TEAM-BASED APPROACHES TO PSYCHOSOCIAL ONCOLOGY CARE

by

Joanne Magtoto

B.A. (Hons), Simon Fraser University, 2011

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SOCIAL WORK

in

The Faculty of Graduate and Postdoctoral Studies

(Social Work)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

December 2014

© Joanne Magtoto, 2014
Abstract

Background
While the health system in Canada recognizes the need for comprehensive cancer care, barriers must be overcome to achieve this goal. One is improving how professionals work together. This study explores social workers’ and counsellors’ experiences offering psychosocial cancer care as part of a cancer system that prioritizes medically related cancer care. My study objective is to increase understanding on how the health care system can better support team-based approaches in providing psychosocial cancer care for families faced with cancer.

Methods
I explored, through a generic qualitative research methodology, the experiences of eight social workers or counsellors who utilize team-based approaches in psychosocial cancer care. Using a semi-structured interview approach, I asked each participant to describe their experiences with team-based approaches in cancer care.

Findings
Findings are presented using the ecological systems perspective, with the themes representing micro, mezzo, and macro level facilitators and barriers to psychosocial cancer care within a team-based approach. The overarching theme identified by participants was the need for building authentic and close working relationships with their colleagues. At a micro level, relationships between cancer care providers was identified as an asset when working in an oncology setting facing larger system influences that detract from offering psychosocial cancer
care. Within this overarching theme participants described the following mezzo and macro factors in facilitating or deterring from team-based approaches in offering psychosocial care: flexible infrastructure and resources, space, staff availability, medical dominance, and limited time and resources.

**Implications**

Exploring team-based approaches in psychosocial cancer care is understudied in oncology and health system research. This study may fill some of this knowledge gap, specifically by highlighting the need for authentic and close relationships with colleagues especially in times of high and demanding workloads within an emotionally fatiguing work environment such as oncology. The participants’ experiences mirror the challenges identified in psychosocial oncology in Canada and future research may expand this study by developing theoretical frameworks for team-based approaches within a psychosocial oncology context, and by translating theory into cancer care practice that addresses the needs of mind, body, and soul.
Preface

This Master of Social Work thesis is the intellectual property of the author, Joanne Magtoto, under the supervision of Dr. Grant Charles (principal investigator and primary faculty supervisor), and thesis committee members Dr. Chris Lovato and Dr. Stephanie Bryson. The author collected, analyzed, and presented the data, with ethics approval from the University of British Columbia Office of Research Ethics (#H13-03186). This research has not been partly or wholly published in articles, part of a research collaboration, or required approval from other research ethics boards.
Table of Contents

Abstract .......................................................................................................................... ii
Preface ............................................................................................................................ iv
Table of Contents .......................................................................................................... v
List of Tables .................................................................................................................. vii
List of Figures ............................................................................................................... viii
Acknowledgements ....................................................................................................... ix

Chapter 1: Introduction .................................................................................................. 1
  1.1 Personal Location ..................................................................................................... 1
  1.2 Research Overview ................................................................................................. 2
  1.3 Research Rationale .................................................................................................. 3
  1.4 Research Questions ................................................................................................ 3

Chapter 2: Literature Review ......................................................................................... 5
  2.1 Psychological, Emotional, Social, and Spiritual Impact of Cancer ......................... 5
  2.2 Addressing Psychosocial Needs Through Integrated Cancer Care ....................... 7
  2.3 Team-Based Approaches in Health Care .................................................................. 7
    2.3.1 Outcomes of Team-based Approaches ............................................................. 10
  2.4 Enablers and Barriers for Team-Based Approaches .............................................. 10
    2.4.1 The Ecological Systems Perspective ................................................................. 11
      2.4.1.1 Micro Level Factors ..................................................................................... 12
      2.4.1.2 Mezzo Level Factors .................................................................................. 13
      2.4.1.3 Macro Level Factors .................................................................................. 14
  2.5 Canadian Context .................................................................................................... 16
    2.5.1 Medical Dominance ....................................................................................... 16
  2.6 Psychosocial Cancer Care Progress in Canada ..................................................... 17
  2.7 Study Context: British Columbia Cancer Care ..................................................... 19

Chapter 3: Study Design and Methodology .................................................................... 22
  3.1 Methodology ........................................................................................................... 22
    3.1.1 Generic Qualitative Research .......................................................................... 22
  3.2 Theoretical Framework ......................................................................................... 23
    3.2.1 Constructivist ................................................................................................. 23
  3.3 Methods .................................................................................................................. 25
    3.3.1 Sampling ......................................................................................................... 25
    3.3.2 Recruitment ..................................................................................................... 25
    3.3.3 Data Collection ............................................................................................... 27
    3.3.4 Ethical Issues .................................................................................................. 28
    3.3.5 Data Analysis ................................................................................................ 28
    3.3.6 Trustworthiness .............................................................................................. 30
Chapter 4: Findings

4.1.1 Descriptive Analysis of Participants

4.2 Participants’ Practice Context

4.2.1 What is offered: “Emotional and practical support for patients and families”

4.2.2 Provider Challenges: “Difficult to support patients and their families”

4.2.3 Team Expectations: “In a perfect world that is a team”

4.2.4 Role Within a Team: “Our expertise is people management, right?”

4.3 Dominant Themes: Experiences in Team-Based Approaches to Cancer Care

4.3.1 Micro Level Factors

4.3.1.1 Building Relationships: “I think like we are ourselves, and our professions full-time”

4.3.1.2 Emotional Support: “I heard you had a tough day”

4.3.1.3 Role Clarification: “Who is doing what and why”

4.3.1.4 Feeling Valued: “The role is valued for the most part”

4.3.2 Mezzo Level Factors

4.3.2.1 Flexible Infrastructure and Resources: “The way it should work”

4.3.2.2 Space, Availability, and Medical Dominance: “Well, it doesn’t always work.”

4.3.3 Macro Level Factors

4.3.3.1 Physician Power: “You put them on a pedestal”

4.3.3.2 Time and Resources: “Do more with less”

4.3.4 Summary of Themes

Chapter 5: Discussion

5.1 Study and Social Work Contribution

5.2 Strengths and Limitations

5.3 Potential Application of Study Findings & Future Research Directions

5.4 Policy Recommendations

5.5 Conclusion

References

Appendices

Appendix A Recruitment Email

Appendix B Study Interview Questions
List of Tables

Table 1 Description of Participants ................................................................. 35

Table 2 Facilitators and Barriers to Team-Based Approaches to Psychosocial Cancer Care ...... 68
List of Figures

Figure 1. Continuum of team-based approaches (Boon et al., 2004) ................................................................. 9
Acknowledgements

First and foremost, I must extend my gratitude to my thesis supervisor, Dr. Grant Charles. Your guidance, optimism, and honesty were invaluable in the process of crafting this thesis.

I especially would like to thank my mentor, Dr. Chris Lovato, with the Canadian Institute of Health Research Training Grant in Population Intervention for Chronic Disease Prevention: A Pan-Canadian Program. You have deepened my curiosity about how social work fits with population and public health through the spirit of inquiry you embody.

Dr. Stephanie Bryson, many thanks for your meaningful contribution to my social work learning and personal growth.

To my fellow research trainee and best friend, Kimberly, sitting with me through the mundane and funniest thesis times I felt supported. Thanks friend.

To my family, where I’ve learned most of my knowledge on social justice and inequities, seeing beauty in challenging times, and the value of family—Mom, dad, Ken, and Emily—love and thanks. This work is yours.

And to my partner through it all—Jordan Magtoto—sometimes I can’t believe you’re real. Unconditional gratitude.
Chapter 1: Introduction

1.1 Personal Location

My interest in team-based approaches and psychosocial cancer care stems from my work experience as a research coordinator at the BC Cancer Agency. My role consisted of developing and empirically examining psychosocial group programs for families faced with cancer. Implementing these group programs into a well-oiled cancer system was challenging, with health care providers resisting collaboration in offering these programs. I returned to school for my Master of Social Work to better understand and gain practical skills of how team-based approaches to health care can facilitate psychosocial support to those faced with cancer.

Once in school, I returned to the BC Cancer Agency for a practicum placement with Patient and Family Counselling Services. During my seven-month practicum, I experienced how working collaboratively with the oncologists, nurses, unit clerks, radiation therapists, and volunteers all contributed to the quality of care provided to patients and their families. Usually patients would provide positive feedback about their experience with their cancer care team when their health care providers had come together and devised a care plan that included the patient. Unfortunately, this way of practice was the exception rather than the rule. I found myself working alone with patients to address their emotional, social, and psychological well-being without the involvement of other health care providers even though they also provided care to the same patient.

Another observation I made during my time at the cancer agency was how vulnerable populations were overrepresented in the cancer system. In this context, I refer to vulnerable populations as populations within Canada with shared social characteristics who are at higher
risk for poorer health outcomes compared the general population in Canada (Frohlich & Potvin, 2008). In my experience as a social worker at Patient and Family Counselling Services, most of my clients self-identified as middle-upper class, visibly White, and well-educated. As a visible minority myself, I was uncomfortable. Uncomfortable because I would see people who look like me in the waiting rooms and cafeteria at the BC Cancer Agency, but rarely did I see people who looked like me at Patient and Family Counselling Services. Uncomfortable because it made me think of my own family, wondering how my parents would feel about accessing psychosocial support from Patient and Family Counselling Services. My parents are first generation, underemployed immigrants from the Philippines, and do not share the same ideas and beliefs about mental wellness as found in North American culture. I do not limit the term vulnerable population to only visible minorities, but it was this initial emotional experience that made me explore how the cancer care system could better support anyone who identified as being oppressed or marginalized.

My work and personal experiences sparked my interest in learning more about what I could do as a social worker, alongside my colleagues, in breaking down psychosocial support access disparities for underserved populations in Canada. There is limited research conducted on understanding team-based approaches in cancer care, and therefore the focus of my thesis is team-based approaches to psychosocial care for those who are facing cancer.

1.2 Research Overview

First, I provide an overview of how cancer impacts all facets of a person and their family, and the need to address the psychological, emotional, social, and spiritual well-being of a person during their cancer experience. Then, I describe the role of the cancer system in offering
psychosocial support, and how team-based approaches may result in holistic care that is comprehensive and efficient. Although health care providers working together in offering care is ideal, in reality it proves challenging. I review the ecological system perspective on the micro (interpersonal), mezzo (organizational), and macro (system) factors that facilitate or detract from team-based approaches to psychosocial cancer care to those faced with cancer. I end the literature review section by describing the current state of psychosocial oncology in Canada, and provide the British Columbia cancer care context for this study.

My theoretical framework and methodology is then outlined, followed by the methods used for this study that includes a constructivist theoretical framework and generic qualitative research methodology. I then report the themes that were identified in the data analysis. This description is followed by a discussion of the themes as they relate to the existing body of research literature, implications of the findings on current cancer care practices, particularly for social workers working in an oncology setting, and recommendations for future research.

1.3 Research Rationale

My study objective is to increase understanding on how the health care system can better support team-based approaches in providing psychosocial cancer care for families faced with cancer.

1.4 Research Questions

1. How do social workers/counsellors describe their experiences with other cancer care providers when offering psychosocial cancer care in a team-based setting?
2. What are the facilitators and barriers they have experienced in providing psychosocial support in a team-based setting?
Chapter 2: Literature Review

Facing cancer requires personal strength drawn from the mind, body, and soul. Canada’s health care system recognizes the need for comprehensive cancer care by offering supportive cancer care for the psychological, social, and spiritual needs of a person faced with cancer (Canadian Partnership Against Cancer [CPAC], 2013). Integrating psychosocial care into primary medical care requires cancer care providers working together in a cohesive manner, but these professional interactions may facilitate or detract from offering integrated cancer care. This study explores social workers and counsellors’ experience with health care providers when offering psychosocial care, specifically within a British Columbia, Canada, cancer care context.

2.1 Psychological, Emotional, Social, and Spiritual Impact of Cancer

People faced with cancer not only report physical challenges related to their cancer experience but also psychological, social, and spiritual challenges (Fann, Ell, & Sharpe, 2012). The psychological well-being of people faced with cancer is challenged due to the unknowns of treatment, recurrence, and life expectancy (Lee-Jones, Humphris, Dixon, & Hatcher, 1997). Specifically, distress rates are 35% to 45% for this population (Bultz, Thomas, Stewart, & Carlson, 2007; Vodemaier, Linden, & Siu, 2008). Prevalence rates of mood disorders, such as depression and generalized anxiety disorder, in the first year since diagnosis are double the rates of the general population although these rates decline after one year and return to levels found in the general population (Burgess et al., 2005). Not surprisingly, given the higher rates of distress, depressive, and anxiety symptoms, suicide incidence rates for those faced with cancer are approximately double that of the general population (Anguiano, Mayer, Piven, & Rosentein, 2012).
Social well-being may be affected due to family and relationship distress and role changes, issues with intimacy and sexual function, self-esteem issues due to physical changes, work issues, and financial strain (Hewitt, Greenfield, & Stovall, 2006). Families often take a caregiving role during cancer treatment that can change dynamics between members (Northouse, Katapodi, Scharenacker, & Weis, 2012; Northouse, Williams, Given, & McCorkle, 2012). Similarly, relationships with friends are tested and re-evaluated during this stressful experience (Helgeson & Cohen, 1996). Work role is tested as well since employers and colleagues have not experienced the cancer journey with the person and require additional information to contextualize the needs of their colleague (Nitkin, Parkinson, & Schultz, 2011). Finally, it is difficult to hide a cancer diagnosis from the community due to the physical markers, such as hair loss from chemotherapy, burn marks from radiation, or facial disfigurement from head or neck cancer resections (Lebel et al., 2011). Consequently, people faced with cancer can feel socially isolated.

