stated above, a provider or a facilitator of team building activities might need to understand what kind of team building activities were appropriate and practical for the interdisciplinary team, in order to increase attendance and interest in participating. Sadly, team building activities are not a major focus, or have not been fully utilized to improve teamwork in the participants' interdisciplinary teams. Incorporating team building activities might help facilitate the level of collaboration in the interdisciplinary team.

4.2.5. Theme 5. Personal Qualities

Connie expressed that “... it’s always about the people you work with, if you work good people, then you don’t mind going to work...” As Connie’s comment above illustrates, working within an interdisciplinary team was all about the people they work with. Personal qualities are aspects that may facilitate and encourage collaboration with other interdisciplinary
team members (Bronstein, 2003; Parker Oliver, Tatum, Kapp, & Wallace, 2010). Participants supported the relevancy of personal qualities working within the interdisciplinary team. Through content analysis, two sub-themes emerged to affirm the value of personal qualities of the interdisciplinary team members: (a) depth and richness of life and work experience; and (b) affinity for working within an interdisciplinary team.

**Theme 5. Personal Qualities: Sub-Themes 5a. Depth and Richness of Life and Work Experience**

Several participants, Anna, Becky, Deb, Elaine, Fiona and Kate, insisted on the importance of both professional life experience as well as work experience within the interdisciplinary team in hospice palliative care. For example, Fiona stated the need for professional experience before team members come to work in hospice palliative care:

It’s more experienced people that come here, they are not anywhere nearing that stage where they can look after the dying. I feel that you have to be an experienced as a [professional] for a while before you can come here...

Fiona added that she believed that new graduates or healthcare workers who lack experience working with dying patients will have difficulties working in hospice palliative care. Also, Fiona expressed the importance of personal experience: “Suitable for the work for one thing, you’ve got the experience behind you as a person in general...”

Deb described how her team members had extensive background experience, which contributed to working as a team:

I think a lot of our team members are, which is a part of the reason maybe our team works so well together, a lot of our team members started out elsewhere, I mean I started [at another job] all through [school], so when you are able to not only see things
from different people’s perspectives…

Previous healthcare sector work experience and life experience are assets to the interdisciplinary team in hospice palliative care. In addition, experience working in an interdisciplinary team might benefit healthcare workers’ understanding of the function of the interdisciplinary team. Elaine commented:

I don’t know how much of other types of resources that they could have and they don’t have, I’m not that experienced with hospice, so for me to say well they don’t have or this is happening, is hard for me, because I don’t really, hospice is quite new to me.

Her lack of experience in working with the interdisciplinary team also demonstrated a lack of understanding of the resources available in her interdisciplinary team, although she had experience working in the field of palliative care, but she never worked with the comprehensive interdisciplinary team. She also shared that she had experienced difficulties understanding the roles of each interdisciplinary team member. As I mentioned in chapter 3, I included Elaine, even though she does not meet the criteria of a participant in this research, specifically that the participants have worked more than one year in the interdisciplinary team in hospice palliative care. Elaine had worked with the interdisciplinary team for only six months when I completed my interview with her. However, Elaine’s interview was a valuable resource in understanding the significance of and benefit of experience in the interdisciplinary team in hospice palliative care. Through her interview, she gave me insight that the complexity of the interdisciplinary team in hospice palliative care was contributing to her difficulties with understanding the resources and the roles of other team members. She helped highlight the fact that work experience with the interdisciplinary team was necessary to understand its function.

In addition, it was interesting to note that participants who have less experience spoke to
narrower topics or themes/sub-themes in their interviews, as compared with participants who have more experience addressing a broader topic matter. The length of work experience in hospice palliative care might affect one's understanding of the interdisciplinary team.

The related literature supports the significance of depth and richness of life and work experience for hiring new healthcare practitioners in hospice palliative care (Dunlop & Hockley, 1998; Peck, 2006a). Depth and richness of life and work experience are some of the most important assets healthcare workers can bring to their interdisciplinary team at hospice palliative care. The participants’ voices resonate that depth and richness of life and work experience which is required to successfully service the interdisciplinary team.

**Theme 5. Personal Qualities: Sub-Themes 5b. Affinity for Working within an Interdisciplinary Team**

In addition to depth and richness of life and work experience, another element of personal qualities emerged through participants’ interviews: the affinity for working within an interdisciplinary team in order to work collaboratively. Affinity for working within an interdisciplinary team means that a person’s character is suitable to work in the interdisciplinary team, or a person is willing to work as a team player in the interdisciplinary team. Connie proclaimed that some people do not have an affinity for working within an interdisciplinary team: “I think so, yes, it doesn’t flow naturally all the time, some people get the team, and some people it’s a struggle...” Fiona illustrated that affinity for working within an interdisciplinary team was assessed during the hiring of her team members:

... when they interviewed team, they really did it in a way of personality as well, they really made sure that, if they hired you, for instance, were you going to get along with, so and so, and so and so, was their personality going to mesh? That was a...
important part of hiring, is how we get along personality wise, we had some nurses that are gone, and there were challenges, they had personal problems, and those personal problems, they were challenges for us to deal with at work, it wasn’t so much about looking after the patients, but it was their personality and their own personal thing.

The literature supports the importance of having an affinity for working within an interdisciplinary team: a person who is not a team player often creates a challenge for his or herself and his or her team (Dunlop & Hockley, 1998, Peck 2006a).

Healthcare workers in hospice palliative care need to deal with death and dying, another element of having an affinity for working within an interdisciplinary team, or ability to work death and dying, might need to be considered. Becky stated: “I absolutely do not want somebody coming into the vulnerability of that life transition without them being anchored themselves and blending gently, and complementing.” Recent loss or other stress from one’s life might affect their ability to work in an interdisciplinary team in hospice palliative care (Dunlop & Hockley, 1998).

Compassion and caring are two specific qualities of an affinity for working within an interdisciplinary team, as described by participants. Hanna commented: “..., caring and committed to the field, and just really caring about people, the patients and families.” Expressing similar opinions to Hanna, Elaine said: “I see really caring nurses, very caring nurses, and they’re good at caring, they seem to work well together.” Also, Kate stated: “I would say compassionate, selfless, just a wonderful group of people, I think it really maintain that focus on what or here to do.” Caring and compassion support hospice philosophy, which encompass whole person care (Bishop et al., 2000). As Kate stated, compassion facilitates a focus on care for the patients. These personal qualities should be included as a part of the
characteristics of an affinity for working within an interdisciplinary team.

Personal qualities are significant factors in working within an interdisciplinary team, based on participants’ experience. However, the results in this study did not provide details of what kinds of personal qualities affected teamwork in positive and negative ways. It would be interesting to explore in future research the kinds of personal qualities that are suitable to working in interdisciplinary teams, and how those personal qualities affect patient care or teamwork.

4.2.6. Theme 6. Institutional Influence

Becky expressed her frustration of working in the system: “... so the frustration sometimes is that, feeling that dominant thing, seeing these incredible people in the system, nurses, physicians, everybody, trying to hold a higher philosophy, but the system hitting them.”

We cannot avoid institutional influence when we work in an organization. Institutional influence was evident in the experience of the participants of this research study. Institutional influence includes seven sub-themes: (a) management/administration; (b) budgetary factors; (c) policies and regulations; (d) available work hours; (e) size of the team; (f) medical or psychosocial team; and (g) nurse as a subgroup, which are described in the following sections.

Theme 6. Institutional Influence: Sub-Theme 6a. Management/Administration

The influence of management and administration was discussed in the participants’ interviews. It was interesting that everyone commented positively about the influence of management and administration. Hanna reported:

I think the bigger system from the, director down, they are really committed to it, and they have a lot of passion about it, about hospice palliative care, and so that really helps knowing that right from the top down, with the passions there and the commitment, and
that you generally can feel heard when you have issues, whereas in maybe some bigger teams or maybe in the hospital, you kind of feel swallowed up in the system, but this way, you really feel more of part of it, and that your issues get heard. I think that is the main strength.

Commitment and passion from the management and administration affects her interdisciplinary team in a positive manner. Some of the participants hoped for positive changes with a new manager. Isabella shared: “There is a huge challenge there, and the new manager has a very clear process for what they are gonna do.” Connie expressed that her manager was a source of psychosocial support. Participants expressed confidence in their management and administration.

However, studies show that issues around management and administration are another source of stress within the interdisciplinary team in hospice palliative care (Dean, 1998; Vachon, 1987). The positive perception of management and administration by the participants suggested that their experiences of working in interdisciplinary teams had been affirmative ones, on the whole. On the contrary, if participants in this research felt the management or administration were a source of stress, we would have elicited very different responses.

Theme 6. Institutional Influence: Sub-Theme 6b. Budgetary Factors

Unlike the participants’ positive perception of management and administration, some of the participants expressed their frustration and fear about budgetary factors impacting their interdisciplinary teams. Gerri feels she often has to defend her position due to the fear of losing her job due to budget cuts:

Well, part of that is the budget cuts, that’s a really big part of it. Because I feel like it somebody notices that maybe I’m not doing enough work, whatever that is, I feel
like if people start to think that I’m not pulling my load for what I’m being paid, that position will be cut, so that is a big reason for that defensiveness in me.

