THE PALLIATIVE CARE TEAM – Competences Necessary for its Success and Factors that Influence the Team Functionality

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Abstract

The aim of this thesis was to gain a deeper understanding and knowledge about palliative care teams and the competences and factors that influence the success and functionality of the team. The method used in the thesis is content analysis, using the deductive approach as described by Elo and Kyngäs (2007). Three themes emerged from the theoretical background: competences necessary for effective palliative team work, factors that promote team success, and factors that inhibit team success. The theoretical background was provided by such authors and palliative care experts as Olthuis (2007), Connor (2009), and Speck (2006) as well as by the World Health Organization and the Ministry of Social Affairs and Health in Finland. Olthuis' (2007) theories about the moral attitude of palliative care workers have provided the theoretical lens for this study.

The results of this study point to communication, education, morals, and responsibility as important competences of palliative care staff. Factors that promote the success of the team are among others respect, interdependence, philosophical alignment. Stress, boundaries, and conflict are among the factors that inhibit team success. This study provides an opening to further research and new thoughts for the regional development of palliative care programs.

Language: English Key Words: palliative care team, Competences, moral attitude

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Contents

1 Introduction

Compassionate palliative care requires commitment from all levels of health care administration and planning. This commitment is required on both the national and on the local level. My personal interest in the subject of palliative care got its start during my first nursing school practice period in geriatric care. One of the patients, a lady 101 years of age, was dying. It was my first experience of a dying patient. Naturally I did not know what to expect, how to behave and how to care for the patient. This lady was born when Finland was a part of the Russian empire. She was already an adult during World War II. She was 60 years old when man walked on the moon for the first time. This long life ended in loneliness and pain with no one to hold her hand as she took her last breaths. I was affected by her death and the way she died. The experience started an interest in and commitment to the improvement of palliative care in Finland. This study is a contribution to the growing amount of research in palliative care at the end of life.

The modern hospice movement started 50 years ago, as a rebellion against the way people were cared for when they were dying. Even though improvements have been made, the majority of people die in institutions, often alone and in pain. (SUPPORT Investigators, 1995) Advances in medical treatment and demographic trends lead to the fact that the elderly part of the population is becoming larger than ever. People want quality of life to continue into old age, leading to a growing interest in palliative care and hospice. Palliative care has become an important part of health care in many countries. Even so, hospice and palliative care is still not understood by the great majority of people. (Connor, 2009, ix).

For the development of the palliative medicine specialty, the creation of a scientific evidence base is of great importance. There is a demand for research that examines the best way to provide palliative care. How should palliative care be organized in order to deliver the best possible outcome for the patients and their families? The wished for outcome will vary from individual to individual

and has to be assessed accordingly. The impact of palliative care teams needs further study. (Teno, 2002, 94-95).

During the spring of 2009, the Ministry of Social Affairs and Health conducted a discussion about the development of palliative care in Finland. The plans of each health care district and large city were reviewed. The government's recommendations for the development of palliative care were published in 2010. As a result of the discussion, a need to identify and develop the chain of care emerged. A well-functioning chain of care is necessary for the continuity of care and for the achievement of high quality care. Included in the recommendations is the development of multiprofessional teams in order to provide the desired quality of care. (Social- och hälsovårdsministeriet, 2010, 31-32).

There is a general assumption that palliative care is best provided by a interdisciplinary team. However, more research is needed into the relationships within teams, the effectiveness of different approaches, and team working styles. (Corner, 2003, 10) This study was conducted in order to throw some light on palliative care teams and the factors that influence the care provided by these teams.

2 Aim and Research Questions

The aim of this study is to identify and describe the factors that influence the success and health of a palliative care team. This study intends to throw light on the competences necessary for the members of a well-functioning palliative care team. Factors that promote the success of a palliative care team will be identified as well as factors that inhibit the success.

What competences and professions does the ideal palliative care team contain? Which factors influence the success and health of the team? What is the ideal model for a team?

3 Theoretical Background

The theoretical background chapter contains a description of the paradigms used as a base for this study. Olthuis' (2007) theories about moral attitude in palliative care have been used as the theoretical lens when approaching the study material. The chapter *The historical development of palliative care* provides a basis for palliative care theories. The World Health Organization's position on palliative care is explored. Lastly, the philosophy of hospice chapter throws light on the underlying ethics and challenges of palliative care.

3.1 Paradigms

There are certain belief systems that influence how the world around us is viewed. These belief systems are called paradigms. The biomedical model belongs to the mechanistic paradigm where everything in life is seen as a machine that can be taken apart and its separate parts studied. In the biomedical view, the human body can be dismantled and its different diseased parts treated, either with surgery or medication. Mind and body have been separated. The view of the patient as a whole human being has been lost. (Nyberg, 1998, 7).

In the organistic belief system the world is seen as an interdependent, growing exchange between several parts which make up a whole. This whole is different from the sum of its parts. In the organistic paradigm the vision of reality is based on the recognition of the interdependence of all physical,

biological, psychological, social, and cultural phenomena. A healthy patient is seen as having a dynamic balance between the physical, mental, and social parts of his being. (Nyberg, 1998, 7-8).

Traditionally, organizations have been viewed and studied as mechanistic systems where the humans in the organization have received little attention. In the organistic system, organizations can be seen as interacting units with characteristics that are more than the sum of their parts. There has been a paradigm shift in health care. There is a beginning understanding of the patient as a holistic being who needs treatment as a whole human being. (Nyberg, 1998, 8).

The paradigm of wholeness is acknowledged by the palliative care approach. The physical comfort of the patient is taken care of first. Symptom control is of outmost importance. When there is a sense of physical well-being, other needs can be addressed. In palliative care the person is seen as a whole, unique being. Illness affects the soul and psyche as well, not just the body. (Connor, 2009, 10-11).

3.2 Theoretical Lens

This study is situated in the palliative approach to care. Olthuis argues that "palliative care requires virtuous practitioners who are able to provide emotionally involved care." (Olthuis, (2007, 7) At the center of palliative care lies the care for patients and their families from all aspects of life; physical, psychosocial, and spiritual. The basis for whole person care is the relationship between the professional and the patient. Due to the unequal relationship, two moral conditions are necessary to achieve the goals of the care: the carer has to be committed to the good of the patient, and the patient has to trust that commitment. (Olthuis, 2007, 13).

To be a competent healthcare professional, one has to commit to certain core values, not just apply the correct skills and knowledge. Palliative care education needs to emphasize a deeper moral view in its curriculum. The care of dying patients has been affected by the trend to medicalize palliative care. The technical approach needs to be balanced with the humanistic, 'total' care approach. The professional competence of physicians consists of seven dimensions: technical expertise, cognition, context, integration, moral attitude, relationship, and habits of mind. Cognitive and technical skills are taught at medical school but palliative care requires more than just applying learned skills. (Olthuis, 2007, 21-25).

A vital dimension of competence in palliative care is the moral attitude. Tronto describes four moral aspects of caring: 1) the recognition of a need for care, 2) taking care of, which demands responsibility from society and individual caregivers, 3) the need for competent care, the need for care is not met if the carer fails to provide good care, 4) the care-receiving, the patient's response to the care offered, a situation where attention needs to be paid to the patient's vulnerability. (1993, 125-137) The four moral aspects emphasize the importance of a wider ethical view of professional competence. (Olthuis, 2007, 29).

The view on health care professionalism is too much concentrated on knowledge and skill achievement. The inter-human contact aspect of professionalism takes a back seat in the practice of care. Professional care consists of two parts; the compassion which leads to the initiative to act and the rewards from experiencing interaction with other human beings. "Professional care centers on skillfulness *and* on ethically relevant inter-human contact between colleagues, caregivers, and care receivers." (Olthuis, 2007, 136).

In order to avoid self-sacrifice, caregivers need to be able to strike a balance while giving care. The caregiver and care receiver communicate through a caring conversation where the uniqueness and suffering other is acknowledged and respected. Practical wisdom can be seen as a competence of a palliative care professional. Practical wisdom contains self-awareness, responsibility and

professional practice. It enables caregivers to choose the right kind of action in a situation while at the same time having the understanding that the quality of the care is dependent on their personal commitment and effort. "A caregiver's intention to care for a palliative care patient implies a responsibility to provide professionally competent palliative care. (Olthuis, 2007, 137-140).

Fredriksson and Eriksson write about the first component of the ethical aim, which Aristotle referred to as 'the good life'. For a nurse, the good life assumes autonomy and self-esteem. These two characteristics turn into the second component which is caritas. Self-esteem turns into self-respect on the moral plane and esteem for others becomes respect. Autonomy, in turn, becomes responsibility. The suffering of the patient inhibits both autonomy and self-esteem, troubling the good life we intend for the patient. Caritas motivates the nurse to care for the patient. "The caring conversation, in the ethical context, is a conversation in which one person through the ethos of caritas, makes room for a suffering person to regain his or her self-esteem, and thus make possible a good life." (2003, 144-146).

According to Olthuis, "caring is a process of paying attention to what other people need, taking the responsibility to fulfill that need, and having the actual competence to provide the care that is needed. (2007, 143) Connor emphasizes the need for the development of a process for recognizing competence in hospice and palliative care. (2009, 206).

3.3 The Historical Development of Palliative Care

The word "hospice" is derived from the Latin word "hospitium". Hospitium means hospitality, lodging, inn, or entertainment. The word evolved into "hospital", a place for the temporarily sick as well as into "hospice", a place of permanent residency for the poor, insane, crippled, and incurable people. Hospitals first served the Roman soldiers. In the fourth century hospitals and

hospices started caring for travelers and sick people. (Sheehan & Forman, 1996, 2).

The word "palliative" is derived from the Greek language. It is translated as "to cloak". In the care of the dying, the interventions are meant to prevent the experience of pain and other agonizing symptoms. The National Hospice and Palliative Care Organization (NHCPO) in the USA defines palliative care as "treatment that enhances comfort and improves the quality of an individual's life during the last phase of life." (Connor, 2009, 2).

In modern times the word hospice is used to describe a care program for individuals who face a life-limiting illness and their families. NHPCO describes hospice as providing "support and care for persons in the last phases of an incurable disease so that they may live as fully and as comfortably as possible." (Connor, 2009, 1).

Throughout human history the suffering and dying patients have been taken care of. However, it is not until the mid1900s that the care of such patients started developing in a revolutionary way. Two female physicians, Dame Cicely Saunders and Elisabeth Kübler-Ross, have been credited with initiating the change in the way society and health care professionals view terminal disease, death, and dying. (Sheehan & Forman, 1996, 1).

In the 1800s, several institutions had perceived the need for humane care of the dying. Several hospices were founded in France as well as in Ireland and the United Kingdom. Dame Cicely Saunders helped found the first modern hospice in London in 1962, St. Christopher's Hospice. Dame Saunders also influenced the founding of several hospices in the USA in the 1970s. (Sheehan & Forman, 1996, 3-5).

