Interprofessional collaboration within fluid teams: Community nurses' experiences with palliative home care

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Abstract
Aims and objectives: To explore how community nurses experience the collaboration with general practitioners and specialist palliative home care team nurses in palliative home care and the perceived factors influencing this collaboration.

Background: The complexity of, and the demand for, palliative home care is increasing. Primary palliative care is provided by community nurses and general practitioners, often in collaboration with palliative home care team nurses. Although these professionals may each individually be part of a fixed team, a new temporary team is often composed for every new palliative patient. These membership changes, referred to as team membership fluidity, challenge professionals to work effectively.

Design and methods: A qualitative research design, using semi-structured interviews with community nurses. Participant selection happened through regional palliative care networks in Belgium. The network’s palliative home care team nurses selected community nurses with whom they recently collaborated. Twenty interviews were conducted. A constant comparative analysis approach was used. Consolidated criteria for reporting qualitative research guidelines were followed.

Results: Formal interprofessional team meetings were not common practice. The other’s approachability and knowing each other positively influenced the collaboration. Time constraints, the general practitioners’ lack of expertise, communication style, hierarchy perception and income dependency negatively influenced the collaboration with general practitioners and determined palliative home care team nurses’ involvement. The coping strategies of community nurses balanced between a behaviour focused to the patient and to the professional relationship. Specialist palliative home care team nurses were relied upon for their expertise but also to mediate when community nurses disagreed with general practitioners.

Conclusion: Community nurses showed to be highly adaptable within the fluid team. Strikingly, dynamics described in the doctor–nurse game 50 years ago are still present.
Introduction

An ageing population and medical developments, which turn deadly diseases into chronic conditions, have contributed to an increasing number of palliative patients (United Nations, 2017). Most palliative patients prefer to remain and die at home whilst surrounded by their relatives (Gomes et al., 2012). Palliative home care is complex and requires a multidisciplinary approach that is delivered by general practitioners (GPs) and registered nurses working in the community [hereinafter referred to as “community nurses” (CNs)] (Beernaert et al., 2015; Borgsteede et al., 2006; Burt, Shipman, Addington-Hall, & White, 2008). Additional assistance from a specialist palliative care nurse from the palliative home care team (PHCT) may be required. The trio of collaborating professionals, namely the CN, the GP and the PHCT nurse, form an ad hoc team, which means that the team composition may change with every patient. Therefore within this context, and considering the complexity of palliative care, it is a challenge to ensure that these different professionals work effectively together to deliver high-quality care. Understanding the dynamics between the collaborating ad hoc team members may help to direct future collaborations and interprofessional education strategies.

Background

In recent years, the focus of care in Europe and North America has shifted from predominantly hospital-based to home-based care, with emphasis on a patient-centred and team-driven approach. These shifts require interprofessional collaboration and specific collaborative skills from the professionals involved (Chen et al., 2006). As the elderly population increases, so does the prevalence of multimorbidity; therefore, the demand for home health care increases and becomes more complex. This increasing healthcare demand and more intensive and individualised patient treatments mean that the role of the CN has evolved, including as a collaborator (for example, case management which requires collaborative skills) (Bodenheimer & Bauer, 2016; Dickson, Gough, & Bain, 2011; Niezen & Mathijssen, 2014).

In palliative home care, the GP and the CN are the key formal care providers (Beernaert et al., 2015; Block et al., 2008; Michiels et al., 2007; Offen, 2015). Community nurses play a central role in primary palliative home care and thus deliver physical, psychosocial, emotional, informational and organisational care (Offen, 2015). Due to its specificity and complexity, palliative care requires a team-based approach (Sepúlveda, Marlin, Yoshida, & Ullrich, 2002; Organization, 2002, 2002); therefore, CNs and GPs often collaborate with specialist palliative care nurses from the PHCTs to adequately respond to the patient’s symptoms and needs (Beernaert et al., 2015; Dahlhaus, Vanneman, Siebenhofer, Brosche, & Guethlin, 2013; Pype et al., 2013; Organization, 2010). Within Europe, PHCTs—similar to the ones in our study—are available in 37 out of 46 countries and the number of PHCTs are expanding (Centeno-Cortes et al., 2013). Palliative home care teams are multiprofessional teams, providing specialised support and advice on today and affect the interprofessional communication. Interprofessional education interventions can contribute to improved interprofessional collaboration.