Spiritual well-being may involve examining the meaning of cancer, re-evaluating religious beliefs, changing hopes for the future and life itself, and struggling with the uncertainty of health and future (Puchalski, 2012). After such a life threatening experience some people re-evaluate priorities in their life, the meaning of their lives, and seek control over problematic aspects of their life (Puchalski, 2012). On the other hand, some find positive meaning in their experience and find that they have an increased sense of hope, inner strength, and feelings of gratefulness (Puchalski, 2012).

Unfortunately, many of the psychological, social, and spiritual needs of cancer patients remain secondary to medical treatment in the cancer care system (Institute of Medicine [IOM], 2008; Vachon, 1998, 2006). The cancer care system’s lack of supportive services has contributed
to poor quality of life, slower recovery, and poor physical and psychological health outcomes (Sanson-Fisher et al., 2000; Wen & Gustafson, 2004). In other words, although medical advancements in cancer treatment and prevention are allowing persons faced with cancer to survive their diagnosis, the current cancer care system is addressing physical needs while poorly addressing this population’s quality of life.

### 2.2 Addressing Psychosocial Needs Through Integrated Cancer Care

One recommendation for addressing cancer-related challenges is integrated cancer care (Fann et al., 2012; Gordon, Beesley, & Scuffman, 2011). Integrated cancer care addresses cancer-related needs in a holistic fashion rather than connecting piecemeal health care services (Fann et al., 2012). Furthermore, an integrated cancer care system can offer a team-based approach to service delivery with the goal of tailoring services that meet the complex needs of the whole person (Fann et al., 2012). Other benefits of integrated cancer care include offering psychosocial care by health care professionals specializing in this area of health and building a cancer care infrastructure that is able to address complex cancer needs in a timely and cost-effective manner (Fann et al., 2012).

### 2.3 Team-Based Approaches in Health Care

One integrated cancer care strategy is utilizing the strengths of each health care profession using a team-based approach. Utilizing the strengths of each health care profession in a comprehensive manner may deliver a level of cancer care that extends beyond the sum of contributions by each health provider (Plsek & Wilson, 2001). Boon, Verhoef, O'Hara, and Findlay (2004) conceptualize team-based approaches as being on a continuum, from health care
professionals working in parallel, yet separate from each other, to an integrated team-based approach (see Figure 1). As team-based approaches shift to integrated health care, there is an epistemological shift towards more emphasis on caring for the whole person, increased acknowledgement of health care profession philosophies, and increased consideration in practice of the biological, psychosocial, and social determinants of health (Boon et al., 2004). At a structural level, there is greater complexity in the interactions between health care professionals, and overlap of roles and responsibilities (Boon et al., 2004). Between health care professionals, there are increased opportunities for communication, synergy, and interdependence (Boon et al., 2004).
The goals of team-based approaches also vary within the literature with the most cited goal for team-based approaches being consensus and similar knowledge bases between health care professionals promoting integrated care for people with chronic illness (e.g. Boon et al., 2004; Molyneaux, 2001; Poulton & West, 1999). More recently, Solomon (2010) rejected the idea of consensus and similar epistemological underpinnings as a prerequisite for integrated care. Alternatively, Solomon suggested that health care professionals are not performing each other’s roles but rather focusing on how the skills and knowledge base of each health care profession can facilitate informed decision-making for patient care.
2.3.1 Outcomes of Team-based Approaches

West and Lyubovnikova’s (2013) literature review on team-based approaches in health care identified benefits to delivering care as a team. At a hospital or health agency level, the high quality team-based approaches may reduce medical errors, reduce mortality cases in hospitals, increase streamlined and cost-effective patient care, reduce physical visits and hospitalization, and overall make more effective use of health care resources. For workers, quality of team-based approaches may reduce work stress, reduce days of missed work, and increase workplace loyalty.

In addition to work-related advantages, some research exists on patient outcomes related to team-based approaches. Within a diabetes patient sample, patients who were provided care by a nurse practitioner and physician team reported better physical health outcomes and health care service compared to those patients who had care from only a physician; however, the two groups of diabetes patients did not differ in health related quality of life (Litaker et al., 2003). Similarly, a review of cancer care team research reported positive impact “in terms of diagnosis and/or treatment planning, survival, patient satisfaction, and clinician satisfaction in terms of communication and cooperation” (Wright et al., 2007, p. 1003).

2.4 Enablers and Barriers for Team-Based Approaches

While there are beneficial outcomes identified by West and Lyubovnikova’s (2013) review, it remains unclear what team is and how a team achieves these outcomes (Lemieux-Charles & McGuire, 2006). There are influences within the health care system that may facilitate or hinder the ability of professionals to work together in providing comprehensive and consistent care to patients and their families. These influences may include micro level factors such as interpersonal factors and group dynamics, mezzo level factors at the health organization or
health institution level, and broader system influences such as health care policies that shape the beliefs around psychosocial care and diversity within the health care system.

2.4.1 The Ecological Systems Perspective

The ecological systems perspective is one way of conceptualizing the environmental influences on team-based approaches in cancer care. In 1979, psychologist Dr. Urie Bronfenbrenner first introduced the ecological systems perspective within a psychological and sociological context, although the study of ecology has existed since the mid-1800s (Bronfenbrenner, 1979). The ecological systems perspective was first utilized by community psychologists studying the interaction of individuals and their environment, and was then adapted for use in social work (Ungar, 2002). In social work, the ecological systems perspective is utilized not as a theory or model, but as a way of thinking about how a person’s environment influences their well-being (Ungar, 2002). This perspective fits with social work practice due to its focus on minimizing dissonance between a person and their environment promoting wellness and harmony (Ungar, 2002).

One assumption of the ecological systems perspective is that different levels of influence within a person’s environment interact, and these interactions are reciprocal between levels (McLaren & Hawe, 2005). This perspective assumes that individual change requires change in a person’s environment as well, and social work may support these changes through social action and transformation within oppressive environments (McLaren & Hawe, 2005). Dr. Bronfenbrenner originally conceptualized the ecological systems perspective as nested circles with each circle representing a level of influence (Bronfenbrenner, 1979). For this study, I utilized the ecological systems perspective as a way of conceptualizing influences on team-based
approaches to cancer care. These levels of influence include micro level (interpersonal and relationships), mezzo level (organizational and institutional) and macro level (system policies and funding).

### 2.4.1.1 Micro Level Factors

Micro level factors refer to the interpersonal communication and relationship characteristics between health care providers within a hospital or health care institution that influence team-based approaches to health care (Bourgeault & Mulvale, 2006). Interpersonal factors that may facilitate team-based approaches to care include: mutual respect for colleagues personal and professional beliefs and values (Hall, 2005), willingness to change or set aside own beliefs and values for greater good of patient and team (Hall, 2005), and consistent communication of patient information that fosters discussion (Virani, 2012). Confidence in colleagues’ ability to do their work, while them also feeling that they have the autonomy to work independently and their colleagues’ trust in their skills, is another facilitator of team-based approaches to health care (Hall, 2005).

Leadership that promotes team-based approaches to health care is characterized by facilitating communication between health care providers, facilitating group dynamics or conflicts that may arise from epistemological differences between health professions, and creating opportunities for health care providers to come together and recognize the strengths of each health care profession (Hall, 2005). While there are indeed interpersonal influences on how well health care providers may offer health care in a holistic fashion, there are also factors that arise from hospital or health institution policies and infrastructure that facilitate or impede this work.
2.4.1.2 Mezzo Level Factors

Mezzo level factors refer to the influences of health care hospitals or agency’s infrastructure and health provider organizations on team-based approaches in health care (Bourgeault & Mulvale, 2006). The health institutions’ policies and the organizational infrastructure directly impact the ability of health care providers to work as a team in offering health care. Health organizations foster team-based approaches by having an explicit mandate whereby health care providers must work together in offering comprehensive health care (Beales, Walji, Papoushek, & Austin, 2011). Another strategy is ensuring that there is time for health care team meetings which provide opportunities to learn other’s roles and engage in case consultations (Beales et al., 2011). Dedicated time and resources reduces the lack of understanding of professional roles and responsibilities (Brown et al., 2011), and provides opportunities for reflexivity in the workplace that critically evaluates whether the care offered is meeting the needs of the patient and their family (West & Lyubovnikova, 2013).

Characteristics of groups of health care providers that are more conducive to a holistic health care approach include defining the responsibility of each health care provider for a particular patient and sharing responsibility and accountability of patient care within each profession’s scope of practice (Beales et al., 2011). Sharing responsibility and accountability proves challenging in the currently medically dominated health care system where physicians hold most of the legal responsibility for patients. With this responsibility it may be difficult to consider all health care providers having shared responsibility when physicians hold most the legal ramifications (Brown et al., 2011). Acknowledging that this hierarchy exists in relation to accountability, responsibility, and power is a beginning point whereby systems can begin
transitioning to a collaborative health care approach that breaks down the hierarchy through shared responsibility and accountability (Lingard, Fleming-Carroll, Rashotte, & Tallett, 2012).

2.4.1.3 Macro Level Factors

Macro level factors refer to policy or economic influences on health care delivery (Bourgeault & Mulvale, 2006). At a policy level, federal and provincial health care policies influence, particularly the payment policies for physicians, the ability of health care providers to work together in offering health care (Bourgeault & Mulvale, 2006). For example, the fee for service model for physicians in Canada detracts from team-based approaches to health care because these physicians are paid based on the specific patient consultations and treatment they provide and not for time used for health care collaboration (Beales et al., 2011; Virani, 2012). The current fee for service payment model for physicians results in time constraints that maximize the number of patients that must be seen by a physician in a work day, leaving little or no time to consult their health provider colleagues on psychosocial challenges for their patients (Rennie & MacKenzie, 2010).

Health professional regulation bodies also detract from team-based approaches as they define exactly what is within the scope of practice for each profession, which then makes it challenging to practice with shared roles and responsibility (Bourgeault & Mulvale, 2006). These professional policies then infiltrate into the education and training of new health care providers, with current health service pedagogy in universities framed as health professions working in silos with specific and sometimes conflicting theoretical practice frameworks (Charles, Bainbridge & Gilbert, 2010; Clark, Spence, & Sheeham, 1988). Education pedagogy promotes the identification with one profession, and some professions prioritize and value the physical
aspects of cancer over the psychosocial aspects of cancer (Charles et al., 2010; Clark et al., 1988). Unfortunately, this health care education culture translates into practice once students enter the field.

Health care challenges with team-based approaches derive from broader systemic beliefs around the health care system’s responsibility in addressing the psychosocial needs of people and families who face illness (McMurtry, 2007). Underlying these practical challenges is the belief that team communication and collaboration is not a primary responsibility for health care professions, and it is perceived as an optional technique for health care delivery (Reeves, 2010). Consequently, the broader systemic beliefs around psychosocial care and team-based approaches underutilize team-based approaches and undervalue the psychosocial aspects that accompany cancer. Overall, past research highlights potential outcomes related to team-based approaches to health care delivery, but future work must explore what health care professionals experience when engaging in team-based approaches that address physical and psychosocial needs of people faced with chronic illness (D’Amour, Ferrada-Videla, Rodriguez, & Beaulieu 2005).

In conclusion, team-based approaches are influenced by factors that range from individual relationships to larger systemic policies. Buttigieg, West, and Dawson (2011) says that “membership in well-structured teams, which show clarity in team and individual goals, meet regularly, and recognize diverse skills of their members, is known to reduce stress.” Although I have outlined what micro, mezzo, and marco factors facilitate or detract from team-based approaches when offering psychosocial cancer care, the current literature does not tell us what the current context is in Canada for utilizing team-based approaches.
2.5 Canadian Context

2.5.1 Medical Dominance

I cannot study the interactions of health care providers without discussing the distribution of power between health care professions. Physicians historically and currently have more power and are more accountable to patient care (Beales et al., 2011). While the physician’s role is centred around the physical needs of a patient, health care is legitimizing patient centred care in practice (Canadian Association of Psychosocial Oncology [CAPO], 2010). Patient centred care refers to allowing the patient to identify and choose how to address their health and wellness (CAPO, 2010). With this shift in patient centred care there is an assumption that health professions are willing and able to change their practice (Cameron, 2011). This assumption is more challenging than originally thought and has been a significant barrier for team-based approaches to health care (Cameron, 2011).

Social work and nursing tend to assume more responsibility in facilitating person-centred care, while physicians are reluctant to accept this role (Gachoud, Albert, Kuper, Stroud, & Reeves, 2012). As a result, medical dominance in health care has made the transition from physical to holistic care challenging because physicians ultimately hold responsibility, regardless of a democratic consultation format (Lingard et al., 2012). Because the physicians still take on this responsibility, willingly or unwillingly, the distribution of accountability for patient care still falls on the physicians (Beales et al., 2011). One reason for not practicing team-based approaches is that allowing other professionals to build relationships may detract from the doctor-patient relationship (Beales et al., 2011). Any reform that does not acknowledge the division of power in health care will face substantial challenges in providing health care that
meets the physical, emotional, social, psychological, and spiritual needs of a person facing a health challenge.

2.6 Psychosocial Cancer Care Progress in Canada

In 1987, the Canadian Association of Psychosocial Oncology was formed with the purpose of “foster[ing] and encourag[ing] interdisciplinary excellence in psychosocial research education and clinical practice in oncology” (CAPO, 2013). This was the first formal body of health care professionals in Canada to recognize the psychosocial spiritual needs for those with cancer, yet CAPO struggled to maintain momentum given the lack of government support (CAPO, 2013). Twenty years later, the federal government addressed the legitimacy of psychological, social, and spiritual issues by redistributing federal health funding to supportive care initiatives. In 2007, Health Canada funded the creation of the Cancer Journey Action Group (CPAC, 2013). The action group vision is “to have a person-centred perspective embedded throughout the cancer journey” by training health care professionals to support people faced with cancer throughout the cancer continuum using a collaborative approach (CPAC, 2013). The goal of developing supportive cancer care initiatives is complementing medical treatment of cancer with services for psychological, social, and spiritual challenges that accompany a cancer diagnosis; however, challenges exist in achieving this goal.

