4. Health Management and Organisation
Refereed Delivered

How emotion promotes multidisciplinary healthcare: An examination of palliative care

Mr Michael Hodgins

School of Business, Western Sydney University, Parramatta, Australia

Email: M.Hodgins@student.westernsydney.edu.au

Dr Ann Dadich

School of Business, Western Sydney University, Parramatta, Australia

Email: A.Dadich@student.westernsydney.edu.au

Dr Jayne Bye

School of Business, Western Sydney University, Parramatta, Australia

Email: J.Bye@westernsydney.edu.au

How emotion promotes multidisciplinary healthcare: An examination of palliative care

ABSTRACT: *Evidence suggests healthcare requires multidisciplinary practices. Yet multidisciplinary practices are often hampered by disciplinary divisions. This is particularly in palliative care, where curing is often juxtaposed against caring. Although research verifies the role of emotion in health(care), this largely considers the emotional sequelae experienced by clinicians, patients, and carers. There is limited recognition of the role of emotion in multidisciplinary practices. This article presents findings from an eight-month ethnography within a community health centre that offered palliative care to patients at home. Findings suggest that emotion can promote multidisciplinary palliative care by: justifying practices; storying and collectivising experiences; and shaping professional identities. These findings have important implications for researchers and clinicians, all of which are discussed.*

Keywords: Community healthcare; healthcare professions; knowledge translation; managing integrated health services; practice, climate, culture, environment; professional identities

Multidisciplinary practice represents a cornerstone of modern healthcare. It might be understood as a group of health professionals from different disciplines who share responsibility for collaborative decision-making and the outcomes of patient-focused care (Liedtka, Whitten, & Sorrells-Jones, 1998). Although sometimes confused with more advanced forms of teamwork, like inter- and transdisciplinary healthcare, multidisciplinary healthcare is that in which clinicians with different knowledge collaborate, rather than combine or converge (Gatchel, McGeary, McGeary, Lippe, & Anderson, 2014). As such, it is likely to typify the types of healthcare found in many Western nations, like Australia and New Zealand.

Multidisciplinary practice has become a prominent feature in many health systems (Lown & Manning, 2010). This follows a more thorough understanding of complex health issues and multimorbidities, and an increasing recognition that addressing these requires complementary skills, knowledge, and perspectives (McCallin & Bamford, 2007). This is supported by evidence suggesting that integrated healthcare is associated with: improved patient wellbeing, reduced hospitalisation, decreased mortality rates, better staff morale, as well as reduced staff burnout and attrition (Safran, Miller, & Beckman, 2006).

Although relevant to all domains of healthcare, multidisciplinary practice is particularly germane to palliative care (Hill, 1998). This is largely because this speciality reflects a biopsychosocial model of care, recognising a dynamic interaction between that which is physiological, psychological, social, and spiritual (Ansari & Rassouli, 2018). Furthermore, end-of-life care can be emotionally-charged, particularly when cultural taboos hinder what patients and carers can discuss, when and how they can discuss it, and with who.

Despite the benefits associated with multidisciplinary palliative care (Forrest & Barclay, 2007; Jongen et al., 2011), it is difficult to enact and demonstrate. It can be hindered by: insufficient resources, including time, workforce capacity, and funds; poor administrative processes; as well as ineffective interdisciplinary communication, particularly when there is friction between and among disciplines within a team (Ratcheva, 2009). Friction can be demonstrated by: limited recognition of the different roles and areas of expertise of each discipline; hierarchies that serve to maintain power imbalances; and disparate discourses that stymie communication (Walsh et al., 2010). Furthermore, friction can be inflamed by emotionally-charged contexts, like palliative care.