Relevance to clinical practice: The study findings uncovered critical knowledge gaps in interprofessional collaboration in palliative home care. Insights are relevant for and related to professional well-being and workplace learning.

Keywords
ad hoc team, community nursing, fluid team, interprofessional collaboration, palliative care, primary health care, qualitative research, teamwork

What does this paper contribute to the wider global clinical community?

- Community nurses showed to be highly adaptable within the fluid team. Noteworthy however, communication dynamics described in the doctor–nurse game 50 years ago—when doctors were regarded as being superior to nurses and nurses’ recommendations had to appear to be initiated by the physician—are still present today.
- In addition to relying on specialist palliative home care team nurses for their expertise, they were relied upon as coalition partners against general practitioners when disagreements arose.
- The study findings shed light on the dynamics between the collaborating ad hoc team members and uncovered critical knowledge gaps in interprofessional collaboration in palliative home care. To improve collaboration and healthcare outcomes, interprofessional education interventions should be further developed in the healthcare professionals’ curriculum, with the era of team fluidity taken into account. Findings highlight the need for further research on interventions, aimed at improving the interprofessional communication in daily practice.
all aspects of palliative care (symptom control, psychological and spiritual support) to patients and their families, as well as to GPs and other healthcare providers (such as CNs). Their mode of action depends on the local model of care delivery and the level of involvement of the primary caregivers (Centeno et al., 2016; Centeno-Cortes et al., 2013).

Xyrichis & Ream, 2008 defined teamwork as “a dynamic process involving two or more health professionals with complementary backgrounds and skills, sharing common goals and exercising concerted physical and mental effort in assessing, planning or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making.”

2.1 Palliative home care in Belgium

Primary palliative home care is provided by CNs and GPs. Belgian CNs either work alone or in group practices, which can either be monodisciplinary or multidisciplinary following the recent integration of home nursing into multidisciplinary primary care practices. The organisation of home nursing is twofold; CNs can either be self-employed or work as employees. Community nurses are mainly employed by private not-for-profit organisations with a specific focus on home nursing. A physician’s prescription is required for the reimbursement of nursing interventions (Sermeus, Paquay, et al., 2010).

General practitioners and CNs often appeal to the support and advice of specialist palliative care nurses, being members of specialised PHCT. Regional palliative care networks were created in the late 1990s, with 15 located in Flanders (the Dutch-speaking part of Belgium). Palliative home care teams, providing specialised palliative care, are organised within the regional palliative care networks and consist of palliative care physicians, psychologists and specialist PHCT nurses. Most PHCT home visits are performed by the PHCT nurses with consent of the GP. The palliative care physicians and psychologists advise and support the PHCT nurses during weekly team meetings where patient cases are discussed (Keirse et al., 2009).

Although the GP, the CN and the PHCT nurse may each individually be part of a fixed team, a new temporary team—also defined as an ad hoc team (Roberts et al., 2014)—is often composed for every new palliative patient. These team composition changes may challenge professionals to work effectively together and provide high-quality care. Existing research described the views and experiences of GPs and CNs regarding their role in palliative care (Beernaert et al., 2015; Burt et al., 2008; Dahlhaus et al., 2013; Groot, Vernooij-Dassen, Crul, & Grol, 2005; Mitchell, Loew, Millington-Sanders, & Dale, 2016; Offen, 2015; Walsh & Luker, 2010), the GPs’ perceptions and preferences regarding their collaboration with PHCTs (Pype et al., 2013) and the evaluation of PHCTs by GPs and CNs (Goldschmidt et al., 2005). Although the ultimate goal of interprofessional collaboration is providing high-quality care, this paper focuses on the experiences of collaboration. To the author’s knowledge, no studies have reported on the experiences of CNs with regard to interprofessional collaboration within the triad of collaborating healthcare providers (CN-GP-PHCT nurse). Gaining insight into these experiences and understanding the dynamics between the collaborating ad hoc team members may help to direct future strategies to improve interprofessional collaboration and education.