Similar to Gerri, Anna commented:

I think it’s mainly with me that I have a fear of how important what I have to offer. It’s that quantifying I suppose, quantifying my practice, but of course I have been scared with the fact that our profession has been cut in Fraser Health.

Also, Isabella described stress due to budget concerns, and she was afraid that she might lose her position:

And some of that is, it is about the team, but some of it is also about motivating factors such as budget. You have to almost show your effectiveness to the team that you are needed as part of the team that does not come from within these team members, it doesn’t come really from there, but it is always is sitting in the back particularly, because of our fiscal restraints right now, so we are all feeling that now.

Four out of five participants who recognized the influence of budgetary factors were psychosocial team members. Budgetary factors influenced how they work in the interdisciplinary team, and were a source of constant stress from the fear of losing their jobs.

In addition, the participants acknowledged that a lack of psychosocial services in the interdisciplinary team affects patient care such as loss of spiritual care, which was mentioned in the section on “1c. expertise.”

Budgetary factors determine levels of service for patients, such as how many employees can be hired into the interdisciplinary team (Dunlop & Hockley, 1984). Discussion of the relationship between interdisciplinary teams and budgetary factors seems absent from the current literature. Even though Bronstein (2003) discussed structural characteristics in her
model of the Influences on Interdisciplinary Collaboration, budgetary factors are missing from the model. Budgetary factors might determine how healthcare workers can work in hospice palliative care, yet it has not been included as an influencing factor on the interdisciplinary team. In the research by Kirk and her associates (2010), a lack of financial resources as a system barrier of the interdisciplinary team was found in their participant data; however, the effect of budgetary shortfalls on the quality of teamwork and quality of patient care was not addressed in their research. Only one article by DiTullio and MacDonald (2010) recognizes the relationship between financial resources, the interdisciplinary team, patient care, and the wellness of healthcare workers. DiTullio and MacDonald proclaim that many American hospice workers are struggling to work as a team, to provide patient care, and to maintain their well-being, due to a lack of sufficient funding for hospice palliative care programs. The response of the healthcare workers and the recent study by DiTullio and MacDonald reflects the importance of recognizing the influence of budgetary factors. These factors influence the quality of teamwork, the quality of healthcare services, and the well-being of interdisciplinary team members.

**Theme 6. Institutional Influence: Sub-Theme 6c. Policies and Regulations**

Policies and regulations can be either a guide or a barrier to the interdisciplinary team in hospice palliative care (Williams et al., 2010). Policies and regulations affect how healthcare workers carry out their work in hospice palliative care units. The participants of this research study expressed their frustration about the changes in policies and regulations.

One participant, who is not identified in order to protect her confidentiality, expressed her frustration about a manual provided to her on how to work as a spiritual care coordinator:

Even though spiritual care, it’s interesting that you would say that. Even though
spiritual care, but it is very much based this particular manual, I didn’t write it, it’s written by someone in Fraser Health, and it’s very much focused on results.

Some participants expressed that healthcare workers have been experiencing a change from service-oriented practice to evidence-based practice. As some of the participants expressed in the previous section about budgetary factors, they felt a need to prove and quantify their services to management and administration, in order to keep their positions.

Another participant, who is a volunteer coordinator, expressed her frustration with implementing a new policy, privacy act:

... the health authority changes to the privacy act, just information to the volunteers that kind of thing, they are cracking down in a way, they don’t realize there’re impacting the quality of care in the specific programs that we have.

Due to the new policy, she could not provide information to her team members or volunteers, hindering the care of her patients. Based on participants’ data, policies and regulations have been interfering with how healthcare workers carry out their work in the interdisciplinary team.

Thus, management/administration and the interdisciplinary team need to monitor and evaluate the impact of policies and regulations on patient care, teamwork, and individual team members, in order to maintain a high level of quality of care for patients.

Theme 6. Institutional Influence: Sub-Theme 6d. Available Work Hours

In the previous sections, the consequences of available work hours was touched on such as the lack of belonging and connection due to available work hours, or being a part time worker (cf. 2d. belonging and connection). Time or available work hours was another factor influencing working in an interdisciplinary team, which was associated with how the interdisciplinary team could function within the hospice palliative care setting.
A full-time worker, Fiona, described that she had enough hours to address psychosocial needs of her patients: “I’m impressed with how much is dependent upon us for psychosocial here, more so than on the other side, simply because we have the time, time is the big, big factor here…”

Most of the part-time workers expressed their frustration with lack of available work hours (Anna, Gerri, and Hanna). Hanna commented:

For me right now, what would improve this job to have more actual time, more time to work more in the hospice, because I don’t feel like I have enough time to do what I need to do here, and I know the team could use more my time.

Connie recognized the lack of connection to their team members due to available work hours, that is, shift work (nights and weekends): “They may not see each other a month or something because nurses are working nights, weekends, yeah, you can go on a month without seeing somebody, that’s not good for team…” Anna noted that she had never met some of her team members because they worked nights and evenings:

... it surprises me sometimes when I meet staff who are, I never see, but who are here regularly, because they are night staff, or maybe on weekends, I’m not here on weekends, so there is a piece about the value of, and the surprise of knowing who has been here when I wasn’t been here.

Participants expressed concerns about challenges of not knowing the other individuals working on their teams. The lack of face-to-face time could also create issues around teamwork. Connie identified the lack of available work hours as a challenge within her interdisciplinary team: “I think it comes down to not having that daily presence, I think that would be better, if we had all the team members there every day, I think that is certainly a
challenge.” A lack of available work hours caused communication problems. Connie elaborated on this issue:

... so I think we could do better, if we had more people here on a regular daily basis, I think sometimes we miss the boat, because somebody wants to talk and there’s nobody there to do that, but the social workers would tell me, “did you phone me? Because I could have talked to them on the phone, I could be done that,” so it’s that challenge of communication as well...

Connie thinks that the nurses, who work at night and on weekends, take huge responsibilities for patient care, but do not utilize their interdisciplinary team well. This is also illustrated in the sub-theme of “1b.sharing responsibilities for patient care.” Connie said: “... the middle of the night or the weekend, and nurses are there ones that are 24/7, so they take on awful a lot...” Also, the inability to meet together as a team was mentioned by several participants (Anna Connie, Deb, Gerri and Jane). Jane acknowledged the challenge of getting together for team building activities due to shift work, or available work hours:

Certainly, it would be hard for staff to come, for all the staff to come, because they have to work, they have to work the night shift, and then it is hard for them to come in the daytime, but I don’t know, maybe we have to do it, we just keep it to the team.

Time is a crucial factor in hospice palliative care settings, because of the limited time some patients have left towards the end of life. Interdisciplinary teams must address patient needs quickly, which was also discussed in “3c.timing of communication.”

How can the interdisciplinary team function as a team without meeting together or getting to know each other? Research data suggests that available work hours is an important factor in influencing the quality of care for patients, and the influence on how the team can
work together to address patient needs in a timely manner.

**Theme 6. Institutional Influence: Sub-Theme 6e. Size of the Team**

The participants in this research highlighted the difference that the size of their team made. Jane suggested that the ability to provide holistic care for the patient is influenced by the number of members she had on her team: “...this team is probably the most comprehensive team, that I work with, because we have more team members,...” Deb commented on why the size of the team matters: “...it adds to the patients benefit, patients get better care, the more team members that are involved, the more input that people have, the better care ultimately the patients get.”

Even though a larger size team may enhance patient care through the sheer number of experts on the team, this may also cause different challenges among the interdisciplinary team members. Hanna proclaimed:

Challenges probably would be, things like with when there’s a whole bunch of team members that try to come together, there’s always gonna be the odd personality conflict or whatever, so that is probably a challenge, having such a big team.

Similarly, Deb described difficulties in working with a larger team:

...three people have different ideas, and how do you choose between them, and sort of talking it out, and sometimes personality dynamics, when you are dealing with large people, sometimes making a decision in a large group, when there’s varying opinion, it is a lot of harder than three or four people, making a decision amongst three or four people a lot of easier than making decision when there’s twelve people in the room,...

This issue of team size related to the challenge of having multiple perspectives in the
interdisciplinary team, as a result of having a greater number of opinions (cf. 1d. multiple perspectives). Maddocks (2006) insists that the size of a team influences not only management but also relationship and communication within the interdisciplinary team in hospice palliative care. As the participants noticed, the influence of team size affected how they worked as a team. Thus, the interdisciplinary team needs to pay attention to how team size impacts them such as: how they manage the team; how they develop relationships among team members; and how they communicate to each other.

**Theme 6. Institutional Influence: Sub-Theme 6f. Medical or Psychosocial Team**

Participants appear to perceive a difference in value of opinion between medical and psychosocial team members. This has been described in the previous sections under the following sub-themes, 2b.professional acknowledgement, 2e.egalitarianism, 3b.form of communication, 3e.content of sharing information, and 6b.budgetary factors. Psychosocial team members felt less valued within their teams (Anna, Gerri and Isabella), had less available work hours as a part-time workers (Anna, Gerri, Hanna, and Isabella), and feared losing their positions due to budgetary factors (Anna, Gerri and Isabella). The gap between medical and psychosocial members is drawn not only from participant experience in the current study, but is demonstrated in the professional literature (Wittenberg-Lyles, 2005; Wittenberg-Lyles et al., 2009). Psychosocial information is often less valued or is addressed as extraneous in the interdisciplinary team, even though the goal of hospice palliative care is to provide holistic care for the patient’s end of life.

