The Impact of Interprofessional Communication/collaboration during times of Transition for Cancer Patients with Advanced Disease - Systematic Analysis Using an Electronic Learning Module

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Abstract

The challenges associated with ensuring continuity of care for patients within the context of contemporary health care delivery are significant. One of the key challenges within a specialty field such as Oncology care involves adjusting to the always-changing foci of the practitioners and students rotating through the Oncology program. When team membership is under constant change and when the learning goals of students disrupt established patterns for ensuring continuity of care for patients, explicit communication strategies are needed to maintain quality in patient care. Undergraduate health professional education in Oncology is quite limited and, in order to ensure recruitment of appropriately trained professionals, the Oncology unit has an incentive to adjust to this constantly changing population of learner-providers. Recent emphasis on interprofessional practice suggests that many of these challenges may be off-set by fostering effective interprofessional teamwork. The purpose of this project was to determine the effectiveness of a standardized tool, the Palliative Performance Scale (PPS), in supporting interprofessional teamwork.

The impact of interprofessional communication/collaboration during times of transition (e.g. progressive disease, physical deterioration) for cancer patients with advanced disease has not been widely studied and is an opportunity for further research that investigates these critical issues. Online educational modules designed to enhance use of the PPS and thus to have a
positive impact on interprofessional practice can be used by students and healthcare practitioners to augment their knowledge of how practicing within a team context is different from, and in some ways similar to, current models of practice.

The Victoria Hospice Palliative Performance Scale (PPS) (Victoria Hospice, 1996), is a valid, reliable, functional assessment tool that has been integrated into a larger project within the province of Ontario, the Palliative Care Integration Project (PCIP). Consistent use of the PPS by care providers has the potential to streamline communication between providers and to predict the need for potential resources that would support patients and families through palliative transitions. Although the tool’s capacity as a prognostic device is not fully understood (Lau, et al., 2007), it can illustrate how quickly a patient’s condition is changing and may help healthcare providers support patients and their families through transitions and decisions at end of life. Through the development of an electronic module incorporating the PPS, practitioners were encouraged to engage in work using common assessment tools to enhance their interprofessional communication (that is, within the context of interprofessional practice) with the aim of improving patient care.

Reports from this group of healthcare professionals indicate that highly functioning interprofessional teams have embedded within their culture the attributes of collaboration and patient-centred care. Systematic analysis of the reports of professionals following exposure to the PPS learning module indicate that use of a common assessment tool such as the PPS generates team-based knowledge that could be used by team members to begin the transition from active to palliative treatment early. Administrative support both within the organization and within the larger healthcare system is required to ensure all healthcare providers have the opportunity to engage in interprofessional, patient-centred practice.
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Chapter 1: Introduction and Background

The majority of my nursing career has been focused on the care of adults with cancer receiving care in an acute care teaching hospital. Patients who receive a diagnosis of cancer can have their diagnosis further defined by whether the ultimate goal of therapy will be cure (full eradication of the cancer), control (not curative but rather, with some medical treatments such as chemotherapy and radiation, as well as some supportive treatments such as blood transfusions and pain management, care that allows the patient to have a relatively good quality of life for an extended period of time), or palliation (not curative, treatment aimed at controlling symptoms, including pain, and providing comfort, quality of life, and dignity in the end stages of disease). Patients in different phases of treatment will have different goals and objectives with respect to the type and amount of treatment they expect, anticipated side effects, stage in life, and disease trajectory.

Within this broad patient population, end-of-life issues have been researched extensively from a patient and family perspective and also from a care provider perspective. Similarly, the concept of “cure” and the long-term sequelae of cancer treatment have been thoroughly researched. There appears to be a gap in the literature, however, regarding those patients who are in neither curative nor end of life stages - those patients who will likely succumb to their disease, but who are still living full, productive lives. They are “palliative” in the broadest sense of the term but may not yet be in need of specialized palliative care.

“Approximately half of all current cancer patients will eventually die as a consequence of their illness or related complications. Caring for people as they die, is therefore an integral part of oncology practice.” (Byock, 2000, p. 123). As such, healthcare professionals working in the
area of Oncology need to develop a certain comfort level with being able to provide care across the disease trajectory, particularly during times of transition for patients (e.g. multiple disease recurrences necessitating changes in therapeutic regimes and declining physical functioning caused by disease progression).

Within my own clinical setting, I have noticed that many discussions take place concerning patient situations that may be leading to the transition from active (curative) treatment to treatment of palliative needs. Nurses consult fellow nurses about the rate at which patients’ conditions are deteriorating, whether they think the patient and the family are aware of the severity of the patient’s condition, and whether the patient and the family are “on the same page” when it comes to treatment options and goals of care. These types of consults are particularly helpful since nurses on this unit work extended shifts (two 12 hour days, followed by two 12 hour nights, then five days off) and may not have a patient assigned to them for significant periods of time. There is a need for the nurses to fill in the gaps from their last interactions with the patients and their families to ensure continuity of care. In turn, nurses call upon social workers and spiritual care providers to help them sort through uneasy feelings and to describe their personal moral and professional ethical obligations to patients and also to their family members particularly when their expectations differ. All members of the healthcare team have discussions with each other - sometimes quite heatedly - about the goals of treatment, whether the proposed treatment is in the best interest of the patient, and to what extent the patient has been involved in the decision-making (i.e. Who’s needs are we meeting?). For example, nurses have questioned providing treatment (e.g. chemotherapy and radiation) to patients knowing the side effect profile will most likely not enhance the quality of life, physicians have
not always considered ‘no treatment’ as an option, and families sometimes believe they have the right to decide treatment instead of the patient.

I have continually returned to two key concepts throughout my course work for my Masters’ degree at the University of Victoria: first, the concept of transitions in patients with advanced cancer; and second, the concept of interprofessional education and collaborative patient-centred practice. This project provides an opportunity for examination of these two concepts as they relate to the impact of interprofessional communication/collaboration during times of transition for cancer patients with advanced disease. The purpose of the project was to determine the effectiveness of a standardized tool, the Palliative Performance Scale (PPS), in supporting interprofessional teamwork. An electronic module was developed that introduced the PPS to practitioners. The educational strategies used within the module were designed to encourage practitioners to engage in work using common assessment tools to enhance their interprofessional communication (that is, within the context of interprofessional practice) with the aim of improving patient care. These concepts of transition along with interprofessional education and collaborative patient-centred practice will be discussed in further detail in the next sections of this paper.

Transition

Before proceeding further, it is necessary to introduce the concept of “transition” as it relates to patients with cancer and to the care that healthcare professionals provide. According to Meleis & Trangenstein (1994), transition can be defined as:

a passage from one life phase, condition, or status to another. ...Transition refers to both the process and the outcome of complex person-environment interactions. ... A transition denotes a change in health status, in role relations, in expectations or in abilities. It denotes a unique constellation of patterns of responses over a span of time (p. 256).
Patients with cancer will experience many transitions throughout the course of their illness. Many times when we meet patients and their families, despite advanced cancer, they are relatively well and able bodied. They are trying to live life to its fullest and in doing so, do not foresee the supports they will require as their disease progresses. This transition is often a gradual one, that can be guided and supported by a highly functioning interprofessional team. Building a strong relationship, taking one’s cues from the patient and his/her family is critical. It is at this early stage that the team can foster the development of a strong relationship and establish a communication pattern for the patient and family. This relationship lays the foundation for ongoing coordination of care, seamless information flow and patient-centred care.

What we know from the literature is that individuals with advanced cancer tend to underestimate the level of support they need (e.g. informational needs and psychological support), perhaps in an attempt to maintain their independence (Nijboer, Triemstra, Tempelaar, Sanderman, & Van den Bos, 1999; Sharpe, Butow, Smith, McConnell, & Clarke, 2005). If, upon taking their cues from the patient, healthcare providers also underestimate the patient’s needs, they may inadvertently and negatively impact the family caregivers by increasing their burden. As such, it is crucial that interprofessional teams build strong relationships with each other so they are able to anticipate these transitions and are prepared to support patients and their families through them when they arise.

Interprofessional Education and Collaborative Patient-centred Practice

Having worked the majority of my career in an Oncology setting in an acute care teaching hospital, I am very interested in interprofessional communication and education, particularly around changes in the patient’s status that necessitates revisiting the goals of the treatment plan. The literature appears to be rich with the impact of physician/patient
communication and nurse/patient communication, but very few articles speak to the impact of interprofessional communication and how an effective team approach is experienced by patients and their families. The one exception, it seems, is in the area of hospice work where practitioners seem to have embraced the idea of collaborative practice. “Deficient communication among providers creates conditions for acrimony, frustration, and distrust that can lead to inferior care and a greater risk of error.” (Burke, Boal, & Mitchell, 2004, p. 40).

What is interprofessional education?