3 STUDY AIM

The study aims were twofold: (a) to explore how CNs experience the collaboration with the GP and the PHCT nurse in palliative home care and (b) to explore the perceived factors influencing this collaboration.

4 METHODS

4.1 Design

A qualitative research design was adopted, using semi-structured interviews. The study was conducted according to the COREQ: consolidated criteria for reporting qualitative research (See COREQ checklist in Appendix S1) (Tong, Sainsbury, & Craig, 2007).

4.2 Setting and participants

In the palliative home care setting, the daily interactions between CNs, GPs and PHCT nurses vary in frequency and type and are defined by the respective responsibilities, for example, doctors provide CNs with prescriptions, a written report is available at the patient’s house, and PHCT nurses have phone call interactions with GPs and CNs for reporting and discussing. Meetings can be scheduled when needed.

Participants were recruited through the regional palliative care networks in Flanders. Four networks in different areas were purposefully selected on a geographical basis. The PHCT in each selected network was contacted and, after informed consent, asked to cooperate. Nurses of the PHCT subsequently selected all CNs with whom they had recently collaborated (shortly after the palliative patient’s death). Of the group CNs that were informed and willing to participate, the researchers selected five per network, paying attention to the diversity of gender, age, years of experience and type of employment. Additional sampling was scheduled if data saturation was not reached after the analysis.

4.3 Data collection

Twenty semi-structured one-to-one interviews were conducted by the authors FM and ADG, and were approximately one hour in length. The participant’s age, number of years in practice and employment type were recorded. FM and ADG reviewed the transcripts of the first three interviews to adapt and refine the interview guide. The interview guide (Box ) was comprised of topics on interprofessional collaboration and interprofessional communication. Follow-up questions were asked based on the responses of the CNs. All interviews took place between May 2013 and February 2014 and were audio recorded and transcribed verbatim.
Box 1 Interview guide

Interprofessional collaboration
- How do you perceive the collaboration with both the GP and PHCT nurse?
- What changes in the interprofessional collaboration with the GP occur when the PHCT nurse joins the team?
- Who takes responsibility in the multidisciplinary team?
- What kind of responsibilities are there?
- What are the influencing factors for sharing tasks and responsibilities?

Interprofessional communication
- How do members of the interprofessional team communicate?
- How are you involved in decision-making processes?

4.4 | Ethical considerations

Ethical approval was obtained (ethical approval number B670201317239).

Participants were provided with oral and written information explaining the objectives of the study. Written informed consent was requested. The information emphasised the preservation of the confidentiality, voluntary participation and the opportunity to opt out at any time. Participants were interviewed at a location of their choice. Interview transcripts were provided with a number.

4.5 | Data analysis

A constant comparative method was used to analyse data (Fram, 2013; Hewitt-Taylor, 2001). Transcripts were read and re-read, so the researchers could familiarise themselves with the data. To validate the analysis process, FM and ADG independently coded seven interviews. Subsequently, the codes were discussed and compared for similarities and differences, hereby constructing an initial coding frame. This coding frame was adapted after each discussion. The remaining 13 interviews were coded by FM. All codes were again compared with regard to their similarities and differences, and categories and subcategories were created. An inductive and iterative approach was used during the analysis process, hereby comparing interviews and codings. Author group discussions (FM, ADG, PP and MDV) were held to identify concepts and to discuss the relationships between the concepts using visual representations. Finally, a researcher familiar with qualitative research (AVH) but not previously involved in the researcher triangulation process read two interviews and the analysis text to verify and enhance trustworthiness. NVivo 10 software was used to support data analysis.

4.6 | Rigour

This study is part of the principal author’s PhD project. All but one of the other authors work within academia, previously gained their PhD and were familiar with qualitative research methods. Lincoln and Guba’s criteria (i.e., credibility, transferability, confirmability and dependability) were used to assure the trustworthiness and rigour of the qualitative data (Lincoln & Guba, 1985). Peer review of the interview style was performed to ensure data credibility. Interview records, transcripts and analysis documents were meticulously maintained. As three of the authors have experience in the delivery of primary palliative care, we continuously reflected upon the interview and analysis process to ensure the analysis was a true reflection of the data. By introspection and mutual collaboration, reflexivity aspects were thus considered. Independent initial coding was compared and discussed to enhance reliability. Researcher triangulation was used at all stages of the review process to enhance data credibility, dependability and confirmability.