The basis for the existence of the modern hospice movement, is the transformation that modern medicine has brought to the death experience. After World War II, the science of medicine advanced rapidly. Medicines as well as technical equipment, were developed. People stopped dying at home and

died in institutions instead. Patients had to be kept alive at all costs, death was a failure. This atmosphere was frustrating to many healthcare professionals. Family members of dying patients became angry with the way their loved ones were cared for. The modern hospice movement got its start in the United Kingdom and the new approach quickly spread. (Connor, 2009, 3).

All palliative care programs have certain characteristics in common.

1. The patient and the family are seen as a unit of care.
2. Care is given at home and in inpatient wards.
3. Symptom management is the top priority.
4. Palliative care uses the holistic approach.
5. There is service available 24 hours a day, all days of the week.
6. Palliative care is provided by an interdisciplinary team.
7. A physician directs the palliative care.
8. Volunteers are an important part of the palliative care team.
9. The receiving of palliative care is not dependent on the payment ability.
10. Bereavement support is offered to the families.

Volunteers are more common in some cultures than others. In the USA the role of the volunteer in the hospice world is very important. (Connor, 2009, 7-8, 32).

3.4 Palliative Care According to the WHO

The World Health Organization (WHO) description of palliative care:

> "Palliative care provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patients illness and in their own bereavement; uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated; will enhance quality of life, and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications." (WHO, 2011).

According to the WHO, palliative care includes symptom management during terminal care as well as during both acute and chronic illness. WHO has published guidelines for health care workers where recommendations for home

care are provided. WHO also provides a list of essential drugs to be used in the clinical management and medication for each symptom. Examples of non-medical treatment for pain, as recommended by the WHO, are psychological, spiritual, and emotional support, answering questions to relieve anxiety and fear, relaxation techniques, and distractions such as music for example. (WHO, 2004).

The WHO publication Palliative care for older people: better practices explains why the need for improving palliative care for older people is an urgent public health priority. Ageing demographics, changing disease patterns, and the complex needs of older people are all factors that contribute to that need. Palliative care has been offered mostly to people with cancer in a hospice setting. The WHO emphasizes the need for palliative care to be integrated more across health care in general and offered more widely. Palliative care for older people with dementia is especially inadequate with too much intervention such as feeding tubes, laboratory tests, intravenous treatment, interventions without benefit. Too little intervention is also common in the form of poor pain control, malnutrition, dehydration, and lack of emotional and social support. "Older people suffer unnecessarily, owing to widespread underassessment and undertreatment of their problems and lack of access to palliative care." (2011, 1, 24).

An important trend in the hospice population is the diminishing proportion of oncology patients cared for. In the United States, of the patients cared for in hospices in the 1970s, more than 90% had an oncology diagnosis. In 2007, the percentage had dropped to 41%. The NHPCO had stated to its members that it is discriminatory not to admit noncancer patients. In 2007 noncancer diagnosis were mainly heart disease, dementia, lung disease and frailty. Only 0,6% had HIV/AIDS. (Connor, 2009, 6) In Finland it is estimated that about 15,000 patients a year are in need of palliative care. 10,000 of those patients have a cancer diagnosis. (Social- och hälsovårdsministeriet, 2010, 11).

3.5 The Philosophy of Hospice

The philosophy of humanism provides a foundation for hospice and palliative care. It is the right of every human being to decide his/her treatment when diagnosed with a life-threatening illness. Humanism requires palliative care staff to be flexible and accept their patients, their lifestyle, their culture, their values, and their decisions unconditionally. The hospice approach allows patients to prepare for death. In palliative care, spirituality is embraced. Hospice patients often want to find meaning in a horrible circumstance when faced with impending death. (Connor, 2009, 10).

The Institute of Medicine (IOM) is the health branch of the National Academy of the Sciences in the USA. In 1997 the IOM described factors important for a good death. The factors include symptom control, preparation for death, a chance for closure and a sense of completion, and good relationships with care professionals. Allowing a person to die with dignity on his/her terms and relatively pain free, is a central concept to a good death. (Dyer, 2006).

The concept of a good death challenges palliative medicine to be multidimensional and truly holistic. Studies show that dying persons, their families, and health care professionals agree on the factors that supports a 'good' death. Pain and symptom management, clear decision-making, completion, preparation for death, and affirmation are valued. (Ashby, 2009, 77, 81-82).

Studies point to challenges in hospice and palliative care. Mainstream medicine tends to encroach on palliative medicine, leading to a tendency to 'over-treat'. There are tensions around the acceptance of death. Professionals rather than the patient himself, tend to define what a 'good' death is. There is pressure from institutions to deliver a 'good' death and disappointment if the goal is not achieved. A more realistic goal has been proposed, introducing the term 'good enough' death. A 'good enough' death is seen as a death in consistent with the life the person has lived, a death with integrity. (Ashby, 2009, 82).

4 Palliative Care Today

In today's world, palliative care is increasingly being regarded as a human right and incorporated in the United Nations' Commission on Human Rights. However, palliative care is not developed to its full extent everywhere in the world. The countries fall into one of four categories. The categories are: 1) no identified hospice-palliative care strategy, 2) capacity building activity but no service, 3) localized palliative care provision, and 4) countries where palliative care activities are approaching integration with mainstream service providers. (Wright, Wood, Lynch & Clark, 2008, 469-470).

Palliative services have been recognized in 115 of the world's 234 countries, encompassing 88% of the total global population. Category 1 contains 33% of the 234 countries, category 2 18%, category 3 34%, and category 4 15%. There is an indication that palliative care is a prerogative of high-income countries. However, there seems to be a stronger connection between the development of palliative care in a country and its Human Development Index than the connection to GDP. The UN's Human Development Index is based on three aspects; longevity, knowledge, and standard of living. (Wright, Wood, Lynch & Clark, 2008, 471).

Finland as well as almost all western European countries and North America falls into the fourth category. Countries in this category are characterized by a large number of activists, multiple providers and types of service. The health care professionals have an awareness of palliative care. Strong, pain-relieving drugs are readily available. There is a development of recognized education in palliative care and a national association exists. (Wright, Wood, Lynch & Clark, 2008, 470).

In many developed countries, including Finland, there is an ongoing debate regarding how to organize palliative care. Research shows that if competent and appropriate care and support would be available, the majority of terminally ill cancer patients would prefer to get their care at home. Several factors affect

the possibility to receive the final care at home: access to competent care, the ability and interest of the family to help, access to beds in hospitals and nursing homes as well as the attitude of society and the health care system in general towards home-based care. (Ahlner-Elmqvist, Jordhöy, Jannert, Fayers & Kaasa, 2004, 585)

There are large differences from country to country in the proportion of cancer patients dying at home. The differences are affected by social, cultural, and health care factors. The differences are illustrated by the percentages for Norway, 12.8%, England 22.1%, Belgium 27.9% and the Netherlands 45.4%. (Cohen, Houttelkier, Onwuteaka-Philipsen, Miccinesi, Addington-Hall, Kaasa, Blisen & Deliens, 2010). Such data is not available for Finland according to Juha Hänninen, chief medical director at Terhokoti Hospice in Helsinki. (Honkanen, 2010).

4.1 Palliative Care in Finland

The Ministry of Social Affairs and Health in Finland has published national guidelines for terminal care. The guidelines state that palliative care is a human right. In palliative care the patient should receive good basic care and symptom relief. Physical, psychological, social, spiritual, and existential needs should be met and the family should be supported. (Social- och hälsovårdsministeriet, 2010, 11)

The guidelines of the Ministry of Social Affairs and Health state that the patient should be able to live without difficult symptoms and pain in the palliative care phase of his/her treatment. Patients should be able to live and be cared for in their desired environment, surrounded by family and loved ones. The foundation for the care is the respect for the patient's autonomy and acceptance of the patient's decisions regarding the care. (Social- och hälsovårdsministeriet, 2010, 11-14).

In Finland 200,000 to 300,000 patients a year are in need of palliative care. In the year 2001, 50,000 people died in Finland. Seventy-five percent of them died in a hospital. About 1,000 patients died in hospices. Annually, at least 10,000 people are expected to die in cancer despite improved treatment. Finland needs one hospice bed per 15,000 residents. There is a need to create 350 new hospice places. (Social- och hälsovårdsministeriet, 2010, 11, 24). The European Association for Palliative Care (EAPC) recommends 80 – 100 palliative care places per one milion residents. EAPC further recommends at least 1.2 nurses and 0,15 doctors per palliative care patient. In Finland there are currently 50 care teams providing care in the home. (Saarto, 2011, 16).

There are currently four hospice homes in Finland with a total of 73 patient beds. Three of the hospice homes are run by the Cancer Association of Finland. The hospice homes are located in the south of Finland, in Helsinki, Tampere, Hämeenlinna, and Turku. Terhokoti in Helsinki and Pirkanmaan hoitokoti in Tampere offer palliative care in the form of at-home care, day clinic services, and on-the-ward care. Koivikkokoti in Hämeelinna offers at-home care as well as ward care. Karinakoti in Turku offers on-the-ward hospice care only. (Saattohoitokodit, 2010).

Finland follows the recommendations of the Council of Europe regarding the development of palliative care. The palliative care is to be integrated into the national healthcare program. EAPC has created recommendations for the education of palliative care staff. In Finland the education in palliative care is in need of systematization. Currently the responsibility for training lies with individuals, hospices, and organizations. Palliative care education in Finland is far from fulfilling current requirements. The goal of nursing education is knowledge based on caring science and strong ethical and professional ability to make decisions. (Social- och hälsovårdsministeriet, 2010, 21-23).

5 Teams in Health Care

Health care organizations are seen as complicated with hard to grasp processes. The complexity makes them difficult to oversee and steer. Every staff member has to have knowledge about what the organization as a whole can offer, as well as individual competence in his/her own field. Working in teams has become one of the solutions to the failures in the chain of care, co-operation, and the holistic view of the patient. (Berlin, Carlström & Sandberg, 2009, 15).

Health care organizations have over time developed a traditional working process where each specialist wait for his/her turn to perform a task. Inefficient ways of working such as referrals, for example, have been preserved. Teams are seen as a way of simplifying and overcoming established inefficiency. A well functioning team can make an organization more efficient. In the organization of a team, non-prestigious co-operation is emphasized and hierarchal relations abandoned. Specialists are collected in a team around a patient with problems that require different competences. (Berlin, Carlström & Sandberg, 2009, 16-19).