Despite recent funding allocations and acknowledgement of comprehensive supportive care as a critical predictor of long-term survival after cancer, the current Canadian cancer care system still face challenges in adequately addressing the psychosocialspiritual needs of this population (IOM, 2008; Vachon, 1998, 2006). Cancer care service gaps that have been identified in Canada include: poor integration of supportive services as part of primary treatment, lack of
integration of hospital and community health services, access disparities to resources in rural and remote areas, and the absence of community participation in decision making for cancer care services (Ristovski-Slijepcevic, 2009). My study provides insight into the factors that may contribute to poor integration of psychosocial cancer care in an environment that prioritizes medical care.

Health Canada recognized the need for integrated health care delivery and identified utilization of health professional teams as one of five strategies for health care reform (Health Canada, 2007). However, team-based approaches in cancer care still lack a conceptual framework and empirical evidence that guides how teams can achieve an integrated cancer care system in Canada. An international review of team models in cancer care shows that most cancer care systems follow a parallel or consultative team-based approaches where psychosocial care is not well integrated into care (Gagliardi, Dobrow, & Wright, 2011). In Canada, the research literature contains mixed results for parallel or consultative team-based approaches that utilize psychosocial screening. For example, a random clinical trial comparing psychosocial screening and intervention versus usual care showed that breast cancer patients at a Quebec breast cancer clinic did not show differences in distress when compared to a control group (Maunsell, Brisson, Deschines, & Frasure-Smith, 1996). In contrast, a similar study was conducted with breast cancer patients accessing care at a cancer centre in Calgary, Alberta, and those who were offered psychosocial screening and intervention had lower levels of distress at follow up compared to breast cancer patients who were not screened or provided psychosocial support (Carlson, Groff, Maciejewski, & Bultz, 2010).

Given the mixed results of using a parallel or consultative approach to psychosocial support, it remains unclear how the utilization of teams may facilitate or detract from offering
psychosocial care for those faced with cancer. Despite this lack of clarity, some British Columbia health professionals and partnering health science universities have a long history of acknowledging the value of team-based approaches when offering health care (e.g. McCreary, 1974). This long-standing commitment extends into today’s health care practices, for example, the University of British Columbia focused on training new health care providers in team-based approaches to health care through the establishment of the College of Health Disciplines that “work[s] with the 15 health and human service programs at UBC to develop learning experiences that give students from different disciplines opportunities to learn about, from and with each other” (University of British Columbia, 2014). It seems that although there is a lack of consistent research on team-based approaches outcomes for cancer care, team-based approaches is a favoured approach by health care settings and educational institutions in British Columbia, and this study provides some insight on factors that facilitate or detract from psychosocial care in a team-based setting.

2.7 Study Context: British Columbia Cancer Care

This study will focus specifically on cancer care in British Columbia, Canada. The cancer care system in British Columbia has one overarching provincial cancer care agency, BC Cancer Agency, which provides outpatient cancer assessment, treatment, and follow up, with collaboration of British Columbia hospitals in offering inpatient cancer care (BC Cancer Agency, 2014). The BC Cancer Agency provides the majority of cancer care for BC and the Yukon, with five main treatment centres and coordination with over 30-cancer treatment community services in rural and remote areas (BC Cancer Agency, 2014). The majority of patients accessing chemotherapy or radiation therapy in British Columbia receive this treatment at the BC Cancer
Agency except for people under 18 years of age in British Columbia who must access cancer care at Children’s Hospital in Vancouver.

Patients with physical cancer-related complications, severe cancer treatment side effects, or who require end of life support are usually admitted to an inpatient oncology ward at their local hospital. The BC Cancer Agency Vancouver Centre is the only BC Cancer Agency centre with an inpatient unit since complex cancer treatment patients from all over British Columbia receive treatment at this particular cancer agency. Because the BC Cancer Agency mostly provides outpatient cancer care, the larger British Columbia hospitals usually have an oncology inpatient ward for patients.

All five BC Cancer Agency centres have a Patient and Family Counselling Services department with graduate level social workers and counsellors providing emotional and practical support for people and families faced with cancer through individual or family counselling, or psychosocial group work (BC Cancer Agency, 2014). British Columbia’s psychosocial cancer care is designed to maximize ease of communication between health care professionals through mandated referral and assessment protocols and an electronic charting system (Linden et al., 2009). These tools facilitate communication between health care professionals, yet researchers have never explored team-based approaches as a phenomenon within this cancer care context. Psychosocial care is still poorly integrated and inconsistently offered at all phases of the cancer care trajectory including diagnosis, treatment, and follow-up care (Bultz et al., 2006). In this study I explore the experiences of cancer care providers who offer psychosocial support to patients and family within a team-based approach to cancer care. The purpose of the study is to gain knowledge of what may be contributing to gaps in services, particularly in psychosocial care for patients and their families. The study questions are: 1) how do social workers/counsellors
describe their experiences with other cancer care providers when offering psychosocial cancer care in a team-based setting? 2) what are the facilitators and barriers they have experienced in providing psychosocial support in a team-based setting?
Chapter 3: Study Design and Methodology

3.1 Methodology

3.1.1 Generic Qualitative Research

This study utilized a generic qualitative research methodology. Caelli and colleagues (2003) conceptualize generic qualitative research as “not guided by an explicit or established set of philosophic assumptions in the form of one of the known qualitative methodologies” (p. 4). This methodology promotes using the exact words of the participants and explaining these participants’ stories in everyday language, and it is useful for researchers when investigating straightforward experiences that do not possess highly complex abstractness (Caelli et al., 2003).

The rationale is two-fold for using generic qualitative research methodology for this study. First, I wanted to present the participants’ stories as descriptive summaries, avoiding as much as possible changing words in the transcribed interviewed during analysis, in the hopes of minimizing inaccurate data interpretation or abstractness of the analysis (Caelli et al., 2003). Importantly, I acknowledge that these descriptions are based on interpretations and people’s constructions of past experiences, and the end result is ultimately my interpretation of the participants’ experiences.

Second, a challenge with a course-based Master’s program, such as the Master of Social Work, is learning and conducting in-depth qualitative research methodologies that are complex and nuanced (Caelli et al., 2003). Generic qualitative methodology should not been seen as a less rigorous in comparison to methodology choices such as grounded theory or phenomenology, but can be thought to borrow complementary elements that fit with the research question (Caelli
et al., 2003). Since there is no formal standard for what is considered a good qualitative research methodology, research methodology should be an “epistemologically and methodologically congruent standard rather than an incoherent amalgamation of methods or techniques.” (Caelli et al., 2003, p. 19).

Caelli and colleagues (2003) outline the research methodology that increases a study’s credibility utilizing a generic qualitative methodology. These research methodology characteristics include: 1) explicitly outlining the theoretical and personal position of the author; 2) outlining and distinguishing between the study methodology and methods; 3) identifying and addressing study credibility; and, 4) stating and justifying the author’s analytical lens. For this study I followed these fundamental elements for conducting a generic methodology; they are integrated them into this written account of the study process and findings.

3.2 Theoretical Framework

3.2.1 Constructivist

The theoretical underpinning of this study stems from a constructivist knowledge paradigm. A constructivist paradigm is common within qualitative research, and comprises of ontological, epistemological, and methodology assumptions (Guba & Lincoln, 1994). The ontological assumption of constructivism is relativism, meaning that people make sense of their experiences so that these experiences are understandable, but their interpretations are confined within their own mental, social, and environmental construction (Guba & Lincoln, 1994). Constructivism’s epistemological assumption is that within a research context a participant’s “truth” is constructed with the researcher and this partnership influences the construction of
past experiences (Guba & Lincoln, 1994). This assumption extends into the methodological assumption of constructivist paradigm that these constructed experiences between the participant and researcher can only be further enriched within this research relationship. The objective of creating a mutually agreed upon construction of an experience is a sophisticated construction that is beyond the contributions of each person independently (Guba & Lincoln, 1994).

A constructivist knowledge paradigm was initially identified in my research proposal that guided the methodology and methods of this study, however, I found it conflicted with my previous school and work research training in quantitative research, which typically assumed a positivist approach. Throughout this research process, I found myself oscillating back and forth from a positivist to a constructivist approach. On one hand, I believe that people make meaning of their experiences, and this meaning making is influenced by past experiences and their current environment. On the other hand, I often times would catch myself looking for “an answer” in my data. I addressed this theoretical dissonance by working with my supervisor during the data analysis. Generic qualitative research methodology also provided support in my challenge because there was less opportunity for disagreement between myself and supervisor if looking at the stated “facts” as said by the participant because the low-inference nature of this methodology (Caelli, Ray, & Mill, 2003).
3.3 Methods

3.3.1 Sampling

A criterion sampling approach was used for participant recruitment, which is guided by the research question and by the selection of those respondents who can shed light on this research question (Palys, 2008). My primary unit of analysis was social workers or counsellors who provide psychosocial services at a British Columbia cancer care hospital or agency. I used criterion sampling by recruiting social workers and counsellors who worked at the BC Cancer Agency or a hospital oncology unit for at least one year, and who worked with cancer care professions when providing psychosocial services as part of a team-based approach. These participant criteria created a homogenous sample of similar experiences with collaborative approaches to supportive cancer care, yet heterogeneous in their professions and years working in the field.

3.3.2 Recruitment

I recruited participants using snowball sampling (Noy, 2008). Snowball sampling is a recruitment strategy where initial contacts will reach out to potential participants by forwarding study information (Noy, 2008). I emailed my personal contacts that work in cancer care, provided them with an introduction to the study, and asked if they would be willing to forward my participant recruitment email to potential participants (see Appendix A for recruitment email). My personal contacts were not interviewed for this study, and all eight of my participants were recruited using snowball sampling.
As stated by Pope and colleagues (Pope, Ziebland & Mays, 2000), the exact number of participants depends on whether or not the research question was addressed by the data received. I aimed for three to four participants from each profession in the sample, six to eight participants in total, and re-evaluated the need for further interviews after coding the data of eight participants. I received eight emails from people who were interested in participating. Six of the participants I had met once or twice since I previously worked in oncology and knew from my previous interactions with these participants that they provided psychosocial care using a team-based approach. Two of the participants I had not met before, and worked at an oncology setting I was not familiar with. These two participants stated they worked in an inpatient unit where they worked in a team, and therefore were eligible to participate in the study. Overall, all eight were eligible to participate in the study. I was able to recruit and interview six social workers and two counsellors. After analyzing the data, it was evident that there were themes within the data that would benefit from further interviews that would supplement the data, however, I was unsuccessful in my attempts to recruit additional participants.

Once potential participants made contact and expressed interest in participating, I provided a study overview and explained the participant role via email. If she/he expressed interest, I provided a consent form to the participant for their reference prior to the interview, and the participant signed a paper copy of the consent at the beginning of the interview. The consent form specified consent for the interview and audio recording of the interview. At the end of the interview, the participants were given a $20 gift certificate to a local coffee shop for their participation.
3.3.3 Data Collection

All interviews were conducted in-person between March and June of 2014. Six of the participants were interviewed at their work office, one at their home, and one was interviewed in a public space. The participants chose the site for the interview. Each interview was audio-recorded by two recording devices. A semi-structured interview approach was utilized that reconstructs the participant’s experiences, while also providing flexibility in the questions based on the dialogue between the participant and I (DiCicco-Bloom & Crabtree, 2006). The semi-structured interviews were approximately 60 minutes. I asked each participant between five to ten questions that explored their experiences with health care professions in their work environment when offering supportive cancer care (see Appendix B for interview guide). The interview questions followed an iterative process where I added or removed questions as I learned from the participants so that questions addressed any emerging themes related to the research question.

Early in the interview process I recognized the challenges participants faced in providing in-depth accounts of their experiences working with cancer care providers. I reviewed the first interviews with my supervisor, and revised questions and my approach in asking probing and prompting questions during the interviews. Specifically, one topic of interest for this study was exploring diversity considerations when offering psychosocial cancer care within a team-based approach, but it was challenging for the participants to engage meaningfully and in-depth. Five participants identified as visibly white, middle-upper class, and with Master degrees. As a visible minority myself, I wondered how comfortable they felt sharing their experiences with minority populations with a visibly minority interviewer. In contrast, my last three participants were two self-identified visible minorities of Asian descent and one participant who was visibly white.
practiced from a predominantly anti-oppressive theoretical framework. These particular participants were able to articulate how they address diversity in an oncology setting, and how they work with their cancer care colleagues in supporting a patient and their family.

3.3.4 Ethical Issues

Many of the participants expressed concern in regards to the anonymity of their experiences in this thesis and future publications. Most participants requested that their names and the cancer hospital or agency they work in not be identifiable in this thesis. Cancer care providers expressing their experiences working with cancer care providers may lead to reporting negative experiences with specific people, professions, executive decision-making, and cancer care systems. A potential social risk for participating in this study was creating tension within the working environment. These social risks were minimized by not publicly disclosing their participation in this study. I interviewed participants individually, and informed participants through the consent process that the opinions of the participant will be anonymous. I also provided all participants an opportunity to review the data analysis; however, all of the participants declined participation.

3.3.5 Data Analysis

Aligning with a generic qualitative methodological framework, I used qualitative content analysis for this study that is “data-derived: codes also are systematically applied, but they are generated from the data themselves in the course of the study” (Sandelowski, 2000, p. 338). Once I completed an interview, within one day of the interview I transcribed verbatim the audio recording of the interview using Microsoft Word® and the transcription software Express
Transcribing the interview soon after completing it decreased the chance of missing data due to inaudible sections in the audio-recordings. In addition, the transcription process lends itself to an iterative research process whereby I revised my interview questions based on the data provided by previous interviews.