Jane stated the value of working within the holistic model to meet the need of the patients and their families as:

I really think that the medical model is not a good model, especially with this type of
work, because you got the families issues, psychosocial stuff, emotional stuff going on, you’re dealing with dying people, dysfunctional family sometimes, and you really need to have all of the, all of the team members having input, and being free to talk about, free to disagree, putting their perspectives in.

As Jane expressed above, hospice palliative care needs both medical and psychosocial team members to work together as a team to provide patients holistic care. The influence being wielded by either medical or psychosocial team members was obvious through participant interviews, and came across through various themes and sub-themes. The effect of unequal influence between the medical and psychosocial team members might be devaluing psychosocial team members’ professions and, as such, their well-being as team members and professionals.

**Theme 6. Institutional Influence: Sub-Theme 6g. Nurses as a Subgroup**

Nurses are the largest group of healthcare professionals, who are at the heart of providing direct care to patients through the interdisciplinary team model (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2006). This is similar to the hospice palliative care programs in the Fraser Health Authority (FHA). Most of the other disciplines are a solo charge, or working by him or herself such as a physician, a pharmacist, or a social worker, but nurses work as a collaborative group. If a hospice unit has 10 beds, 10 regular full- and part-time nurses will work together in the unit through shifts.

Connie described nursing as a subgroup:

I do see the interdisciplinary team works with nursing, but I think nursing is a huge subset that can easily go a bit wild on you, so those are probably where my challenges are, the team, I see as good as supportive, as having a team set up make
sure that issues are covered, and that they’re identified, so I just see nursing as a little bit on the side, but it’s constantly drawing in.

She was concerned that nursing staff might not be integrated well in the interdisciplinary team. Nursing issues were discussed in the sub-themes of “1b. sharing responsibilities for patient care” and “3d. recipients of information sharing” such as the belief that nurses tended to take all of the responsibilities for patient care, or kept patient information within their professional group.

How nurses can be integrated or better collaborate with other interdisciplinary team members might be an area for improvement within interdisciplinary teams.

All six themes and 29 sub-themes were described above. Each participant’s voice was unique, and provided a rich understanding of the function of the interdisciplinary team in hospice palliative care. In the next section, the integration of these six themes and my knowledge and experience from clinical work will be revealed as a synthesis of this research.

4.3. Synthesis: An Integrative and Multidimensional Model of an Interdisciplinary Team Approach to Hospice Palliative Care

Through content analysis of the interviews with 11 healthcare workers working in interdisciplinary teams in hospice palliative care, six themes and 29 sub-themes emerged as described in the previous sections. These six themes are reflections of the healthcare workers’ experiences which illustrate the primary characteristics of interdisciplinary teams, as emerged from the research. These six themes are interrelated to each other, interplay with each other, and determine the function of the interdisciplinary team in hospice palliative care as a whole. Therefore, these six themes reflect the nature of teamwork, or quality of teamwork, for the interdisciplinary team. Each participant experienced a different quality of teamwork in their own interdisciplinary team, which they elaborated on in their interviews. The participants’
voices or the content of their interviews embraced various dimensions of the qualities of teamwork within the six themes, such as professional/clinical, relational, psychosocial, communication/interpersonal, personal, and environmental/institutional aspects.

The quality of teamwork in the interdisciplinary team might determine the quality of patient care and the quality of healthcare worker wellness. In order to provide a “beautiful end” or peaceful death for the patients, teamwork is essential within the hospice palliative care unit (Parker Oliver et al., 2007), specifically to provide various benefits to patient care (Wiebe & Von Roenn, 2010) and to increase patient satisfaction of the care they receive (Grumback & Bodenheimer, 2004). Participants recognized the relationship between the quality of teamwork and quality of patient care in the interdisciplinary team. Jane expressed that the team involvement, or quality of teamwork, and quality of patient care affect each other:

... you have to look at it, definitely I think there should be big team involvement, if patient care is suffering, then it is not just a matter of some manager disciplining somebody, we are talking to somebody, but I think if patients are suffering then, that affects the whole team, and the care we give,…

Moreover, Deb proclaimed that the quality of teamwork affects the quality of patient care: “… but I think it helps the team definitely needs to work cohesively together, and if they don’t then, the patient is the one suffers usually…” Jane expressed that quality of teamwork for the better patient care: “I think teams are great, and I think that the more opportunity in healthcare, to work in that team environment, it can only improve healthcare for patients and families…”

In conclusion, the quality of teamwork affected quality of patient care, which determines quality of life for patients towards the end of life, based on the healthcare workers’ perspectives
in this research.

The research participants did not mention the relationship between the quality of teamwork and their well-being directly in their interviews, but it was evident that quality of teamwork had a positive or negative affect on healthcare worker wellness in different areas such as professional, emotional, spiritual and physical health. For example, some participants felt frustrated due to the lack of understanding of their expertise or role within the team (cf. 1c.expertise). Some of the participants did not feel connected with other interdisciplinary team members or felt isolated from their interdisciplinary team (cf. 2d. belonging and connection). Some others felt a lack of validation from other team members (cf. 2b.professional acknowledgement), with several experiencing an enhancement in their wellness through having support from other interdisciplinary team members (cf. 2c.psychosocial support), and others still were under stress due to a fear of losing their job as a result of budget cuts (cf. 6b.budgetary factors). Other studies support the idea that the quality of teamwork influences the wellness of healthcare workers such as emotional and spiritual well-being, social support, prevention for burn out and compassionate fatigue, and job satisfaction (Dean, 1998; DiTuillo and MacDonal, 1999; Peck, 2006a; Rafferty et al., 2001; Vachon, 1987). Thus, the quality of teamwork impacts the quality of healthcare worker wellness. Furthermore, Yi and Wood (2011) proclaim that healthcare workers' well-being affects the quality of teamwork for the entire interdisciplinary team. Healthcare worker wellness contributes to the quality of patient care and the quality of teamwork, yet a lack of support for the healthcare workers’ well-being is obvious (DiTuillo & MachDonald, 1999; Huggard & Nicholas, 2011). The development of support for healthcare worker wellness must be addressed in order to provide better quality teamwork and quality of patient care.
Another quality was added to this synthesis, after I consulted with an expert reviewer. The expert reviewer and I reviewed this summary of six themes and 29 sub-themes, and the previous version of my synthesis. She pinpointed that the model, or my synthesis, was missing discussion of the effects from the financial aspect, or how financial resources influence other three factors, and vice versa. She recommended including quality of financial resources into the synthesis in order to add another significant influence for the understanding of quality of teamwork. She described to me a few examples of interconnections of financial resources and three existing factors. For example, in the hospice program where she works, the interdisciplinary team members take fewer sick hours (quality of healthcare worker wellness), due to increased job satisfaction (quality of healthcare worker wellness) as a result of the vision of their hospice program and how they work as a team (quality of teamwork). Because they save money by not paying over-time to substitute staffing (quality of financial resources), they could provide more programs to patients (quality of patient care). From her example, you can see how these three existing factors and the additional factor, “quality of financial resources,” are interrelated. Moreover, the expert reviewer expressed that having financial resources was important in addressing patient care, and can provide support for healthcare workers such as providing regular retreats to the interdisciplinary team members. She also insisted that financial resources are a by-product of quality patient care, as demonstrated by donations from the patient’s family members, who were satisfied with the service and quality of care provided by the interdisciplinary team. Her comments and the study by DiTullio and MacDonald (2010), which investigated the relationships among teamwork, service for the patients, and well-being of care, corroborate the participants’ experience in this research, which was described in sub-theme 6b (i.e., budgetary factors). Thus, without adequate financial support, an
interdisciplinary team or a hospice palliative care program cannot function effectively. Embracing the quality of financial resources in the synthesis enriches the understanding of a whole picture of the experience of working in the interdisciplinary team.

In summary of this research synthesis, a concept was emerged, which is an integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care, which refers to influential factors of the functioning of the interdisciplinary team. The model illustrates how four factors, quality of teamwork, quality of patient care, quality of healthcare worker wellness, and quality of financial resources, interrelate to each other, and how the composition of six themes determine these four factors’ qualities. As a synthesis of this research, I created a figure of the integrative and multidimensional of the interdisciplinary team in hospice palliative care (cf. Figure 2: An Integrative and Multidimensional Model of an Interdisciplinary Team Approach to Hospice Palliative Care). This figure is a presentation of six themes, which shows how they are interconnected with each other, and how those six themes reflect the quality of teamwork, quality of patient care, quality of healthcare worker wellness, and quality of financial resources.

The experience of the interdisciplinary team in hospice palliative care was the focus of this research study. Eleven healthcare workers’ voices were heard through the process of content analysis of their interviews, further analyzed in light of the current available literature, and reflected into the synthesis as the integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care as an answer to the research question, “What is the experience of being on an interdisciplinary team in hospice palliative care?” Each person’s experience of the interdisciplinary team was valuable to this research in understanding of the research question, or experience of being on an interdisciplinary team in
hospice palliative care. The holistic view of the interdisciplinary team through six themes and the integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care are reflections of the healthcare workers’ voices, which might touch to other healthcare workers to advance their teamwork in order to provide better care for patients and their families.