Team dynamics can be described in different ways. One way of describing teams is by separating them into unidisciplinary, multidisciplinary, interdisciplinary, and transdisciplinary teams. The unidisciplinary team is made up of persons who all have the same profession, for example social workers. Each one performs the same activity and the interaction might be minimal. The multidisciplinary team consists of individuals with different professions. Each one is responsible for their own area and works independently of the other team members. Most health care teams work this way. The interdisciplinary team also consists of people of different disciplines but here hierarchy is not so important. The input of all members is valued and each contributes to the picture of the whole patient. There are still boundaries between the members but some blurring of the boundaries occurs. In a transdisciplinary team there is

no hierarchy. The lines separating each discipline are deemphasized. Each member of the team is necessary for the team to function. (Connor, 2009, 19-21).

The following chapter provides an insight to the characteristics of a palliative care team. Descriptions of the specific members deemed necessary for a successful team, are provided by different authors.

5.1 Hospice and Palliative Care Teams

A team of professionals collaborating on the care of terminally ill patients, is seen as the most effective way of improving quality of life and providing symptom management. The team work approach is also seen as a way to lessen the potential for stress and exhaustion for palliative caregivers. An effective interdisciplinary team fully utilizes the expertise of all members on the team. The level of morale is high, communication efficient, the trust and respect between members high, and conflict management effective. (Connor, Egan, Kwilosz, Larson & Reese, 2002, 340-341).

A key to the effectiveness of a team is how the individuals in a team link with each other, supplement each other, support each other, and maintain the moral of the team. In short; how they communicate with each other. (Maddocks, 2006, 140). How leaders and followers in a team relate to each other is important in the life of a team if the goals are to be achieved. Speck describes leadership as "a social process through which one person, for example a team leader, harnesses the knowledge, skills and motivation of other team members in order to achieve an agreed task." (Speck, 2006, 65).

Health care staff and others who work with dying people need to keep some important issues in mind. It is imperative to always remember that it is the dying person who decides about the care and sets the agenda. Ideas from the staff cannot be imposed on the patient. The efforts should be aimed at tying up

loose ends, not digging up new issues. The dying people are a cross section of society as a whole. There will be all kinds of people requiring hospice care, not just "regular" folks but persons who might have suffered a variety of illnesses for a long time . The dying process should not be seen as a mental illness. The dying person is under great stress and should be treated with patience and tolerance. (Connor, 2009, 12-13).

Because palliative care patients display a range of ailments that affect all dimensions of their lives, an interdisciplinary care team is key in the deliver of the care. The expertise of many disciplines is required. The health care system is often run in a hierarchal manner. Physicians are directing the care and the focus tends to be put on the patient's medical condition. Emotional, social, psychological, and spiritual needs are often ignored. The interdisciplinary team is directed by the goals of the patients and their families. All dimensions of the human life and experience are recognized and focused on. (Connor, et.al, 2002, 341-342).

Meier and Beresford writes about the first priority in the development of a palliative care team. The most important step in creating a successful team is the process of choosing and hiring the right people. The selection process also lays the base for the team's goals, sense of purpose, and expectations. Hiring the right people is also of outmost importance for the quality of patient care and for the functioning of the team. The ability to work well with other team members may be even more important than knowledge of palliative medicine. (2008, 678).

Cassell's theory about personhood states that each human is a holistic being. A being whom is affected by having to adapt and change as his/her disease progresses and death approaches. These changes involve the physical, the emotional, and the spiritual dimension. (1991) Byock and Merriman suggest the following dimensions and the disciplines necessary for the optimal care team:

1. Physician, nurse, therapist, nutritionist, pharmacists and volunteers for the physical dimension.
2. Registered nurse, licensed practical nurse, therapists, and volunteers for the functional dimension.
3. Psychologist, counselor, social worker, and volunteers for the interpersonal dimension.
4. Psychologist, chaplain, social worker, counselors, and volunteers for the well-being dimension.
5. Counselors, chaplain, social worker, psychologist, and volunteers for the transcendent dimension. (Byock & Merriman,1998).

According to Speck, potential team members could be: the patient and family, nursing staff, medical staff, social worker, chaplain/spiritual care provider, physiotherapist, occupational therapist, pharmacists, dietitian, complementary therapists, psychologist, and volunteers. (2006, 15-16) An interdisciplinary team provides interdimensional care "focused on the experience of those served and core disciplines that can best support that experience." (Connor, et.al, 2002, 346).

5.1.1 The Registered Nurse

The palliative care situation is complex. It is challenging to support the stability and balance of a family. It is important to have knowledge of medical technique and pain relief as well as about existential philosophy issues. Building meaningful and trusting relationships is a large part of the role of the nurse on the palliative care team. The nurse identifies and acknowledges the patient's problems while remaining objective in order to be able to decide on the best course of action for the unique situation of each patient. (Friedrichsen, 2005, 378).

Nurses belong to the clinical staff along with physicians and nursing assistants. Nurses are at the center of palliative care, often taking on the role as case

managers. As case managers, nurses keep all palliative care activities and all disciplines moving and goal focused. They are responsible for the coordination of care and the development of most of the care plan. Nurses inform, educate and prepare patients and families. In fact, education is seen as the largest activity of nurses. Family caregivers are supported and encouraged to participate in the care of the patient as much as possible. For this to be possible they need to be educated and prepared by the palliative care nurse. (Connor, 2009, 23-25).

Sometimes the most important supportive task of the nurse is simply to be present. To be present in the situation is a passive action where understanding and attention is given without necessarily being visible. Verbal and non-verbal communication is part of the nurse's professionalism. Conversations with the patient and his/her family can be about all the dimensions of the care, social, existential, psychological as well as physical. Humility and respect for the patient's wishes are important in the communication also when the nurse herself does not agree with the patient. (Friedrichsen, 2005, 379-380).

5.1.2 The Social Worker

Palliative care is distinguished by the emphasis on the psychological and social needs of the patients and their families. The social worker on the team is responsible for most of the emotional support provided. The social worker also helps with the practical arrangements such as insurance and estate planning. He/she also coordinates community support and volunteers. The social worker also provides counseling as needed, helping the patient to identify unfinished business and to prepare for death. (Connor, 2009, 25-26).

When the concepts of "pain" and "burden" are considered, it is relevant to also acknowledge the worry that patients feel for the financial and legal situation of the family. The expensive medicines, sick leave and hospital fees associated

with long-term illness can lead to financial difficulties more worrisome for the patient than the actual disease. In order to alleviate the worry and support the patient, cooperation between the social worker and physician is vital as the physician has the knowledge regarding prognosis, treatments, and the needed certificates. The social worker functions as a link to the outside world. After the death of the patient, the social worker offers bereavement support to the family and relatives as well. (Hultkvist & Olsson, 2005, 399).

5.1.3 The Physician

The team physician helps in the creation of the patient care plan. The physician's responsibility is to determine the prognosis of the patient and to help with symptom management. Physician willingness to collaborate in a palliative care team varies greatly from team to team. Some physicians will take a unidisciplinary approach, insisting on controlling the care provided. Others will take multidisciplinary approach and some appreciate the interdisciplinary team approach. As hospice and palliative care has been accepted as a recognized specialization, physicians trained in this specialization will ensure high quality care for dying patients. (Connor, 2009, 27-28).

In palliative care the continuity of care in the patient-physician relationship is especially important. To stay "one step ahead" is one of the physician's most significant tasks. Common clinical developments should be anticipated and if possible alleviated and/or prevented. Keeping the family well informed and prepared will make the family into a valuable asset for the whole palliative care team. It is the task of the physician to share his medical knowledge with the palliative care team during team meetings in order to facilitate the planning of holistic care. The ability to communicate well and to correctly interact with the surroundings are decisive for patient care success as well as for team success. (Thoren Todoulos, 2005, 372-375).

5.1.4 The Licensed Practical Nurse

Licensed practical nurses (LPNs) are especially valued by patients and their families, providing the most tangible help. LPNs provide the patient with personal care such as showering, grooming, and feeding if needed. The LPN takes some of the burden off the family by providing personal care. LPNs also assist with simple nursing functions as well as with household chores. The intimate care provided by LPNs allows some patients to open up about their emotions and thoughts. (Connor, 2009, 28).

5.1.5 The Chaplain

The spiritual needs of a dying patient are also recognized by the palliative care team. Patients approaching death face issues of meaning, faith, and existence. Spirituality in palliative care is seen as more than religion. Palliative care is nondenominational and provides the patient with the spiritual care he/she wants and requests. Some palliative care programs may employ a chaplain while other programs rely on the social worker to coordinate with community clergy as needed. The spiritual needs of the patient and the family need to be assessed and addressed accordingly. (Connor, 2009, 29).

5.1.6 The Psychologist

All disciplines in a palliative care team have a responsibility in the patient counseling, meaning emotional support and education. Most of the time the social worker and the nurse play the prominent roles in counseling. Sometimes, however, a mental health professional is necessary for interventions and therapy. Psychologists and psychiatrist can be utilized as needed for psychosocial assessments, family therapy, and bereavement counseling. (Connor, 2009, 31).

5.1.7 The Volunteers

In the United States, volunteers have an important role in hospice and palliative care. Volunteers are not paid for their services. They are there because they choose to help out selflessly, adding an extra dimension to the care. Volunteers most often help by giving practical assistance such as running errands, relieving the primary caregiver, helping with household chores and transports. Volunteers usually receive training in communication and the basics of palliative care. An on-staff volunteer coordinator organizes the work of the volunteers and provides training. (Connor, 2009, 32-33).

5.1.8 The Therapists

The palliative care team also contracts various therapists as needed. The therapists included are physical, occupational, respiratory, speech, massage, nutritional, aroma, music, art and pet. Rehabilitation in palliative care can maintain important abilities even as death approaches. (Connor, 2009, 33) According to WHO, one of the purposes of palliative care is to offer the dying patient help with living as actively as is possible. Therapists as part of a multiprofessional team can meet the varying and complex needs of terminally ill patients. It is important for the patient to understand his/her situation to be able to set realistic goals for the rehabilitation. Severe disease can limit activities of the patient, leading to increased pain, fatigue, and a lower quality of life. In the rehabilitation, the independence and the dignity of the patient should be at the fore front. (Axmacher, 2005, 386-389).

The administrative team is also an important part of the palliative care provision. Without administrative support such as medical records maintenance, billing services, stocking, supply ordering, and computer support, palliative care delivery would not be possible. (Connor, 2009, 33-35).

5.1.9 The Patient and Family

Lastly, the patient and family are important parts of the palliative care team. The patient is the one who determines the goals of the care if empowered to do so. If the patient is cared for at home, the family members are the ones providing most of the actual care. Family members benefit from being involved and may cope better after the death if they have been actively participating in the care. (Connor, 2009, 34-35).

Patients may take part in service planning and the evaluation of services. Patients may also participate in support and self-help groups. Several elements are part of the process of patient involvement. Pre-requisites for patient involvement in the care planning are trust, empathy, and genuineness. The palliative care team needs to see and treat the patient as a care collaborator, capable of understanding the treatment alternatives, drugs and their side effects. (Oliviere, 2006, 42-46).