Emotion is inherently interwoven into clinical care, notably community-based palliative care. In addition to the patients and carers who receive palliative and bereavement care, clinicians can also experience varied emotional states (Weissman, 2009). However, the role of emotion in multidisciplinary healthcare has received limited scholarly attention. For instance, following an ethnography, McCallin and Bamford (2007) found team members required emotional intelligence to work effectively with colleagues, patients, and families to integrate disparate views. Similarly, in their study of relationship-centred theory and its relationship with clinician interactions, Safran and colleagues (2006) noted the importance of emotional intelligence in multidisciplinary practice as enacted by mindfulness – that is, organisational and employee awareness of self and others. And during weekly interdisciplinary conferences in a palliative outpatient ward, which followed clinical supervision, Nordentoft (2008) described how emotion work involved care for both patients and fellow clinicians.

Here, emotions are understood as embedded in social and cultural contexts, mediated by language, bodily performance, politics and culture. This recognises the socially-embedded nature of feeling and experience; it also acknowledges that these 'sensate, coporeal' (Burkitt, 1997, p. 43) and experiences are localised in the body and relationships between bodies (Pile, 2010). Research on palliative care clinicians' emotions is primarily concerned with: negotiating social interaction; giving voice to dying patients (Li & Arber, 2006); and the emotional strain associated with moral distress

(Brazil, Kassalainen, Ploeg, & Marshall, 2010; Weissman, 2009), particularly when treatment ceases (Harrington & Smith, 2008). Liaising with a referring physician and conferring with a consulting physician can be ‘an emotional mine-field’ (Weissman, 2009, p. 865) – this is largely due to conflict about: the withdrawal of potentially life-prolonging treatment; as well as symptom management and pain control. Yet the tension between palliative care and other specialities that aim to cure, is poorly understood (Hillman & Chen, 2009). This article therefore examines the relationship between emotion and multidisciplinary palliative care. More specifically, it considers how emotions serve to align professions with other professions to produce collectives.

METHOD

Following the approval of the relevant Human Research Ethics Committees, an eight-month ethnography was conducted within a community health centre that offered palliative care to patients at home. Twelve community health nurses participated on a rotating basis, with different nurses shadowed at different times (Czarniawska, 2014; Gill, Barbour, & Marleah, 2014). They were shadowed while delivering palliative care to patients and carers, and attending to related duties, such as: documenting clinical notes; organising equipment; liaising with general practitioners and carers; and conferring with fellow community health nurses, formally and informally. Participants included: specialist palliative care nurses and generalist community health nurses who delivered palliative care. Although these clinicians were the group that was shadowed, other clinicians were observed incidentally, while they interacted with core participants. Given the community-based context of this study, where palliative care was delivered in patient homes, patients and carers were also observed, incidentally. In addition to patient homes, clinicians were shadowed while: on commute to and from home visits; at the centre at which they worked; and within the affiliated local hospital, which they frequented irregularly, for meetings or to collect or return equipment. A thematic model of narrative analysis was used to interpret the qualitative data that was constructed with the participants (Riessman, 2005). These data included: a ‘thick’ journal and ‘thin’ memos of observations and experiences, maintained by the lead author, while on and offsite (David & Baron, 2010; Geertz, 1973; Sergi & Hallin, 2011); as well as transcripts of interviews with the shadowed participants. These were used to construct prototypical or normative stories around central conceptual groupings related to emotion and multidisciplinary practice, which were revisited and revised as analysis progressed.

RESULTS

The community-based palliative care model within the local health district involved a team of specialist nurses who served as a consultant to generalist community health nurses who coordinated patient care. In addition to palliative care, the community health nurses: delivered wound care; administered intravenous antibiotics; and drained bodily fluids, among other tasks. Palliative care was therefore one component of their generalist role. The specialist palliative care nurses were also supported by specialist palliative care medics based at the local hospital, who attended the regular case reviews at the centre as well as home visits, when required.

Justifying Practices

Although not necessarily a novel finding, the palliative care nurses and medics regularly affirmed the multidisciplinary nature of palliative care, suggesting it was a necessary and vital part of community-based care. This was reflected in how care was enacted, with the generalist and specialist nurses consulting each other, general practitioners, hospital-based medics, social workers, and clinicians at aged care facilities, among other services:

> Palliative care… is… not just the nurse, the patient; it's the patients in the centre and we're around them… In that circle, you've got the nurse, you've got the doctor, the OTs [occupational therapists], the physios [physiotherapists]; everyone is involved in palliative care.