For the first phase of the data analysis I used open coding where the “…concepts emerge from the raw data and later [are] grouped into conceptual categories. The goal is to build a descriptive, multi-dimensional preliminary framework for later analysis” (Khandkar, 2014, p. 8). I printed hard copies of each transcribed interview, and read the interview alongside the audio recordings where I checked for accuracy of the transcriptions and identified common and outlier themes within and between interviews. I thoroughly listened to each interview two or three times. Throughout the research process I carried a notebook that was used for writing my observations of any themes and changes needed to the research methods. I would also write notes about my observations on the left column of each hard copy interview. An open coding method allowed for the emergence of themes organically by becoming familiar with the interview data, identifying experiences that are related, similar, or different for the participants (Khandkar, 2014). Although these themes emerged, I recognize that this organic state is confined within my interpretation of the participants’ descriptions.

Through open coding I identified emerging themes from the interviews, and then I organized the data using NVivo for Mac©. I created overarching categories by reading each interview line by line, looking for sentences or paragraphs that were relevant to the research question. I was also cautious of leaving out data that may be relevant to the research question but that I assumed was irrelevant. I addressed this data analysis bias by keeping codes that I thought were not relevant, and discussing these particular codes with my supervisor.
Once the data were organized into these broad categories, I printed out the data for each category and used a highlighter to identify themes within these categories. I then went back into NVivo for Mac© and placed codes from the broad categories into the categories sub-themes. I also organized the data so that it told a cohesive and collective story of the participants’ experiences, while also highlighting differences between participants. When making these categories and themes I sought to stay “data near”, meaning I used language for my codes that was used by the participants (Caelli et al., 2003). I then would review the themes and their respective codes every few days and also after each interview, and then add or remove codes as needed.

### 3.3.6 Trustworthiness

Trustworthiness was addressed in this study through applicability and truth value, and the use of “thick” descriptive data and peer debriefing. Applicability refers to how research findings can be transferred between different contexts within a specific time and space (Guba, 1981). Applicability of the data between varying oncology settings, particularly between inpatient and outpatient cancer care systems, was addressed by collecting thick descriptive data on each oncology setting context. Then, I determined the applicability of transferring the findings to each cancer agency centre context by examining each centre’s composition of health care teams, the supportive services are offered, and the way in which services are offered.

Truth value refers to if and how the research findings represent the participants from data are gathered (Guba, 1981). I conducted the data analysis, and my own views and beliefs about cancer care and team based approaches inevitably influenced the data interpretation. In response to this trustworthiness threat, I used peer debriefing throughout the research process (Guba,
1981). For peer debriefing, my research supervisor provided feedback on the interview guide, interviews, revision of interview questions, and data analysis.
Chapter 4: Findings

During the interviews, participants were asked to speak about their experiences offering psychosocial cancer care. The interviews specifically focused on their experiences offering this type of care with cancer care providers in their oncology setting. Due to the confidentiality and anonymity concerns expressed by the participants, I changed the participants’ names in the findings, provided only participant descriptors that are relevant to the research question, and removed identifiable information within participants’ quotes. For ease of reading, repeated utterances such as “um,” “uh,” “like,” and “you know” were removed from the quotations.

First, I present contextual information about the participants and their work environment. This contextual information sets the foundation for presenting the study themes. I present participant descriptions such as self identified age, race and gender identity, number of years working as a social worker or counsellor, and educational background. I then present the participants’ practice context that outlines what psychosocial support is offered in their practices, and the challenges in offering psychosocial care in a team-based practice. Finally, I present generally what participants expressed as their roles within a team of cancer care providers.

Following is a section in which the themes are categorized into micro, mezzo, and macro level factors that facilitate or detract from social workers or counsellors offering psychosocial support within a team-based approach. The emergence of these categories was derived from an open coding data analysis approach where I found that the participants’ experiences fit into these categories. When I started coding the data I did not pre-determine that the codes would fit within micro, mezzo, and macro facilitators or barriers, but rather let the categories emerge from the data itself. Micro level factors are presented first because interpersonal factors represented
an often-discussed element of participant experiences and therefore an overarching theme for this study. Next, mezzo and macro level factors are outlined. In the participants experience these different levels did not occur in isolation, but interact with each other and influence psychosocial cancer care. Although micro, mezzo, and macro level factors are presented separately for ease of reading, throughout the descriptions of mezzo and macro level factors I will relate these factors back to relationships between individuals which is a overarching theme of this study.

There were four micro factor levels described by the participants, including: 1) building personal and working relationships with colleagues; 2) providing emotional support to colleagues; 3) clarifying roles of cancer care professions; and 4) feeling valued as a profession and person. Participants described three mezzo level factors: 1) infrastructure and resource flexibility; and, 2) limited space and worker availability; and 3) medical dominance. Finally, for macro level factors, participants identified 1) physician power and 2) political and economic constraints as detracting from offering psychosocial cancer care using team-based approaches.

4.1.1 Descriptive Analysis of Participants

Participant descriptors as self-identified by the participants are listed in Table 1 in the order they were interviewed. The participants’ ages ranged from early 30s to early 60s. Seven participants identified as female and one as a male, six identified as visibly white and two as visible minorities. In terms of professional backgrounds, six had a Master of Social Work degree and two were Registered Clinical Counsellors. The number of years working in psychosocial oncology varied, with the greatest number of years in the field represented by the two registered clinical counsellors- Kelly with over 20 years experience and Derrek with over 10 years
experience. The six social worker participants reported working in psychosocial oncology between from 2 to 12 years.

All participants worked in a hospital setting that offer medical and psychosocial care to people facing cancer and all are involved in delivering psychosocial cancer care using a team-based approach. These hospital settings are all within an urban area in the Lower Mainland. Three of the participants, Kara, Tamara, and Jesse, work within an inpatient unit within a hospital, where they specifically work with people with cancer who are admitted into an oncology ward. The other five participants work within an outpatient model for cancer care, where patients have booked appointments for cancer treatment and follow-up by their cancer care team, but they are not admitted into the hospital. Within this outpatient setting, there is also an inpatient unit at the centres they work in, but their role is not specifically focused on only people who are admitted into the hospital.

Two of the three social work participants who worked in an inpatient oncology setting, Kara and Jesse, had recently left their oncology position in the past year. When I probed these participants for the reasons for leaving their social work position, they both expressed experiencing compassion fatigue as one of the reasons for changing work positions. Both of these participants still work in health care, with Kara now working at another inpatient unit at the same hospital as her previous role, and Jesse now working in an end-of-life inpatient setting. While these participants’ experiences are different than the other six since they no longer work in oncology, their experiences were recent and they were able to share their stories of how oncology is an emotionally charged environment and the implications of this environment on social worker well-being. They provided rich information on how team-based approaches
facilitated or detracted from offering psychosocial cancer care, and how they ultimately decided to leave oncology social work.

Table 1. Description of Participants

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Visible Minority</th>
<th>Gender</th>
<th># years working</th>
<th>Professional Background</th>
<th>Currently Working in Oncology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Becky</td>
<td>30s</td>
<td>No</td>
<td>Female</td>
<td>&lt; 5</td>
<td>MSW</td>
<td>Yes</td>
</tr>
<tr>
<td>Julie</td>
<td>30s</td>
<td>No</td>
<td>Female</td>
<td>&lt;5</td>
<td>MSW</td>
<td>Yes</td>
</tr>
<tr>
<td>Darrek</td>
<td>60s</td>
<td>No</td>
<td>Male</td>
<td>&gt;10</td>
<td>RCC, MBA</td>
<td>Yes</td>
</tr>
<tr>
<td>Sharon</td>
<td>40s</td>
<td>No</td>
<td>Female</td>
<td>&lt;5</td>
<td>MSW</td>
<td>Yes</td>
</tr>
<tr>
<td>Kara</td>
<td>30s</td>
<td>Yes</td>
<td>Female</td>
<td>&gt;5</td>
<td>MSW</td>
<td>No</td>
</tr>
<tr>
<td>Kelly</td>
<td>50s</td>
<td>No</td>
<td>Female</td>
<td>&gt;20</td>
<td>RCC, MA</td>
<td>Yes</td>
</tr>
<tr>
<td>Tamara</td>
<td>30s</td>
<td>Yes</td>
<td>Female</td>
<td>&gt;5</td>
<td>MSW</td>
<td>Yes</td>
</tr>
<tr>
<td>Jesse</td>
<td>30s</td>
<td>No</td>
<td>Female</td>
<td>&gt;10</td>
<td>MSW</td>
<td>No</td>
</tr>
</tbody>
</table>

1 I acknowledge that the racialized category “visible minority” are social and ideological constructions that further perpetuate a system of oppression and segregation. With critical consideration, participant confidentiality, and my own ontological limitations I chose to use a general categorization such as visible minority; however, I will continue my own deconstruction of racialized categories used in research and everyday discourse.
4.2 Participants’ Practice Context

4.2.1 What is offered: “Emotional and practical support for patients and families”

Participants provided thorough descriptions of their role, their work setting, and the need for psychosocial cancer care. All participants described how facing cancer affects many facets of a person and their family. As one said:

[…] medical care oncology is only half of the family’s journey, and that psychosocial is as important if not more sometimes […] (Jesse)

I asked participants to describe what they offer in terms of “psychosocial support.” All participants described psychosocial support as providing a blend of practical and emotional support:

My role on the team is to offer practical, support, advocacy, and counseling to patients and their loved ones. (Becky)

Counselling, psycho-ed, practical support, advocacy, being a safe place for them… certainly a guide to the system. (Jesse)

My role is to provide both emotional and practical support for patients and families. That is counselling relationships and also more practical things…advocating in community…resources and that sort of thing. (Julie)

Participants described reasons why people with cancer and their family may seek psychosocial support from their cancer care team. Many participants identified heightened distress during times of transition within the cancer trajectory as one of main reasons for
accessing psychosocial support. This cancer trajectory starts from pre-diagnosis to survivorship or end of life:

We all go on a spectrum from new patient to end of life because we’re on that cancer trajectory. And that’s what we’re always looking for, that cancer trajectory where the distress level is in there and how we are able to best support the people who surround them, as well as the patient themselves. (Sharon)

[…] particular junctures in people’s care might be a time for a patient to get flagged to me, for example, if someone has been just signed onto palliative care benefits, so if they have officially become palliative, that would be an important juncture for me to get involved in terms of transitioning them into the community for supportive care because there are in end-of-life and dealing with other end-of-life issues that go alongside that. So, that’s a very pivotal moment when social work does need to be involved. (Becky)

Of particular interest to me is the diverse nature of the cancer population in terms of income level, gender expression, spirituality, sexual orientation, age, ability, and ethnic culture, and how these variables impact the cancer journey and psychosocial needs. Participants spoke of their experiences working with patients and families that represent minority groups in Canadian culture and recognized the importance of considering diversity within the cancer care system:

We’re often dealing with complicated and socially…complicated medical and social situations, and trying to trying to sort them out. (Derrek)

We are very diverse in every way possible. And so, just within our culture ourselves, we have different cultures that we have to take into consideration, and we have to take that into consideration in our medical environment. (Sharon)

Furthermore, participants mentioned that for some people there is a stigma attached to having cancer:
And the other thing around stigmas is cancer it’s… even having a cancer diagnosis can have a lot of stigma. So, talking about that is loaded. It can be very difficult for people of all walks of life. (Julie)

A challenge arises when social or cultural beliefs intersect with facing cancer, potentially leading to heightened distress and need for psychosocial support:

The more, social problems, psychiatric problems, financial problems, that’s when the needs are highest when you have cancer on top of it. […] It’s sort of like a building block of needs, and they just keep getting higher and higher and then multiple and multiple, and then it will fall down. [laughs]. It will eventually tip over, right? And that’s what happens. The more needs a person has the more the more they may need to see a counsellor to just be able to just sort out thing[s]. (Sharon)

Sharon then described the implications of not addressing distress or lack of psychosocial support on cancer treatment:

If their distress level is really high, we know that they don’t function well in cancer treatment. Either they will be noncompliant with their cancer treatment for whatever reasons. There are various different reasons why people are not able to comply with treatment just based on anxiety levels or depression levels. (Sharon)

Given the need for psychosocial support, participants describe situations where patient and families accessed psychosocial support that required balancing the cultural beliefs around cancer, death, and dying and a Western approach to cancer care. Kara illustrated this theme through her experience supporting a family:

The family was of the belief that she was going to make it through this. Regardless of what the care team presented, they felt that their faith was gonna carry them through and she was gonna survive because they had a strong faith she would […] That was very hard. Just ethically because, knowing what we know, wanting to support that patient wanting to advocate for her to have as comfortable of a quality of life, I guess, as best, as good a
quality of life as possible, and then try to support the family as well because they were just so rigid as to where they were, and it all came from a fear of losing their loved one, which we completely understood. But...but it gave...it kind of left you with that, that whole dilemma of about what are we, who are we supporting here, and who’s needs are we meeting, and are we doing justice to our patient? (Kara)

Based on the participant descriptions, providing support to people and their families facing cancer may address needs or concerns, all within the social context of the client. The work settings for each participant differed slightly, but the support provided was consistent with most participants identifying “meeting where they are at” in their practices. From this framework, the emotional or practical support offered is tailored based on these needs. Participants often spoke of challenges in providing this support due to the emotional and serious nature of cancer as a chronic illness.

4.2.2 Provider Challenges: “Difficult to support patients and their families”

All participants expressed concerns around the emotional toll on cancer care providers that offer psychosocial support to those faced with cancer. Participants described the supporter role for people and families faced with cancer as “hard,” “stressful,” “difficult,” and “challenging.”