The basis of holistic, whole person care is the relationship between the patient and the professionals. The relationship is unequal in nature, making commitment to the patient's good and the patient's trust in that commitment necessary to meet the aim of the relationship. (Olthuis, 2007, 13).

The studying of the material that has provided the theoretical background, the theoretical lens, the philosophy of palliative care, and the composition of a palliative care team, has provided me with the interpretative framework used in the development of the themes described and analyzed in the Data Analysis and Results sections of this study.

6 Methodology

The Methodology section of this study consists of a description of the systematic review and content analysis methods of research. The deductive and inductive content analysis methods are compared. The deductive content analysis method was used in this study.

6.1 Systematic Review

A systematic review is conducted when existing research evidence about a particular research question is methodically integrated. Before a systematic review is performed, sampling and data collection procedures are carefully developed and determined. Discipline and transparency is required when conducting a systematic review. Careful integration of research evidence is necessary for evidence-based practice. An intergrative systematic review is not simply a literature review but largely follows the same rules as those of primary studies. (Polit & Beck, 2012, 653).

A recent development in systematic reviews is the integration of findings from both quantitative and qualitative studies as well as mixed methods studies. Mixed studies reviews are fairly new. Different strategies for them are being pursued and developed. The term systematic mixed studies review is used as a description for this type of systematic review. The driving force behind a mixed studies review is the research question. Conducting a mixed studies review requires comparability work where the reviewers impose differences and similarities on the studies reviewed. (Polit & Beck, 2012, 654, 672-673).

6.2 Content Analysis

Polit and Beck defines content analysis as "the process of organizing and integrating material from documents, often narrative information from a qualitative study, according to key concepts and themes." (2012, 723). The use of qualitative content analysis has a long history in nursing studies. Elo and Kyngäs describe content analysis as "a method of analysing written, verbal or visual communication messages." (2007, 107). Graneheim and Lundman presume that "a text always involves multiple meanings and there is always some degree of interpretation when approaching a text." (2003, 106). When discussing the trustworthiness of findings, this interpretation is an essential issue. (Graneheim & Lundman, 2003, 106).

As a research method content analysis is systematic and objective. In content analysis replicable and valid inferences are made from data with the purpose being to provide new insights, knowledge, and a practical action guide. The advantages with the content analysis method is that it is content-sensitive and flexible in terms of research design. Some critics in the quantitative field find the method to be too simplistic and not sufficiently qualitative. However, other researchers state that the method is as easy or as difficult as it is determined to be by the researcher. (Elo & Kyngäs, 2007, 108).

The content analysis method may be used to analyze either quantitative or qualitative data. The method can be used in an inductive or deductive way. If not much previous knowledge exists about the phenomenon, the inductive approach is used. When there is a lot of knowledge already in existence, the deductive approach is used. In both the inductive and the deductive approach, the preparation phase is similar. The main phases in the process are preparation, organizing, and reporting. The key to all content analysis is the classifying of words in the text into smaller content categories. The process starts with the selection of the unit of analysis. (Elo & Kyngäs, 2007, 109).

The following figure is based on Elo and Kyngäs model of the phases of preparation, organizing and resulting in the content analysis process. The figure illustrates the deductive approach to content analysis. (Elo & Kyngäs, 2007, 110). In this study the deductive approach was used. The themes identified in the background material for the study were used in a structured category matrix. Text units were broken out of the articles included in the study and organized in the matrix (see figure 2).

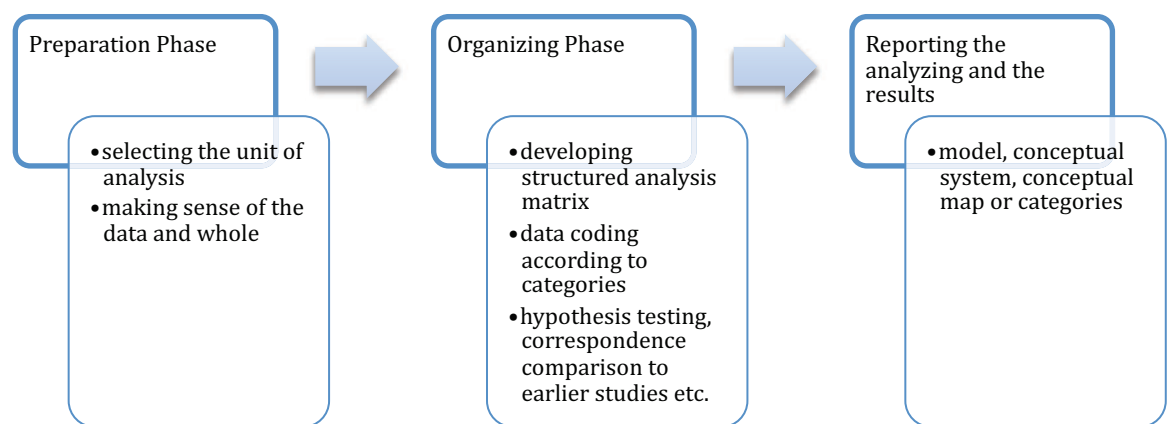| Preparation Phase	Organizing Phase	Reporting the analyzing and the results
• selecting the unit of analysis • making sense of the data and whole	• developing structured analysis matrix • data coding according to categories • hypothesis testing, correspondence comparison to earlier studies etc.	• model, conceptual system, conceptual map or categories

Figure 1 The content analysis process, the deductive approach (based on Elo & Kyngäs figure Preparation, organizing and resulting phases in the content analysis process. (2007, 110).

Graneheim and Lundman suggest that a content unit or meaning unit is a collection of words or statements that are related to the same central meaning. Words, sentences, or paragraphs that are related to each other through their context, can be considered meaning units. A content area is a part of the text that deals with specific issues. A category can be seen as a descriptive level of content. A category can include varying levels of sub-categories at different levels of abstraction. Creating themes is a method to link the categories according to their meanings. (Graneheim & Lundman, 2003, 106).

Next follows a total immersion in the data in order to make sense of it. After the researcher is completely familiar with the data, the analysis is conducted, either inductively or deductively. In inductive content analysis the qualitative

data is organized through open coding where abstractions and categories are created. The categories are then grouped under headings. The process is meant to generate knowledge and increase understanding. In deductive content analysis a categorization matrix is created first and the data is then coded according to the categories. In order to perform a successful content analysis, it is a requirement that the researcher is able to simplify the data and form categories that reliably reflect the subject of study. (Elo & Kyngäs, 2007, 109, 112).

The trustworthiness of the analysis involves the aspects of credibility, dependability, and transferability. The selection of the most suitable content unit is critical for achieving credibility . The inclusion of all relevant data and the exclusion of irrelevant data is also important for credibility. The dependability refers to the extent the data change over time. Lastly, transferability refers to the degree to which the result can be transferred to other settings. In order to achieve transferability, it is important to clearly describe the selection of units for analysis, the data collection, and the process of analysis. (Graneheim & Lundman, 2003, 110).

7 Conduction of the Study

The data for the study was collected by choosing studies based on criteria described in the following chapter. Following the selection, the studies were analyzed based on the themes that had emerged from the theoretical background.

7.1 Data Collection

Through the Novia University of Applied Sciences and Åbo Akademi I accessed the Nelli-portal database where I located the Academic Search Elite Database

(EBSCO). I used EBSCO to access the journal *Palliative Medicine.* In order to find articles that could be of use in my research I searched through every issue of *Palliative Medicine* from 2000 to 2011, a total of 88 issues.

I read the titles and a shortened abstract of each article. The procedure was time consuming but yielded many articles of interest. Of those articles, four were chosen for the content analysis. I limited my search to the years from 2000 to 2011 in order to concentrate on the latest research in palliative care. I concentrated on articles and studies produced in Europe and North America due to the similar development in palliative care and healthcare in general as well as a similar cultural background.

In the Sage Journals Online database I used search words such as "palliative care", "hospice" and "palliative care team" to which I added such key words as "stress", "communication", "dynamics", "job satisfaction" and "ethics". Again I limited the search to the years 2000 to 2011. Articles were found in such journals as *Journal of Interprofessional Care, Journal of Pain and Symptom Management, Journal of Clinical Nursing, American Journal of Hospice and Palliative Medicine, Qualitative Health Research, American Behavioral Scientist,* and *Clinical Journal of Oncology.* A total of 32 articles were identified as being of interest. After reading the articles thoroughly, 14 articles were selected for inclusion in the final grand total of 18 articles to be analyzed.

All articles from years prior to 2000 were excluded. Articles that were systematic reviews based on meta analysis were excluded. Theoretical studies were excluded as well. Articles included in the analysis are based on both quantitative and qualitative studies. Methods used in the studies are questionnaires, surveys, interviews, semi-structured interviews, and ethnographic studies. The articles were labeled A1 through A18. (Appendix 1)

7.2 Data Analysis

The selected studies were analyzed using the deductive approach based on the Elo & Kyngäs content analysis process (see figure 1). A category matrix was developed in order to organize the themes that had emerged from the theoretical background material. The themes have emerged mainly from the writings of Olthuis (2007), Connor (2009), and Speck (2006). Units of texts illustrating the themes were broken out of the studies and placed in the matrix. The units of text can be identified through the article labels A1 – A18. The category matrix has 19 pages of text.

	Responsibility	"The most systematic and successful networks were those that had been established and nurtured by palliative care nurse consultants whose role involved liaison and co-ordination activities." (A2) "Preliminary work is required before it is possible to make any decisions in communication with palliative patients." (A5) "This collaborative process requires collective ownership of the goals of the team, including shared resposibility for the design, definition, development, and achievement of goals." (A6) "In interdisciplinary team meetings, teams form a comprehensive plan of care and divide responsibilities so that each person implements part of the plan." (A9)
Competences necessary for effective palliative care teamwork	Effectiveness	A key component of effective communication was the capacity of nurses and GPs to ascertain what the other 'needed to know' to practice effectively." (A2) "An optimistic approach and identification with the team's goals have been shown to be positively associated with team commitment, team performance and work satisfaction." (A3) "A more unified team approach might improve the holistic care effort for patients, also decreasing frustrations and prejudices produced by disciplinary differences." (A10) "A key aspect of effective interdisciplinary care is to be knowledgeable about other team members' disciplines, as well as to recognize and understand each discipline's perspective about patient care plans and goals." (A10) "High-functioning teams are characterized by clearly understood goals, a positive interpersonal climate that allows for trust, the ability to learn from mistakes, and technical and emotional support. Additionally, job satisfaction has been found to be significantly correlated with team functioning." (A14)

Figure 2. An excerpt from the category matrix created for the analyzis of the studies.

7.3 Themes

1. Competences necessary for effective palliative care teamwork.
2. Factors that promote team success.
3. Factors that inhibit team success.