5 | RESULTS

5.1 | Participants

Twenty CNs were interviewed. As the last interview did not reveal new themes, researchers did not perform additional interviews. Out of 20 participants, 16 were female. Their mean age was 46 years (range 35–57 years), and their professional experience in community nursing ranged from 5 months to 35 years. Four CNs worked solo, and 16 worked in monodisciplinary group practices (five were employees).

Sample characteristics are shown in Table 1.

Results are presented according to the research aims. In addition, the different concepts with respect to the interprofessional collaboration are described. The following results are illustrated with quotes from participants. Each quote is identified with participant number, gender and age.

5.2 | Experiences of collaboration

Within the triad of collaborating healthcare providers, the experiences of CNs were diverse with regard to interprofessional contact. In addition to the written observations and messages in the patient’s file at their home, most CNs had ad hoc telephone contact on a one-to-one basis with both the GP and the PHCT nurse to update each other on the patient’s situation. For some CNs, meeting other involved healthcare providers occurred in an unplanned manner, and formal interprofessional team meetings rarely took place. However, for others, interprofessional team meetings were common practice and were perceived as a necessity to streamline patient care.

It happens sometimes that we are there at the same moment by accident, and of course, then you have a chat. But we don’t really arrange a team meeting, not really... Moreover, if you have a good handover by
After all, the GP is busy and so are we, so if things go well... If somehow something goes wrong, of course then we will inform each other... We are not the organizing kind... (CN 20; F: 40 years)

With every new patient case - and in chronic care most of the time many people are involved - we take everybody on board in our practice... It doesn't work if you forget to invite one of the involved caregivers for the meeting. (CN 6; M: 44 years)

Some interviewees reported that a PHCT nurse joining the team meant that extra attention was paid to task agreements and updating each other on the patient’s case. The interprofessional collaboration as such was said not to be influenced or changed; however, the results of this study show the significance of PHCT nurses and their influence on the collaboration dynamics.

5.3 | Factors influencing collaboration

Collaboration with the GP and the PHCT nurse was perceived to be influenced by specific factors (Figure 1). Approachability and knowing each other positively influenced the collaboration.

5.3.1 | Approachability

Community nurses felt respected and acknowledged when GPs were approachable to discuss a patient’s case, when they answered the CNs’ questions or when they responded to their observations quickly. Furthermore, GPs jointly deliberating with CNs on treatment decisions was strongly appreciated.

... For instance last week, I’m visiting a patient with a lot of problems: a high blood pressure, irregular pulse, an uncontrollable headache, well I just need to send him an SMS: “Doctor, these are my observations”, on the spot I get his answer: “I’ll go and see him tonight”. After his visit I get a message again: “This and that has been done, please do follow-up”. That’s really superb you know, you really feel respected and acknowledged. (CN 2; F: 40 years)

Several GPs around here attended the palliative care course with the PHCT, and they know all about it. When I enter the patient’s house those GPs tell me: ‘Come and take a look, I did the calculation like this, what do you think about it’. ‘Well doctor, that’s ok, I always do it like this well’, or something alike. In mutual deliberation, that’s just superb, to be consulted like this. (CN 16; F: 44 years)

Concerning PHCT nurses, all CNs perceived them to be highly approachable and willing to help. Several CNs frequently relied on the experience of PHCT nurses. Some CNs regarded PHCT nurses as their backup to seek confirmation from after changing a patient’s medication dose. Although a GP’s permission was given, they asked...
for additional confirmation as they preferred not to take sole responsibility for administering medication. Furthermore, the ability of PHCT nurses to demonstrate technical procedures resulted in CNs’ learning and feeling more confident.

Yes, the PHCT has always been my back-up. Some GPs tell us, “Yes, you can increase the dose of the plaster, go ahead”. As one GP told us: “Yes, you know better than us”, and it is true indeed but I don’t want to do this on my own responsibility. So I’ll check with the PHCT to see if it’s okay that I raised the dose… then also they know about it. I don’t like to do this on my own. Because you never know…

(CN 12; F: 40 years)

5.3.2 | Knowing each other

A history of working together and knowing each other resulted in feelings of trust and knowing what to expect from each other. Furthermore, CNs stated that working together improved the interprofessional relationship, which in turn positively influenced interprofessional collaboration.