[…] especially in oncology, I mean I think certainly every team that I work, we’re kind of like the walking wounded sometimes, and we’re kind of these traumatized professionals that who’s friends and families can’t really understand what we witness everyday. (Jesse)

For some participants, the challenge stems from facing death and dying everyday; however, they still described the work as rewarding:
We saw a lot of death and dying. We saw a lot of our long term patients pass away. So it was...it was difficult. And that was one of the reasons that I had chosen to leave oncology just because of the toll it takes on you as well as providing support to patients and families [...] that journey with them which was one of the things that was always left me with such so much gratitude that they allowed me to be a part of their journey, and allowed me to support them during those times [...] I find that you have the opportunity to do such amazing work, and in-depth [...] It's a challenging role, but so rewarding [...] the most rewarding work that I've done yet. I just personally couldn't continue on doing it just on my own coping, but the most rewarding. (Kara)

Working within an emotionally charged environment had direct implications for the well-being of the cancer care providers and also their patient care. Participants described committing to this role where they strive to provide the best care for their patients and families, but as a consequence they face morale burnout and feeling overwhelmed:

Just do what needed to be done until I felt the patient was getting the care that they needed, but then that often means staying late and your kind of over-functioning, and you're working really hard. (Jesse)

It is very hard to work in an emotional environment. There is morale burnout that people face, and you can take stuff home. (Derrek)

In contrast, when speaking of cancer care providers that work predominantly on the medical aspects of care, such as nurses and doctors, some participants described poor psychosocial care by these providers as a result of compassion fatigue:

At times it [compassion fatigue] may come out against a patient. In blaming, in stereotypes. If their...maybe part of our homeless population or an ethnic group that stereotypes may come out within the physician against the patient...something like that. I've seen that. A lot of the times if they are a vulnerable population that [...] the physician will group stereotype and put the blame on and then become very angry [...] It's a privilege, and when you stop thinking of it as a privilege the organization, the bureaucracy,
has just taken you. It has destroyed you. And I have seen that in that professionals when
the organization has just claimed them, and they become ineffective in what they do.
(Sharon)

Two of the participants described leaving their social work positions in oncology due to
the emotionally fatiguing nature of the work. While the other six participants continue working
in psychosocial oncology, they acknowledged the challenges in maintaining their own health and
well-being. When I asked the participants who have worked in an oncology for more than 10
years how they access and receive support, these participants spoke of maintaining their
autonomy in the work setting and keeping their work varied and interesting. More generally,
most participants spoke of how their peers within their work setting was the most significant
asset for engaging in this work while maintaining personal balance and wellness.

4.2.3 Team Expectations: “In a perfect world that is a team”

One way that participants described how they manage the emotional environment of
psychosocial oncology is through the support of their team:

Certain families are more resistant to having those conversations than others. So, working
on a team in those conversations I think is really important. Important not just to patient
care, but also to our well-being as health care providers in terms of preventing burn out
and that kind of thing. (Becky)

We kind of need our colleagues for that support. (Jesse)

I asked participants what they would name their interactions or support from the cancer
care providers they work with. Participants working in an inpatient unit identified with working
as a “team” with other cancer care providers on their ward, whereas participants working in an
outpatient setting identified working as a team on an ad-hoc basis, but most of their work with patients was offered not as a team. Although participants differed in identifying as a team based on their work setting, all participants described similar expectations of what constitutes a well-functioning and supportive team. One characteristic described in almost all the interviews was a shared responsibility for psychosocial care:

[…] I think it’s everyone’s role in a health care team to acknowledge the unique needs of each patient, that’s what patient centred care really is. (Becky)

I thought I was the one responsible for psychosocial care of all the inpatients, and within a couple of hours I realized that’s…no, I can’t do that. I realized that everybody is, from…and the cleaners do a lot of psychosocial care. It’s the way the nurses interact with people, it’s the way the doctors interact with people, it’s the way the pharmacists interact too. And we’re all responsible for psychosocial care. (Derrek)

I think that everyone has a role in supporting patients and being aware of their psychosocial needs […] (Julie)

There was one participant who described the role each cancer care provider as separate, with no overlap in roles and responsibilities in regards to patient care:

Nurses and doctors they have their function, which is medical focused. It is focused on giving that patient their treatment, making sure that treatment is the right treatment for them, accessing…making sure it’s the right treatment. And making sure their physical health is well taken care of. That’s their first priority. Ok, whereas our [social work’s] first priority is more psychosocial…is the psychological, so that’s our first priority as it relates to cancer and the treatment of cancer. (Sharon)

Other characteristics of a team that were described by the participants included commitment to patient needs and good working relationships with colleagues:
I think [...] showing up, being keen, being committed, responding to patient needs, not complaining about patients and families, about costs, all that stuff. I think helps enhance your credibility, it sounds really mundane, but it’s so, so, so essential (Jesse)

It means a number of different roles and perspectives coming together to support a patient. It’s really about supporting the patient and working together. (Julie)

Working so closely on a team like this you really do need to have good team dynamics. You need to have a good working relationship with your colleagues, (Becky)

Participants described what they find valuable in a well-functioning and supportive team, but their expectations for a team differs from what they experience working in an oncology setting. The next sections describe participants’ experiences working with cancer care providers using a team-based approach, and their role within this team, and what aspects of their experiences detracted or facilitated their ability to offer psychosocial care to those faced with cancer.

4.2.4 Role Within a Team: “Our expertise is people management, right?”

Participants described their role within a team as a facilitator between cancer care providers and patients. As Sharon expressed it, “Our expertise is in people management, right? That’s our expertise, whether it’s a social worker or counsellor by trade.” Many of the participants’ experiences also mirrored this idea of managing people, assuming the role of facilitator with the hopes of easing and clarifying information between all parties involved a patient’s care. Most participants described experiences where they smoothed communication between patients, families, and the cancer care team:
And so talk it over with the parent, or the patient, so that’s, it’s as transparent as possible, and I’ll either bring them to see the oncologist or I’ll just talk to the oncologist [...] (Jesse)

I’ve got a patient who has been followed by them medically who was just in touch with me because she just got admitted to St. Paul’s. So I’ll keep them up to date. I’ll often get information…the medical information from St. Paul’s and talk to them about it and they’ll clarify to me what that means. (Derrek)

From the patient perspective the team isn’t working well, another system issue, then I think that’s maybe where I would get involved and say, “Well, how is it not working? How can we support you better as an organization and as a…yeah…to get you through treatment?” Because really that’s what its about. (Julie)

Becky described how communication between team members impacts the care offered to patients:

I do a lot of helping smooth out communication on the team, and I think it really helps patients to know that everyone on the team is communicating and that offers a level of security somehow or confidence in your team…your health care team. (Becky)

Generally, participants described their role as facilitating communication that may lead to cancer care that integrated many facets of a person’s well-being including their physical, emotional, social, and psychological needs. As the participants spoke of their experiences caring for patients within a team of cancer care providers, specific themes emerged that highlighted aspects of working in a team that facilitated their ability to offer psychosocial care.
4.3 Dominant Themes: Experiences in Team-Based Approaches to Cancer Care

4.3.1 Micro Level Factors

Micro level factors refer to the interpersonal communication and relationship characteristics between health care providers within a hospital or health care institution that influence team-based approaches to health care (Bourgeault & Mulvale, 2006). When describing their experiences offering psychosocial care using a team-based approach, all participants often spoke of relationships they hold with each person on the team. Interpersonal relationships were described in depth and often by the participants, and are an overarching theme for this study. Even when describing mezzo or macro level factors, participants would bring the discussion back to how these factors impact their ability to build authentic and meaningful relationships with cancer care providers in their oncology setting. Amidst current barriers to team-based approaches to cancer care, participants expressed their commitment to team-based practice and supporting each other in the emotionally charged work setting.

4.3.1.1 Building Relationships: “I think like we are ourselves, and our professions full-time”

All participants spoke about their interactions and relationships with cancer care providers in their respective oncology settings. Relationships between the participants and their colleagues, individually and as a team, were a central focus in their descriptions of their experiences. All participants described developing and maintaining relationships with their colleagues on a daily basis, working in an environment that forces communication between cancer care providers for patient care. No participants described their role as working completely separately and alone.
Participants stated the importance of building authentic relationships with their colleagues since these relationships influence their ability to work with a patient and other people involved in this person’s care. For example, Jesse described a situation where she was receiving referrals from her team members that were not part of her social work role. In response to these referrals, Jesse describes how her personal relationship allows for challenging work conversations with her colleagues:

I think because I’ve worked to build the relationship it’s always been fine. I might say “it’s not a really a social work issue,” and they’re like, “oh, sorry.” (Jesse)

Participants described personal and professional relationships within a team as facilitating professional role transparency, shared commitment to psychosocial care, and emotional support, which allows cancer care providers to continue supporting those with cancer. As Tamara stated, “I think like we are ourselves, and our professions full-time,” and the essence of this statement permeated throughout the participant interviews. One participant described their interactions with cancer care providers as respecting and communicating as two humans rather than taking the humanness out of the cancer care provider:

It’s about us all coming and realizing we are human, and how can we work together to make this the best of a worst situation, right? And I think that’s what we have to realize is that we all put on pants one leg at a time. Whether you are a patient, whether you are a professional. And, I think that bringing humanness to any part in helping each other to validate the other’s professions I think is really important. (Sharon)

By recognizing everyone’s humanness, participants were able to build personal relationships with one another that make them feel valued and cared-for by their colleagues in an emotionally taxing work environment:
He said, “Oh, I just felt like with you, you really cared about me, like you care about me.” And, and I think that’s… I do try to pride myself on building authentic relationships with the staff, and we can do our jobs better when we have good authentic relationships with our colleagues. (Jesse)

Another benefit in building authentic relationships with colleagues is learning how to work with cancer care providers given that people bring their personal nuances and flair to the work:

I knew their personalities, so that I could help to be able to shift things when I needed to, like I said, be able to bring clarification to patients and families. Sometimes physicians and nurses have quirks […] (Sharon)

Once participants develop relationships with their team members, they are able to utilize these relationships to enhance their collaborative support for patients faced with cancer. Participants said that most referrals came from people with whom they have close working relationships; thus, they are more likely to informally consult on a patient:

I think this work is all about relationships. So, it’s with patients and the team, and I think one way is sometimes we can bring light to a lot of different things that the patient is experiencing from a different angle to help the team work better with the client. (Julie)

Participants described their interactions with anyone they encounter, whether it a person with cancer and their family or a colleague, as building relationships. The term relationships within this context did not necessarily mean close relationships outside the work setting, but rather relationships that offer a level of psychosocial cancer care that meets the complex needs of persons facing cancer. Participants described the intention of building relationships in oncology is to serve the best interests of the client. Despite a focus on building relationships in their
practice for emotional support in an environment prone to compassion fatigue, participants stated that working in an oncology setting left social workers and counsellors “morally burned out.”

4.3.1.2 Emotional Support: “I heard you had a tough day”

Throughout the interviews, participants mentioned the emotional fatigue they feel working with people and families faced with cancer. One source of support for these participants is their cancer care colleagues. Jesse spoke of how close working relationships with her colleagues led to unsolicited emotional support, with team members approaching her after a challenging situation and saying “I heard you had a tough day.” While this was Jesse’s experience in receiving emotional support, many participants also spoke about supporting oncologists and nurses during difficult conversations with patients and their families. However, importantly, these participants do not necessarily feel that these cancer care providers would support them in return during difficult situations in their practice:

I think that when we’re having those conversations as a team, then, yes, I do feel supported. I do feel that we are holding that together to some extent […] I don’t know that other people in the team see that so much as their role at all is to support other members of the team. I think the social work position is particularly unique in that way. (Becky)

Participants described situations where they would accompany the oncologist to speak with a family when they are giving news of a poor prognosis. Most participants described their role as supporting the family and oncologist during the conversation, sitting with the family afterwards through their feelings and thoughts, and afterwards debriefing with the oncologist and other cancer care providers who were involved in the conversation. Kara described her
experiences facilitating a three-hour family meeting, where the family’s faith conflicted with the medical opinions given by the participant’s team:

We had ten members of our team and three or four members of the family. We had a home health, an OT, we had PT, we had dietary, myself, we had the manager, the doctor, and I’m sure I’ve missed somebody there, but, but it was a large team […] So, we as a team would debrief, especially after a meeting like that. Just about what our thoughts were, how we thought the meeting went, and what the next steps are. […] It ended off on a positive and we didn’t think we were going to get it there. We debriefed just about the length…it was exhausting, about what the families concerns were, and what the next steps would be, and just about what everybody felt about the meeting and how it ended. (Kara)

This exemplifies how complex and exhausting providing psychosocial care may be in conjunction with medical decision-making, and how the team supported each other. While Kara did not specify whether she had personal working relationships with any of these team members, this experience provides an opportunity for cancer care providers involved in a case to emotionally connect and support each other. Many participants described similar experiences in their work, which then led to describing how they were more likely in the future to collaborate on patient care in a comprehensive and cohesive manner.