Competence can be defined as "a cluster of related abilities, commitments, knowledge, and skills that enable a person (or an organization) to act effectively in a job or situation." (Competence, 2011). To be competent is an indication of sufficient knowledge and skills to act in many different situations. (Competence, 2011). In her description of the five levels of nursing experience, Benner describes the "Competent" level as a nurse who "gains perspective from planning own actions based on conscious, abstract, and analytical thinking and helps to achieve greater efficiency and organization. (Nursing Theories, 2011).

The competences necessary for effective palliative care teamwork are described by the following categories: Communication, Leadership/Conflict Management, Education, Morals/Ethics/Reflection, Flexibility/Collaboration, Responsibility, Effectiveness, and Coping Skills.

The categories identified in the theme "Factors that promote team success" are: Respect/Trust, Support, Interdependence, Team composition/Role definition, Philosophical alignment, Collective ownership of goals/Collaboration, Job Satisfaction/Rewards and Spirituality.

The categories identified in the theme "Factors that inhibit team success" are: Stress/Burnout, Grief/Anxiety, Boundaries/Barriers/Territorialism, Conflict/Friction, Team suffering, Compassion fatigue, Lack of communication/Lack of role definition, and Lack of resources.

7.3.1 Competences Necessary for Effective Palliative Care Teamwork

7.3.1.1 Communication

The competence of communication skills refers to both the communication between the team and the patient as well as to the communication within the palliative care team. Good communication is key in effective teamwork. "Clients, families and health professionals agree that there is a need for regular communication between all parties to ensure smooth transition between services, facilitate continuity of care, avoid duplication of services, improve quality of care and provide patient control." (Street & Blackford, 2001, 644) "The ability to share information from multiple perspectives contributes to the interdependent nature of hospice care." (Wittenberg-Lyles & Parker-Oliver, 2007).

In their study *"Decision-making in palliative care practice and the need for moral deliberation; a qualitative study"*, Hermsen and ten Have discuss the importance of the patient having access to clear and detailed information. "The process of breaking bad news and informing patients about their prognosis is closely related to the patient's right to information." And "Acceptance is a part of the idea of a good death in the hospice and caregivers try to communicate this to the patients." (Hermsen & ten Have, 2005).

7.3.1.2 Leadership/Conflict Management

Leadership is a relationship where one person has the ability to influence the behavior of other individuals. (Speck, 2006, 65) In the study "Job satisfaction among hospice interdisciplinary team members" DeLoach highlights the importance of good supervisors. "With the support of one's supervisor, however, the stress of working with dying individuals and their families is more bearable and the job is more satisfying." And "Supervisors appear to play a

critical role in determining the degree of job satisfaction among hospice workers." (DeLoach, 2003).

"Effective IDTs are characterized by a positive organizational climate, a shared language among staff from different disciplines, and team leadership that is provided by different disciplines to help ensure that interdisciplinary collaboration is taking place." (Wittenberg-Lyles & Parker-Oliver, 2007).

7.3.1.3 Education

Learning and teaching are important parts of the philosophy and activity of palliative care. Personal growth and education progresses throughout a specialty. (Lawrie & Lloyd-Williams, 2006, 153). According to Hermsen and ten Have; "The broader skills of supporting the patients in their coping process and in managing their so-called unfinished business were also seen as needing to be developed." "The technique for working together with colleagues in a multidisciplinary team came up as another skill where instruction could be useful." "All caregivers in favour of moral deliberation had the impression that with training, (post-graduate) courses, clinical lessons, theme or case discussions, it should be possible to demonstrate and learn the methods and principles of moral deliberation in palliative care practice." and "One frequently mentioned point was the importance for caregivers of education in communication skills." (Hermsen & ten Have, 2005).

"The need for education and research on team functioning is essential for the success of interdisciplinary approaches." "These findings suggest that there is a need for continuing education of the interdisciplinary team, especially in regard to their role on the team as well as the role of team members." (Wittenberg-Lyles, Parker Oliver, Demiris & Regehr, 2010). "Ideally, the shared educational experience breaks down discipline-specific barriers and fosters the development of trust and understanding between and across disciplines, and joined learning provides an immediate context for practice and modeling." (Goldsmith, Wittenberg-Lyles, Rodriguez & Sanchez-Reilly, 2010).

Brayne, Farnham and Fenwick concentrate on existential issues in their study "Deathbed phenomena and their effect on a palliative care team: A pilot study" and find that "the interviewees expressed a need for further education and training to deal with existential issues." And "they shared concerns that, although they work at the frontline, current training for palliative workers does not specifically prepare them to deal with the personal needs of the dying." (Brayne, Farnham & Fenwick, 2006).

7.3.1.4 Morals/Ethics/Reflection

Palliative care requires a multi-professional approach to handle the difficulties associated with caring for the terminally ill. The complicated medical problems involved demand that caregivers have a sensitivity to the moral issues that arise. Hermsen and ten Have state that "deliberation can be considered as the process of reflecting upon decisions in a way that will eventually lead to a wise and prudent choice. It is a dialog based on mutual respect." And "part of this judgment involves regular evaluation of the quality of life of the patient." They go on to state that "moral deliberations - in which attention has been paid not only to medical factors but also to the nursing, ideological and organisational factors relevant to the case - offers the possibility of doing justice to a patient's narrative, in which all relevant facets are taken into account." (Hermsen and ten Have, 2005).

In the study "The power of interdisciplinary collaboration in hospice" Wittenberg-Lyles and Parker-Oliver elaborate on the reflective process; "the reflective process allows team members to evaluate outcomes collectively and internally assess their own collaborative efforts." And "the reflective process creates collaborative communication that demonstrates barriers to achieving these collective goals." (Wittenberg-Lyles and Parker-Oliver, 2007).

7.3.1.5 Flexibility/Collaboration

Wittenberg-Lyles and Parker-Oliver define interdisciplinary collaboration as "an interpersonal process leading to the attainment of specific goals that are not achievable by any one team member alone." They state further that "interdependence and flexibility are actually collaborative acts that take place among IDT members and non-hospice staff." And "Interdisciplinary collaboration in hospice also includes crossing the boundaries of medicine." (Wittenberg-Lyles and Parker-Oliver, 2007).

In the study "Examining variables related to successful collaboration on the hospice team", Parker-Oliver, Bronstein and Kurzejeski find that "Solid collaborative interdisciplinary teamwork has been found to affect patient care in positive ways." (Parker-Oliver, Bronstein & Kurzejeski, 2005).

7.3.1.6 Responsibility

The responsibility of skilled palliative care workers refers to a readiness to act and to a respect for both themselves and others. Palliative care staff need to take the responsibility to act for dying patients, who cannot act for themselves any longer. Being a competent palliative care nurse demands a personal motivation and a capacity to achieve a standard of excellence in the practice of care. (Olthuis, Dekkers, Leget & Vogelaar, 2006).

"This collaborative process requires collective ownership of the goals of the team, including shared responsibility for the design, definition, development, and achievement of goals." (Parker-Oliver, Bronstein & Kurzejeski, 2005). "In interdisciplinary team meetings, teams form a comprehensive plan of care and divide responsibilities so that each person implements part of the plan." (Wittenberg-Lyles, Parker-Oliver, Demiris & Regehr, 2010).

7.3.1.7 Effectiveness

Effectiveness as defined by Wojtczak refers to "a measure of the extent to which a specific intervention, procedure, regimen, or service, when deployed in the field in routine circumstances, does what it is intended to do for a specified population. In the health field, it is a measure of output from those health services that contribute towards reducing the dimension of a problem or improving an unsatisfactory situation." (Effectiveness, 2011).

"A key aspect of effective interdisciplinary care is to be knowledgeable about other team members' disciplines, as well as to recognize and understand each discipline's perspective about patient care plans and goals." (Goldsmith, et.al, 2010). Wittenberg-Lyles and Parker-Oliver state that "high-functioning teams are characterized by clearly understood goals, a positive interpersonal climate that allows for trust, the ability to learn from mistakes, and technical and emotional support. Additionally, job satisfaction has been found to be significantly correlated with team functioning." (Wittenberg-Lyles and Parker-Oliver, 2007).

7.3.1.8 Coping Skills

Lazarus and Folkman define coping as "cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person". Two types of coping are identified; emotion-focused coping which alleviates emotional stress and problem-focused coping in which management of the problem causing stress is attempted. (Lazarus & Folkman, 1984, 41).

This definition is supported by Payne in her study "Occupational stressors and coping as determinants of burnout in female hospice nurses. Payne found that "two coping strategies were also found to be related to reduced burnout. The first strategy was a problem-focused strategy (planful problem-solving) which

supports previous research.... However, the second strategy was an emotion-focused strategy (positive reappraisal)." And "the low levels of burnout reported by hospice nurses could be explained by the evidence that they utilize more effective burnout prevention coping strategies than other nurses." "Therefore, a good coper may be someone who can draw on different strategies adaptively depending on the situation." (Payne, 2001).

Optimism, self-efficacy, and socials support are noted by Hulbert and Morrison as increasing coping skills. "Occupational samples are found to benefit from higher levels of optimism by engaging in more successful coping efforts, thus resulting in lower stress and burnout levels." And "optimistic individuals have lower negative affectivity thus perhaps appraise their support as more satisfactory, thereby decreasing their stress levels." (Hulbert & Morrison, 2006).

7.3.2 Factors that Promote Team Success

7.3.2.1 Respect/Trust

The interdisciplinary collaboration process is affected by structural characteristics and professional roles. "Professional roles include the values and ethics of each team member's discipline, an allegiance to the agency setting and profession, respect for professional colleagues, and a similar or complementary perspective of other team members." And "In order to promote positive collaboration, reciprocal respect for both the individual's profession and for their role as a team member is necessary." (Wittenberg-Lyles, Parker-Oliver, Demiris, Baldwin & Regehr, 2008).

In their study "Refractory suffering: The impact of team dynamics on the interdisciplinary palliative care team" Swetenham, Hegarty and Grbich recognized "the importance of the interdisciplinary team, but multiple disciplines make up this team, and each discipline has specific skill sets of value that require recognition and respect." Further they found that "some of the

participants identified that respect among the disciplines was needed in order to effectively manage refractory suffering." (Swetenham, Hegarty & Grbich, 2011).

The clarity of roles is also emphasized by Junger, Pestinger, Elsner, Krumm and Radbruch; "The level of trust within a team is closely related to the clarity of roles." And "Trust describes the mutual reliance on each other's support." (Junger, Pestinger, Elsner, Krumm & Radbruch, 2007).

7.3.2.2 Support

The concept of support refers to team members supporting each other, to organizational support from the management as well as to the team members receiving support from families and friends in their professional role.