The definition of interprofessional education (IPE) that appears to be the most widely used in the literature is “occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care.” (CAIPE, 2002). While interprofessional education has had a long standing history in the United Kingdom (UK), an increasing interest in interprofessional education and collaboration in Canada was sparked in part by a federal government review on the state of healthcare in Canada. In 2002, Roy Romanow indicated in his final report to the federal government entitled “Building on Values: The Future of Healthcare in Canada”, that if health care providers are expected to work together and share expertise, in a team environment, it makes sense that their education and training should prepare them for this type of working arrangement. (Romanow, 2002). Since that time, there has been a shift toward interprofessional education in several undergraduate healthcare curricula (e.g. University of British Columbia, University of Victoria, Queen’s University, Dalhousie) with the assistance of federal funding through Health Canada for the Canadian Interprofessional Health Collaborative (CIHC). There remains a gap in the literature regarding professionals currently practicing who were educated in their professional silos and who were perhaps not exposed to the professional cultures of other disciplines until they entered the workforce. In
addition to collaboration between professionals, patients and their healthcare practitioners define the goals of care based on the available treatments and on patients’ goals for their own health. In order for the care delivery to be patient focused, communication between health care providers must be seamless. In our current healthcare system, many factors affect communication between healthcare providers but also with their patients and with patients and their families. Some of these factors will be discussed further in the following chapters.

**PPS in Palliative Care**

While there are many valuable assessment tools available to assist practitioners [e.g. Karnofsky Performance Scale (KPS), ECOG (Eastern Cooperative Oncology Group), Activities of Daily Living (ADL) and the Instrumental Activities of Daily Living (IADL)], the PPS is the tool that has been adopted for use at my workplace and its associated Cancer Centre. As such, the PPS was the tool of choice for this project. The PPS, a tool developed by Victoria Hospice and modeled after the Karnofsky Performance Scale, is an objective tool that assists health care professionals to assess the patients’ functional capacity, providing a framework for measuring the progressive decline of patients with advanced cancer. Assessment areas include: the degree of ambulation, ability to do activities (including work and hobbies)/extent of disease, ability to perform self-care activities, food/fluid intake, and level of consciousness. Patients with a PPS score of 40-60% are considered to be in the transitional phase; this phase requires the greatest amount of nursing care and is the most difficult for patients (Anderson, Downing, Hill, Casorso, & Lerch, 1996). The care team is challenged to support the patient and family as they each navigate their own unique paths on this continuum. For example, aside from the physical care and management of symptoms and side effects of treatment, all of which require intensive patient/family teaching and planning, we must also think of issues such as the patient’s quality of
life; support systems for the patient and family caregivers; ensuring documents are in order
(Power of Attorney, wills, guardian for children, Substitute Decision Maker); and spiritual needs
(beliefs, hopes, strengths, fears). Consistent use of the PPS by care providers has the potential to
streamline communication between providers and to predict potential resources for patients and families. Although the tool’s capacity as a prognostic device is not fully understood (Lau, et al., 2007), it can illustrate how quickly a patient’s condition is changing and may help healthcare providers support patients and their families through the many transitions and decisions associated with them.

The role of the PPS in interprofessional collaboration is not entirely clear, however, the use of a common assessment tool that quickly identifies a patient’s stage based on functional performance indicators, can be anticipated to move forward from what is happening with the patient (present oriented) to what needs to occur to ensure the supports are in place for the transition to occur (future oriented). I believe that there is a need to education all professional groups represented on the care team to increase awareness about interprofessional collaboration and to challenge current models of care in order to improve patient care in our ever changing environment. An asynchronous web-based learning module was created with the principles of Adult Learning in mind. Adult learners are autonomous and self directed, goal- and relevancy-oriented, practical, with a wealth of life experiences, knowledge and a need for respect. (Lieb, 1991; Russell, 2006). By creating an electronic learning module utilizing the PPS with various types of questions (true/false, critical thinking, and reflective questions) centering on the applicability of a common assessment tool to enhance collaborative patient-centred care, the goal of the project was to enable me to gain a better understanding of the functioning of our oncology
team. In particular, I was interested in the communication that takes place during the transitional phase of a patients’ disease.
Chapter 2: Literature Review

The concepts of “transition” and “interprofessional education and collaborative patient-centred practice” are broad and have been thoroughly discussed within the academic literature. The focus of this literature review was on team effectiveness and team functioning within the context of caring for patients with advanced cancers. Multiple databases were accessed including CINAHL, Medline, HealthSTAR, Proquest and PsychINFO as well as websites such as Health Canada, Canadian Nurses Association (CNA), and Registered Nurses Association of Ontario (RNAO). Literature was limited to that which is written in English and published within the last twenty years with a few exceptions for original articles. Key search words included: transition, interprofessional education, interprofessional collaboration, patient-centred care, teamwork, cancer, and palliative care. Quantitative, qualitative and evaluative research studies were reviewed but given the lack of research literature surrounding interprofessional education/collaboration, I also included scholarly opinion papers written by experts in the field as well as theoretically derived papers. Articles that included patients with chronic conditions other than cancer, were not included; however, articles that included cancer patients along with other chronic disease conditions were included (e.g. articles relating to palliative care in general).

Transitions

Transitions occur in many forms over the course of one’s lifetime and are often associated with key life events. Examples of types of transitions include: illness experiences, developmental and lifespan transitions, and social and cultural transitions (Meleis & Trangenstein, 1994; Meleis, Sawyer, Im, Hilfinger Messias & Schumacher, 2000). In Ontario, the RNAO has developed a best practice guideline entitled “Supporting and Strengthening Families through Expected and Unexpected Life Events” as a resource for nurses providing care
to patients who are experiencing these transitions. They describe expected life events as those relating to developmental and life-span transitions (e.g. marriage, birth, aging) as well as social and cultural transitions (e.g. retirement, family caregiving); whereas, unexpected life events are those which are not anticipated (e.g. chronic illness). This best practice guideline provides concrete examples and supporting evidence for supporting patients and families through the types of transitions identified above.

With respect to palliative care literature, transitions may relate to personal meaning in life, life/role changes, perception of the end of treatment, and likelihood of death (Larkin, De Casterle & Schotsmans, 2007). All of these authors agree that transitions are complex and multidimensional events that occur over time rather than as a single event. Meleis, et al. (2000) describe “essential properties of transitions” (p. 18):

- Awareness - a person must have some awareness that changes are occurring. Lack of awareness may indicate the person may not have begun the transition experience. A key unresolved question is: Whose awareness (professional’s or patient’s) triggers the beginning of the process?

- Engagement - the degree to which the patient demonstrates involvement in the process.

- Change and difference - transitions are both the result of change and result in change but are not synonymous with change; whereas, difference is exemplified by “feeling different, being perceived as different, or seeing the world and others in different ways.” (p. 20).

- Timespan - constituted by an identifiable end point, it “extends from the first signs of anticipation, perception or demonstration of change; through a period of instability, confusion and distress; to an eventual “ending” with a new beginning or period of
stability.” (p. 20). However, it is likely impossible to define the length required for the transition to occur.

- **Critical Points and Events** - “associated with increasing awareness of change or difference or more active engagement in dealing with the transition experience.” (p. 21).

  The authors argue that nurses’ attention, knowledge and experience is required at each critical point in order to facilitate the transition and support the patient and family through their periods of uncertainty. In addition, several personal and environmental factors may facilitate or inhibit the transition.

  Meleis and Trangenstein (1994) claim that nursing is “concerned with the process and the experiences of human beings undergoing transitions where health and perceived well-being is the outcome” (p. 257). Furthermore, they claim the concept of transition is captured in many of our nursing theories - adaptation (Roy, 1999), self-care (Orem, 2001), unitary human development (Rogers, 1989), expanding consciousness (Newman, 1986), and human becoming (Parse, 1981).

  While other professions may also be concerned with transition, nursing is unique in that its goal is in helping the patient to achieve a sense of well-being (Meleis & Trangenstein, 1994).

  The PPS also speaks about transition within the context of a patients’ declining functional status. Transition in the PPS is defined as a stage where the functional score falls between 40% and 60%. The transitional phase of a cancer patient’s disease has been described as the most difficult for patients - impacts on all spheres of life (need for holistic, patient and family-centred care), requiring the greatest amount of nursing care, and having increasing care and educational needs for patients and families (Anderson, et al., 1996). Using these two ways of looking at transition, first, through the patient’s perception (awareness and level of engagement) of the
process; and second, through the use of a valid, reliable assessment tool, healthcare providers may be better prepared to provide timely, appropriate care.