However, the emotional and relational nature of this collaboration was an important part of teamwork. Positively-valanced experiences promoted collaboration, negatively-valanced experiences divided those professions that did, and did not appear to embody the different facets of palliative care.

The palliative care specialist medics had one of the closest external relationships with specialist and generalist nurses. They consistently and regularly worked with the palliative care specialist nurses, both within and beyond the centre. This consistency and regularity strengthened the camaraderie and affection, explicated by the way the medics were described:

> I think they're a different breed of doctors that… go into palliative care. I think they have a lot of compassion and I think that's also what palliative care is all about… compassionate care… I think they do a lot more holistic care.

The palliative care specialist medics differed from other 'breed[s]' of doctors. According to those who were shadowed, the medics were more likely to understand the needs of patient and carers, and provide compassionate care, accordingly. The participants revered medics, largely because of the compassion they witnessed and experienced:

> [The registrar] just gets to the real nut of it… She's a good interviewer… She just takes it slowly and gets everything she need[s] to, out of them… Doesn't jump around; sticks to the point.

This collective appreciation for the medics helped the generalist nurses recognise their value as a point of contact and a trusted source of information and support. These emotional attachments suggested a safe culture of approachability and collaboration among the medics and all nurses, justifying practices like planned joint visits and unplanned telephone calls.

Storying and Collectivising Experiences

Clinicians portrayed their collaboration with diverse professionals via emotion-laden stories, using these to shape, understand, and reaffirm the varying nature of the disciplines they worked with In healthcare, the role of talk in identity-construction has been examined in doctor-patient consultations, where patient accounts contained emotive and vivid descriptions of their experiences (Webb & Stimson, 1976). In this construction of identity through emotion-talk, elements of drama constitute what Webb and Stimson called atrocity stories. Emotion-laden stories can serve two purposes. First, they can help to make sense of past events. Second, they can redress the doctor-patient power imbalance by construing patients as rational and sensible beings, and chastising a doctor's actions as inappropriate, irresponsible, or insensitive. Atrocity stories were shared in the context of multidisciplinary practice. For instance, senior nurses within the centre sometimes recounted an anecdote that helped their junior counterparts to understand what it can be like to work with speech pathologists, oncologists, haematologists, and an array of other '-ologists'. These were supplemented with vivid emotional performances and imagery to portray the merits and misadventures of multidisciplinary palliative care. These instances served to implicitly establish the values of palliative care and collectively align team members with and against different professions. These shared anecdotes and collectivised experiences became central to the multidisciplinary relationships. A discipline's 'capacity for compassion' and its alignment with palliative care – as understood by the participants – were defining features of each profession. Several exemplars serve to highlight and explicate these findings.

Participants alluded to discord between palliative care and the disciplines of cardiology and nephrology. This manifested as outbursts of anger from palliative care nurses and medics towards cardiologists and nephrologists – these occurred in collective settings, like the case reviews, and during private discussions about patient care. These intense, emotional performances served multiple purposes. They were cathartic for the aggrieved clinician; they showed others the aggrieved clinician's patient-centric approach and their empathy for the patient and carer; they reinforced the meaning of palliative care, as understood by the participants; they helped to delineate palliative care from other specialities; they helped palliative care nurses and medics to bond; and they enabled generalist nurses to recognise these points of difference and define palliative care:

> I think [palliative care] is the only stream that does [continuity-of-care]… well; whereas other teams will focus on cardiac or orthopaedics and that's their only focus.

Shaping Professional Identities

Participants' stories and emotional performances shaped professional identities, as understood by the collective. Instances of poor referral processes consolidated and reified the foreign '-ologist' as unempathetic of patients, carers, and the palliative care specialists. In these identity-shaping stories, the foreign '-ologist' would refer patients with limited detail on patient history and patient preferences. This made it difficult for the participants to initiate contact with a patient and continue their care:

> They're only interested in looking after their specific thing. They don't look at the whole patient. As soon as they can't treat them anymore, they just dump them off.