The chaplain often takes on a supportive role in general. "A prominent group role that emerged was spiritual care for team members with 35% of chaplains providing one-on-one self care assistance to team members." And "overall, 73% of chaplains identified their everyday team communication role as the "encourager", defined as the one who offers praise, understanding, and acceptance." (Wittenberg-Lyles, et.al, 2008).

In the study "Job satisfaction among hospice interdisciplinary team members", De Loach found that "Supervisory support, for example, had the most effect on job satisfaction." And "supervisory support is particularly important in hospice and palliative care because death is an imminent reality both for patients and the professionals caring for them." (2003) According to Payne "the hospice organization should monitor staff conflict particularly closely and promote positive staff relations through the use of support and discussion groups and/or regular monitoring/counseling sessions for individuals to discuss problems with an independent party". (Payne, 2001).

7.3.2.3 Interdependence

Wittenberg-Lyles et.al define interdependence in a palliative care team as "each professional on the team relying on interaction with other professionals in order to accomplish their goals." (2008). "Collaborative acts occur as a result of interdependence between team members. Within hospice, interdependence occurs as individuals deviate from discipline specific boundaries." (Wittenberg-Lyles & Parker-Oliver, 2007). "The synergy that defines successful collaboration begins with the team members' reliance on interactions among each other to be successful with necessary tasks." (Parker-Oliver, et.al, 2005).

7.3.2.4 Team Composition/Role Definition

Successful networking between health professionals in multidisciplinary teams is dependent on the professionals understanding each other's expertise and roles across disciplines as well as between different health care settings. (Carter, McKenna, MacLeod & Green, 1998, 383-384). The clarity of roles affects the level of trust within the team and contributes to team commitment and job satisfaction. (Junger, Pestinger, Elsner, Krumm & Radbruch, 2007, 348).

7.3.2.5 Philosophical Alignment

Junger et.al found that "team philosophy means that the team members have a common understanding of their goals, procedures and their personal identification with their work." "Adequate room for the discussion of goals, which may be regarded as an important prerequisite for a coherent team philosophy." And lastly; "Team philosophy as a mutual appreciation of the goals and the meaningfulness of the team tasks is regarded as an important prerequisite for successful team work." (Junger et.al, 2007).

In their study about refractory suffering, Swetenham et.al found that "in order to manage refractory suffering, a philosophical alignment between patient and family goals and healthcare goals was necessary." "Given that palliative care crosses boundaries into the very private world of dying people, a shared philosophy concerning treatment goals is critical if both patient and team suffering are to be minimized in the setting of refractory suffering." And "staff is required to make significant investments in patients and families who are facing death and sustainable practice may be reliant upon philosophical alignment of palliative care services." (Swetenham et.al, 2011).

7.3.2.6 Collective Ownership of Goals

Interdisciplinary collaboration is described as having five main components: "interdependence between team members, newly created professional activities, flexibility, collective ownership of goals, and a reflection on the process." (Wittenberg-Lyles, et.al, 2008). As a result of collaboration, collective ownership of goals emerges "as individuals share responsibilities for all aspects of decision-making as well as work together to implement the decision." (Wittenberg-Lyles & Parker-Oliver, 2007).

Swetenham et.al found in their study about refractory suffering that "Accepting that difference within a team is healthy, cohesion of the team mind-set regarding the goal and plans of management were identified by participants as important when faced with the patient and family's refractory suffering." (Swetenham et.al, 2011). In her study about questions as a strategy in within interprofessional interaction, Arber found that "the use of the collegial 'we' is part of the process of social alignment that enables doctors, nurses, and others to work together and to achieve optimum management of complex symptoms and access to scarce resources." (Arber, 2008).

7.3.2.7 Job Satisfaction/Rewards

In the study about job satisfaction among hospice interdisciplinary team members, DeLoach found "that hospice IDT members are very satisfied with their work environments." DeLoach describes factors such as supervisor attentiveness and employee autonomy contributing to job satisfaction; "attentiveness by supervisors to the needs and concerns of employees plays an integral role in the degree of employee job satisfaction." And "IDT members in this study who reported high job satisfaction also reported fewer instances of conflicting roles, higher degrees of task significance, fewer instances of routinization, minimal instances of negative moods, and an increased sense of team functioning." And lastly, "respondents reported more job satisfaction when their roles were clear, when they felt they had some autonomy, and when they did not feel hemmed in by routine and repetitive responsibilities." (DeLoach, 2003).

A study about spirituality and job satisfaction among hospice IDT members states that "it is widely shared that high-quality care in various health care settings is enhanced by maintaining a low staff turnover rate, which in turn is closely related to employee job satisfaction." (Clark, Leedy, McDonald, Muller, Lamb, Mendez, Kim & Schonwetter, 2007).

7.3.2.8 Spirituality

In the study "Spirituality and Job Satisfaction among Hospice Interdisciplinary team members", Clark et.al state the following; "spirituality has been recognized as the core or essence of a person and as an essential part of an individual's well-being. Clark et.al found that "spiritual care for patients was too critical to be left exclusively to clergy, and that hospice care nearly always includes the spiritual dimension." The study showed that "from the survey, over 98% of the IDT members viewed themselves either 'spiritual' and/or having 'spiritual belief'." And lastly, "The structural path model revealed that job satisfaction is more likely to be related to the transformation of one's spirituality

into the process of integrating spirituality at work and self-actualization rather than spirituality having a direct impact on the job satisfaction." (Clark et.al, 2007).

In a study about deathbed phenomena, Brayne et.al stressed the need for "a greater understanding of spirituality to enable engagement with patients at a level that is appropriate and right for them as well as the caregiver." (Brayne et.al, 2006).

7.3.3 Factors that Inhibit Team Success

7.3.3.1 Stress/Burnout

Lazarus and Folkman define stress as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being." (1984, 19). Maslach and Jackson define burnout as "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do people work of some kind." (Maslach & Jackson, 1981, 99).

Junger et.al found that "There are three major role stressors in (new) teams: role ambiguity, role conflict and role strain." (2007). "Interdisciplinary team members often encounter stress while managing the day-to-day care of patients and their families, especially when they struggle to maintain the patient's dignity during the dying process." (DeLoach, 2003).

In her study on burnout in female hospice nurses, Payne found that "physical environment stressors such as workload, social environment stressors such as conflict with staff and psychological environment stressors such as death and dying, lack of staff support, uncertainty concerning treatment and inadequate preparation to deal with the emotional needs of patients and their families." And "these studies appear to suggest that the use of problem-focused coping

strategies may prevent burnout whereas avoidance or emotion-focused strategies contribute to burnout. And lastly "social interactions rather than organizational factors, are the source of the chronic emotional stress that may lead to burnout." (Payne, 2001).

7.3.3.2 Grief/Anxiety

Previous studies show that long-term care staff may feel symptoms of grief after the death of a patient. Rickerson, Somers, Allen, Lewis, Strumpf and Casarett found in their study about grief-related symptoms among long-term care staff that "staff reported a wide variety of grief-related symptoms that they attributed to the death of a patient in the past month." And "as long-term care programs increasingly take on the difficult task of caring for older adults near the end of life in diverse settings, it will be important to carefully consider the effects that these deaths have on staff." They also found that "experience does not appear to "protect" staff from the experience of grief." (Rickerson, Somers, Allen, Lewis, Strumpf & Casarett, 2005).

In their study about the impact of refractory suffering on palliative care teams, Swetenham et.al found that "clinicians need to recognize both the cultural and personal philosophies and beliefs at play in order to control the anxiety and disharmony that may result from managing refractory suffering." (Swetenham et.al, 2011).

7.3.3.3 Boundaries/Barriers/Territorialism

The quality of palliative care is highly affected by the continuity of care. Ashley writes about the difficulties in developing a collaborative approach; "The key problems identified are: territoriality between professions, lack of a common philosophy, language and style between professions and services; and restricted contact between the various busy professionals of one service and another." (Ashley,1995). "Whenever territorialism existed between the various

service providers, it jeopardized their potential to develop continuity of care." Territorialism also existed between services, restricting the use of a common history that was transferred with the client or a common database to track client information." (Street & Blackford, 2001).

In their study about the dynamics of the interdisciplinary palliative care team, O'Connor and Fisher found that "The lack of role boundaries in the psychosocial realm leads to professionals claiming special expertise." "This results in palliative care members becoming engaged in a struggle where they are trying to differentiate themselves from other health professionals and promote their place in the team." (O'Connor & Fisher, 2011). "First, bureaucracy in the clinical setting determines the amount and type of interaction among team members, inadvertently creating barriers to team effectiveness. Second, a disciplinary split can result from differing regulatory and accredition barriers among the disciplines." (Goldsmith, Wittenberg-Lyles, Rodriguez & Sanchez-Reilly, 2010). And lastly, "Common problems in IDT meetings include interpersonal conflicts and 'turfdom' wherein team members become protective of their discipline and their contributions based on their expertise." (Wittenberg-Lyles & Parker-Oliver, 2007).

7.3.3.4 Conflict/Friction

Conflict and friction exists between the different members of the palliative care team as well as between the team members and the patient. Swetenham et.al found that "the greatest difficulty experienced is where goals of care among healthcare providers, patients, and families do not match up." "One doctor identified that conflict could arise between a patient and his or her carer when patient choice was not in keeping with clinician expectations." And "often the treating teams were all philosophically aligned regarding what care needed to be provided as the prospect of cure diminished, however the patient and/or family, having accepted palliative care's involvement, were not always ready to accept that all measures should be directed towards comfort and away from cure." (Swetenham et.al, 2011).

"Task conflict referred to discrepancies between the team members regarding their goals and work concepts." (Junger, et.al, 2007). "A lack of understanding across disciplines and interpersonal conflicts that arise from role competition, role confusion, turf issues, and role definition can lead to friction within the team and isolation of members." (Wittenberg-Lyles et.al, 2010). "Cultural patterns, perceived absence of equity and fairness in expectations, and a lack of understanding between the team members can contribute to power differentials among team members." (Goldsmith et.al, 2010).

7.3.3.5 Team Suffering

Swetenham et.al describe team suffering "the suffering of patients and their families affects clinicians, who grapple personally and professionally with their own suffering in the face of another's distress. Clinicians also feel impotent and powerless when unable to relieve it. Yet this 'mutual suffering' is often not articulated within palliative care teams." "As a result of a patient insisting on the continuation of a curative approach in spite of an advanced degenerative neurological condition, deep rifts occurred within the team." And "this crisis was sparked by two conflicting philosophies, determination of the patient for the team to focus on cure, and individual personal philosophies that were often at odds with those of fellow team members." Lastly, "reluctance to talk openly about philosophical differences has been identified through this study as an unseen, unrecognized root cause of team suffering." (Swetenham et.al, 2011).