Interprofessional Education and Collaborative Patient-centred Practice

Although there is little available research to support the benefits of interprofessional education for improving patient care because the concept is still in its infancy, exploring the roles and responsibilities as well as the worldview of each profession may provide richer experiences for patients and their families. My opinion is consistent with that of Roy Romanow’s claim that the Canadian health care system is struggling to maintain its universality and excellence, and part of the solution is embodied by collaborative patient-centred practice teams (Romanow, 2002). Certainly this is an evolving process, particularly for team members who have been practicing for extended periods of time in a system deeply entrenched in its professional silos, and in hierarchical organizations that are most concerned about efficiency and measurable outcomes rather than team functioning and patient-centred care. However, as our patient populations age, live longer, and present with multiple co-morbid conditions that add to the complexity of their care, health care teams must also develop innovative methods to provide patient and family centred care, across the continuum of care from diagnosis to death. A report from the Institute of Medicine entitled Health Professions Education: A Bridge to Quality, cites interprofessional, team-based practice and delivering patient-centred care as two of the five core competencies all healthcare professionals working in the 21st century must possess (the other competencies being: practicing evidence-based medicine, focusing on quality improvement, and using information technology) (Greiner and Kneble, 2001). The CNA also has developed a position statement regarding interprofessional collaboration wherein they state: “...the responsiveness of the health system can be strengthened through effective collaboration among health professionals” (2006,
These are but two examples of professional bodies’ support of interprofessional collaboration to improve patient care. In my opinion, interprofessional collaboration is essential for continuity of care required for patients with chronic, potentially life-threatening illnesses particularly as they approach end of life. Continuity of care is said to improve efficiency and effectiveness to the healthcare system (Anderson & Helm, 2000; Rosser & Shultz, 2007), enhance adherence to therapy, increase patient/provider satisfaction with care, and to improve chronic disease outcomes (Rosser & Shultz, 2007). Outcomes of interprofessional collaboration on the healthcare system suggested to date are patient-centred, timely delivery of safe, accessible care while continuity is maintained (HealthForce Ontario, 2007). In addition, findings from a recent comparative study of hospitalized cancer patients suggest that the “intensity of interprofessional collaboration has a positive effect on patient satisfaction, reduces uncertainty, and improves pain management.” (San Martin-Rodriguez, D’Amour, & Leduc, 2008, p.18). One could theorize then that lack of interprofessional collaboration may lead to discontinuity of care, and less efficient healthcare delivery, reduced patient/provider satisfaction, increased uncertainty and poorer pain management.

In order for healthcare professionals to develop strong, patient focused interprofessional teams, they must be able to identify within their own workplaces those factors that either facilitate or inhibit team functioning. Some of the factors reported in the literature are discussed below.

**Barriers and Facilitators**

Within the current reality of the acute care setting, one could argue that there are likely more barriers than facilitators in working with patients with advanced cancer. While several barriers/facilitators are discussed below, there are far too many to capture within this paper. The
following are those that I see as the major factors in the acute care, teaching environment: evidence-based medicine vs. patient-centred care, communication and collaboration, interprofessional team functioning, and resources (human and financial). Where barriers exist, I believe, these represent opportunities to examine our current healthcare practices and evoke positive changes within our healthcare system. I don’t believe these factors are independent of each other but rather intertwined with the potential to have positive or negative effects on patients depending on the providers involved and the specific situation.

Evidenced based medicine vs. patient-centred care.

Our heavily weighted Medical Model could ultimately be seen as a barrier to health promoting practice because if we focus too much on treatment and procedures, we spend little time focusing on the patient and the meaning of the disease process to him/her, and even less time on health promotion. While evidence-based care forms the basis for healthcare practices today, Bensing (2000) argues that evidence-based medicine and patient-centred medicine are two separate and distinct paradigms. Evidence-based medicine, he claims, is not the same as patient-centred medicine for two reasons: 1) Evidence-based medicine is disease oriented, not patient oriented. He argues that randomized controlled trials (RCTs), the gold standard for research, are not patient-centred. “Patients enroll in RCT’s because they fulfill inclusion criteria, which are only based on the strictly defined diagnostic criteria of the disease under study ... Patient characteristics are considered a nuisance that might disturb the results of the study, instead of providing valuable extra information” (Bensing, 2000, p. 19). 2) Evidence-based medicine is designed to generate knowledge gleaned from research on populations. “It does not tap from patient’s unique knowledge and experience...” (Bensing, 2000, p. 19). Conversely, patient-centred medicine implies that healthcare providers practice according to a bio-psycho-social-
spiritual model rather than simply a biomedical model and that those providers must explore patient preferences and provide them with sufficient information such that they are able to make informed decisions (Bensing, 2000). The disconnect between evidence-based care and patient-centred care is particularly evident with pain and symptom management in advanced stages of cancer. An example is the widespread use of complementary and alternative therapies by patients. For example, RCT’s done in the areas of therapeutic touch and medicinal marijuana, have not shown statistical significance, but patients continue to choose them to aid in symptom management and claim these therapies are equally as or more effective than the “standard” therapies. The challenge is not in choosing one paradigm over the other but in integrating the two to provide safe, effective cancer care and also to add to the richness of the available research in this area.

Communication and collaboration.

Despite healthcare literature being rife with publications espousing the benefits of good physician-patient communication and nurse-patient communication in providing patient-centred care, as well as patient preferences regarding communication and information giving at various points along the disease trajectory in cancer care, none of the literature reviewed examines the effects of how the functioning of interdisciplinary teams impacts patients or what impact these communications have on overall patient care and patient/family satisfaction. One is lead to believe that the various healthcare professions work in isolation with patients, each exacting their own interventions, but none collaborating to work towards common goals. Brogan & Naysmith acknowledge the lack of research examining interprofessional communication: “Whilst there is a lot of published research exploring the doctor-patient relationship, and nursing hand-overs,
there is little research investigating the complexities of interprofessional communication.” (2004, p. 260).

And yet, in-spite of the lack of literature examining interprofessional communication and collaboration, nursing and medical research suggests that there are numerous barriers to communication with patients. The literature alludes to challenges such as: experience of the practitioner (Norton & Talerico, 2000), comfort of the practitioner with end-of-life discussions (Norton & Talerico), and current educational systems that are ill-designed to address end-of-life care or prepare professionals for interdisciplinary practice (Fineberg, Wenger, & Forrow, 2004; Kristjanson, Dudgeon, Nelson, Hentleff, & Balneaves, 1997). Communication between patients and caregivers (professional and non-professional) is critical during the transitional phase of cancer care and yet it can be especially challenging. There are many reasons for this, but in the acute care teaching setting, there are multiple practitioners at various stages of their professional development - from students to novice through expert practitioners. Month long clinical rotations for our resident and attending physicians and high turnover rates among other healthcare professionals limit communication from one clinical group to another and are often focused only on the current physical needs of the patient. This constant turnover of care providers may threaten the stability of the team as well as its ability to provide seamless care delivery that can focus not only on current needs but also plan for anticipated future needs. Other common themes within the research literature include: patient-centredness (Butow, Devine, Boyer, Pendlebury, Jackson, & Tattersall, 2004; Kristjanson, Dudgeon, Nelson, Hentleff, & Balneaves, 1997), quality care and services including care coordination between settings (Curtis, Engelberg, Wenrich, Shannon, Treece, & Rubenfeld, 2005; Kristjanson, et al., 1997; Morita, Akechi, Masayuke, Kizawa, Kohara, Mukaiyama, et al., 2005; Norton & Talerico,
2000; Woods, Craig, & Dering, 2006), access to care (Kristjanson, et al. 1997), patient/family satisfaction with end-of-life care (Morita et al, 2005; Norton & Talerico, 2000) and mutual trust and respect (Fineberg, Wenger, & Forrow, 2004). None of the studies reviewed focused on the healthcare providers’ satisfaction with the end-of-life care they provide. This gap indicates an opportunity for further detailed research.

Similarly, there are many published opinion papers regarding how to improve end-of-life care. These papers discuss strategies and theories to overcome barriers and they run the gamut from insisting on interprofessional education; patient/family education, attention to needs and preferences; to arguments that interprofessional cultures and skill sets are the answers to our current concerns (Borduas, Frank, Hall, Handfield-Jones, Hardwick, Ho, et al., 2006; Gilbert, 2005; Hall, 2005).

Interprofessional team functioning.

Highly functioning interprofessional teamwork “...depends on providing interventions early in the professional’s education which serve to build bridges between the neophytes before the walls of their silos become so thick and high that reaching across the professions becomes too difficult” (Hall, 2005, p. 194). The concept of interprofessional education is attracting attention from Health Canada and is subsequently drawing significant amounts of funding across the country to research existing teams and to build interprofessional education programs at the undergraduate level. In Ontario, a local University has secured funding for an interprofessional patient-centred education project with the goal to “create an interprofessional educational environment at [the] University that enhances the ability of learners and faculty to provide patient-centred care, while recognizing the contribution of the health care team within a respectful and collaborative framework.” (urban University in Central Canada, 2006). Still in
the early stages of developing curriculum for undergraduate programs, this project has enormous potential within the acute care environment for helping to improve interprofessional communication and collaboration. Development of strong interprofessional teams will help to ensure all dimensions of the patient are supported throughout the disease trajectory from diagnosis to death. Many of the students attending the University also have clinical placements within the acute care hospital setting. Over time, the interprofessional learning environment being created will most likely filter into the team practices at the hospital.

**Resources - human and financial.**

Global shortages of all healthcare professionals are threatening our healthcare system. The nursing workload in our acute care environment is unmanageable in terms of even being able to provide basic physical care and administer medications and treatments as scheduled. I suspect this is not unusual and that workloads are quite similar in other health science centres. There is support within the healthcare community that collaborative patient-centred practice may serve to help recruit and retain healthcare providers as well as improve the efficiency of health human resources (Oandasan, et al., 2004). However, for ongoing practice change, sustainable ongoing funding as well as high level support from administration (top down approach) must occur, rather than reliance on “champions”. Without administrative support, there is little motivation to engage in interprofessional teamwork. (Barker, Bosco, & Oandasan, 2005; Borduas, et al., 2006; Oandasan & Reeves, 2005).