Rather than delegitimise other professions, participants' frustration and anger about what they failed to do bonded the specialist and generalist nurses. This helped to implicitly reaffirm the embodied empathic nature of palliative care towards the patient and carer journeys. This echoes Ahmed's (2004) findings on the cultural politics of emotion, suggesting emotions 'do things' (p. 26) – they work to align individuals with collectives through the intensity of their attachments.

Emotion also shaped the multidisciplinary relationship between palliative care specialists (both medics and nurses) and general practitioners. The general practitioners had a relatively more complex working relationship with the specialist and generalist nurses. Their role in patient care often fluctuated, depending on their presence and relationship with the patient (and carer). Nevertheless, they were viewed as an important link in palliative care, often represented by a participant's frustration when a general practitioner was uncontactable or seemed indifferent:

> It's very frustrating going out to a patient and they want to die at home for example and you can't get a local doctor to certify, or you can't get a local doctor to write up medication or whatever.

Working with a general practitioner who was present in the life of a patient and carer, and who genuinely consulted with palliative care specialists – both medics and nurses – was important for effective multidisciplinary palliative care. A recurring story was of a general practitioner who contacted the appropriate interstate government body to place a large order for a schedule 8 (or S8) drug to manage a patient's pain. Rather than unhelpfully provide a repeat prescription for a small quantity of the drug, which was likely to be insufficient, the general practitioner negotiated bureaucracy for the benefit of the patient and their carer. Although this might seem like a trivial act, it meant so much to the patient and carer who appreciated the general practitioner's thoughtfulness. This story, which was recounted at different times with different people, shaped how the nurses perceived general practitioners. They considered how others matched with this touchstone, their capacity for compassion, and the ways they embodied the different facets of palliative care. This in turn nurtured, or hindered a relationship between the nurses and general practitioners.

Although alliances among different clinical disciplines were apparent during fieldwork, so too were alliances that divided the clinical realm from the non-clinical realm. Consider for instance, the ways in which some participants defamed or vouched for ‘management’, ‘the government’, bureaucrats, administrators, patients, and carers. Sometimes they questioned the accountability mechanisms espoused by the officials ‘up the hill’, and the grievances aired by some carers. These utterances enhanced or flavoured a collective, clinical identity as the participants’ defended their clinical counterparts and aligned with the frailties and capacity for error:

> When they were complaining about mistakes that had been made by the pharmacist, they had given the wrong medication and I found that hard to answer because, all of us, we’ve all made some sort of drug error or some sort of mistake or human error.

This interview excerpt followed a home visit with a generalist nurse where the patient had expressed anger at a pharmacist who had made a prescription error. Here the clinician considered her past mistakes and concerns regarding drug prescription and how this could have easily been her own mistake. In this instance the participant was a relatively junior generalist nurse and, as outlined, generalist nurses have a purview beyond merely palliative care, and so their alignment with other, generalist, medical professions were more likely.

DISCUSSION

As the shift towards patient-centric care and a recognition of complex health issues and multimorbidities continue, multidisciplinary practice will remain an important focus for research and practice within many Western health systems. This is certainly so in community-based palliative care in Australia, where there is an increasing demand for teamwork that seeks to ‘[not only] control pain and physical symptoms of the patient, but also to provide a set of mental, spiritual, social and family healthcare’ (Ansari & Rassouli, 2018, p. 46). Emotions and the related relational components of multidisciplinary practice are complex. Furthermore, poor interprofessional relationships can thwart teamwork and compromise patient care (Ansari & Rassouli, 2018; Hill, 1998; Mahmood-Yousuf, Munday, King, & Dale, 2008; Sargeant, Loney, & Murphy, 2008). Empirical research on the emotional attachments associated with multidisciplinary healthcare can inform and promote effective collaboration in this context.