Figure 2. An Integrative and Multidimensional Model of an Interdisciplinary Team Approach to Hospice Palliative Care
Chapter 5

Discussion and Conclusion

5.1. Experience of Being on an Interdisciplinary Team in Hospice Palliative Care

At the beginning of Connie’s interview, she expressed that:

…, I worked with team set up for a long time, which actually made it difficult, or I don’t know, it’s just, how it is, as far as I am concerned, it’ll be interesting to see whether, your questions, actually I can answer them, or whether it’s just ingrained me now, we’ll see…

As Connie’s comment above shows, even though the healthcare workers work with the interdisciplinary teams in hospice palliative care every day, the nature of the interdisciplinary teams is not fully understood, and its function has not been clearly described (Kirk et al., 2010; Wittenberg-Lyles et al., (2010; Wittenberg-Lyles & Paker Oliver, 2007). Street and Blackford’s study (2001) has shown that the interdisciplinary teams in hospice palliative care rely heavily on people’s benevolence rather than on formal guidelines or standards. It was my concern that the research participants might not be able to articulate their experiences of the interdisciplinary teams well because most people rarely had an opportunity to talk about the interdisciplinary teams with other team members, or they did not have a formal guideline for how to work within the interdisciplinary team, just as Connie expressed above. However, my assumption was not supported in the data collected during this research. The healthcare worker participants in this research were able to clearly articulate answers to the primary research question, “What is the experience of being on an interdisciplinary team in hospice palliative care?” They answered in a holistic manner and provided many dimensions, as illustrated by the six themes and 29 sub-themes identified in chapter 4.
5.1.1. Summary of the Six Themes from the Research Findings

From the participants’ voices, six themes emerged to construct the core elements of the interdisciplinary teams, through content analysis. Content analysis allowed me to accurately reflect the healthcare workers’ voices and thus to better understand their experiences of working in the interdisciplinary teams. Therefore, these six themes were reflections of the healthcare workers’ voices, which described actual experiences they had as members of the interdisciplinary teams. I will now summarize these six themes that emerged from the research findings.

Theme 1. Collaborative Work

Without interdisciplinary teamwork, effective patient care at the end of life cannot be provided in the hospice palliative care programs because a single discipline cannot address the complexity of dying patients’ needs (Parker Oliver et al., 2007). The results of this study showed that collaborative work was a central part of the interdisciplinary team. Collaborative work contained five sub-themes: (a) common goal of striving for holistic care; (b) sharing responsibilities for patient care; (c) expertise; (d) multiple perspectives; and (e) leadership. The culmination of these five sub-themes illustrates the importance of collaborating work among interdisciplinary team members.

In order to serve patient needs at the end of life, the interdisciplinary team is required to have common goals and to provide holistic care, which was evident from these research results and current literature (DiTuilo & MacDonald, 1999). Based on the common goals of the team, members work as a team to share responsibilities for patient care through utilizing expertise, providing multiple perspectives, and developing effective leadership among the team members. Both the research participants and related literature (Dean, 1998; Parker Oliver, Wittenberg-
Lyle, & Day, 2007; van Staa et al. 2000), agreed that those sub-themes were the strengths of the interdisciplinary teams, yet they were also challenges for the interdisciplinary teams. For example, the participants stated that they can help and support each other by sharing responsibilities for patient care, yet they face difficulties deciding how to share these responsibilities with others due to a lack of clear roles in the interdisciplinary teams. Based on these research results and supportive literature, it has become clear that guidelines for and education on collaborative work are required to further develop and improve the effectiveness of teamwork.

**Theme 2. Quality of Relationships**

Relationships among the interdisciplinary team members are an important source of support (Dean, 1998), and help develop job satisfaction for healthcare workers (DeLoach & Monroe, 2004). The participants in this research recognized the importance of relationships among team members, and identified various characteristics of relationships as shown in seven sub-themes: (a) mutual respect and trust; (b) professional acknowledgment; (c) psychosocial support; (d) belonging and connection; (e) egalitarianism; (f) continuity; and (g) personal relationships. These seven sub-themes support teamwork and the wellness of healthcare workers. For example, developing mutual trust and respect becomes a bridge among the different disciplines, and enhances how they respect and trust each other’s work (quality of teamwork), or while providing psychosocial support for each other might help improve one’s well-being by making them feel supported by the other team members (quality of healthcare worker wellness).
The participants’ voices reflected the issues around the quality of relationships, just as the related literature did (Coompan, 2001; Dean 1998; Kirk et al., 2010; Vachon, 1987): for example, lack of acknowledgement (b. professional acknowledgement); isolation (d. belonging and connection); and power differentials (e. egalitarianism).

From participants’ voices and related literature, it is evident that quality of relationships enhances team members’ support for one another, yet further study is needed to understand how each of these sub-themes affects the quality of teamwork and the degree of healthcare worker wellness.

Theme 3. Communication

Communication is one of the problems found in the interdisciplinary team (Dean, 1998; DiTullio & MacDonald, 1999; Kirk et al., 2010; Vachon, 1987). The participants recognized the challenges with communication, as well. As mentioned in chapter 4, identifying a team's communication struggles, or what the main barriers to effective communication are, could be a challenge. These five sub-themes of communication—(a) mode of communication; (b) form of communication; (c) timing of communication; (d) recipients of information sharing; and (e) content of shared information—suggested the composition of communication, and might provide a greater awareness about the root issues of communication in the interdisciplinary team.

Various issues relating to communication were illustrated by the participants as well as supported by the literature (Baldwin et al., 2011; Bergen-Jackson et al., 2009; Demiris et al., 2008; Kirk et al., 2010; Street & Blackford, 2001; Wittenberg-Lyles et al., 2009). For instance, the lack of a formal protocol for documentation (3a. mode of information), a lack of standard
procedures and training in team meetings (3b. form of documentation), inadequate timing of sharing information (3c. timing of information), a lack of sharing information among team members (3d. recipients of information sharing), and issues of confidentiality (3e. content of shared information).

Other research (Demiris et al., 2008; Kirk et al., 2010; Street & Blackford, 2001; Wittenberg-Lyles et al., 2009) suggested that education should be provided to improve communication among interdisciplinary team members. Further study is needed to understand and improve communication in the interdisciplinary teams and to develop training and standardized protocols for team communication among interdisciplinary teams in hospice palliative care.

**Theme 4. Team Building Activities**

The need for team building activities became apparent throughout the participant interviews. Four important aspects of team building activities were coded from the data: (a) education; (b) social events; (c) on-going team review; and (d) formal debriefing, to advance teamwork through building cohesiveness among the team members.

Education enriches collaborative work within interdisciplinary teams (Reeves et al., 2009). The participants expressed the need for education to clarify roles, improve communication, and strengthen psychosocial training. Social events help to develop support among team members (Meier & Bereford, 2008b). My findings suggested that social events provided an opportunity to get to know team members on a personal level. A lack of on-going team review was evident from the results of this study. Only two participants recognized the need for on-going team review, but the lack of related discussion among the remaining
participants more clearly demonstrated that their hospice palliative care programs did not provide any on-going team review. The importance of team review has been thoroughly examined in the relevant literature (Bainbridge et al., 2010; Bruce & Boston, 2008; Dean 1998; Dunlop & Hockley, 1998). Team reviews are believed to maintain and improve teamwork (O’Connor et al., 2006; Resse & Sontag, 2001), and to provide accountability of the hospice palliative care programs (Richie, 1987). In addition to a lack of on-going team review, the lack of formal debriefing was explicit from the result of this study. None of the participants’ hospice programs had regular formal debriefings, which might provide support for team members, offer an opportunity for feedback with each other, and provide an opportunity for self-care (Johnson, cited in Meier & Beresford, 2008b).

Theme 5. Personal Qualities

Personal qualities also play an important role in collaborative teamwork in the interdisciplinary teams (Bronstein, 2003; Parker Oliver et al., 2010). Participants articulated two sub-themes that affected the quality of teamwork: (a) depth and richness of life and work experience; and (b) affinity for working within an interdisciplinary team.

Research participants insisted that having life and work experience were assets to working in the interdisciplinary team and for continuously coping with patient deaths. Furthermore, experience in working with an interdisciplinary team was required to understand the complexity of the function of the interdisciplinary teams in hospice palliative care. This became obvious from one of the participants’ lack of experience working in the interdisciplinary team. A person’s affinity for working within an interdisciplinary team was also coded in the results. The ability to work as a team player was necessary to work effectively in the
interdisciplinary teams. A lack of affinity might affect not only impact on how you can work in the teams, but also the quality of teamwork (Donlop & Hockley, 1998; Peck 2006a).

The importance of personal qualities was described in both the results of this study and in the related literature (Bronstein, 2003; Parker Oliver et al., 2010). Further studies are needed to understand what kind of personal qualities are essential to work effectively within interdisciplinary teams at hospice palliative care.

**Theme 6. Institutional Influence**

The influences from the health organization impacted how the research participants worked in the interdisciplinary teams. From their interviews, seven sub-themes emerged: (a) management/administration; (b) budgetary factors; (c) policies and regulations; (d) available work hours; (e) size of the team; (f) medical or psychosocial team; and (g) nurse as a subgroup.