These themes drawn from current literature will be revisited in the discussion section of this paper where parallels between our oncology team and the literature will be drawn or differences noted.
Chapter 3: Description of the Project

I work in an acute care hospital associated with an academic teaching centre where healthcare professionals from all disciplines rotate through the Oncology program on a regular basis. These practitioners and students are all at different points in their professional and academic careers. Adjusting to the always changing foci of the practitioners and students rotating through the Oncology program poses challenges for the communication between team members and continuity of care for patients with advanced cancer. As well, undergraduate health professional education as it relates to Oncology is quite limited. In the work settings, patient acuity and the volume of the workload often do not permit staff to engage in educational opportunities within the organization. In my experience of working in a tertiary care setting, we focus so much on medical treatment that we run the risk of losing sight of the patient’s goals. As well, referrals to palliative care often occur in the very late stages of the dying process where there is little opportunity to build relationships with the patient and the family. In fact, Byock (2000) indicates “it is often appropriate to offer certain elements of palliative care early in the course of illness. As disease progresses, physical comfort and enhancing quality of life increasingly become primary goals of cancer care.” (p. 123). If we are able to identify patients transitioning from curative to palliative treatment as their disease progresses, we may be able to identify more easily the elements of palliative care they require and engage the palliative care team earlier so that they have the opportunity to build stronger relationships with patients and their families. The PPS is designed to contribute to this process of making explicit the palliative care needs of patients. For clinical and organizations reasons identified earlier, the PPS was selected as a tool to support an investigation of the relationship between standardized assessment tools and the effectiveness of interprofessional team functioning.
In 2001, a project that eventually became known as the Palliative Care Integration Project (PCIP) began under the guidance of Dr. Deborah Dudgeon. This project set out to “promote the integration of efficient, high quality palliative care delivery to palliative patients and their families across the continuum of care” (PCIP, 2005, p. 1) using common assessment tools, collaborative care plans, and symptom management guidelines. Despite initial excitement with the project during a pilot on an inpatient medical unit with a number of oncology beds, it was never fully adopted into practice for many reasons namely, lack of clarity surrounding how to determine if a patient’s disease is truly palliative, practitioners claims that they “don’t have time” to learn how to use the tools, and “not everyone is doing it”. The nurses were instructed on how to use the tools along with the associated care plans and were expected to incorporate them into their practice but it was not an expectation of other healthcare professionals. Although no evaluations of the pilot project were undertaken at that time, I believe that a systematic and collaborative approach to the education and subsequent implementation would have provided the learners with a better understanding of the value of the project. The Palliative Care Team is the only true exception to adopting the project across the disciplines. Having completed one of my clinical placements with this team, I have come to fully appreciate the value of the PCIP in ensuring timely appropriate care to patients with palliative needs.

About the time that it became clear that I was most interested in transitions experienced by patients with advanced cancer and their families as well as the impact of team functioning on these transitions, I had the opportunity to participate in the inaugural Interprofessional Teaching and Learning Certificate Program (IPTL) at a local university. The program was a 40-hour certificate program which culminated in interprofessional presentations of projects the teams had developed. I had the pleasure to work on a module with another nurse and a physician colleague
to teach fellow professionals about interprofessional education. During the creation of the IPE module, my physician colleague and I began to brainstorm about developing other modules related to oncology to help support the learning needs of students and other professionals new to cancer care. We acknowledged the lack of clinical time to offer or attend in-services due to workloads and criticized the organization’s current practice of offering materials on the intranet that can be accessed only from within the organization. One of our goals was to make our modules available on the internet allowing for easy access wherever internet access was available. We plan to continue to build on these electronic resources to create Oncology related materials that may be used by students and healthcare practitioners to augment their knowledge of how practicing within a team context is different from, and in some ways similar to, current models of practice. These electronic resources will be interactive and they will be developed in the form of building blocks from which any curriculum can be built. The content and activities will be connected to patient cases. The cases will integrate basic sciences and clinical care and will represent a variety of patients (12-15) with a variety of diagnoses at different stages of treatment. The collection of cases will form a “virtual waiting room” where one can learn about an individual patient or disease process (e.g. Mr. Smith with Prostate Cancer). As in everyday practice, cases will be cross-linked. For example, learners can engage with the complex psychosocial issues if required to address the case of Mr. Smith augmented to indicate that he has a grandchild with Acute Leukemia. Learners will then be required to expand their thinking about caring practices to include caring for family members as they develop a plan of care for Mr. Smith’s daughter who is struggling with both her father’s and her child’s diagnoses. Specific content related to interprofessional education will be integrated into the cases to allow learners to understand the links and distinctions between the roles of the various healthcare
professionals who may be involved in the care of this family to illustrate to the learner the degrees of overlap within the professions as well as the complexity of the patient/family situations.

Scope of the Project

In my practice setting the cancer program provides care to patients mainly in the Cancer Centre; however, with the more complex treatment regimes, closer monitoring and more complex care may be required necessitating a hospital admission. The inpatient environment is nothing short of chaotic. People and their families cared for within the following medical specialties are represented on this unit: Hematology (e.g. anemias, hemophilia, VonWillebrands), Hematology Oncology (Leukemia, Lymphoma, Myeloma, Stem Cell Transplant), Medical Oncology (Solid Tumors), Radiation Oncology (Solid Tumors), as well as Internal Medicine and Nephrology. The clinical diversity is such that nurses struggle not only to achieve competence with such rapidly changing knowledge and technology bases but are challenged also to maintain competence. On any given day, upwards of seven different medical services may be providing care to patients and their families on this thirty five bed unit. Surprisingly, amidst the chaos, a significant amount of interprofessional collaboration and patient-centred practice takes place. Given that the bulk of our work concerns patients with cancer diagnoses and because of my passion for Oncology Nursing, I chose to focus my project on the functioning of the oncology team which encompasses the Hematology Oncology, Medical Oncology, and Radiation Oncology patient populations. Using the PPS to identify patients in the transitional phase of their cancer journey, I was curious as to how the concepts of transition and of interprofessional collaboration and patient-centred care were reflected in the practice of the Oncology team as they related to the overall purpose of this project which was to determine the
effectiveness of a standardized tool, the Palliative Performance Scale (PPS), in supporting interprofessional teamwork. Comparison or evaluation of other assessment tools was not within the scope of this project.

Within the larger work of creating electronic resources for Oncology related materials described above, the building block I have created is one using the PPS. The development of the electronic module incorporating the PPS is intended to encourage practitioners to engage in work using this common assessment tool to enhance their communication together (that is, within the context of interprofessional practice) with the aim of improving patient care. Ethical reviews of the project proposal were sought and obtained through ethical review boards both in my practice setting and the University of Victoria, Victoria, British Columbia. In this evaluation project a sample of approximately ninety novice to expert interprofessional colleagues working in cancer care were invited via e-mail (Appendix A) to evaluate the actual and potential effects on interprofessional education/collaboration of an electronic learning module using the PPS.

This module introduced those unfamiliar with the PPS how to use it within the context of the Palliative Care Integration Project using interactive exercises (e.g. true/false questions, critical thinking). Participants were then asked to consider, through reflective questions, how this assessment tool could be used to enhance the communication between professionals providing care to patients with advanced cancer and to help the team determine the appropriate timing of discussions involving changes in the treatment plan (e.g. advancing disease). If one chose to participate in the evaluation project, he/she first had to set up a portfolio (see instructions in Appendix B) in order to retrieve the information. The portfolio then retained the information, indicated the number of times each question was attempted, and tracked the time spent working on the module. Once the module was complete, participants printed their
portfolios, removed any identifying information, and submitted the answers to the student. It was not possible to obtain results from participants in any other manner. A consent form (Appendix C) was attached to the original e-mail invitation. Participants were asked to print and return the consent under separate cover from the portfolio they also submitted.

A systematic analysis of the responses received from practitioners occurred based on the following short-term indicators that were used to guide the analysis both through the implementation of the module and evaluation of the responses.

Indicators included:
1. Reported impact of an electronic educational resource on the learning and clinical practice of novice to expert healthcare professionals within the cancer program of an acute care teaching centre.
2. Value of 24/7 access to educational materials.
3. Reported effects of educational intervention on clinical practice.
4. Reported barriers to interprofessional collaboration.
5. Reported effect of the educational intervention on ability to provide patient-centred care.

Demographic data included:
1. Professional affiliation.
2. How many years have you been practicing?
3. How many years have you been in your current position?

Introductory questions designed to focus the practitioner on palliative needs and to determine whether there were differences noted between professional groups were:
1. Palliative Care is...
2. As a healthcare provider, the most significant thing I can do for a patient with palliative needs is...