...with those others, I regularly share palliative patients, which makes me know where we stand with one another, and that we can trust each other blindly and that I also know how they’re working.

(CN 10; F:56 years)

Because the closer the collaboration, the better the relationship. The more you understand one another, the better you’ll collaborate. (CN 11; M: 36 years)

Factors that put the collaboration with the GP under stress included time constraints, the GPs’ lack of expertise, their communication style, the perception of hierarchy and income dependency. These factors also determined the involvement of the PHCT nurses in the collaboration process. The coping strategies of CNs balanced between a behaviour focused to the patient and to the professional relationship. For example, some CNs would not hesitate to initiate a discussion on collaborative problems with the GP, as their “primum movens” was the dedication to optimal patient care; however, others did not dare to question the GP’s acts as they did not want to harm the professional relationship. In contrast, CNs felt more comfortable expressing themselves to PHCT nurses as they were regarded as equals.

When I feel something’s wrong, I’ll always make a phone call or I’ll go to the GP and I talk with him. On the spot I mean, I won’t let it simmer for days because this we can’t do. I’m quite straightforward actually. Most of the times it’s just some fine-tuning, or getting a better understanding, nothing more. Because actually we all want the same, you know. We all want the patient to die comfortably. (CN 11; M: 36 years)

With the PHCT nurse I can express myself better. She’s a nurse too you know, that’s actually the same level as me. I don’t dare to say to the doctor ‘Why do you still put him on a drip?’ I’m scared of doing something wrong by this. (CN 9; F: 40 years)

5.3.3 | Time constraints

The collaboration between the CN and GP was put under stress when the nurse could not rely on the GP to deliberate on the treatment decision due to time constraints. When the GP was not able to be reached or had restricted the CN’s phone calls, the CN turned to the PHCT nurse for advice. On the one hand, they were worried about keeping the patient waiting in discomfort, but on the other hand, they did not want to take decisions on their own. In contrast to the GP, the PHCT nurse was always perceived as willing to listen and responding immediately.

They (PHCT nurses) do listen to your problem and they give you an answer on the spot. Whereas when you’re calling a GP he never has time or you can’t even reach him. You may leave him a message but he doesn’t call you back. Then you feel uncomfortable, because you know that the patient is suffering, or is being agitated and you don’t want to decide on what to do yourself. So, in the end, you call the PHCT, as they communicate better compared to the GPs.

(CN 12; F: 40 years)

5.3.4 | GPs expertise

Collaboration with the GP was also negatively influenced when he was perceived to be less experienced in palliative care. Accordingly,
when the GP and CNs judged the patient’s situation differently, tensions occurred when CNs did not feel that their concerns were being recognised (for example, the anticipation of possible urgent complications). Hence to prepare for potential emergencies, the PHCT nurse was asked for additional information as she was regarded as an expert in the field.

I called this GP and I told him “Doctor, this patient suffers from the vena cava superior syndrome, and I’m not experienced in this”, “Oh but you don’t have to worry about that…” was the answer! He didn’t know it either, I guess, otherwise you don’t say such a thing. That wasn’t helping me at all. And then I’m glad the PHCT was there because these people are more knowledgeable and experienced. I was afraid the patient would suffocate, and then what? So I consulted the GP and asked him “What can we do if this happens?” “Well, then you just call me”, he said. But you know, if something like this is happening, you don’t have time to make phone calls, you know, you need to be able to do something. But they (GPs) don’t always understand… (CN 16; F: 44 years)

5.3.5 | Communication style

Some CNs felt inhibited to ask questions to the GPs because of their communication style. When open communication with the GP was absent, some CNs preferred to rely on the PHCT nurse. In contrast, other CNs would ask their questions to the GP nevertheless. They did not want to risk the GPs feeling bypassed and them disagreeing to future collaborations with PHCT nurses.