7.3.3.6 Lack of Communication

In their study about successful multiprofessional cooperation, Junger et.al state that "a lack of communication - together with task conflict - turned out to be the most frequently mentioned factor which impaired cooperation." And "ambiguity concerning goals and procedures contributed to a negative evaluation of the cooperation." (Junger et.al, 2007). "One study found that some families of

deceased hospice patients felt that better communication among hospice team members would have improved the deliver and effectiveness of hospice services." (Parker-Oliver et.al, 2005).

O'Connor and Fisher found that "differences in terminology may inhibit interdisciplinary team communication, promote miscommunication and may serve to constrain interdisciplinary collaboration." (O'Connor and Fisher, 2011). "This lack of regular professional communication places a larger burden on clients and their families, who need to spend time and energy keeping the different health professionals abreast of often rapidly changing symptoms and treatments." (Street & Blackford, 2001).

7.3.3.7 Lack of Role Definition

The close ties between the different disciplines in the palliative care team can lead to a blurring of the roles. "Although team members represent distinct disciplines on the hospice team, prior research has found that many team members experience role ambiguity." (Wittenberg-Lyles et.al, 2010). "The social work perspective and values are so inherent in hospice that roles among hospice professionals can become inappropriately blurred." (Parker-Oliver, et.al, 2005). "Too much broadness in their role definition, a responsibility for being the spiritual anchor in a largely secular environment, and the lack of effective communication with their colleagues contribute to significant stress for chaplains." (Wittenberg-Lyles, et.al, 2008).

7.3.3.8 Lack of Resources

Lack of time and lack of funding plague most health care settings. "A regular complaint was that there was rarely time available for GPs and palliative care nurses to have an adequate discussion to ensure continuity of care or to conduct a joint home visit for assessment purposes." (Street & Blackford, 2001). Rickerson et.al found that staff bereavement support is lacking. "Most

staff also said that they would use additional sources of support if they were offered." (2005). In their discussion about the paradigm shift from holistic care to physical symptom management, Swetenham et. al found that "this focus was sharpened when psychosocial care was seen as being inadequate and where doctors felt either insufficiently skilled or under-resourced to provide supportive care." (Swetenham et. al, 2011).

8 Interpretation of Results

The research questions stated at the beginning of the thesis are: What competences and professions does the ideal palliative care team contain? Which factors influence the success and health of the team? What is the ideal model for a team?

This study is based on the concepts of competence, virtuosity, morals, humanity, and responsibility of palliative care workers as described by among others, Olthuis, Connor, Speck, Ashby and Tronto. The purpose of this study is to provide a compilation of the competences necessary for the success of palliative care teams as well as a compilation of the factors that promote or inhibit that same success.

The most important themes emerging from the theory and the article study, are **communication, moral attitude, responsibility**, and the holistic approach to palliative care. Good **communication** skills are key in successful teamwork. Not only is good communication necessary between team members but it is also of outmost importance in the contact with the patient and the patient's family. The competences of **leadership** and **conflict management** skills can also be related to the communication skills. Leaders are able to influence others through good communication skills.

Olthuis uses Tronto's description of the moral aspects of a caring relationship in order to emphasize the importance of the **moral attitude** in palliative care. Olthuis also stresses the unequal relationship between the patient and the professional carer and the moral demands placed on both partners in the caring relationship. (2007, 21-25). Sensitive issues often arise in palliative care situations. Hermsen and ten Have discuss the importance of **moral reflection** in order to make a wise choice. (2005).

Responsibility indicates a readiness and a willingness to act on behalf of a dying patient who can no longer act for themselves. The competence of **education** relates to responsibility in the way that a professional carer takes responsibility for the upkeep and development of learned and inherent skills. The development of **coping skills** competence is a responsibility of the professional care team member as well. It is the duty of the carer to use appropriate stress alleviation and coping strategies in order to be able to handle the emotional burden of the palliative care work.

In the study of factors that promote team success, **respect, support, collaboration** and **philosophical alignment** emerge as the main categories. **Interdependence** results in collaboration between team members. Collaboration is difficult without respect for and trust in the competences and abilities of fellow team members. According to Junger, Pestinger, Elsner, Krumm and Radbruch, trust is closely related to role clarity. (2007).

The successful palliative care team enjoys support from fellow team members as well as from management, families and friends. **Job satisfaction** is closely related to supervisory support. Management support can be in the form of promotion of positive staff relations and the availability of counseling sessions for individuals. (Payne, 2001).

Ashby states the facts thatsupports a 'good' death according to the hospice philosophy. Pain and symptom management, clear decision-making, completion, preparation for death, and affirmation are important values in the philosophical alignment of care. (2009, 77, 81-82). A shared goal and a shared

vision for reaching that goal are critical for minimizing both patient and team suffering.

Among factors that inhibit team success, the factors of **stress, boundaries**, and a **lack of communication** were found to be of most significance. The study by Junger et.al mention a lack of communication as the most frequently mentioned factor which impaired cooperation. Olthuis stresses the need to strike a balance while giving care in order to avoid self-sacrifice. A caring conversation is necessary where the uniqueness and the suffering other is communicated and acknowledged. (Olthuis, 2007, 137-140). The tendency to over-treat has led to tensions around the acceptance of death. Pressure from the institutions to deliver a 'good' death leads to stress and disappointment if the goal is not achieved. (Ashby, 2009, 82).

Palliative care theorists stress the importance of a team approach in order to achieve a high quality of care. A team of professionals collaborating increases effectiveness and lessens the potential for stress and exhaustion. (Connor, et.al. 2002, 341-342). **Territoriality** between professions and a lack of contact and communication between them leads to difficulties in developing a collaborative approach.

What is **the ideal palliative care team** like? Olthuis states that "palliative care requires virtuous practitioners who are able to provide emotionally involved care". (Olthuis, 2007, 7). A palliative care team has to be able to care for the patients and their families from all aspects, physical, psychological, social, spiritual and cultural. The ideal palliative carer has to be able to commit to the core values of care and to the good of the patient.

My study and the interpretation of the results have provided answers to the research questions stated in the beginning of this study.

9 Conclusion

This study was conducted in order to answer certain questions regarding palliative care teams and to provide useful information for the future development of palliative care in the Vaasa region. The concluding part of this study contains a critical review of the study and a discussion chapter.

9.1 Critical review

In the critical review of the study, I will use Larsson's criteria for the quality of qualitative studies. The criteria used are perspective awareness, internal logic, and quality of results.

9.1.1 Perspective Awareness

According to the hermeneutic tradition, understanding is always dependent on the part relating to the whole in order to have meaning. Facts are always dependent on the perspective. Before we are to interpret something, we already have a pre-understanding of the meaning. In the interpretation process, the pre-understanding is constantly changing. Through clarifying the pre-understanding, the starting point of the interpretation is made clear. The clarification of the pre-understanding becomes a quality criteria. The clarification of the pre-understanding can be either a recounting of personal experiences or a choice of an interpretation theory. (Larsson, 1994, 165-166).

I have performed this study based on the perspectives on palliative care provided by the organistic paradigm of wholeness. The theoretical lens through which I have approached the material has been provided by Olthuis in his 2007 ethical study of the moral attitude of professionals in palliative care practice. Ashby and Connor have also provided me with theoretical starting points

regarding what high quality palliative care and a 'good' death are. My own experiences with palliative care, elderly care and oncology ward work have influenced my pre-understanding of the concepts I have chosen to study.

9.1.2 Internal Logic

The internal logic criteria can be described as a harmony between research questions, data collection, analysis technique and choice of qualitative method. The techniques for data collection and analysis are governed by the research questions. The chosen methods also contain perspectives that affect the result produced. A scientific work should be a well-constructed, closed system. The discussion at the end of the study should connect back to the problem statement and the research that existed prior to the study. At the same time, the study author's own contribution should be clear against that background. The degree of harmony between parts and wholeness becomes the quality criteria. (Larsson, 1994, 169-170).

The purpose of the study was to identify competences necessary for the creation of the ideal palliative care team. In addition, factors that promote/inhibit the success of a palliative care team were identified. The scientific articles studied provided me with the answers to such questions as: What significance does the ability to communicate well have? Is the moral attitude of the care giver of importance? How does intra-team respect, trust and interdependence affect the team? What do boundaries, territoriality, and lack of communication do to team harmony and how are patients and their families affected by said factors? The study result can provide the local Cancer Society and other organizations with information useful in the planning of future palliative care in the Vaasa region.

The data collection method which is systematic review and content analysis of 18 studies, is suitable for this type of theoretical study where the purpose was to compile previous research. To further expand the study, the next step could

be interviews with palliative care experts, patients, and relatives. In the discussion chapter of this study, I have made connections back to the aim of the study and to the research questions. The connections to the background material make this study into a closed system with internal logic and harmony.

9.1.3 Quality of Result

Richness of content is part of the result quality along with structure and theory contribution. Categories descriptive of concepts are supposed to catch what is important and be rich in content while still keeping the nuances. Phenomena have to be described as they appear to us regardless of the theories and the prejudices we have about the phenomena. Richness of content is of central value in qualitative method. (Larsson, 1994, 172).

Structure refers lucidity and reduction of complexity. There is tension between the richness of content criteria and the structure criteria. This tension should lead to a poignancy in the interpretation of the results. The interpretation is not supposed to be full of compromises but should bring out something fundamental in the raw data. Structure helps in bringing out the essence of a study. The reasoning should be easy to follow without important steps missing. In good studies the details of the reasoning are specific and clear. The reader can follow the reasoning and become convinced since the arguments are a carefully arranged basis for a interpretation or conclusion. (Larsson, 1994, 173-175).

Theory contribution is valuable in research. Finding patterns and central features in the raw material lead to the building of a theory. An interpretation of data is necessary, an interpretation that highlights the commonalities. The first step is to choose questions that have a potential to build on the current knowledge of the research area. (Larsson, 1994, 175-176).

In my study I have structured my findings in an easy-to-understand manner. The competences necessary for the ideal palliative care team are listed,

defined and illustrated by quotes from the data. The factors that promote/inhibit team success are listed in a similar way with descriptive quotes as well. My methods for finding, choosing, and analyzing the studies are described thoroughly. The difficulty with this study lies in the recounting and description of the pre-understanding of the material. As Larsson states, almost everything that one thinks has the ability to affect the interpretation. (1994, 165).

9.2 Discussion

Self-reflection in palliative care is a sign of a maturing specialty. Through self-reflection scientific evidence is produced which is helpful in treatment decisions as well as in improvement of palliative care team efficiency. (Teno, 2002, 94). Self-reflection and the resulting evidence produced is also a guidance for the planning, implementation, and the evaluation of palliative care development and improvement.