These two themes, building relationships and emotional support, are presented first and foremost since participants described their relationships with cancer care providers as the most significant asset in providing psychosocial cancer care. Participants described these relationships as particularly important given the challenges the cancer care system currently faces, and that these relationships are the foundation of addressing the complex system containing blurred roles and responsibilities in cancer care.
4.3.1.3 Role Clarification: “Who is doing what and why”

Within an oncology context, all eight participants spoke about bringing clarity to the social work/counsellor role in their oncology setting:

I think social work…because we don’t have [a] specific role, there’s so much that our role encompasses – we could be helping somebody with something as simple as a transportation request, or we could be helping somebody with a dying family member in the unit. So, our role…other healthcare professionals know what we do, anything that doesn’t fall under “health,” or any of those other healthcare professionals’ realm, kind of falls on social work, so then it’s up to us to kind of tease it through, and see what we could help with, and who we need to refer to. (Kara)

Many participants spoke about how patient care is impacted if the social work role is unclear:

If we did have a healthcare professional who didn’t know what the other, what their team members’ roles are, then that could be something that the patient misses out on, but because, because we had daily rounds, um, you know – we could pick things up from, from just sitting together and talking about, about all our patients, and, and laying our concerns down on the table. (Kara)

Most participants assume responsibility in carving out and clarifying the social work role to their colleagues, however, defining the role within an oncology environment with shared and often overlapping responsibilities proves challenging:

That’s the challenge I find because you have like, you know, social workers, psychologists, child life specialists, psychiatrists, special care providers, and sometimes everyone’s involved in the same family. And so, that’s the challenge is trying to, within that space, is like, deconstructing who is doing what and why. (Jesse)
Participants described two ways that they addressed role ambiguity between cancer care providers. First, participants often described acting in ways that make the social work role as transparent and clear as possible with their team members:

Be transparent with them and say, “I got this phone call, you don’t have to do anything, I just, you know wanted to keep you in the loop.” So, just trying to be transparent. (Jesse)

Second, most participants describe experiences in which there was confusion about what social work could offer to patients and families, and the participant saw the confusion as an educational opportunity that assuaged the misunderstandings of the social work role. Participants provided examples of situations where the misrepresentation of the social work role led to other health care workers promising services or support to patients that the social worker could not provide. This misrepresentation resulted in patient mistrust and anger with their cancer care team. The participants expressed frustration with their colleagues since they were often the one who had to diffuse the situation and also provide education on the parameters of the social work role for future patients. Unfortunately, although participants provide information to their team members, these situations re-occur:

Kelly: […] I think one oncologist I work with, I constantly had that conversation – I had to say, you know, “This is it. This is it. I’m not a aware of any other resources that are out there that can help this person, this is as good as it gets.”

Interviewer: What is usually the response to saying something like that?

Kelly: I get referrals for that person again, down the road.
While there was consensus regarding the social work role within an oncology setting by the participants, they were divided on which cancer care providers were also responsible for psychosocial care. All participants acknowledged that each cancer care profession, including oncology, nursing, occupational therapy, physiotherapy, psychiatry, radiation therapists, unit clerks, possess specific skills and strengths. Also, the participants described trust in their colleagues to refer patients for particular aspects of care, for example, referring to social work or counselling for people facing cancer with complex psychosocial needs. Participants differed in their beliefs of their cancer care team’s ability or desire to integrate psychosocial skills into their practices.

For participants who described psychosocial support as everyone’s responsibility, they believed that any cancer care provider who contacts the patients must have a foundation of psychosocial skills:

So we are working on it together, you know, and we are all really making tries as it. I took a swing at it, she tried to take a swing at it, and we will keep trying. I think part of the interdisciplinary work is we both have taken on the problem like it’s our problem. It’s not…he didn’t say to me “you go do that because it’s multidisciplinary so that’s your job” […] We both share the problem, but the matter is that she is a radiation oncologist and I’m a counsellor, and we are both concerned about this guy. (Derrek)

These participants do not suggest that their cancer care team take on the responsibility of psychosocial care equally, but rather be alert for the signs of distress or need for further support by a social worker or counsellor. In order to have the skills to look out for these signs, some participants suggested that there must be a level of awareness of psychosocial challenges related to the cancer experience. In contrast, some of the participants described the responsibility of
psychosocial care resting solely on social work, with medical-focused professions focused on the physical aspects of the cancer experience:

A nurse, I would much prefer for her to get her injection with precision, you know what I mean? And her needles into the right vein, to be honest with you, than I would for her being really a nice cozy person to talk to. Yes, that is important, you know to have skills that way, but their focus is medical and medication management. (Sharon)

Participants who described the psychosocial support role as separate did not frame this separation as a “bad thing” since it comes with trust from the cancer care team that they are committed to psychosocial support for the patient. These participants also mentioned that compartmentalizing the social work role avoids errors that perpetuates distress for patients:

Whether it is a physician, a nurse, a radiation therapist, whoever it is, but saying to them, “You know what, I’m not sure about that.” Or “I don’t know that, but I do know somebody that might be able to help you.” And I think that is probably one of the best things because what I would find is I was always trying to wipe up messes sometimes because some people have tried to be the expert about something they don’t know anything about. [...] You’ve got to make sure you got the information correct before you go relaying it to somebody else, otherwise, there’s such a health...precarious health situation, you go doubling the difficulty for them. Creating stress that they really don’t need at that point, and you basically said you don’t care because you didn’t take the time to really investigate what that need was that they had and give them the correct information. That’s what it says. (Sharon)

Whether or not the participants believed that psychosocial support was the responsibility of social work or the entire cancer care team, all participants identified their hope for cancer care that addresses the many facets of a person or family’s life with cancer. As stated by Jesse, cancer care providers were “[...] letting go of the ego or attitude” in hopes of working together as a team of health care providers in supporting people through their cancer journey.
4.3.1.4 Feeling Valued: “The role is valued for the most part”

Overall, participants describe their role within an oncology setting as valued by their colleagues:

I get the sense that the value of social work is very valued on this team actually, maybe more so than on others. (Becky)

When I starting working I think physicians saw, really saw the utility of what I do, and it was kind of meaningful […] (Kelly)

A challenge for participants was feeling valued yet also struggling with their observations that psychosocial cancer care is generally less valued than medical cancer treatment. Many participants described how family meetings would focus on cancer treatment, and psychosocial needs were not addressed. When participants advocated for the acknowledgement for a psychosocial presence for people and families faced with cancer, often times there was a lack of support by the cancer care team. For example, Becky described a situation where the strengths of a psychosocial presence in patient care was undervalued by her cancer care team:

There was an opinion given at the last rounds that they don’t think the social worker should be the first one calling because often people have very specific medical questions and he thinks it looks unprofessional if the social worker is just sort of stumbling over those questions and not really being to offer clear answers to them. […] It is just interesting because I think it illustrates or speaks to the fact that sometimes there is this belief that what’s offered in the oncology setting is oncology related information, and that those are patient’s primary needs, but actually patients have so many other needs going on that are not acknowledged in that belief. […] After he said that comment the room kind of fell to some silence. I think there was an understanding that maybe that was a bit of an inappropriate comment, and no one wanted to kind of question it or anything, but at the same time I think the silence did speak loudly. I think that the fact that no one said anything made it clear that [no one] really agreed with him, but at the same time those comments do come out and those beliefs are out there, and their affect patient care, and
affect how social workers I think can work...how closely they can work with other members of the team because of that. (Becky)

Some participants made the distinction between being valued for the support offered by social work, and being valued based on who you are personally:

I felt sometimes [I] was only really recognized and valued if people respected or liked me as Jesse- a person. (Jesse)

This quote by Jesse illustrates the overarching theme that it is a balance of personal and professional relationships within a team of cancer care providers that influence the quality of psychosocial support offered to those faced with cancer. From the participants’ descriptions, it seems that there is no separating the values placed on an individual as a person and as a social work professional. Participants’ attempts to clarify the role of social work must be done in conjunction with building working relationships with their cancer care provider team. In this section I presented the individual and interpersonal factors influencing team-based approaches to psychosocial cancer support. The next section will focus on mezzo, or organizational, influences on team based approaches to psychosocial cancer support.

4.3.2 Mezzo Level Factors

Mezzo level factors refer to health care hospital or agency’s infrastructure and health provider organization influences on team-based approaches in health care (Bourgeault & Mulvale, 2006). All participants spoke of their workplace infrastructure and policies, and its influence on providing psychosocial care to those faced with cancer. Participant descriptions of how mezzo level factors impact their work differed between whether the participant worked in an inpatient
or outpatient cancer care setting. There were similarities between all participant experiences, such as describing having the flexibility of building ad-hoc teams based on patient needs as facilitating their work. In addition, having organizational mandates that acknowledge the need for psychosocial care and a shared responsibility was described as facilitating the work. Where the inpatient and outpatient cancer care providers experience differed was when they were speaking of the physical space of their working environment and the availability of their colleagues.

4.3.2.1 Flexible Infrastructure and Resources: “The way it should work”

All participants described experiences where cancer care providers worked together when supporting people faced with cancer. These cancer care professions included oncologists, nurses, psychiatrists, occupational therapists, physiotherapists, pharmacists, speech pathologists, dieticians, radiation therapists, and unit clerks. Most participants described their experience between cancer care providers as on an “ad-hoc” basis, where the organization designed the cancer care system to build teams that meet the needs of individual people or families facing cancer:

[…] with the patient and family members and the care team, whoever needs to be involved, so not everybody is involved at all the, the meetings, but whoever needed to be involved would get an invite. (Kara)

And often with inpatients we will have a family meeting, a team meeting, with everybody on the team who really needs to be there and the whole family and sit down and just talk about how you are doing and where you are going. (Julie)
Participants also spoke of how this flexibility in building ad-hoc teams facilitates their work, with some stating that the flexibility allowed more time and resources for patients with complex cancer care needs instead of a system that provides the same level of care to all patients and families who access cancer care. Jesse explained the challenges of inflexible team approaches as being “like your cookie cutter approach to care sometimes, and not everyone is included who fit[s] outside of this construct of what patient and family might need.” Sometimes patients’ needs required help from more than one professional from a health discipline, and this flexibility allowed the composition of the cancer care team to reflect the person’s needs at that moment. Participants also described the team as fluid, changing as the client’s needs change through the cancer journey.

This flexibility also extended in the participants’ organization providing time and resources for team consultations and meetings. Participants working in an inpatient unit described attending daily team meetings at the beginning of their shifts, whereas participants working in an outpatient setting described seldom attending team meetings since there was limited time allocated for outpatient professions to gather for team meetings. For participants who attended daily team meetings, they described how the team meetings provided opportunities to consult on patients with complex cancer care needs.

Participants working in outpatient settings also acknowledged the value and need for team meetings provided by their cancer organization. For example, Julie described her challenges with limited time and resources for team meetings, and how team meeting could facilitate offering psychosocial cancer care:

I think that being able to setup the systems so that we can meet every new patient, which right now is not feasible, with the number of patients who come in, that would really help.
Be able to create that initial relationship, and this “hi, this is who I am, this is kind of what I do,” I think that would help the barriers to care, and I think that would also help the team work better, and to build to sit down with the team, and I’m talking about the team in the example of supporting [cancer], so like, sit down with the team and figure out what’s going on with the patient – that would be helpful. (Julie)

Most participants also spoke of how allocated time and resources for team meetings facilitated informal team-building initiatives that support an emotionally taxing work environment. For example, Jesse spoke of how her colleagues at her inpatient ward participated in a daily team meeting, and this had led to building relationships with her colleagues throughout the years. By establishing these relationships, her team created self-care practices in hopes of preserving health and wellness for all staff working in her oncology setting:

When someone passes away that day we have “tea at three.” And, and then often lots of people come, from like many different roles, and it’s not facilitated, it’s just kind of like… This nurse brings tea and people might not want to talk about it ‘cause you can’t really be present to your experience because you have to jump into patients in 10 minutes, but people physically want to be together. (Jesse)

Jesse’s description illustrates the impact of having opportunities to build relationships, personally and professionally, with her colleagues. Many other participants also described their experiences similarly, with formal organizational processes providing time and resources for relationship building that created supported environments that are much needed when working in an oncology setting.

4.3.2.2 Space, Availability, and Medical Dominance: “Well, it doesn’t always work.”

Participants working in an inpatient setting described how organizational decision-making facilitates psychosocial support within an oncology setting through dedicated time and resources
for formal team meetings. In contrast, participants working in an outpatient setting described
the barriers created by organization infrastructures and decisions. A barrier identified by all
participants working in an outpatient setting is the physical layout of the oncology setting that
physically separates each cancer care department and services:

I don’t, in the outpatient clinic, get as much face to face unfortunately with the
doctors and nurses unless we’re called down on intake. However, on the inpatient unit we
work… I work very closely with the entire team to support the patient. (Julie)

For the five participants who work in an outpatient setting, they described the barriers in
accessing cancer care providers since offices are arranged by profession and access is not
permitted to other professions’ offices. One barrier identified by all five participants working in
an outpatient setting was the lack of opportunity in building relationships with their colleagues:

[...] I get referrals from the docs that I’ve worked with closest, and so proximity really just
as familiarity with people sort of work, just does increase the likelihood of being referred
to. (Kelly)

I think the nature of this space…of this building is also set up. It is very divided between
the different areas of work, and so unless your working on a specific crisis with a patient,
with another care provider its hard to really get to know people in the building. (Julie)

Julie then went on to describe preferring face to face communication because it allows for
gathering information for a better understanding of the person’s context:

I think being able to understand more in-depth what is happening with treatment would
be helpful in the therapeutic relationship with the client. We can read the note and get a
sense of understanding and talk over the phone with an oncologist if we need clarification,
but that face to face you can sometimes get more in-depth…the full understanding of
what’s going on. (Julie)
Limited access to allied cancer care providers also has direct implications on crisis situations that require immediate action by the cancer care team. For example, Jesse described a situation where she was left on her own with a person who with suicidal ideation and the implications of having separated and unavailable cancer care providers by virtue of the constrained cancer care system:

I had a patient once who, you know tried to commit suicide, and there’s no one around, and there, I’m the only psychosocial resource, there really wasn’t psychologists, if I could find the psychiatrist she wasn’t returning my pages, I couldn’t, the psychologist wasn’t returning my call, the nurses didn’t know what to do, and I’m on deck. It…and I think that was very challenging for sure, like couldn’t find the staff and I think, in the adults [cancer care] there’s so many patients. […] I, did a suicide risk assessment, I ended up just staying with the patient for a really long time, and then finally the psychiatrist came, like hours later to assist, […] but it was really up to me because the nurses were freaking out, and no one was responding to my pages […] I think it’s a much more isolating, providing psychosocial care in the adult world, you’re on your own […] (Jesse)

Jesse’s experience illustrates the barriers in providing psychosocial care when the infrastructure of the cancer system is not conducive to smooth and timely communication between cancer care providers involved in a person’s cancer care. Fortunately, this particular person facing cancer eventually received the support from his cancer care team, but the lack of formal processes and resources for people with suicidal ideation speaks to the potentially imminent consequences when emotional, social, and psychological is not valued by a cancer organization. Jesse stated that this example represents the climate when she worked in adult oncology, and one of the reasons she chose to leave her workplace.