These sub-themes had both a positive and a negative impact on teamwork. Most of the participants expressed positive impressions of their management, such as when receiving psychosocial support (6a. management/administration). On the other hand, many participants experienced the negative impact from the influence of financial cut backs (6b. budgetary factors). Furthermore, the issues around institutional influence were discussed by the participants are also addressed in current literature. For example, the issue which was raised in sub-theme “6c., policies and regulations,” is very similar to Williams et al.’s (2010) theme of lack of monitoring of policies and regulations, and the challenges which emerged in sub-theme “6e., size of the team,” is echoed by Maddocks’s (2006) findings regarding the number of team members.

In summary, the impacts from institutional influence on the quality of teamwork were
found in both the healthcare workers’ discussions and in current available literature. Further studies are required to better understand the relationship between the six themes and the quality of teamwork and how those themes are playing a role in working collaboratively within interdisciplinary teams.

5.1.2. Strength of the Study: Holistic View of Interdisciplinary Team in Hospice Palliative Care

One of the strengths of this study is that it is based on the clinical experience of healthcare workers who have provided the data for this study. As discussed in chapter 1, there is a lack of qualitative studies which are based on the clinical practice of interdisciplinary teams (Guilfoyle, 2006). Guilfoyle proclaims that interdisciplinary team studies for hospice palliative care should transition from rhetorical presumptions to actual clinical experience. In acknowledging the demand for a shift in research methodology in the field, this study presented specific clinical examples from participants’ real experience in working on interdisciplinary teams in hospice palliative care units.

Another strength of this study is that this research illustrated voices from multiple disciplines typically found in interdisciplinary teams, something that was lacking in the current literature (McCallin, 2001). Most past research is based on single disciplines such as nursing or social work (Blacker & Deveau; 2010; MaCallin, 2001; Parker Oliver et al., 2010; Wittenberg-Lyles et al., 2008). However, current studies of interdisciplinary teams have begun to contain participants from multiple disciplines (Goldsmith, Wittenberg-Lyles, Rodriguez, & Sanchez-Reilly, 2010; Kirk et al., 2010; Qaseem, Shea, Connor, & Casarett, 2007). Thus, this research will be another source of understanding interdisciplinary teams from multiple perspectives, across disciplines.
The uniqueness of this study is illustrated by the six themes, which represent the healthcare workers’ holistic experience in various dimensions. The levels focused on include: a professional level (Theme 1. collaborative work); relational and psychosocial levels (Theme 2. quality of relationship); communication and interpersonal levels (Theme 3. communication); a personal level (Theme 4. personal qualities); the educational and social levels (Theme 5. team building activities); and an organizational and system levels (6. institutional influence).

Unique for this study is also the emergence of an integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care. The model illustrates the interrelations of teamwork, patient care, healthcare worker wellness, and financial resources. It is hoped that this study will foster a holistic picture of interdisciplinary team work.

In my review of the literature, I found research that examined only some partial elements of the interdisciplinary team in hospice palliative care, rather than a whole picture. For example, Bronstein’s Model of Interdisciplinary Collaboration (2003) does not embrace various levels of composition of interdisciplinary teamwork. It does not appear to have been developed as a specific model applied to interdisciplinary teamwork in hospice palliative care. Bronstein’s Model of Interdisciplinary Collaboration was constructed based on theories, and not on healthcare workers’ clinical experience (Bronstein, 2003; Wittenberg-Lyles & Parker Oliver, 2007; as mentioned in chapter 2). DiTullio and MacDonald (2010) investigated the relationship between the financial factor and interdisciplinary teams with clinical experience, but their study addressed only a certain functional aspect of interdisciplinary teams. The need for a model that can articulate the function of the interdisciplinary team in hospice palliative care, was described in Chapter 2 (cf. Wittenberg-Lyles & Parker Oliver, 2007).

The current study seems to be able to address the need for a model of an interdisciplinary
team approach to hospice palliative care based on reported clinical and professional experiences of front line healthcare workers. This research may not be generalized to a large population due to its small sample size, which is discussed in the next section (5.2. Limitations of the Study). Further research is needed to understand the influence of each theme and sub-theme within the interdisciplinary teams. In addition to examining the influence of each theme and sub-theme, an investigation of how these four qualities interrelate to each other may prove beneficial, meanwhile the integrative and multidimensional model attempts to cultivate a potential conceptual framework of the holistic picture of the function of interdisciplinary teams.

5.2. Limitations of the Study

Before I provide suggestions for a clinical implementation and further research from this study, I would like to acknowledge the limitations of this qualitative research.

First of all, the number of the research participants is limited. This research is based on interviews with 11 participants. They all worked under one health authority in British Columbia, Canada. Perhaps we might have elicited different outcomes from a larger sample of healthcare professionals with diverse backgrounds. A future study might involve interviews with randomly sampled participants from various geographic areas. Moreover, all of the participants in this study appear to have had positive experiences with interdisciplinary teams, and they are motivated to work within the interdisciplinary team model. The result of this research might have been different, if participants had more negative experiences with their interdisciplinary teams. However, this research is not quantitative; therefore, it cannot to generalize the research findings. The purpose of this research is grounded from a qualitative research perspective to understand one’s unique experience of working in an interdisciplinary team.
Another limitation is my ability as an interviewer and a researcher. I recognized my lack of interviewing skills through transcribing the interviews, which I mentioned in Chapter 4. Although I could have asked additional questions to delve more deeply into the meaning of participants’ experiences, it was judged that spending too much time on one topic would take the participants away from discussing other aspects of their experience and getting a whole picture of their experience in the interdisciplinary teams. Thus, what the participants shared with me provided me with a broad picture of their experience of being on interdisciplinary teams. Illustrations of how they articulated and recognized their teamwork are found throughout Chapter 4, where quotations are included from their interviews as supporting evidence.

In addition, my lack of skills in data analysis as a novice researcher might have affected the outcomes of the data analysis. In order to ensure accuracy in my data analysis and thematic coding and to achieve trustworthiness of my data analysis, I had on-going consultations with my thesis supervisor, conducted peer reviews of my coding accuracy, and expert reviews throughout the research process, as described in Chapter 3.

My positive bias towards an interdisciplinary team approach may be regarded as another limitation in this research. I have a positive attitude towards team working and recognize the importance of members’ being collaborative players and providing support for each other on interdisciplinary teams. My unique work experience, subjective preferences, and worldviews unavoidably had an influence on my research and understanding of the research data. In this process, however, I made every effort to be aware of my own biases, values, and viewpoints regarding interdisciplinary teamwork. I tried to go back to raw data and stayed with the original data and verbatim quotations to remain as true as possible to the participants’ voices.
In addition to these limitations, a time gap between the interviews and data analysis might have affected the results of this research. There was an interruption during time of completing interviews and analyzing the data due to my taking a maternity leave. The participants’ experience of the interdisciplinary teams might have changed over that time. However, such a time lag gave me an opportunity to see the data more objectively, as evidenced by the participants’ validation of the accuracy of my analysis of the interview data.

In spite of such possible limitations as discussed above, the purpose of this research was to understand one’s unique experience of working on an interdisciplinary team with other healthcare workers from cross-disciplines. I believe that this research achieved the objective to answer the research question of “What is the experience of being on an interdisciplinary team in hospice palliative care?” based on content analysis of the participants’ voices.

5.3. Suggestions for Clinical Implications from the Research Results

I considered how the voices of healthcare workers from this research could be used to help or improve the quality of teamwork for the interdisciplinary teams in hospice palliative care. Although this research was a small scale qualitative research project, the results of this research offers insights for improving the quality of interdisciplinary teamwork in hospice palliative care. Resulting from this research, an integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care has emerged. The model may be useful for designing team building activities for members of an interdisciplinary team. It may provide a meaningful way of assessing the effectiveness of palliative care teams on an on-going basis, and a formal protocol may be developed for team reviews. Such an evaluation protocol may incorporate healthcare workers’ perspectives as reported in this research and published studies (Bainbridge, Brazil, Kruger, Ploeg, & Taniguchi, 2010; Bruce & Boston, 2008; Dean
Therefore, an integrative and multidimensional model such as the one discussed in this thesis may be found useful in identifying and evaluating an interdisciplinary team’s strengths and areas in need of improvement. For example, an interdisciplinary team might benefit from having discussions about the six themes and their sub-themes (e.g., exploring a topic of “In which areas do we have strengths or are we experiencing challenges as an interdisciplinary team?”). After identifying their strengths and weaknesses, they might wish to inquire how their strengths and weaknesses are related to the four qualities identified in this study (i.e., teamwork, patient care, healthcare worker wellness, and financial resources), and further explore their goals and actions for improving the quality of their teamwork.