The patient is the focus at the center of palliative care team activity. As carers we help the patient maximize his/her potential to live a full life to the end, physically mentally, and spiritually. In order to have the ability to help, we need to have a knowledge of ourselves, an understanding of our own morality, awareness, conscience, and fears regarding death. We need to have an understanding of our own role and obligations in the palliative care team. We also have to have an understanding for how our own actions, attitudes and style of communication affect the team and in extension the patient. An incompetent carer feels insecure and unsafe. Competence creates security which extends to the patient and his/her family.

The care competence and the emotional and moral commitment to the care is of outmost importance in palliative care. Palliative care staff needs specialized training and further education in order to feel secure in their role. Olthuis writes about the unequal relationship between the carer and the patient. The

inequality of the relationship demands the moral commitment from the carer, the commitment to the good of the patient. The other moral condition is the patient's trust in that commitment. (Olthis, 2007, 13).

According to Ashby studies show that dying people, their families, carers and health professionals agree about what a 'good' death is. Symptom and pain management is valued as well as clear decision-making, life completion and time to prepare for death. A bad death is feared more than the dying itself. The emphasis on the biomedical aspects, to 'cure' has affected palliative care as well. In palliative care it is necessary to recognize the need for the ability to 'accompany' a dying person. Palliative care team members need to be comfortable with the thought of there being no cure for their patient. (Ashby, 2009, 83). Olthuis states that "balancing technical intervention with a humanistic, caring approach to patients lies at the heart of palliative care, as it does elsewhere in medicine." (Olthuis, 2007, 22).

The tension between acceptance of death and the tendency to 'over-treat' affect palliative team members as well. It is important to have a philosophical alignment in the team, a common understanding of what the goals for the care are. A fractured philosophy concerning the treatment goals leads to suffering for both the patient and the team. When the care goal of palliative care team members differ from that of the patient and the family, conflict arises. Conflict and friction are also the result of treatment goal discrepancies between individual team members.

Successful interdisciplinary teamwork requires interdependent collaboration. Communication problems leading to interpersonal conflicts are among the greatest challenges for palliative care teams. Communication problems can lead to a low level of trust and misunderstandings between different professions. A successful palliative care team is characterized by an atmosphere of trust and goodwill where goals and roles are clearly defined and understood. (Connor, et.al, 2002, 348-349).

Most patients with a incurable disease, approaching death, want to live and be cared for at home for as long as they can, if at all possible. (Ahlner-Elmqvist et.al., 2004, 585). The at-home death percentage varies from country to country and there is no percentage available for the situation in Finland (Honkanen, 2010). The aim in Finland is to further develop palliative care. If more regions focused on creating and developing palliative care teams, more palliative care patients would get their wish of dying at home fulfilled. Finland is following the recommendations of the European Association for Palliative Care for the integration of palliative care into the national healthcare program and for the improvement of palliative care education.

Hiring the right people is seen as the first priority in the palliative team development process. The ability to work well with other team members is important both for team well-being and functioning as well as for high quality patient care. (Meier & Beresford, 2008, 678). This study can provide ideas and recommendations for the development and the organization of a palliative care system in the Vaasa region. Whether the development is aimed towards palliative care integrated into existing health care institutions or towards more or less independent palliative care teams, this study throws light on the competences necessary for successful team work.

The Ministry of Social Affairs and Health has identified issues in the palliative care education in Finland. A specialized continued education in palliative medicine has been established for medical doctors. Palliative care classes in the basic education for medical doctors, differ from university to university. Palliative care education for all levels of health care staff is in need of systematization. The responsibility for the palliative care education currently lies with individuals, hospices and other organizations. (Social- och hälsovårdsministeriet, 2010, 22).

This study will be helpful in mapping the need for palliative care education for health care personnel in the region. It will also be helpful in planning the education so that important competences are emphasized in future education and courses.

This study gives a general introduction into palliative care teams and the factors that influence them and their work. It provides an opening to further research and new thoughts to go on in the regional development of palliative care programs.

"You matter because you are you, and you matter to the end of your life.
We will do all we can not only to help you die peacefully,
but also to live until you die."

Dame Cicely Saunders, founder of the modern hospice movement (1976)

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Title	Author/Year	Aim	Method	Result
Communication dynamics in hospice teams: Understanding the role of the chaplain in interdisciplinary team collaboration (A1)	Wittenberg-Lyles, E., Parker Oliver, D., Demiris, G., Baldwin, P. & Regehr, K. 2008	To investigate how hospice chaplains percieve their role in interdisciplinary team meetings.	Phone survey of 100 hospice chaplains in a 10-state region (USA).	Hospice chaplains experience professional role conflict primarily with social workers.
Communication issues for the interdisciplinary community palliative care team (A2)	Street, A. & Blackford, J. 2001	To examine the communication channels used by community palliative care nurses.	Interviews with 40 palliative care nurses in Victoria, Australia	Effective palliative care communication requires unambiguous decision making concerning the case management role and interdisciplinary relationships.
Criteria for successful multiprofessional cooperation in palliative care teams (A3)	Jungner, S., Pestinger, M., Elsner, F., Krumm, N. & Radbruch, L. 2007	To provide a systematic inventory of factors relevant for team work in palliative care.	Semi-strucutred interviews with 19 palliative care members at the University Hospital in Aachen.	Crucial factors to cooperation were close communication, team philosophy, good interpersonal relationships, autonomy
Deathbed phenomena and their effect on a palliative care team: A pilot study (A4)	Brayne, S., Farnham, C. & Fenwick, P. 2006	To explore the impact that deathbed phenomena have personally and professionally on those who care for the dying.	A questionnaire and an interview with nine members of a palliative care team in Camden, UK.	There is a lack of education and training to help palliative care teams recognize the wider implications of deathbed phenomena.

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Decision-making in palliative care practice and the need for moral deliberation: a qualitative study (A5)	Hermsen, M. & ten Have, H. 2005	To discuss how the palliative patient is informed about treatment decisions.	Qualitative semi-structured interviews with caregivers.	The autonomy of the patient is becoming an increasingly important factor in decision-making in palliative care.
Examining variables related to successful collaboration on the hospice team (A6)	Parker Oliver, D., Bronstein, L. & Kurzejeski, L. 2005	To explore relationships between selected variables and teamwork in the hospice setting.	The Index of Interdisciplinary Collaboration and selected demographic questions of social workers in the Missouri State hospice association	Hospice social workers report a high level of interdisciplinary collaboration with colleagues.
Exploring the dynamics of interdisciplinary palliative care teams in providing psychosocial care: "Everybody thinks that everybody can do it and they can't"(A7)	Connor, M. & Fisher, C. 2011	To explore team members' perceptions and experiences of team dynamics in psychosocial palliative care	Semi-structured interviews with seven palliative care team members.	The major themes that emerged were lack of clear role boundaries and strategies for maintenance of role boundaries.
How well are we caring for caregivers? Prevalence of grief-related symptoms and need for bereavement support among long-term staff (A8)	Rickerson, E., Somers, C., Allen, C., Lewis, B., Strumpf, N. & Casarett, D. 2005	To define the prevalence and correlates of grief experiences among long-term care staff.	A cross-sectional survey of long-term care staff who care for patients near the end of life.	Most of the staff surveyed said they would use additional support services if offered.

Title	Author/Year	Aim	Method	Result
Interdisciplinary collaboration in hopsice team meetings (A9)	Wittenberg-Lyles, E., Parker Oliver, D., Demiris, G. & Regehr, K. 2010	To explore the perception of collaboration among hospice team members and acutal collaborative communication practices in team meetings.	Analysis of videotaped team meetings and team member completion of a survey in the Midwestern USA	The team's reflection on process was most likely to occur in team meetings.
Interdisciplinary Geriatric and Palliative care team narratives: Collaboration Practices and Barriers (A10)	Goldsmith, J., Wittenberg-Lyles, E., Rodriguez, D. & Sanchez-Reilly, S. 2009	To explore interdisciplinary geriatric and palliative care team member narratives about dying patients, their families and the team process	Semi-structured interviews of an interdisciplinary geriatric and palliative care team at a Veterans Affairs hospital in the USA	A divergence in the team members' conceptualization of teamwork and team effectiveness was revealed
Job satisfaction among hospice interdisciplinary team members (A11)	DeLoach, R. 2003	To investigate job satisfaction among hospice interdisciplinary team members.		There are significant relationships between job satisfaction and autonomy, role ambiguity, role conflict, supervisory support, and team functioning.
Occupational stressors and coping as determinants of burnout in female hospice nurses (A12)	Payne, N. 2001	To examine stressors, coping and demographic variables as predictors of burnout.	Questionnaires answered by 85 female nurses .	Stressors made the greatest contribution to burnout and demographic factors contributed the least.

Title	Author/Year	Aim	Method	Result
"Pain talk" in hospice and palliative care team meetings: An ethnography (A13)	Arber, A. 2006	To explore how teamwork is positioned as a central component of specialist palliative care and to explore boundary issues.	An ethnography were data was collected through audio recording of eight team meetings in hospice, hospital and community palliative care settings.	Specialist palliative care nurses use rhetorical strategies as a platform for building a reputation in managing pain.
The power of interdisciplinary collaboration in hospice (A14)	Wittenberg-Lyles, E. & Parker Oliver, D. 2007	To identify collaborative communication and extend the theoretical framework of interdisciplinary collaboration in a hospice setting.	Mixed methods with qualitative observation and quantitative information involving 5 interdisciplinary hospice teams in western USA	Interdisciplinary collaboration among team members are sustained through collaborative communication.
A preliminary study into stress in palliative care: Optimism, self-efficacy and social support (A15)	Hulbert, N. & Morrison, V. 2006	To understand stress within the palliative care sector, addressing individual and occupational differences.	Questionnaires answered by 36 palliative care team members.	Differences in reported stress levels were found between settings and between care giver type.
Refractory suffering: The impact of team dynamics on the interdisciplinary palliative care team (A16)	Swetenham, K., Hegarty, M., Breaden, K. & Grbich, C. 2011	To describe the skill sets that experienced palliative care clinicians possess when managing refractory suffering.	Semi-structured interviews and on-line questionnaires with experienced palliative care practitioners.	Team cohesion was identified as the key requirement in handling refractory suffering.

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Spirituality and job satisfaction among hospice interdisciplinary team members (A17)	Clark, L., Leedy, S., McDonald, L., Muller, B., Lamb, C., Mendez, T., Kim, S. & Schonwetter, R. 2007	To determine the prevalence of spirituality among interdisciplinary team members and whether spirituality has a relationship with job satisfaction.	A survey of 215 fulltime interdisciplinary team members.	Hospice interdisciplinary team members' integration of their spirituality at work and greater self actualization significantly improve job satisfaction.
Team meetings in specialist palliative care: asking questions as a strategy within interprofessional interaction (A18)	Arber, A. 2008	To understand how palliative care teams talk together about patients and the rhetorical features of talk.	Ethnography of institutional discourse.	The questioning strategy enables the boundary between one profession and another to be negotiated in a mutually acceptable manner.