Who to call first? Not easy you know! Because we want to keep the GPs approving the PHCT’s involvement for future patients. The younger GPs rarely refuse this, but if it’s an older one, and he feels mistreated, we don’t want him to say, ‘Next time, I don’t want them to get involved’.

(CN 1; F: 47 years)

Through experience, CNs learned how to approach and communicate with GPs so as not to affront them. One communication strategy sometimes used was to make the GPs feel like they had solved the problem, whilst the CNs had really prompted it. Some CNs reported not entering into a discussion with the GP, even if the quality of patient care suffered. Despite knowing that the GP’s prescribed medication dose was insufficient, they preferred to wait for the results and report this to the GP. As such, they created an opportunity for the GP to make treatment conclusions and propose adaptations. However, other CNs found it easier to express their objections, especially when the patient’s comfort was at risk. The PHCT nurses were perceived to be important mediators in disagreements when GPs were not open to discussing the patient’s treatment options.

GPs… you have to learn how to work with them, that’s not always easy. But sometimes you can turn the whole thing around, to make it seem as if it’s coming out of their mouth. You have to make some suggestions. (CN 16; F: 44 years)

When they say ‘We can talk about it but it should be like this’ then you know already, ‘I will prescribe this, what do you think about it?’, then I know to some of them I can say ‘Yes, or maybe it’s too much or not enough’. But with others, I know I won’t discuss, let’s wait and see. Then I say ‘Yes, we can start like this, but is it ok for you if I call you tomorrow to report on the effect?’ And then they are glad to be able to adapt if necessary. (CN 10; F: 56 years)

...we’re having less conflicts with doctors who are open for discussion and deliberation. Often, we have the feeling that mostly solo working GPs don’t see enough palliative patients. They lack experience and feel some fear to start certain drugs or they do not master certain techniques, which makes them not use them. And so you get conflicts when the nurse wants to start up a syringe driver and the GP doesn’t agree. There the PHCT plays a major role, as a mediator, listening to both sides, and making sure that they reach a certain level of agreement. (CN 6; M: 44 years)

5.3.6 | Hierarchy

The GP was regarded as the professional who was ultimately responsible. Depending on the GP’s style, hierarchy was perceived to be an influencing factor in the collaboration. When confronted with GP’s hierarchical style, some CNs felt obliged to use a cautious approach and choose their words carefully. Conversely, other CNs reported a perceived change in the interprofessional relationship with GPs in general compared with recent years, which was less affected by hierarchy. This resulted in CNs feeling more relaxed towards GPs who treated them as equals. Accordingly, they felt more comfortable discussing the patient’s care policy. In contrast to GPs, PHCT nurses were perceived as equals (as described above).

Some GPs we’re calling to say, “Doctor we think this or that”, respond to us by saying ‘I am the doctor and I am making the decisions’. They simply do not accept suggestions, as a nurse you actually have to be so very careful and pay attention… you really
have to be so careful to what you’re saying. Not all doctors are open for this kind of collaboration, no, absolutely not.

(CN 2; F: 40 years)

A PHCT nurse, that’s the same level, so different comparing to contacting a GP. Well yes, some GPs act in a normal way, there are some doctors who say, ‘You don’t need to call me doctor, just call me Jan’, this makes me feel more at ease. On the other hand, some doctors don’t have this attitude and they really treat us like ‘You are the nurse and I am the doctor’.

(CN 9; F: 40 years)

5.3.7 | Income dependency

In addition to hierarchy, income dependency was also perceived to be an influencing factor in interprofessional collaboration, in particular by self-employed CNs. They indicated that they did not wish to risk disrupting the interprofessional relationship with GPs, as their income depended on the GPs’ patient referral. As such, they restrained themselves from open communication with regard to suggestions about diagnosis or treatment decisions.

And you really have to be careful about what you’re saying... because nurses are only allowed to describe the symptoms, we are certainly not allowed to make a diagnosis. So yes, I’m a little scared for this! And we also need his patient referrals. If he turns against you, then you are in trouble.

(CN 18; F: 44 years)

I know the GPs and they are easily offended. I am a nurse eh. If I say to a colleague ‘Look here, you are not doing it the right way actually’, or let me put it differently, ‘I think there are better solutions for this situation’, she will accept, we are equals. And you know, I am not an equal to the GP. The GP is also my employer. So I have to take care not to upset him.