Another option is to develop a chart or a diagram. Use of charts might make it easier for team members to visually recognize their strengths and weaknesses as a team. For example, Likert-type scales such as the ones shown in Appendix D (“Example: A Chart for the Six Themes and 29 Sub-themes”) might be an easy way of starting a dialogue and a group discussion, with the use of a summary graph for the six themes (Figure 3a. A Graphic Presentation of Ratings on a Proposed Scale for Assessing the Quality of Interdisciplinary Team Experiences). I will describe a possible activity using this chart and graph for team review. For instance, as an activity for team review, the interdisciplinary team members could discuss and rate each sub-theme from 1 to 5, then the responses to sub-themes in each theme could be calculated as a mean of the total scores of the sub-themes in the chart; see: Appendix D (“Example: A Chart for the Six Themes and 29 Sub-themes”). As the next step, the facilitator might indicate visually the rate of each theme as a summary figure to assess the quality of teamwork (cf. Figure 3b. “A Proposed rating scale on Interdisciplinary Team Experiences: An
Figure 3a. A Graphic Presentation of Ratings on a Proposed Scale for Assessing the Quality of Interdisciplinary Team Experiences

![Graph of Six Themes]

Figure 3b. A Proposed Rating Scale on Interdisciplinary Team Experiences: An Illustrated Representation of Response Ratings on the Six Central Themes

![Graph of Six Themes with ratings]
Illustrated Representation of Response Rating on the Six Central Themes”). After determining the degree of importance of each theme and rating on each theme, an interdisciplinary team might wish to hold discussions based on each theme or each sub-theme, the strengths and challenges in their team, and the influences of these strengths and challenges on the four qualities, thus attempting to improve the quality of teamwork. Using the graph for the quality of teamwork as a visual aid and a guide for the interdisciplinary team members may turn out to be a convenient way of identifying and understanding their areas of strength and weakness and developing team goals and concrete ways of improving the quality of the team.

Lack of education of the interdisciplinary team was pointed out by the research participants, and in other studies (e.g., Cohen Fineberg et al., 2004; Hall & Weaver, 2001; Weissman et al., 2011). The integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care discussed here might be used as an educational tool for various interdisciplinary teams. For example, one participant said that her challenge was in understanding how an interdisciplinary team worked together or what each discipline’s role was in the team. Deb stated that orientating new interdisciplinary teams was an issue for her because newly hired interdisciplinary members required education about the function of the interdisciplinary team. The proposed integrative and multidimensional model might be able to help educate newly hired team members about how an interdisciplinary team works together as part of their orientation. By using the model designed to provide a holistic picture of the functioning of an interdisciplinary team, interdisciplinary team members might be able to enhance their awareness toward how to work together effectively in an interdisciplinary team.

In addition, each theme or sub-theme reported here might be a useful discussion topic for the on-going professional education of interdisciplinary team members. For example, an
interdisciplinary team can pick a topic out of the six themes, or their sub-themes from the integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care. Members may be asked to research on a chosen theme, and share their thoughts and feelings with other interdisciplinary team members in order to generate new clinical knowledge for their interdisciplinary team.

5.4. Suggested Future Research

While the function of the interdisciplinary team had been only partially understood (O’Connor et al., 2006; Resse & Sontag, 2001; Wittenberg-Lyles & Paker Oliver, 2007), the current research has generated a broader conceptual framework for understanding interdisciplinary teamwork in hospice palliative care. In order to better understand interdisciplinary teams in hospice palliative care, each theme or sub-theme might be considered for future investigation. Future research may inquire how an interdisciplinary team handles the sharing of the responsibilities of patient care. It may identify the areas of strengths and weaknesses of a particular team approach, and recognize the role of any particular theme or sub-theme, as identified in this study, in the function of interdisciplinary teamwork. For such inquiries, ethnographic studies of interdisciplinary teams might be helpful to increase our understanding of the meaning and value of sharing responsibilities for patient care in each interdisciplinary team.

Relationships may be explored in future research among: (a) quality of teamwork, (b) quality of patient care, (c) quality of healthcare worker wellness, and (d) quality of financial resources, all of which were found important in the present study. Further studies might provide a deeper understanding of how these four qualities are interrelated with each other, and what role they play in the functioning of an interdisciplinary team.
Another possible future research topic based on this current study might be that of a program evaluation. It has been well documented in the literature that there is a need for program evaluation in order to increase the accountability of hospice palliative care programs (Richie, 1987) and understand the function of an interdisciplinary team (O’Connor et al., 2006; Resse & Sontag, 2001; Wittenberg-Lyles & Paker Oliver, 2007). Perhaps, a participatory program evaluation of a hospice program can be done using the currently proposed integrative and multidimensional model to demonstrate accountability of having a functional and effective interdisciplinary team. Participatory program evaluation not only has the potential for active participation in the evaluation process, as opposed to passive traditional team evaluation, but also contributes productive utilizations of the results from the evaluation process (Greene, 1988). Action-oriented evaluation, or participatory program evaluation, might contribute to the understanding of the function of the teamwork, and may also provide solutions to challenges on the interdisciplinary team. Thus, an inquiry using an integrative and multidimensional model such as the one currently proposed might reveal the core issues associated with how an interdisciplinary team functions in details. Such an inquiry might enhance the accountability of a patient care program, and identify possible solutions and strategies for effectively addressing issues in interdisciplinary teamwork.

Program evaluation might be conducted as an international study on interdisciplinary team approaches in hospice palliative care. Ahmedzain and his associates (2004) insisted on the need for international studies on hospice palliative care programs to increase quality assurance for hospice palliative care world-wide. By using the proposed integrative and multidimensional model as a program evaluation framework, as suggested earlier, we might be able to investigate the quality of support associated with a particular teamwork approach or in
various hospice programs in different parts of the world. Comparing hospice programs in different countries would offer insight into the influence of geographic, social, or cultural factors on the quality of teamwork in hospice palliative care.

5.5. Conclusion: Voices of Healthcare Workers

The importance of the interdisciplinary team is significant if one wants to address the patient’s needs holistically, through the voices of the healthcare workers. This has become clear in this study, as well as in the existing literature (Billings, 1998; Bishop et al., 2000; Crawford & Price, 2003; Demiris et al., 2008; Parker Oliver et al., 2005; Parker Oliver et al., 2010). The healthcare workers’ voices are their reflections of the experience of being on interdisciplinary teams. In the present study, their voices were found to have a number of themes and subthemes.

Hanna shared her perspective: “It does really work this [interdisciplinary team model], the interdisciplinary team definitely in hospice palliative care for sure.” Similarly, Connie expressed that an interdisciplinary team approach was the best way to offer hospice palliative care. Connie also stated that the interdisciplinary team needed on-going improvements. It was clear that an interdisciplinary team needs to have on-going opportunities for refinement for purposes such as maintaining and advancing teamwork, improving the quality of patient care, supporting the quality of healthcare workers’ wellness through their teamwork, and developing financial resources to allow them to provide appropriate and holistic patient care and improve healthcare workers’ own wellness.

In conclusion, I hope that this study and the resultant model (i.e., an integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care) will be found useful and able to contribute new knowledge and suggestions to further research in field
of hospice palliative care. I hope that this study will contribute to the enhancement of high quality teamwork of healthcare members, which in turn will contribute to improving the quality of life for patients and their families. I also wish that the quality of life for healthcare workers, who dedicate their work by sharing and celebrating life with dying patients for their end of life, will also be enhanced.
Chapter 6

Post Script

6.1. Self-reflection: Personal Learning

The voices of the healthcare workers answered the research question, “What is the experience of being on an interdisciplinary team in hospice palliative care?” as six themes and 29 sub-themes as the components of the integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care through content analysis. As a novice researcher, I found it challenging not to be able to predict the outcome of this research during the process of data analysis through content analysis. I also had some fears about not having any significant results from this study. As I mentioned at the beginning of this chapter, my expectations and fears were overcome when I learned about the insights of the participants regarding teamwork and their understanding of the function of the interdisciplinary team, through their eyes. As a researcher, I have learned that receiving feedback from different people—supervision from my thesis supervisor, peer review, and expert review—helped me to see the data from different angles. I gained new insight from their feedback, and they helped me stay focused on my topic and to authentically represent the participants’ voices. There were a few bumps in the path of the research analysis of this study, but I believe I maintained the integrity and authenticity of the healthcare workers’ voices as they represented the experience of working in their interdisciplinary teams. As mentioned before, there is a lack of studies regarding the functioning of interdisciplinary teams in hospice palliative care. This study might be an addition to the current knowledge of the interdisciplinary team. In the future, I would like to continue contributing to the research about the interdisciplinary team.

As a clinician, I learned that the interdisciplinary team encompasses various aspects of
its function. Prior to conducting this study, I was unaware of these various elements, which support working collaboratively within an interdisciplinary team, even though I had worked in interdisciplinary teams for over ten years. Through this research process, I learned about the complexity of the structure of the interdisciplinary team, and I learned how little opportunity, we, as healthcare workers, have to talk about the interdisciplinary team, as Connie expressed in the previous chapter. Even though she had been working in the interdisciplinary teams for a long time, she rarely had opportunities to reflect on what the constructs of the interdisciplinary team were. As a clinician, I would advocate for the importance of interdisciplinary teams, and for how we, as healthcare professionals, can provide better care for patients and support to one another within this team model.