This article contributes to this aim by detailing the findings of an eight-month ethnography within a community health centre that offered palliative care to patients at home. Findings suggest that emotion can promote or hinder multidisciplinary palliative care by: justifying practices; enabling clinicians to story and collectivise experiences; and shaping professional identities. This study suggests a need to foster of cross-disciplinary empathy, to enable clinicians to understand and be moved by the experiences of diverse disciplines. This reflects the literature on effective elements of multidisciplinary practice. This extends to the study of intercultural communication focused on building the capacity for empathy' (Delia, 1987; Williams, 1983). Clinicians can function as cultural groups, and as such, interprofessional communication is effectively intercultural communication (Gauthier, 2013). In a study involving interprofessional primary health clinicians, participants cited that effective collaboration required: an understanding of, and respect for team members' roles; a recognition that teams require work; and communication among other features (Sargeant et al., 2008).

Implications for practice suggest a need for opportunities in community-based palliative care to share perspectives and values across diverse disciplines. This could be achieved through short-~~–~~term secondments between and among disciplines. Additionally, collaborative reflexive opportunities could promote shared understanding of the diverse roles required in palliative care. Cross-disciplinary video reflexive ethnography has a demonstrated capacity to reveal and shape the visible and invisible ways that clinicians work (Dadich, Collier, Hodgins, & Crawford, 2018; Hor, Iedema, & Manias, 2014; Iedema, Long, Forsyth, & Lee, 2006). Similarly, training that involves different disciplines can help to improve communication and teamwork (Mahmood-Yousuf et al., 2008).

Although this study helped to clarify how emotion promotes multidisciplinary healthcare, a limitation is the absence of other perspectives from non-nurse participants who are (a)typically involved in community-based palliative care. As such, further research would be valuable, particularly that which uses a critical, participatory methodology fostering the necessary inter-relational webs promoting cross disciplinary empathy. This repeats the call for doing visual reflexive ethnography to both describe practices and change them as well, as 'ethnography and intervention are not distinct but interwoven practices' (Mesman, 2007, p. 281).

REFERENCES

Ansari, M., & Rassouli, M. (2018). Team approach in palliative care. *Basic & Clinical Cancer Research, 10*(1).

Brazil, K., Kassalainen, S., Ploeg, J., & Marshall, D. (2010). Moral distress experienced by health care professionals who provide home-based palliative care. *Social science & medicine, 71*(9), 1687-1691.

Burkitt, I. (1997). Social relationships and emotions. *Sociology, 31*(1), 37-55.

Czarniawska, B. (2014). Why I think shadowing is the best field technique in management and organization studies. *Qualitative Research in Organizations and Management, 9*(1), 90-93.

Dadich, A., Collier, A., Hodgins, M., & Crawford, G. (2018). Using POSH VRE to examine positive deviance to new public management in healthcare. *Qualitative Health Research, Epub-ahead-of-print*. doi:https://doi.org/10.1177/1049732318759492

David, J. C., & Baron, R. (2010). *Into the thick of things: Connecting consumers to community life - A compendium of community inclusion initiatives for people with psychiatric disabilities at consumer-run programs*. Retrieved from Philadelphia, PA:

Delia, J. G. (1987). Communication research: A history.

Forrest, S., & Barclay, S. (2007). Palliative care: a task for everyone. *Br J Gen Pract, 57*(539), 503-503.

Gatchel, R. J., McGeary, D. D., McGeary, C. A., Lippe, B., & Anderson, N. (2014). Interdisciplinary chronic pain management: past, present, and future.(chronic pain and psychology)(Author abstract). *The American Psychologist, 69*(2), 119. doi:10.1037/a0035514

Gauthier, B. (2013). Drawing Professional Boundaries: Professional organizations, communication and interprofessional collaboration in health care: ProQuest Dissertations Publishing.

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. *Culture: Critical Concepts in Sociology, 1*, 173-196.

Gill, R., Barbour, J., & Marleah, D. (2014). Shadowing in/as work: Ten recommendations for shadowing fieldwork practice. *Qualitative Research in Organizations and Management, 9*(1), 69-89.

Harrington, S. E., & Smith, T. J. (2008). The role of chemotherapy at the end of life:“when is enough, enough?”. *Jama, 299*(22), 2667-2678.