Jesse’s story and similar stories by other participants also identified the emphasis on medical aspects of cancer care as a barrier to offering psychosocial support. Participants described that this medical dominance often results in oncologists or nurses, who focus on the
medical aspects of cancer care, may assume a gatekeeper role where they make decisions on whether or not someone requires psychosocial care:

I’ve had the example of a doctor feeling like the patient is well supported and doesn’t really need...one example on an inpatient unit doesn’t need that extra support. And then at the end of day the patient does request support and needs me. So that kind of power thing. (Julie)

Participants who work in an outpatient setting often described frustration with their dependence on medical focused cancer care providers for psychosocial care referrals. Within the context of a work setting where there are minimal opportunities to build personal or working relationships with colleagues, participants questioned whether patients were being referred because of their need or based on the cancer care provider who puts in the referrals understanding, or lack of understanding, of the psychosocial needs or role of social work:

There isn’t a lot of awareness of the unique considerations of each of those populations. I mean, some of the people on my team are pretty aware of some of those issues and some of the barriers that certain people might face, and other people on my team are not. So their just not offering specialized care in that way, and I think sometimes that’s where my role really does come in...is to, how do we offer really more informed care that it is taking into consideration any special factors in people’s lives or identity issues, or things that impact service. (Becky)

While Becky and the other participants described what features of their cancer organization facilitate or detract from offering psychosocial care, they also recognized that their organization represents the larger health care system and political system. Often, participants would describe their experience by disclaiming it is the “nature of the system.” Participant experiences providing psychosocial support within an oncology setting must also investigate the macro influences at a political and educational system level.
4.3.3 Macro Level Factors

Many of the challenges participants faced at a micro and mezzo level when offering psychosocial cancer care were usually coupled with identifying macro level influences. These macro level factors were described as trickling down into how cancer care is offered by the cancer organization and cancer care providers. The two macro level factors that were identified by most participants through their stories were: 1) medical dominance leading to physician power; and, 2) constrained cancer care system funding leading to constrained time for adequate cancer care. Each of these macro level factors will be described in detail.

4.3.3.1 Physician Power: “You put them on a pedestal”

It was apparent through the participant descriptions that there was a divide between oncologists and the “other” cancer care providers. Often times, participants would describe their experience with a physician by using the word “we” for the team, and then separate out the oncologist, for example:

We started off with the doctors first because they had so many patients to see, so we wanted them...come in, provide the information, answer any questions and leave. And then we as a team would sit together and talk about whatever was next. (Kara)

One explanation as described by some of the participants for this separation of the oncologists from the rest of cancer care providers is that health care funding and policies place oncologists “on a pedestal.” Specifically, participants described how entering the cancer system “forces a conversation with medicine” by creating and funding a cancer system that focuses solely on the medical treatment of cancer. Health systems create a standard where oncologists
have legal responsibility for people’s cancer treatment and results in over-valuing the physical aspects of cancer while simultaneously de-valuing the psychological, emotional, and social aspects of cancer:

[…], psychosocial concerns occupy the minds and hearts of patients and families [and] in the adult system are invalidated I think by virtue of the system, and so many patients by the docs being very medically ensconced […] [Oncologists] wouldn’t ask or care if I was providing counselling to someone, it was just “oh yeah, that’s not necessary, that’s all in the context – we meet the medical needs” and it wasn’t cause they didn’t value that per se, it’s just not valued by the system and it’s the system kind of being jam packed with patients. (Jesse)

Participants acknowledged that the value placed on psychosocial needs varied between oncologists, but that the larger political and health care system played a significant role in creating this social construction of medical dominance. Participants reflected on the interplay of legal responsibility for medical cancer treatments, increasing workloads, and the increasing health complexity for people has stretched oncologists’ capacity for meaningful contributions to comprehensive cancer care:

I look at the oncologist and they are all, tell me about it, they got more and more patients and their numbers are not increasing, and there are more complicated treatments and more complicated situations, more pressure on them, so, they don’t have time to deal with stuff. And when they don’t have time it is harder to connect. (Derrek)

As a consequence, participants often described their interactions with oncologists as challenging, usually adapting to the oncologists’ schedules, not having close personal or working relationships, and oncologist leaving quickly after giving news of a poor prognosis resulting in the social worker or counsellor sitting with the person or family afterwards. Most interactions between cancer care providers and people with cancer was described as the social worker or
counsellor initiating and organizing a team meeting, with the physician walking in, taking up most of the space within the meeting, and leaving the meeting before patients and families feel they have the information they need. The participants’ descriptions of their experience illustrate the value of psychosocial cancer care workers, but how the medical dominated oncology context undervalues their work and the psychosocial needs of those who face cancer.

4.3.3.2 Time and Resources: “Do more with less”

Time constraints are not unique to oncologists. Many of the participants spoke of their own time constraints due to the increasing workload without corresponding funding increases for staff and resources. All but one participant identified time constraints and heavy workloads as a barrier to offering psychosocial care using a team based approach. Participants described these time constraints as stemming from political and economic influences on government level decision making for health care:

Economics plays a huge part in the individual’s life, as well as in the organization’s life, right? And, over top of that you’ve got your government, right? So, when you put that into place and it’s the “do more with less.” That’s the philosophy in government. That’s the philosophy, of course then would be in our health care organization. When you do that, you have to prioritize. And the things your may want to do may take a lot longer to accomplish because of that. Does that mean that you don’t know about them? No. Does that mean that you don’t value them? No. But it certainly means that you have to keep a balance within what you’re able to do and the expectations of what you are able to do. (Sharon)

Challenges identified by most participants in a resource limited oncology setting included limited time available for working with their colleagues on in-depth case consultation and communication:
The more time limited, the less likely you’re going to be able to consult with your peers. Because, you know, the time’s got to come from somewhere. (Kelly)

So there was two of us, with a crazy amount of patients, yeah, I sort of just felt like the social workers were just sort of like going rogue a bit. We had all these patients that no one really knew. I mean we had social worker practice leaders and stuff, but [the] medical team didn’t really know what you were doing, no one read your chart notes, the patients really respected and valued you for sure, but, you could just do whatever you thought was best, there was no expectation from the team. (Jesse)

Furthermore, Sharon described how addressing this system issue becomes lost within a working environment that is high demand with a lack of resources:

You’re just so busy at the individual level…with individuals and families that it’s really hard to keep that social work systems piece. And I think that’s it. And I think that’s what happens when you get so busy with the work, you forget about that piece. (Sharon)

Limited time and resources was a theme that was often spoken of in conjunction with many other challenges at the micro and mezzo level that detract from offering psychosocial support using team-based approaches. Participants acknowledged the value and importance of working together with cancer care providers, but that also noted that system pressures strongly influence the priorities of cancer care providers. Unfortunately, participants described team-based approaches as secondary to maintaining basic level of cancer care to the many people accessing support daily. When I would probe participants further about the priorities of cancer care, they would describe situations where in times of pressure and limited time, offering care as separate cancer care providers was the default, with team based approaches becoming lost in the process. Participants provided one reason for this priority sequence, stating that it is often not within knowledge base or education to frame their work as working as a team in providing psychosocial support. For example, Jesse described her experience working with nurses who
continue referring to oncology social workers for situations that do not fall within an epistemological nursing framework, and do not necessarily fall within the scope of social work practice:

I think social work’s a bit better at creatively problem solving how to manage situations, whereas, sometimes some more nurses, they’re very busy, they’re like, “construction, construction, construction.” And then situations evolve from that construct…it’s very hard for them in a fast paced environment to figure out what to do. So they just page [social work]. And so I think I try to contextualize, be really respectful, and help them maybe understand why it isn’t a page-able issue. (Jesse)

The participant descriptions provide a glance at how working together in providing psychosocial care does or does not work in the British Columbia cancer care system. It is the interplay of interpersonal relationships, cancer organization or hospital influences, and political and economic pressures on the cancer care system that contribute to the success and failings of team based approaches in providing cancer care that addresses wellness in a holistic fashion. Generally, participants valued and acknowledged the strength of team-based approaches in cancer care, and practice using this approach. Unfortunately, system forces impact cancer care at the organizational and cancer care provider level, creating barriers through limited time and resources for team activities such as face-to-face consultations and team meetings. Overall, cancer care providers value psychosocial cancer care, but the system creates a tiered system of care where this type of cancer care takes a seat to a medical dominant oncology culture.

4.3.4 Summary of Themes

Table 2 summarizes the micro, mezzo, and macro facilitators and barriers for offering psychosocial cancer support using a team-based approach. All participants spoke of the
importance of building relationships within the oncology setting, and how these relationships supported them during emotionally charged situations. These relationships are also advantageous in an oncology setting that faces multiple barriers to psychosocial cancer care using team-based approaches. Participants identified these barriers as mezzo and macro level factors, including constrained time and resources, limited availability of other cancer care providers, medical dominance and physician power, and being physically located away from other cancer care professions such as nursing and medical oncology. Despite these barriers, participants described how their relationships within a team or with individual cancer care providers allowed them to offer integrated cancer care within this context of multiple barriers.
<table>
<thead>
<tr>
<th>Micro</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building personal and working relationships with colleagues</td>
</tr>
<tr>
<td>Providing emotional support to colleagues</td>
</tr>
<tr>
<td>Clarifying roles of cancer care professions</td>
</tr>
<tr>
<td>Feeling valued as a profession and person</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mezzo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure and resource flexibility</td>
</tr>
<tr>
<td>Limited space and worker availability</td>
</tr>
<tr>
<td>Medical dominance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Macro</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician power</td>
</tr>
<tr>
<td>Political and economic constraints</td>
</tr>
</tbody>
</table>
Chapter 5: Discussion

The study objective was to increase understanding on how the health care system can better support team-based approaches in providing psychosocial cancer care for families faced with cancer. My research questions were: 1) how do social workers/counsellors describe their experiences with other cancer care providers when offering psychosocial cancer care in a team-based setting?; and 2) what are the facilitators and barriers they have experienced in providing psychosocial support in a team-based setting? Participants’ descriptions fit within the ecological systems perspective, with their experiences highlighting micro, mezzo, and macro level influences on offering psychosocial cancer care within a team-based approach. While the participants’ descriptions of working in an oncology setting did not reveal anything surprising since it was consistent with the literature on facilitators and barriers to team-based approaches in health care, the findings emphasized the need for authentic working relationships between social workers/counsellors, and other cancer care providers who are all providing support to people and families faced with cancer.

This study provided preliminary understanding on the value of relationships for social workers and counsellors when offering psychosocial support in an environment with multiple mezzo and macro level barriers to team-based approaches to cancer care. At a micro level, a team-based approach to psychosocial cancer care is limited without recognizing the importance of personal relationships with colleagues since it is a vital when engaging in emotional conversations with people and families faced with cancer. The well-being of cancer care providers also depends on support from their colleagues so they can continue working in a high-paced and emotionally fatiguing oncology setting. Without this emotional support within a team of cancer care providers, providing psychosocial support in the cancer system may prove
challenging. Specifically, lack of support for the social worker or counsellor may result in compassion fatigue that impacts the social worker/counsellors ability to provide support for people with emotional, psychological, social, and spiritual needs related to their cancer experience.

The mezzo factors, which both facilitated and detracted social workers and counsellors from providing psychosocial care related to relationship building were: infrastructure and resource flexibility, limited space and worker availability, and medical dominance. At a mezzo level, we cannot ignore the role of the work place in facilitating or hindering relationship building amongst cancer care providers. A theme that emerged from this study was the influence of work place design in inpatient and outpatient settings on team-based approaches to psychosocial cancer care. This distinction has previously not been discussed in the literature on team-based approaches for psychosocial support or cancer care. The participants working in an outpatient setting described being physically away from their cancer provider colleagues acted as a barrier in offering psychosocial support using a team-based approach. As a result of these physical space barriers that limit informal opportunities for relationship building, social workers or counsellors are potentially not receiving referrals from their cancer care colleagues because they described that referrals are reliant on whether or not they have meaningful working relationships with their colleagues. In this context, relationships do matter when offering psychosocial cancer care since institution protocols are insufficient in addressing access inequities for psychosocial support.

In contrast, participants working in an inpatient unit described physically close working quarters with cancer care providers was conducive to relationship building so the team could consult cases frequently and provide care with consideration of the person’s physical and
psychosocial needs. In addition, participants also described dedicated time for case consultations set by their cancer organization or hospital as a facilitating psychosocial cancer care. This theme was consistent with previous literature that identified time for team meetings as an opportunity for case collaboration (Beales et al., 2011), which may bring clarity on the roles and responsibilities of each team member (Brown et al., 2011).

The macro factors that both facilitated and detracted social workers and counsellors from providing psychosocial care related to relationship building were: physician power and limited time and resources. A theme touched upon by some of participants was the dominance of physicians in cancer care that creates challenges in working as a team to offer psychosocial cancer care. Lingard and colleagues (2012) suggest that addressing this dominance and acknowledging that a hierarchy exists between health care professions may transition the health care system from working separately to a collaborative approach to care. For this study, physician power impacted psychosocial cancer care as they assumed a gatekeeper role where they were in a position to decide whether or not a patient would be referred to a social worker or counsellor for emotional support. Often this gatekeeping resulted in tension between social workers/counsellors and physicians and this carried into future case consultations with poor communication and collaboration.

Physician power is perpetuated by the policies enacted by federal and provincial health care systems. Participants did not speak specifically about the policies related to physicians, such as the fee-for-service physician payment system, but they acknowledged that physician power is created from systemic issues in the health care system. Participant descriptions of the consequences of health care policies that facilitate physician power are consistent with previous literature that fee-for-service policies do not promote team-based approaches to offering care.
(e.g. Beales et al., 2011; Virani, 2012). Specifically, fee-for-service policies produce limited time and resources for physicians that create a hierarchy for care that prioritizes the medical aspects of cancer care (Rennie & MacKenzie, 2010).