Some people might question how this study is related to the field of counselling psychology. In chapter 1, I explained that counselling psychology is concerned with interpersonal processes and the wellness of people. It is my hope that this research might help to generate a new knowledge about interpersonal processes and the wellness of healthcare workers, through understanding their experiences of working as members of interdisciplinary teams. From the results of this research study, you can see that various issues of interpersonal processes, such as interpersonal communication and relationship, were integral to the interdisciplinary team in hospice palliative care. Through this research, I realized there was a lack of facilitation of team building and team consultation, within the participants' own interdisciplinary teams. I believe that a counsellor can take on a consultant role within the interdisciplinary team, that he or she can understand interpersonal process and group dynamics of the interdisciplinary team, and that he or she can provide support in using empathy skills while facilitating wellness for team members. As a counsellor, I would like to play a part in
providing education, consultation and support for the interdisciplinary team.

Through listening to the voices of healthcare workers, I learned about needs of the interdisciplinary team in hospice palliative care, especially the need for further education and research about interdisciplinary team functioning. This research could bring the field of hospice palliative care one step closer to understanding the interdisciplinary team model.

What does the concept of the interdisciplinary team in hospice palliative care mean to me? By supporting each other through the challenges of working in a palliative care setting, the interdisciplinary team provides holistic care for dying patients, and celebrates life—not only the lives of our patients, but also our own lives.

The voices of the healthcare workers reflected in this research as well as the further studies that explore the six themes and 29 sub-themes and the interconnectedness of four qualities of the integrative and multidimensional model of an interdisciplinary team approach to hospice palliative care in more depth are needed if we want to utilize and cultivate the function of the interdisciplinary team, which might in turn help to enrich the quality of teamwork, patient care, the healthcare worker’s well-being, as well as the financial wellness of the interdisciplinary team. I admire the healthcare workers who dedicate their work to hospice palliative care, and hope this research will support those working in interdisciplinary teams for the patients and their families, and to advocate for the needs of supporting healthcare worker wellness through the integrative and multidimensional model of the interdisciplinary team in hospice palliative care.
References


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October 5, 2009

Invitation Letter and Informed Consent

UNIVERSITY OF BRITISH COLUMBIA

INVITATION TO THE RESEARCH & INFORMED CONSENT STATEMENT

Title of the Project: Voices of Healthcare Workers: Experience of Being on an Interdisciplinary Team in Hospice Palliative Care

Megumi Okubo, BMus, BMT, MTA, FAMI.
(Master in Arts: Counselling Psychology student)

You ______________(name) are invited to participate in a research study. The purpose of this study is to explore your experience of being on an interdisciplinary team in the hospice palliative care setting. The investigator of this research is a third-year counselling psychology graduate student at University of British Columbia, and this research is a part of the Program’s course work and the findings of this research will be included in a master thesis.

Each research participant will have one or one and a half hour interviews about his/her experience of being on an interdisciplinary team in hospice palliative care. This research focuses on your unique experience. The interviewer/researcher will conduct a conversation with you around your experience of working within the interdisciplinary team.

Names of the participants will be recorded separately from the data collected. Participants will not be identifiable in reports. If quotations appear in publications, all the names and ages will be changed. Participants will be asked their permission for use of these quotations. They also have the chance to veto the quotes. Data (audio/video tapes and written transcripts) will be stored securely. Only the researcher, Megumi Okubo will have access to all of the data. In addition, faculty members of the UBC Counselling Psychology program and peer reviewers, who are involved this master thesis will share the information and data with the researcher through the research process. The research results will be published as a master thesis, and supportive qualitative data will be presented in educational settings. The researcher will be using the data for research and educational purposes only. Participants will have an opportunity to
review final findings of this research through e-mail or face to face meetings depending on your preference.

Your interview will take place at _______________________.

Dates: _____________________ Time: ___________________

Your participation in this study is voluntary. If you decide to participate, you may withdraw from the study at any time without penalty. If you withdraw from the study before the data collection is completed your data will not be used in the study/publication/presentation. You have the right to omit any question(s)/procedure(s). If you have questions at any time about the study or the procedures, you may contact the researcher, Megumi Okubo, by phone _____, or e-mail _______. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in this research have been violated during the course of this project, you may contact the Clinical Research Ethics Board, University of British Columbia, _______.

You, as a research participant, have read and understand the above information. You give permission to audio/video tape the interviews and publish/present the research results, quotations and supporting qualitative data in educational setting. You have received a copy of this form. You agree to participate in this study.

Research participant’s Name (Print): ________________________________

Research participant’s signature: ____________________________________

Date: ________________________________

Investigator’s Name (Print): Megumi Okubo __________________________

Investigator’s signature: __________________________________________

Date: __________________________

Investigator’s signature: __________________________________________
SUBJECT INFORMATION AND CONSENT FORM

Date: September 8, 2009 Version: #2

**Title of the Study:**
Voices Of Healthcare Workers: Experience Of Being On An Interdisciplinary Team In Hospice Palliative Care

**Principal Investigator:**
Megumi Okubo, BMus, BMT, MTA, FAMI
Hospice Residence, Langley Memorial Hospital,
Contact Numbers: ___________

**Research Site(s):**
All Hospice Palliative Care Programs in the Fraser Health Authority

**INTRODUCTION**

You are being invited to take part in this research study because you have been working within the interdisciplinary team as a healthcare worker at hospice palliative care.

**YOUR PARTICIPATION IS VOLUNTARY**

Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks, and discomforts.

If you wish to participate, you will be asked to sign this form. However, if you do decide to take part in this study, you are still free to withdraw at any time without giving any reasons for your decision.

Please take time to read the following information carefully before you decide to participate this research.

**WHO IS CONDUCTING STUDY?**

I am a third-year counselling psychology graduate student at University of British Columbia. This research is a part of the Program’s course work, and the findings of this research will be included in a master thesis.
BACKGROUND
Hospice palliative care programs provide holistic care through an interdisciplinary team. In the literatures, the importance of the interdisciplinary team has been recognized, yet the nature of the strengths and challenges of the interdisciplinary team in the clinical work has not been understood fully. This research is aiming to understand the strengths and challenges of the interdisciplinary team at the hospice palliative care programs.

WHAT IS THE PURPOSE OF THE STUDY?
The purpose of this qualitative research is to understand the strengths and challenges of the experiences of the interdisciplinary team at the hospice palliative care units through exploring the experiences of the interdisciplinary team by the health care workers.

WHO CAN PARTICIPATE IN THE STUDY?
- A regular full time or part time worker at hospice palliative care program, which includes either acute palliative care programs or residential hospice programs at the FHA.
- Either medical or non-medical/psychosocial discipline
- Who has been working at the same site for more than one year

WHO SHOULD NOT PARTICIPATE IN THE STUDY?
- The workers at the hospice residence in the Langley Memorial Hospital where I am currently employed.
- The workers whom I have known not only professionally but also personally.
- The workers of the home care hospice programs
- Casual workers

WHAT DOES THE STUDY INVOLVE?
Each research subject will have one or one and a half hour interviews about his/her experience of being on an interdisciplinary team in hospice palliative care. This research focuses on your unique experience. The interviewer/researcher will conduct a conversation with you around your experience of working within the interdisciplinary team.

In addition to the interview, subjects will have an opportunity to review final findings of this research through phone or face to face meetings depending on your preference in summer 2010.

WHAT IS THE SUBJECT'S RESPONSIBILITIES?
Your responsibilities as a subject of this research are:
- To attend a one or one and a half hour interview
- To participate in one or two short meeting(s) to review the final findings

WHAT ARE THE POSSIBLE HARMS OF PARTICIPATING?
Through the interview process of this research, a participant may experience emotional distress when answering the questions. The participation of this research is voluntary, and the interviewee/participant can withdraw from this research any time without any penalty.

If a participant requires further support for emotional distress due to this research, the researcher will provide the referrals to appropriate counselling agencies.
WHAT ARE THE BENEFITS OF PARTICIPATING?

No one knows whether or not you will benefit from this study. There may or may not be direct benefits to you from taking part in this study. I hope that the information learned from this study can be used in the future to benefit other healthcare workers who are working on an interdisciplinary team at a hospice palliative care program.

WHAT HAPPENS IF I DECIDE TO WITHDRAW MY CONSENT TO PARTICIPATE?

Your participation in this research is entirely voluntary. You may withdraw from this study at any time. If you decide to enter the study and to withdraw at any time in the future, there will be no penalty or loss of benefits to which you are otherwise entitled.

The study investigator may decide to discontinue the study at any time, or withdraw you from the study at any time, if they feel that it is in your best interests.

If you choose to enter the study and then decide to withdraw at a later time, all data collected about you during your enrolment in the study will be retained for analysis.

WHAT HAPPENS IF SOMETHING GOES WRONG?

Rights and Compensation:

By signing this form, you do not give up any of your legal rights and you do not release the study doctor or other participating institutions from their legal and professional duties. There will be no costs to you for participation in this study. You will not be charged for any research procedures. If you become ill or physically injured as a result of participation in this study, medical treatment will be provided at no additional cost to you. The costs of your medical treatment will be paid by your provincial medical plan.

CAN I BE ASKED TO LEAVE THE STUDY?

If you are not complying with the requirements of the study or for any other reason, the study investigator may withdraw you from the study. You will not have any penalty by leaving from this study.

WHAT WILL THE STUDY COST ME?

This research has no cost for the subjects. The participation of this research is entirely voluntary. Also, the subjects won’t be paid for this study.