Hill, A. (1998). Multiprofessional teamwork in hospital palliative care teams. *International Journal of Palliative Nursing, 4*(5), 214-221.

Hillman, K., & Chen, J. (2009). Conflict resolution in end of life treatment decisions. *Sydney: Sax*.

Hor, S.-y., Iedema, R., & Manias, E. (2014). Creating spaces in intensive care for safe communication: a video-reflexive ethnographic study. *BMJ Qual Saf, 23*(12), 1007-1013.

Iedema, R., Long, D., Forsyth, R., & Lee, B. B. (2006). Visibilising clinical work: video ethnography in the contemporary hospital. *Health Sociology Review, 15*(2), 156-168.

Jongen, J. L., Overbeck, A., Stronks, D. L., van Zuylen, L., Booms, M., Huygen, F. J., & van der Rijt, C. C. (2011). Effectiveness of a multidisciplinary consultation team for cancer pain and palliative care in a large university hospital in the Netherlands. *BMJ supportive & palliative care*, bmjspcare-2011-000087.

Li, S., & Arber, A. (2006). The construction of troubled and credible patients: a study of emotion talk in palliative care settings. *Qualitative health research, 16*(1), 27-46.

Liedtka, J. M., Whitten, E., & Sorrells-Jones, J. (1998). Enhancing care delivery through cross-disciplinary collaboration: A case study/practitioner response. *Journal of Healthcare Management, 43*(2), 185.

Lown, B. A., & Manning, C. F. (2010). The Schwartz Center Rounds: evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. *Academic Medicine, 85*(6), 1073-1081.

Mahmood-Yousuf, K., Munday, D., King, N., & Dale, J. (2008). Interprofessional relationships and communication in primary palliative care: impact of the Gold Standards Framework. *Br J Gen Pract, 58*(549), 256-263.

McCallin, A., & Bamford, A. (2007). Interdisciplinary teamwork: is the influence of emotional intelligence fully appreciated? *Journal of nursing management, 15*(4), 386-391.

Mesman, J. (2007). Disturbing Observations as a Basis for Collaborative Research. *Science as Culture, 16*(3), 281-295. doi:10.1080/09505430701568685

Nordentoft, H. M. (2008). Changes in emotion work at interdisciplinary conferences following clinical supervision in a palliative outpatient ward. *Qualitative health research, 18*(7), 913-927.

Pile, S. (2010). Emotions and affect in recent human geography. *Transactions of the Institute of British geographers, 35*(1), 5-20.

Ratcheva, V. (2009). Integrating diverse knowledge through boundary spanning processes – The case of multidisciplinary project teams. *International Journal of Project Management, 27*(3), 206-215. doi:10.1016/j.ijproman.2008.02.008

Riessman, C. K. (2005). Narrative analysis: University of Huddersfield.

Safran, D. G., Miller, W., & Beckman, H. (2006). Organizational Dimensions of Relationship-centered Care. *Journal of general internal medicine, 21*(S1).

Sargeant, J., Loney, E., & Murphy, G. (2008). Effective interprofessional teams: “Contact is not enough” to build a team. *Journal of Continuing Education in the Health Professions, 28*(4), 228-234. doi:10.1002/chp.189

Sergi, V., & Hallin, A. (2011). Thick performances, not just thick descriptions: The processual nature of doing qualitative research. *Qualitative Research in Organizations and Management, 6*(2), 191-208.

Walsh, J., Harrison, J. D., Young, J. M., Butow, P. N., Solomon, M. J., & Masya, L. (2010). What are the current barriers to effective cancer care coordination? A qualitative study. *BMC Health Services Research, 10*(1), 132.

Webb, B., & Stimson, G. (1976). People’s accounts of medical encounters. *Studies in everyday medical life*, 108-122.

Weissman, D. E. (2009). Moral Distress in Palliative Care. *Journal of Palliative Medicine, 12*(10), 865-866. doi:DOI 10.1089/jpm.2009.9956

Williams, R. (1983). *Culture and society, 1780-1950*: Columbia University Press.