3. In dealing with a palliative patient, I would be worried about…

Questions asked of the participants who to part in the on-line module combining the concepts of transition as well as interprofessional practice and patient-centred care were:

1. What are some of the specialized skills people within your own professional group bring to patients in transition?

2. Think about some of the other healthcare professionals you would need to collaborate with while providing care to a patient in transition. What are some of the specialized skills each of these professionals brings to the care team?

3. Describe your experience and/or comfort level with end of life discussions.

4. Describe the approach you currently take to discussing the need to shift from curative/ active treatment to palliative treatment with patients and their families. How might you incorporate the PPS into this approach?

5. How does this approach fit with the interprofessional team?

6. What are some of the challenges your team has had with helping patients transition from active to palliative treatment? Would using an assessment tool such as the PPS aid in overcoming some of the barriers? If so, how?

7. In your opinion, what are some of the barriers to interprofessional collaboration within the cancer program?

8. What are some of the positive experiences you’ve had?

9. Would having access to learning materials and information about interprofessional team work help you, and your clinical team, to provide better care?
In the next chapter I will review the responses obtained in each of these categories. Descriptive themes were developed following analysis of the responses and I offer a discussion of the responses obtained from this interprofessional team.
Chapter 4: Systematic Review of Responses

A total of nineteen respondents from the fields of Nursing (11), Medicine (4), Social Work (3) and Physiotherapy (1) participated in the module and submitted learning portfolios. Although they were invited to participate, no learning portfolios were submitted from Dietitians, Pharmacists or Religious and Spiritual Care providers. Participants submitted their learning portfolios anonymously to the researcher. A systematic content review of the responses received was undertaken. Situated within the methodological paradigm of naturalistic inquiry, qualitative content analysis is “sufficiently open and flexible to permit exploration” (Patton, 2002, p. 255) of the experiences of these healthcare providers with interprofessional, patient centred care of patients with advanced cancers. The goal of content analysis is to “provide knowledge and understanding of the phenomenon under study” (Hsieh & Shannon, 2005). Given that the bulk of published literature to support interprofessional education and collaboration is primarily theoretical, examining the experiences of healthcare professionals who engage in interprofessional collaboration for patient centred care is essential to determine whether interprofessional collaboration improves outcomes for patients and families. Certainly, the risk with this content analysis is that text may have multiple interpretations depending on the subjective interpretation of the researcher (Graneheim & Lundman, 2003). In my case, interests of organizational support for interprofessional practice and experiences of patient and families undergoing transitions shaped my interpretations of the data. Review of the learning portfolios yielded many diverse themes that were further clustered as they related to the main concepts of transitions, interprofessional education and collaboration, and patient-centred care previously identified in the literature. The themes I identified as being related to transitions were: level of acceptance by patient/family, trajectory of functional decline, indicators of a need to shift from
active to palliative treatment, and palliative care. Themes identified as relating to interprofessional education and collaboration were: self/others’ professions and scopes of practice, available supports (organizational, team members), past experiences with interprofessional collaboration and patient-centred care, approach to discussions, efficient communication, barriers to interprofessional collaboration, time, PPS, and IPE. Finally, themes identified as relating to patient and families were: patients’ and families’ needs and practitioners’ comfort level and experience with EOL discussions.

It has been argued that “caregivers must be competent to practice interprofessional care.” (HealthForce Ontario, 2007, p. 8). Competency statements are generally expressed in terms of essential knowledge [e.g. clinical expertise (McKeon, Oswaks & Cunningham, 2006), knowledge and understanding of professional roles (Borduas, et al, 2006; Fineberg, Wegner & Forrow, 2004)] attitudes [e.g. responsibility, (McKeon, Oswaks & Cunningham, 2006; Hall, 2005); professional stereotyping (Gilbert, 2005) and cultures (Ginsburg & Tregunno, 2005)], and behaviours/skills [e.g. communication, adaptability, cooperation, and coordination (Hall, 2005; McKeon, Oswaks & Cunningham, 2006)] exhibited by individuals and systems. The themes from the learning portfolios were therefore, further clustered according to knowledge, attitudes and behaviours expressed by the participants as they identified competencies specific to individuals who function well within an interprofessional team environment. In other words, the central question asked of the data was: “what specific qualities do the members of this team demonstrate that are unique?” The themes as they relate to the previously identified categories are summarized in the following paragraphs.
Demographic Data

Registered Nurses (RNs).

All of the nurse respondents had been practicing nursing for ten years or more (range: 10-39 years). Nurses reported having been in their current positions from six months to 15 years. Of the RNs who responded, only four were clinical nurses (i.e. bedside nurses). The others were working in advanced practice, administration and educational roles.

Physicians (MDs).

Of the four physicians who responded, only one was a resident (i.e. still in a learner role while gaining additional experience in his area of specialization) working within Radiation Oncology. The other three physician respondents were attending physicians who work within Palliative Care and who were very experienced in their profession and in their current roles. While one physician did not identify his level of experience, the others had been working in their profession for nine years or more (range: 9-27 years). They had been working in their current positions from two years to five years.

Social Workers (SW).

All of the Social Workers who responded had been working in their profession for five years or more (range: 5-20 years). They had been in their current positions from seven months to 2.5 years.

Physiotherapy (PT).

The Physiotherapist who responded was a new graduate of seven months and had been in her position since graduation.
Focus on Palliative Needs

The definition of palliative care we espouse in our organization is **active** (emphasis added) total care of patients for whom curative therapies are no longer possible. This philosophy is consistent with the World Health Organization (WHO) definition of Palliative Care (WHO, 1990). The respondents of this project had similar descriptions of what palliative care means to them. Additional components of the definitions provided included providing care to families and with a focus on quality of life [i.e. “living well” (RN #8)].

Transition, Interprofessional Practice and Patient-centred Care

All participants were able to identify specific skills their own professional group could bring to the care of patients with palliative needs. For example, nurses identified that they provide patient advocacy, holistic assessments of patients and families, physical care, patient and family teaching and pain and symptom management skills [e.g. “facilitating a ‘good death’” (RN #5)]. Physicians described skills such as providing palliative radiation, patient/family counseling [e.g. “expected course to assist with end of life planning” (Physician #1)], and medical symptom management. Social Workers self identified bringing the skills of counseling regarding family coping, illness adjustment and end of life issues, knowledge of community resources, and the ability to manage practical issues such as financial concerns, drug program applications, along with wills and power of attorney. Finally, the physiotherapist identified knowledge of transfer techniques and mobility devices as key to the care she provides to maximize the patients’ function during the transitional phase.

In addition to being able to describe skills from their own professional group, many respondents noted that there are degrees of overlap between their professions. For example, several professions indicated that they and others provide counseling, education, comfort care
and support. Several also noted that unregulated care providers (family, friends, volunteers, and support workers) are integral to the healthcare team and ought to have their voices heard.

Finally, all respondents were able to identify skills other professionals from outside their professional group bring to the team. Their descriptions of other professions were consistent with the descriptions each profession offered of themselves; however, not in the same degree of detail. For example, physiotherapists were described as providing the best quality of life through “exercise”; nurses were described as being able to provide emotional support and physical care, and to act as a liaison; doctors were described as being able to provide medical assessments and care planning; social workers were described as providing counseling, emotional support and assisting with paperwork related to placements, pensions, and financial assistance. Certainly, descriptions of other professional groups were not as detailed as those provided by those working within the profession themselves.

*Helping with Transitions*

Two consistent themes were identified by care providers as being integral to helping patients transition from curative to palliative treatment. These themes were first, whether the patient and family had accepted that the disease was incurable and second, whether the patient and family were able to identify their goals of care. Many of the caregivers who have been part of end of life discussions with patients indicated they begin these discussions by asking patients and their families what changes they have observed over time and what they expect to happen in the future. While fifteen of the providers indicated they were relatively comfortable having end of life discussions, they acknowledged it is never easy and they are continually learning how to modify their approach. One respondent explained the approach she uses in her practice when
involved in these discussions: “focus on the individual and family, listen more than speak, it is such a privilege to be engaged in this way with patient/family.” (RN #8).

Acceptance.

Approaching some of these difficult discussions by asking patients and families about the changes they have observed in the patient’s overall condition, these healthcare professionals are assessing whether patients and/or family members are aware of the decline and have begun to accept that the outcome of this disease will likely be death. One RN aptly described what families struggling with acceptance often looks like: “occasionally families see a decline in health status due to disease progression or complications as a failure. They encourage people to try harder, to fight, to seek another opinion.” (RN #8). Another RN describes these types of situations as being challenging for the healthcare team when “family members are not on the same page as the patient in regards to their conditions or treatment plan.” (RN #4).

Goals of care.

A key component to determining the need to revisit the goals of care according to these professionals is the trajectory of the disease process. In other words, how quickly the patient is changing by virtue of the “speed of change in the functional status.” (MD #3). “A change in the PPS may indicate that something needs to be reassessed.” (MD #4). They use these changes to explore the related meanings with patients and families (MD #4). Once meanings have been explored, one nurse noted that for patients it is “sometimes a relief to stop active treatment.” (RN #8). Often, as one social worker noted, “families want reassurance that their family member is not in pain or they have a fear of the dying process.” (SW #3). When these meanings are uncovered, the care team can focus on ensuring these needs are met. This can make certain patients’ goals remain central to our short term and long term plans of care.
The ability to help patients and their families’ transition is impacted, according to these healthcare providers, by a number of challenges and barriers related to interprofessional learning and collaborative practice. Some of these barriers will be discussed in the following section.