WILL MY TAKING PART IN THIS STUDY BE KEPT CONFIDENTIAL?

Your confidentiality will be respected. You will be assigned a unique study number. Only this number will be used on any research-related information, including personal data, and research data, collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential. The research information will be sent to the department of educational and counselling psychology, and special education at the University of British Columbia. Information that directly discloses your identity will remain only with the Principal Investigator and her thesis committee members at the University of British Columbia. The list that matches your name to the unique identifier that is used on your research-related information will not be released without your knowledge and consent unless required by law or regulation.
No information that discloses your identity will be released or published without your specific consent to the disclosure. However, research records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the University of British Columbia, and the FH Research Ethics Board for the purpose of monitoring the research. These personnel are required to keep your identity and personal information confidential. However, no records which identify you by name will be allowed to leave the Investigators' offices.

OTHER DISCLOSURES REQUIRED AS APPLICABLE:

Anonymization:
Your research-related information will not identify you in any way because all identifying information has been removed such that the information is now anonymous and there is no possibility of linking your identity to your information.

Research-related Records Leaving the Research Site:
Because this research is for the master degree thesis, the research-related information will be transferred to the principal researcher’s home office and the department of the education and counselling psychology, special education, at the University of British Colombia.

Archiving Research Records:
The principal researcher will keep all the research-related information for five years at the locked storage unit in her home office.

Mandatory Disclosure of Subject's Identity: Reportable Communicable Diseases/Suspected Child Abuse
In most cases, your personal information or information that could identify you will not be revealed without your express consent. However, if as a result of your participation in this study, facts become known to the researchers which must be reported by law to public health authorities or legal authorities, then your personal information will be provided to the appropriate agency or authority.

(a). This requirement applies to communicable diseases which include but are not limited to, hepatitis B or C, West Nile Virus and Human Immune Virus [HIV].
(b). Similarly, information that leads the researchers to strongly suspect that a child or others are being harmed or is in danger of being harmed, may have to be disclosed by law. Also, information that leads the researchers to strongly suspect that you may cause serious risk of imminent bodily harm to either yourself or another person may result in immediate action to protect your safety and may require your information and circumstances to be disclosed.

Except for the circumstances described above the risk of disclosure of personal information is usually very small

WHO DO I CONTACT IF I HAVE QUESTIONS ABOUT THE STUDY DURING MY PARTICIPATION?
If you have any questions or desire further information about this study before or during participation, you can contact Megumi Okubo at ______.
WHO DO I CONTACT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT MY RIGHTS AS A SUBJECT DURING THE STUDY?

If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, please contact with Dr. Marc Foulkes and/or Dr. Allan Belzberg, Research Ethics Board [REB] co-Chairs by calling ______. You may discuss these rights with the co-chairmen of the Fraser Health REB.

SUBJECT CONSENT TO PARTICIPATE:

- I have read and understood the subject information and consent form and am consenting to participate in the study, “Voices of Healthcare Workers: Experience of Being on an Interdisciplinary Team in Hospice Palliative Care.
- I have had sufficient time to consider the information provided and to ask for advice if necessary.
- I have had the opportunity to ask questions and have had satisfactory responses to my questions.
- I understand that all of the information collected will be kept confidential and that the result will only be used for scientific objectives.
- I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time without changing in any way the quality of care that I receive.
- I understand that I am not waiving any of my legal rights as a result of signing this consent form.
- I understand that there is no guarantee that this study will provide any benefits to me.
- I have read this form and I freely consent to participate in this study.
- I have been told that I will receive a dated and signed copy of this form.

SIGNATURES:

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Printed name of principal investigator/Designated representative

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Megumi Okubo

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Appendix C

Interview Protocol

Time of interview:
Date:
Place:
Interviewee’s Name:
Job Title:
How many years working in the interdisciplinary team?:
Educational Background:
Gender:

Interview Question Guide:

(All of the participants will be asked the first question which is the research question, however, the following questions from question 2 to 4 may change depending on each interview process.)

A. The following statement will be read by the interviewer to the interviewee:
“The purpose of this research is to further understand the interdisciplinary team in hospice palliative care. This research will specifically examine your unique personal experiences, as a member within the interdisciplinary team. I would like to ask a few questions about your experiences.”

B. The interviewer will ask the following questions:

1. Can you tell me in your own words, what is your experience of the interdisciplinary team in hospice palliative care?
   (If an interviewee has difficulties to express his/her experience, then the next question will be asked: Think about a time before you started working in an interdisciplinary team. Compare it with the time when you started working with the interdisciplinary team, can you describe to me what was the difference when you started with this interdisciplinary team? Can you go back to your memory before you worked within the interdisciplinary team, then can you describe when you started working within the interdisciplinary team? What happened when you began to work with the interdisciplinary team? Can you tell me in your own words?)

2 (a). What are the strengths of working within the interdisciplinary team?
2. (b). What are the challenges of working within the interdisciplinary team?

3. How would you describe the interdisciplinary team in hospice palliative care in your own words, or what kind of things do you associate with the words, interdisciplinary team?

4. What would you like to see happen with the hospice palliative care interdisciplinary team at your workplace in future?

6. Do you have anything else would like to add this interview?
Appendix D

Example: A Chart for the Six Themes and 29 Sub-Themes

1. Collaborative Work
   Degree of Collaborative Work, or mean of sub-themes of the Collaborative Work

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<tr>
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   a. **Common Goal of Striving for Holistic Care** (eg. Your interdisciplinary team embraces Common Goal of Striving for Holistic Care.)

      | 1 | 2 | 3 | 4 | 5 |
      |---|---|---|---|---|
      | Extremely Poor | Below Average | Average | Above Average | Excellent |

   b. **Sharing Responsibilities for Patient Care** (eg. Your interdisciplinary team practices Sharing Responsibilities for Patient Care.)

      | 1 | 2 | 3 | 4 | 5 |
      |---|---|---|---|---|
      | Extremely Poor | Below Average | Average | Above Average | Excellent |

   c. **Expertise** (eg. Your interdisciplinary team contains Expertise.)

      | 1 | 2 | 3 | 4 | 5 |
      |---|---|---|---|---|
      | Extremely Poor | Below Average | Average | Above Average | Excellent |

   d. **Multiple Perspectives** (eg. Your interdisciplinary team includes Multiple Perspectives.)

      | 1 | 2 | 3 | 4 | 5 |
      |---|---|---|---|---|
      | Extremely Poor | Below Average | Average | Above Average | Excellent |

   e. **Leadership** (eg. Your interdisciplinary team has strong Leadership.)

      | 1 | 2 | 3 | 4 | 5 |
      |---|---|---|---|---|
      | Extremely Poor | Below Average | Average | Above Average | Excellent |
2. **Quality of Relationships**

   Degree of Quality of Relationships, or mean of sub-themes of the Quality of Relationships

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   **a. Mutual Respect and Trust** (eg. Your interdisciplinary team embodies qualities of Mutual Respect and Trust.)

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   **b. Professional Acknowledgement** (eg. Your interdisciplinary team encourages Professional Acknowledgement.)

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   **c. Psychosocial Support** (eg. Your interdisciplinary team provides Psychosocial Support to each other.)

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   **d. Belonging and Connection** (eg. You have a feeling of Belonging and Connection with your interdisciplinary team.)

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   **e. Egalitarianism** (eg. Your interdisciplinary team embraces Egalitarianism.)

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   **f. Continuity** (eg. Your interdisciplinary team has Continuity in their membership.)

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g. **Personal Relationships** (eg. Your interdisciplinary team encourages developing Personal Relationships among team members.)

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3. **Communication**

Degree of Communication, or mean of sub-themes of the Communication

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a. **Mode of Communication** (eg. Your interdisciplinary team uses Mode of Communication.)

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b. **Form of Communication** (eg. Your interdisciplinary team practices Form of Communication.)

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c. **Timing of Communication** (eg. Your interdisciplinary team manages Timing of Communication.)

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d. **Recipients of Information Sharing** (eg. Your interdisciplinary team considers Recipients of Information Sharing.)

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c. **Content of Shared Information** (eg. Your interdisciplinary team recognizes the importance of Content of Shared Information.)

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4. **Team Building Activities**

Degree of Team Building Activities, or mean of sub-themes of the Team Building Activities

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a. **Education** (eg. Your interdisciplinary team has adequate opportunities for Education.)

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b. **Social Events** (eg. Your interdisciplinary team supports Social Events among the team members.)

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c. **On-going Team Review** (eg. Your interdisciplinary team has On-going Team Review to improve teamwork.)

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d. **Formal Debriefing** (eg. Your interdisciplinary team facilitates Formal Debriefing for the team members.)

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c. **Policies and Regulations** (eg. Policies and Regulations support your interdisciplinary team.)

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d. **Available Work Hours** (eg. Available Work Hours support your interdisciplinary team.)

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e. **Size of the Team** (eg. Size of the Team supports your interdisciplinary team.)

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f. **Medical or Psychosocial Team** (eg. Your interdisciplinary team values and utilizes either Medical or Psychosocial Team.)

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g. **Nurse as a Subgroup** (eg. Your interdisciplinary team integrates Nurse as a Subgroup into your interdisciplinary team.)

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