Limited time and resources is an issue for all health care professions that results in prioritizing “essential” services, such as medical care, and undervaluing supportive health care. This hierarchy of care detracts from offering psychosocial cancer care, and social workers/counsellors must advocate for system change within British Columbia cancer care. One advocacy strategy is utilizing relationships with colleagues in solidarity for social and system change in cancer care. Participants described situations where their cancer care team stood together for change within their work setting and exemplifies how strong working relationships can facilitate system and work setting reform.

Some participants also identified varying knowledge bases as an explanation for systemic barriers to providing psychosocial cancer care. My intent was to further explore this theme in my interviews; however, I was unable to recruit more participants. This theme requires further investigation into how epistemological influences, both personally and as a health professional body, impacts a team’s ability to offer cancer care in a holistic fashion. There is extensive literature around this topic, suggesting that this way of thinking begins at university and extends into the working world that reinforces the belief that team-based approaches to care is optional (e.g. Reeves, 2010). Consequently, the broader systemic beliefs around psychosocial care and team-based approaches underutilize team-based approaches and undervalue the psychosocial aspects that accompany cancer.

When participants spoke of the factors that impact their ability to offer psychosocial cancer care within a team-based approach, most stories came back to the overarching theme of
this study—that is, having personal or close working relationship with their colleagues. Regardless if the participant was facing barriers by the larger system, the cancer organization or hospital, or by their colleagues, they found comfort and solidarity in addressing these barriers if they had close or personal relationships with their colleagues. None of the participants stated that this closeness means personal relationships outside the workplace, but rather feeling that at least within their work setting that people had a genuine care and concern for their well-being.

5.1 Study and Social Work Contribution

Currently, there is limited research that looks specifically at team-based approaches within psychosocial cancer care. Cancer care warrants examination in this area since this illness impacts many facets of a person and their family. Psychosocial support is imperative in reducing feelings of distress, anxiety, and depression that may accompany the cancer journey (CAPO, 2010). This study provides a preliminary examination into how social workers and counsellors work together with other cancer care providers in offering psychosocial support, and what factors facilitate or detract from offering this support. The participants’ experiences mirror the challenges identified in psychosocial oncology in Canada and team-based approaches. By examining psychosocial oncology and team-based approaches together within a British Columbia context, it provides new knowledge in this area, specifically highlighting the need for authentic and close relationships with colleagues especially in times of high and demanding workloads within an emotionally fatiguing work environment such as oncology.

The first principle outlined on the British Columbia College of Social Workers Standards of Practice (2009) is the social work relationship with clients. This principle advocates for mutual decision-making, communicating for clarification, respect, acceptance of self-
determination, and reflexivity (British Columbia College of Social Workers, 2009). Social workers may also apply this principle to their relationships with colleagues in providing health care. In my social work education I learned that my ability to build rapport and connect with clients is fundamental to any social work context in my career. Social work advocates for social justice and honouring the worth of people and society, and my hope is that the findings of this study will challenge people to honour not only the clients we work for but also the people around them that also made a commitment to social justice and change. Social work in health care is associated with high stress levels and compassion fatigue (Lloyd, King, Chenoweth, 2002; Potter et al., 2010), and receiving emotional support in the workplace allows for social workers to continue offering psychosocial support within emotionally taxing and high demand work environment while preserving their own wellness.

Recently, I was hired at a health care setting with the objective of developing and implementing strategies that will create more communication and collaboration between the health care departments. After completing this study, I realized the word that was missing out of this objective was the word “relationship.” Conducting this study has direct implication for my own social work practice, where it made me acknowledge and address the micro, mezzo, and macro influences contributing to a fragmented health care system, but also the need for everyone at the agency to build relationships with each other. Only once we have worked on relationship building can we together address the many challenges that detract from offering health care to those who face an illness.
5.2 Strengths and Limitations

A strength of this study is the use of a qualitative research methodology in examining a relatively understudied and complex phenomenon in cancer care. Qualitative research methodology allowed for in-depth data collection and detailed accounts of social worker and counsellors experiences when offering psychosocial cancer care using a team-based approached. These specific experiences within a British Columbia cancer care context would be difficult to collect using a quantitative research methodology.

Another strength of this study is interviewing participants from both inpatient and outpatient cancer care delivery systems. Participants from both delivery models represents the two models of care that is offered to people faced with cancer, and provides context into how these two settings may facilitate or detract from offering psychosocial cancer care. Initially, I recruited from only outpatient cancer settings, and then opened my recruitment strategy to people working in an inpatient setting since the initial participants, who worked in an outpatient setting, described differences in psychosocial care for people who are admitted into hospitals and those who are receiving outpatient care. Interviewing participants from both work settings provided a better understanding of workplace environment aspects that facilitate or detract from team-based approaches to psychosocial cancer care. The heterogeneity of the participants in regards to number of years working in oncology, age, professional background, and work status in an oncology setting provides variability that may have hindered my ability to identified similarities between participants. In reality, I found that from this diverse pool of participants I could derive a thematic story by through the richness of the data.

The purpose of qualitative research is not generalizability to the whole population yet this limitation warrants further explanation. For this study, a generic qualitative research
methodology presents an in-depth description of an experience or event for a participant, and thus, these experiences as a whole cannot be applied to all social workers and counsellors within an oncology setting. However, team-based approaches are common in health care settings, and my research findings acknowledges that the health care system can utilize collaborative care that addresses the psychosocial spiritual needs for people faced with cancer.

Some themes in this study warranted further interviews for data saturation but my recruitment efforts did not yield further interest. How a researcher reaches data saturation is ill-defined in the qualitative research literature although Guest, Bunce, and Derrekson (2006) suggest that it is “reliant on the researchers qualities and has no boundaries” (p. 77), in other words, examining the data itself is not enough to determine saturation, but requires the examination of how the researcher uses the data. This research data warrants further interviews that could shed light on emerging themes, particularly in the areas of diversity considerations and epistemological differences among health care professions and team-based approaches. These two themes were of particular interest to me, unfortunately the recruitment limitations did not allow for further explorations of these themes or for data saturation.

I originally proposed that I would conduct member checking by engaging two of the study participants who would provide feedback on data analysis biases and logic flaws. Engaging in member checking may increase the credibility and plausibility of the study findings (Guba, 1981). All participants were asked if they were interested in reviewing the findings of this study, and all participants declined further involvement in the study. In response to the lack of participant involvement during the data analysis, I worked closely with my supervisor during the analysis process. Although my supervisor provided feedback on the analysis, it does not replace
the value of feedback from social worker or counsellors who experience working directly with people faced with cancer, and therefore presents as a limitation to this study.

5.3 Potential Application of Study Findings & Future Research Directions

My study provides preliminary knowledge for a relatively new field of research and practice. Exploring team-based approaches in offering supportive services is understudied, and this study provides some clarity in this knowledge gap. Future research may extend on this study by exploring the *how* question- How do we build relationships with our colleagues? How do these relationships extend into our social work practice? How do we work within team-based approaches that strengthen our ability to offer psychosocial care? This study acknowledges the need for strong relationships within team-based approaches, but it does not provide a practical process of moving from theory to practice.

One suggestion for addressing the *how* question is developing theoretical frameworks for team-based within a psychosocial oncology context, and translating this theory into practice that promotes holistic cancer care addressing the needs of mind, body, and soul. The development of team-based, or *interprofessional*, theoretical frameworks are usually within universities that offer undergraduate or graduate level degrees for health-related professions. For example, the University of British Columbia College of Health Disciplines developed an interprofessional theoretical framework that facilitates “understanding and developing interprofessional educational experiences reflective of the distinct needs of students and practitioners at various points in their pre-licensure education and early post licensure professional careers” (Charles et al., 2010, p. 13). An adaptation of these frameworks could lend themselves to a cancer care
context, and this study may provide some context on the current state of offering psychosocial support to those faced with cancer.

Another possibility for exploration is studying the types of team-based approaches as outline by Boon and colleagues (2004), and how these different types of team-based approaches are used in the cancer care system. Specifically, future research could examine what aspects of psychosocial cancer care are and are not offered on the continuum of team-based approaches (Boon et al., 2004). For example, how are meetings between families faced with cancer and their cancer care team similar or different between a consultative and interdisciplinary team-based approach to cancer care? What are the health implications for families faced with cancer that are receiving different types of meetings with the cancer care team based on team-based approaches adopted by their cancer institution? Researchers could examine these questions from the perspective of the cancer care system users, or the cancer care providers such as oncologists, nurses, and social workers. This study did not attempt to answer such questions, but highlights the need for additional research in this area of cancer care practice and research.

5.4 Policy Recommendations

The participants’ experiences highlighted a need to revisit policies within the cancer care system, particularly in the area of psychosocial cancer care. At the cancer care hospital or agency level, the psychosocial care referral system must be reevaluated. This study highlights the current challenges with referral-based systems for psychosocial oncology care, with challenges in offering psychosocial support stemming from the dependence on other cancer care providers for referrals created by a referral system. It seems that the number of referrals depends on factors such as the limited time and resources, psychosocial oncology knowledge by cancer care providers, and team-based approaches for cancer care. Unfortunately, because of these factors it is unclear whether or
not people who are facing cancer with psychosocial concerns are being referred to social workers or counsellors for support.

I recommend reforming the psychosocial referral policies at cancer agencies and hospitals so that social workers or counsellors meet with people and families during their first visit so they can introduce psychosocial support into the cancer care plan. With social workers embedded into the intake procedure for people entering the cancer care system all people and families faced with cancer are then informed of the support they may access. Also, having a team at the initial appointments for a person or family includes and addresses all of these facets of cancer and how it impacts wellness and quality of life.

Reforming psychosocial referrals policies in this way would prove challenging since the health care systems works with less funding and resources, and it is unlikely in this political and economic climate that the cancer care systems could hire enough social workers or counsellors for this approach to succeed. Policy and funding reform at a provincial government level would consist of increased funding for creating an infrastructure for team-based approaches. This infrastructure would hire more social workers and counsellors so all patients have an opportunity to meet with a social worker or counsellor during the intake to a cancer care hospital or agency, and can continue accessing support by this cancer care provider if requested. Referral policy reform at the organizational level will succeed only with provincial and federal level support where cancer care system decisions are heavily influenced.

5.5 Conclusion

As I reach the conclusion of this study, I sit here with emails from two of my social work peers with a quotation by cultural anthropologist Margaret Mead, “Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that
ever has.” This quote came to me in a pertinent and timely way as I end my Master of Social Work journey. We not only have to work with our clients or patients in achieving personal and community health and wellness, but also work with our fellow colleagues who one of the participants called the “walking wounded.” This is particularly true when supporting people and families through emotionally vulnerable experiences such as cancer. As social workers in oncology we are not exempt from the emotions that come alongside witnessing death and dying on a daily basis. There is strength in cancer care providers coming together in supporting people and families faced with cancer care, however, this support is often inconsistent and dependent on the relationships within a team of cancer care providers.

Team-based approaches is one way model of cancer care that provides support for the physical, emotional, psychological, social, and spiritual needs that accompany the cancer journey. This study sheds light on the strengths of using team-based approaches and also the challenges stemming from interpersonal to larger system influences. I wish for the day when this world is free of cancer, but until that day more research must examine how the cancer care system, and the workers within this system, support people faced with cancer in an integrated and holistic fashion.
References


doi:10.1016/j.ejca.2007.01.025
Appendices

Appendix A  Recruitment Email

THE UNIVERSITY OF BRITISH COLUMBIA

Psychosocial Care In an Oncology Setting
RESEARCH STUDY

About the study
This is a master’s research study entitled, “Social Workers/Counsellors Experiences with Other Health Care Professionals When Offering Psychosocial Cancer Care."

You are invited to participate in an approximately 60 minute interview where you will be asked questions about your experiences working with other health care professionals when offering supportive care. This interview will take place in-person at a place and time of your choice.

Eligibility Criteria
- Social worker or counsellor with one year work experience in an oncology setting;
- Work role includes providing supportive services such as psychological, emotional, spiritual, or practical support or resources.

If you are interested in participating or would like to find about more about this study please contact Joanne Magtoto at:
Email:
Phone:
Appendix B  Study Interview Questions

Research Questions
How do social workers/counsellors describe their experiences with other cancer care providers when offering psychosocial cancer care?
What constituents of their experience facilitate or detract from providing psychosocial support?

1. Could you describe your role as a social worker/counsellor in your work setting?
   PROMPT: How long have you been in this role?

2. How are the psychosocial needs of people faced with cancer addressed in your work setting?
   PROMPT: Given the diversity in B.C. in terms of race, gender, income level, and sexual preference, is this true or not true for all patients?
   PROMPT: Any considerations for underserved (i.e. vulnerable) populations at your work setting?

3. What are your experiences like working with other cancer care professionals in offering psychosocial care?
   PROMPT: What names do you use to describe the team? How do you define it?
   PROMPT: What is your role within a team of various health care professions?

4. What would you say is the role of other health care professions besides social work/counselling in supporting the psychosocial needs of patients and families?
   PROBE: How would you define it?
   PROBE: What words come to mind? What images?

5. Please describe a situation in which you worked with other cancer care professionals at your work setting in providing psychosocial support to a patient or a family that you would consider having barriers to accessing services. If possible, choose an experience that happened recently. Be as specific and detailed as possible.
   PROBE: Can you tell me more about the accident? Exactly what happened?
   PROBE: What were your thoughts/feelings/images/sensations/memories in this situation?

6. Is there anything else about your experience working with varying cancer care professionals that would help me understand what you experience and how you experience offering supportive services to people faced with cancer?