Challenges and Barriers to Interprofessional Collaboration

The many challenges identified by these care providers stem mainly from two consistent themes - time and communication. Time to build rapport with patients and their families as well as amongst members of the team is difficult to set aside in the acute care setting which is designed around efficiencies measured by tasks completed. Time is also required for new team members to gain an understanding of the disease processes and to develop a comfort level with working with patients who will not likely recover from their cancers. One respondent noted:

A common barrier in a teaching hospital is the reluctance of residents to shift from curative/active to palliative. I think they see this as a failure, and want to keep going until the new team takes over. If the residents were familiar with the PPS they might be more open to shifting to palliative care realizing it is a normal progression of events. (RN #5).

Lack of time prohibits team members from face to face contact when they deem it is necessary for care planning. Closely linked with the concept of time is the allusion to the lack of adequate staff as noted by the physiotherapist. In addition, the often incongruent schedules [e.g. shift work, cross coverage by physicians on evening, night and weekend shifts (i.e. back shifts)] of the care team members limit the ability to “get in touch with the necessary person to discuss issues at the point of care.” (MD #3). RN #5 noted:

Difficult times are almost always on the back shift when you are dealing with on-call people, less likely to be familiar with the tools we use. I think for the most part, when there is written support of suggestions, the on-call person is more apt to be receptive.

Within our inpatient setting, we talk about “on the fly” communication. In other words, much information is exchanged and short term plans determined between care providers passing
each other in the corridor rather than in predetermined care planning sessions. This type of communication occurs not only due to time constraints but because of the lack of common meeting space for care planning. The organization itself is undergoing a major reconstruction process which had necessitated closing a significant number of conference rooms previously used for care planning. Even family meetings take place in common areas on the unit (e.g. patient sun room) that may incur numerous interruptions. However, despite the numerous barriers, the respondents similarly listed a number of positive experiences they have had with interprofessional collaboration within the cancer program.

*Positive Experiences*

The two main themes capturing the positive experiences of these healthcare providers are patient-centredness and shared care. While several respondents indicated their focus on the patients in providing care, there were some subtle differences in their responses, perhaps related to their professional backgrounds. For example, “optimizing seamless, accessible care that meets the need of *that* (emphasis added) patient and family” was seen as central for MD #3. Whereas SW #2 viewed “ensuring that their wishes, desires and worries are understood and respected by those responsible for their medical care”, and providing “a safe outlet to allow them to process their feelings and thoughts” as integral components of her role. SW #2 also indicated her role is to “ensure they are being heard and understood.” One RN respondent believed her role is to “see them as a unique person with information to share with me that I can use as I apply my knowledge and experience to help them in ways that are appropriate and acceptable to *them* (emphasis added).” (RN #8).

With respect to shared care, respondents noted that in collaborative teams they are able to provide care for a larger number of patients. Additionally, collaboration and overall shared
concern for the well-being of patients from all perspectives is achieved while benefitting from the strengths of each member of the team. Inherent in this is a sense of mutual trust and respect from the care providers. The physiotherapist, the team’s most recent addition, eloquently described her experience with interprofessional collaboration:

I work on 2 main interprofessional teams. One team is a great team. There is clear communication between all, information and goals of care are made very clear to all involved, and we all get along and enjoy each other. Most importantly, we value and respect what each other has to say in their area of expertise. In comparison, the other team definitely lacks communication and this makes it very, very difficult to provide quality care. (PT #1).

24/7 Access to Educational Resources

Fourteen of the respondents indicated that they thought it would be beneficial to the team and potentially to patient care to have access to resources around the clock via the internet. Those who offered further information were careful to caution that availability of resources is only one of the factors to consider. Other factors are: buy-in from the team; a wide variety of opportunities that would include electronic media and sessions offered after usual hours; lack of awareness of available resources due to the rapid turnover of some team members; and support and encouragement to engage in interprofessional teamwork by management. One participant was particularly adamant that administration ought to “facilitate working conditions and working models that are naturally conducive to interprofessional collaboration - we all want it, now we need ‘help from above’ to make it happen in concrete ways.” (MD #2).

Pros and Cons of using a Common Assessment Tool

All of the participants were able to identify several advantages as well as disadvantages to utilizing a common assessment tool such as the PPS in their practice. The PPS was viewed as being a relative time saver for participants who communicate about changes in patients’ conditions several times a day. All of these participants indicated they spend significant amounts
of time communicating patients’ conditions to other care providers throughout the day in the form of hand-overs, rounds, discharge planning and family meetings. One social worker estimated she spends up to four hours some days in this type of communication. Also, the PPS was believed to provide an objective perspective of patients’ conditions. Providers thought the tool was reliable, meaningful and reproducible in that all care providers use a common language allowing for precision of communication that has implications for the entire team when it comes to care planning. Finally, the healthcare professionals noted that trends identified in the PPS demonstrate significant changes in patients’ conditions - “it speaks volumes to her needs without having to say them.” (MD #1).

Perhaps the biggest disadvantage to using a common tool identified by this group of practitioners was the potential of oversimplifying patients’ conditions to the point of losing sight of individual patient needs. One RN noted that it is important not to forget other specific assessments that may be needed (e.g. vital signs, inspection, palpation, chest assessments, mood, cognition and the needs of the patient’s family). Hence the PPS should not be considered to be the only assessment tool. Patient’s conditions are complex and therefore require comprehensive assessments. Several practitioners also thought that by using the PPS, there was a risk of getting “hung up on numbers” without interpreting the meaning of such numbers. An example cited was the use of oxygen saturations. The number itself is more meaningful when considered within the context of patient norms, hemoglobin values and underlying conditions such as COPD before determining the implications of the number on the patient’s overall condition. Similarly, the PPS score must be considered within the larger context of the patient’s condition and is specific to each patient. For example, a patient with cancer who has also been using a wheelchair for a number of years due to a traumatic spinal cord injury will have a PPS score between 40 and 50%
if taken at face value. And yet, this person, within the context of his overall functioning, is likely functioning at a much higher level than the PPS would indicate. Conversely, utilization of a g-tube to administer nutritional supplements to a patient no longer able to tolerate oral nutrition may disproportionately increase the PPS score unless the context of the individual patients’ situation is accounted for.

In the following chapter, I will discuss the relationship of these topics with the current literature related to the knowledge, attitudes and behaviours about interprofessional collaboration and patient-centred care.
Chapter 5: Discussion

While the number of respondents was relatively small in this project, I was struck by the consistency of the information they provided about their own experience in the interprofessional oncology team within their organization with the published literature on the subject. Perhaps these responses reflect the experiences of care providers who function well within an interprofessional team environment and who demonstrate the core competencies of collaborative practice. Responses from this group of healthcare professionals indicate that highly functioning interprofessional teams have embedded the attributes of collaboration and patient-centred care within their culture.

Many concepts explored within the module related to the use of a common assessment tool (PPS) for patients with palliative needs, interprofessional teamwork and patient-centred care, and transitions. These concepts are further discussed according to the three themes of knowledge, attitudes and behaviours of the respondents.

Knowledge

First and foremost, each professional must have a sound knowledge of their own professional identity and scope of practice. While the impact of professional cultures on interprofessional collaboration is important to note, an in depth discussion is beyond the scope of this paper. What is noteworthy within this project was the depth in which each professional was able to describe their various roles in providing care to patients with advanced cancer. There were no significant discrepancies noted between members of the same professional group. Inherent in this professional identity was the evidence of reflective practice particularly around areas of practice respondents found to be difficult (e.g. initiating end of life discussions).
Respondents noted that their ability to engage in difficult discussions with patients and families was “better than in the past” but “still improving”.

Second, the knowledge and respect of the contributions of other professionals in providing care to this complex patient population was key in demonstrating the collaborative practice of this team. While the respondents were unable to describe the contributions of other professionals outside their own professional group with the same degree of depth as professionals could describe contributions of their own profession, they appeared to have a solid grasp of some of the key functions of each. As well, they occasionally described some overlapping functions (e.g. counseling and education) but recognized that each profession brings a different focus to each of these functions. They did not indicate that these areas of overlap were problematic for patients or families. Trust and respect of contributions of other professionals was also identified by Fineberg, Wenger, & Forrow (2004).

While I have no doubt that these respondents are painfully aware of the health human resource shortage plaguing us today, interestingly inadequate staffing was not seen as one of the predominant barriers to interprofessional practice or patient-centred care within this team. In fact, “lack of staff” was mentioned by only one respondent. And while collaborative patient-centred practice may indeed serve to help recruit and retain healthcare providers as well as improve the efficiency of health human resources as Oandasan, et al. (2004) claim, it is not clear from this group whether recruitment and retention or efficiencies are directly linked to collaborative patient-centred practice. Where efficiencies are noted is in the use of the PPS to streamline communication of patient’s conditions between care providers, some of whom spend hours a day in this form of communication.
Knowledge of the PPS and potential benefits it offered was seen as valuable once team members had acquired the skills of using the tool. To acquire the skills necessitated an investment of time to use the tool accurately and it was noted that not all practitioners will make themselves familiar with the tool and there is potential burden for those who do use it to teach others how to use it.

Several respondents within the fields of medicine and social work described the communication and continuity of care between the inpatient and outpatient settings as fragmented. These observations are consistent with the findings of Curtis, Engelberg, Wenrich, Shannon, Treece, & Rubenfeld (2005); Kristjanson, et al. (1997); Morita, Akechi, Masayuke, Kizawa, Kohara, Mukaiyama, et al. (2005); Norton & Talerico (2000); and Woods, Craig, & Dering (2006) who also indicated that quality care and services including care coordination between settings are challenges to patient-centred care. I suspect that these concerns were identified by those professionals who follow patients throughout the continuum of care and across all settings. They are certainly in the best position to observe the gaps in the system.

Transition.

The practitioners who responded to this project described, in various ways, some of the essential properties of transitions described by Meleis et al. (2000). These practitioners described “awareness” in terms of information they elicit from patients and their families regarding “what has been happening, where they think they are, what they think may happen, worries, etc.” (MD #1). They use the responses as ‘jumping off’ points to begin the discussions, clarify concerns and understand changes. In some cases, these discussions are initiated by the care providers and in others they are initiated by pro-active patients and families. Lack of understanding of the term “palliative” is seen as a barrier to transition. In the minds of many it is
“giving up”; “there is nothing more we can do.” (RN #8). This statement is consistent with the findings of Thompson, McClement and Daeninck (2006) that also indicate patient/family lack of knowledge regarding the goals of palliative care is viewed as a barrier to the transition process.

The level of “engagement” in the transition process was described by “exploring references regarding care now and in the future and options available if they want to know them” (MD #3). Certainly, several practitioners acknowledge that some patients and families prefer to take a more active role than others. Doane and Varcoe (2005) caution us to refrain from the assumption that expert knowledge represents the complete reality of families. “...Even the treatment of physical disease must be located within the personal and contextual uniqueness of people and their everyday lives.” (Doane & Varcoe, 2005, p. 7). In other words, we can not rush or force the transition process, we need to take our lead from the patient and the family despite the anxiety and frustration incurred by the healthcare providers.

In terms of “change and difference” the practitioners approached this element in two ways. The first and most predominant description was to begin exploring the patient’s and family’s observations of “how the patient’s condition and function has changed over periods of time, especially recently” (MD #3). But the second and perhaps most creative way of identifying the need to approach “change and difference” with patients and families was in utilizing the PPS as a reliable, meaningful guide for practitioners. “A change in PPS raises the flag that something needs to be re-assessed. Maybe it is the medical condition, maybe it is the goals of care but something has changed so we need to look again.” (MD #4).

“Timespan” is closely linked to the respondents’ descriptions that the “concept of trajectory of functional decline would be central to the discussion.” (MD #4). In addition, the PPS was again seen as a valuable asset to describe the trajectory particularly among the members
of the healthcare team. “The PPS is useful to inform care team of how much a person has changed over what time and helps guide the types of discussions we might initiate.” (RN #8).

And finally, “critical points and events” were elicited from the overall discussions centred on changes in the patients’ condition over time. Respondents believed part of the role of the healthcare team was to “help them understand the path a person has travelled and the magnitude of their decline.” (RN #8). Discussions such as these, in turn, sometimes led to further discussion of hopes and fears.

**Attitudes**

While many of the respondents indicated they are comfortable with end of life discussions, indicating they have acquired a certain level of skill over time, most of the respondents believe that these types of discussions, although always difficult, are integral to the care they provide to patients with advanced cancer. They also indicated that their degree of comfort is shaped by their past experiences both with end of life care and interprofessional collaboration. The literature indicates that both the experience and comfort of the practitioner with end-of-life discussions (Norton & Talerico, 2000) may pose challenges to their ability to communicate with patients about such topics. Certainly these practitioners appear to have developed a certain comfort level and skill with these difficult discussions. What several of these practitioners do note is their reliance on other members of the team for mutual support in coping with difficult patient situations. Often patient or family situations evoke strong emotional reactions from some team members. Whatever the source of the emotion, (e.g. if the patient is very young or has young children; if the patient has no family support) these team members found strength in support provided by other members of the team. This finding has not previously been cited as a key component of interprofessional team functioning, but is an area
for future research. Sadly, the attitudes of novice practitioners in the fields of medicine, nursing and social work are not available for comparison to these experienced staff since none responded to the survey. The one novice physiotherapist who responded believed her role was more within the context of discussions amongst the interprofessional team members rather than in initiating these discussions with patients themselves.

The attitude of these practitioners regarding interprofessional collaboration has been to embrace the concept as integral to their practice. However, they note that top down support and active engagement to foster the culture of interprofessionalism is required to sustain this team and to motivate others to engage in interprofessional, collaborative practice. In other words, administrative support both within the organization and within the larger healthcare system is required to ensure all healthcare providers have the opportunity to engage in interprofessional, patient-centred practice while simultaneously demonstrating the value to patients and to healthcare outcomes. This is consistent with the theories on interprofessional education and teamwork of Barker, Bosco, & Oandasan (2005); Borduas, et al. (2006); and Oandasan & Reeves (2005).

**Behaviours**

According to Hall (2005), the following skills are essential for collaboration and effective teamwork: cooperation, assertiveness, responsibility, communication, autonomy, and coordination. All but one of the respondents had fairly extensive experience practicing in their professional roles which may be indicative of them having had the opportunity to build linkages between their professional silos once engaged in clinical practice, or perhaps the culture of this particular team is one that embraces interprofessional collaboration and patient-centred care. Given that approximately half of patients with advanced cancer will die as a result of their
disease process or complications from it, this team appears to have developed the skill of caring for people as they die which is consistent with Byock’s (2000) claim that this skill is an integral component of cancer care. Sadly, none of the respondents were from the disciplines of pharmacy, dietitians, or religious and spiritual care. As well, only 4 of the respondents were clinical nurses, all with extensive experience working with patients with advanced cancer. It would have been interesting to see if novice nurses had similar or different experiences from their more experienced counterparts. Similarly, the lack of response from residents was notable.

One of the key behaviours evident in this care team is the consistent focus on the needs of the patient and family. In fact, one of the common themes raised by practitioners as the most important thing they could do for a patient with advanced cancer was to take time to “listen.” My sense is that in the rapid pace of the acute care setting, these practitioners are pressured to produce tangible, measurable results or outcomes which are sometimes in direct conflict with the need to address patients’ individual needs such as their hopes and fears. Taking time to listen conveys the message that the needs of the patient are more important in this moment than the needs of the organization. Since the “transitional” phase of a cancer patient’s disease as characterized by a score of 40-60% on the PPS, is viewed as the most difficult for patients due to increasing physical and informational needs and impacting all spheres of life (Anderson, et al., 1996), it stands to reason that these patients will require a greater amount of time from their care providers. Although not explicitly stated by these respondents, utilization of a valid, reliable tool such as the PPS may enable care providers to meet the needs of administration by offering a means to describe workload of practitioners and the needs of patients.

And certainly, while evidence-based care has been described as the polar opposite to patient-centred care (Bensing, 2000), this team appears to have developed a certain comfort level
with the shades of grey in between the two. Definitely much of our practice in terms of medication and procedures is based on quantitative, gold standard research, but qualitative research also plays a key role in understanding patients’ lived experiences during their cancer journey and in particular, in the area of comfort care.

The members of this team also appear comfortable with the degrees of overlap between their professions and view this as a positive quality that enables them to benefit from the strengths of each member of the team. This quality is deemed essential for collaboration and teamwork by Hall (2005), but has been criticized by others. While each professional discipline functions within a scope of practice as defined by their governing body, the evolution of each profession as practices change is beginning to lead to blurred boundaries between professions; that is, some skills may now be common to one or more professions. Some authors argue that these blurred boundaries lead to ambiguity and confusion (Rushmer, 2005). I disagree with that opinion and would argue that in our current acute care environments, these blurred boundaries have created a better understanding of the challenges each profession faces and have in turn created a safety net which has reduced a number of errors and oversights in patient care. In addition, these respondents do not appear to have fallen prey to the power imbalances and protective professional cultures often cited within the hierarchical nature of healthcare settings (Borduas, Frank, Hall, Handfield-Jones, Hardwick, Ho, et al., 2006; Gilbert, 2005; Hall, 2005).

Implications for Practice

The inpatient oncology setting is only a small component of the ongoing care continuum of patients with advanced cancer. Cancer care also takes place in the ambulatory, community and long term care settings. It is therefore imperative that clinicians develop ways of ensuring seamless care for these patients not only within the acute care environment but across settings.
While these professionals readily acknowledge the challenges they face in providing care to patients with advanced cancer (e.g. little time, inability to meet as a team, readiness of the patient/family to revisit the goals of care), they have developed some strategies that enable them to work around these barriers in the short term recognizing that upper level support is required to sustain these practices in the long term. I think that this is what is most evident from the information they have provided; that they have focused their energies on the needs of the patients in an action oriented way and in so doing, have developed some very innovative means of collaborating. Yet, I am also not so naive as to assume that this sample is representative of healthcare professionals in general nor that the opinions expressed by this group are necessarily shared by their professional counterparts working either in cancer care or in other areas of practice. I am confident that they share a mutual trust and respect both for each other and the patients and families they work with who are affected by cancer. Whether this mutual trust and respect develops over time or is inherent in their practice by virtue self preservation due to the chronic and stressful nature of cancer care, I do not know.

The PPS is viewed as a useful tool in that it quickly and accurately describes a patients’ functional condition. The respondents however, cautioned that the tool must be used in conjunction with other assessments in order to get a comprehensive picture of the patient. The objective nature of the tool itself can be used as a jumping off point to initiate discussions with patients and families when it is identified either by the practitioner or the patient and family that the goals of care need to be readdressed. In addition, the common language used within the PPS transcends the various languages individual professionals learned within their respective disciplines.
The often conflicting schedules of staff working in the acute care setting was a challenge that they saw access to educational resources available via the internet as helping them to partially overcome. Resources that relate to both interprofessional collaboration and to the PPS were thought to augment their knowledge and to support the functioning of the team.

Implications for Advance Practice Nurses

Advanced Practice Nurses (APNs) have the opportunity to strengthen and cement the nurse-patient relationship because they are able to work with patients and their families across the continuum of cancer care from diagnosis to palliation and in so doing help them through the many transitions they experience along the way. Nurses in advanced practice function within five roles: clinical practice, research, leadership, collaboration, and change (CNA, 2002). All of the roles are interwoven and enacted simultaneously on many levels and also within three spheres of influence - patient/families, nurses/nursing personnel and systems/organizations (Fulton, 2003).

APNs working within clinical practice are aware of the multiple influences on a patient’s experience and must help the whole team to approach each situation from the unique patient and family perspectives. APNs are able to use their advanced knowledge within their area of expertise to anticipate patient and family needs in the near and distant future. If we agree with Meleis and Trangenstein (1994) when they claim that nursing, more so than other professions, is concerned with the process and experiences of people undergoing transitions and that health and well-being is the outcome, then an APN serves to continually redirect the team toward these goals. The team studied here identified that acceptance of the goals of care was key in helping patients to transition from curative to palliative care. The APN is integral in assessing whether patients and their families have come to accept the implications of having a diagnosis of
advanced cancer and to help them define or redefine their goals of care. In addition, APNs support staff to utilize potentially time saving tools such as the PPS that also improve communication between members of the interprofessional team. Excessive workloads, patient acuity and the learning needs of inexperienced clinicians take their toll on the physical, mental and emotional well-being of staff as well as their abilities to collaborate as a team. APNs provide clinical support and education to less experienced staff in ambiguous and complex patient situations.

Within the role of research, an APN advances research in the field of interprofessional collaboration and patient-centred care. Incorporating research that is both quantitative and qualitative into practice is essential for patients with advanced cancer. Focusing on research that enhances our understanding of the lived experiences of our patients is an essential role of the APN. This type of research adds value to nursing and our understanding of transitions as well as to the goals of health and well-being.

The leadership role may well be the most challenging. When a system is undergoing the level of change that is now the case within health care, many individuals and groups respond by holding onto traditional, familiar practice models – even when these can be demonstrated to have less positive outcomes for patients and families. APN’s are well positioned to provide and advocate for organizational and political support for clinicians to practice safely within their scopes of practice. Furthermore, APNs provide the required leadership to analyze scopes of practice, particularly in nursing, to ensure staff are functioning to their full scope. This enables teams to utilize the skills of each team member as fully and effectively as possible to deliver the best quality of care despite dwindling healthcare resources. Given that patients with advanced
cancer have very complex needs, healthcare teams must be able to focus holistically on future needs while also attending to those in the present.

Within the role of collaboration, APNs advocate on behalf of patients while addressing roadblocks that occur at micro, meso, and macro levels of the healthcare environment. Several members of this team identified that communication between care settings is fragmented. An APN works within these teams utilizing her in depth knowledge of patients, teams and systems to facilitate innovative methods of communication that meet the needs of patients and practitioners across the continuum of care. Improving continuity of care between settings may ultimately improve patient and family satisfaction of the care they receive. By continually seeking the input of all members of the team, an APN models the collaborative process of planning patient care.

As a change agent, the APN who models collaborative practice and patient-centred care demonstrates the value placed on all members of the healthcare team whether they are professional or non-professional care providers. An APN would be well positioned within the organizational structure of an acute care setting to advocate for ongoing support of teams engaging in interprofessional practice. Recognition must be given to the multiple barriers that affect interprofessional teamwork and the innovative ways teams have overcome some of these barriers.
References


Centre for the Advancement of Interprofessional Education (2002). *Interprofessional Education.*


*Clinical Nurse Specialist, 20*(6), 298-304.


Appendix A
Recruitment Notice

Dear Colleague,

I am seeking your assistance in evaluating the impact of interprofessional communication/collaboration during times of transition for cancer patients with advanced disease.

I have created an electronic learning module using the Palliative Performance Scale (PPS) which is incorporated into the collaborative care plans from the Palliative Care Integration Project. There are reflective questions within the module that should you choose to participate in my project, you will be asked to print and submit to me for content analysis. If you do not choose to participate, please feel free to use the module to enhance your learning of the PPS.

Thanks for your consideration.

Lee Ann Fox, RN, BScN, CON(C), CHPCN(C), MN(student)
University of Victoria
Appendix B

Module Instructions

1) On your internet toolbar, type in:  URL link

2) Click on "The Palliative Performance Scale". You may need to scroll down through the modules.

3) The first time you sign in, you will need to create an account.

4) On the left side of the page, "register" your portfolio.

5) Create an account following instructions on the page.

6) Once your account is set up, the screen will indicate: “Hello, your portfolio does not yet contain any activities. Log out. Note: You will only have to do this once.

7) Again, type in :   URL   link  on your toolbar.

8) Click on “The Palliative Performance Scale”.

9) On the left side of the page, type in your e-mail address. The left side of the screen will then indicate: “hello (your name).”

10) Complete the module.

11) Save your answers. Note: You may complete portions of the module at your convenience, just remember to save the information each time.

12) Once completed, click "View Portfolio"

13) Choose "View Customized Portfolio"

14) Print your answers.

15) Remove any personal information from the print copy and return to Lee Ann Fox.

16) Don’t forget to log out.
Appendix C

Participant Consent Form

NURA 598/599 Course Project, School of Nursing, University of Victoria

Topic:

The impact of interprofessional communication/collaboration during times of transition (e.g. progressive disease, physical deterioration) for cancer patients with advanced disease.

Student Investigator: Lee Ann Fox

Student ID Number: 0437353

You are invited to participate in a study entitled: “The impact of interprofessional communication/collaboration during times of transition (e.g. progressive disease, physical deterioration) for cancer patients with advanced disease” that is being conducted by Lee Ann Fox.

Purpose:

In participating in this project you will be asked through completion of the electronic learning module to reflect on and to describe your experience with the topic of the project (The impact of interprofessional communication/collaboration during times of transition (e.g. progressive disease, physical deterioration) for cancer patients with advanced disease.) and to reflect on the meaning this may have for you.

Importance of the research:

This type of study would serve to allow healthcare professionals a better understanding of each other’s roles in end-of-life discussions thereby improving communication between providers and with patients.
Participant Selection:

You are being asked to participate in this study because you work in an interprofessional setting with patients with advanced cancer.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the project is about and what your participation will involve. If you want more information than is mentioned here you should feel free to ask. Please take the time to read this carefully and understand any accompanying information.

Before you agree to participate you should know that:

- Participation is voluntary.
- Your identity will remain private. Your real name will not be attached to any of the project information.
- Because of the small and specific sample size (e.g. participants potentially know each other and work with each other) there may be limits to confidentiality.
- You have the freedom to stop using the module and to withdraw from the project at any point in time.
- There is no payment for your participation in this project.
- There is no known risk to you for participating in this project.
- All data will be destroyed by shredding within 6 months of the completion of this project.
- A copy of the results will be made available on your unit at the completion of this project.

Your signature on this form indicates that you have understood to your satisfaction the information regarding this course project. If you have further questions, please feel free to contact Lee Ann Fox, Graduate Student in the School of Nursing at the University of Victoria;
Alastair Lamb, Program Operations Director, Integrated/Regional Oncology Program Cancer Centre at an urban hospital in Central Canada; Dr. Mary Ellen Purkis, Dean, Human and Social Development, University of Victoria at (250) 721-8049; or UVic Human Research Ethics Office at (250) 472-4545.

__________________________________________  _______________________
Participant’s signature                      Date

__________________________________________  _______________________
Investigator’s signature                     Date

A copy of this consent form has been given to you to keep for your records and reference.