(CN 10; F: 56 years)

6 | DISCUSSION

This study aimed to provide insight into the experiences of CNs with regard to interprofessional collaboration during palliative home care, within the CN-GP-PHCT nurse triad. Furthermore, it also aimed to explore the perceived factors that influenced this collaboration. To the best of the author’s knowledge, this is the first study to describe the dynamics within the CN-GP-PHCT nurse triad, through the eyes of the CNs.

Within the aforementioned triad, all respondents were members of an ad hoc team that changed composition for every new palliative patient. These team changes are referred to as team membership fluidity (Bedwell, Ramsay, & Salas, 2012; Tannenbaum, Mathieu, Salas, & Cohen, 2012). As such, participants provided care according to the needs of the patient and within a temporary team. Moreover, some aspects of the GP-CN relationship (for example, when the GP was perceived to not be open to discussing treatment options) influenced the position of the PHCT nurse (for example as a mediator) within the triad.

In answer to how CNs experience the collaboration with the GP and the PHCT nurse, good aspects of the collaboration arose when healthcare professionals were contactable, when asking questions was possible, when there was sufficient opportunity to discuss the patient’s case and when CNs were involved in the deliberation processes. These results are aligned with research results which showed that repeated opportunity for effective, frequent and reciprocal informal communication was the most important tangible element of interprofessional collaboration (Morgan, Pullon, & McKinlay, 2015). Furthermore, participants reported that meetings with other care providers were unplanned and that formal team meetings were not common practice. Literature described ad hoc interactions to be positive and effective for the informational continuity of patient care (O’Reilly et al., 2017). Nevertheless, prior research also stressed the importance of regular formal team meetings for effective team working (Xyrichis & Lowton, 2008).

This study showed that collaboration with PHCT nurses was particularly valued, and that most CNs reported often relying on their expertise. These findings support those from previous studies where CNs emphasised the benefits of teamwork and appreciated specialised palliative care nurses as a source of advice (Goldschmidt et al., 2005; Offen, 2015; Tomison & McDowell, 2011). In contrast, other studies found PHCT nurses to be regarded as having a higher hierarchy. This led to CNs fearing that they would be edged out of their established role and thus leading to a defensive response (Burt et al., 2008; King, Melvin, Ashby, & Firth, 2010; Offen, 2015); however, this was not confirmed in this study.

In answer to the perceived factors influencing the collaboration, several notable factors influenced the collaboration with the GP and put stress on interprofessional collaboration. First, hierarchy and income dependency negatively influenced collaboration with GPs. To deal with the GPs’ hierarchical style and safeguard future patient referrals, respondents stated that they used a cautious approach so as to not harm the interprofessional relationship. Conversely, PHCT nurses were regarded as equals. Other research results showed that a hierarchical culture impacts on effective team functioning (Hall, 2005; McInnes, Peters, Bonney, & Halcomb, 2015; O’Reilly et al., 2017; Youngwerth & Twaddle, 2011). When considering income, funding structures that support patient-team encounters rather than patient-doctor encounters and where doctors and nurses are employed alongside each other are some of the factors that enhance efficiency and promote teamwork (McInnes et al., 2015; Pullon, McKinlay, & Dew, 2009).

Second, collaboration was negatively influenced when open communication with GPs was perceived to be absent. Several participants reported that they held back from expressing their doubts or objections on treatment decisions. Alternatively, another strategy
was to make GPs feel as though they had solved the problem, whilst it was actually the CN prompting it. Existing evidence endorses the nature of communication as a key factor in teamwork (O’Reilly et al., 2017). In 1967, Stein described “The Doctor-Nurse Game,” where open disagreement between the players (the doctor and the nurse) was to be avoided at all costs. The relationship between doctors and nurses was hierarchical, with doctors being superior to nurses, and the nurse had to make her recommendation appear to be initiated by the physician (Stein, 1967). Price, Doucet, and Hall (2014) reported that the historical social positioning of nursing and medicine still influences interprofessional collaboration, despite the fact that the nurse–physician relationship has positively evolved. This is confirmed by the results of this study. Moreover, it is striking that the dynamics described by Stein in 1967 still exist today, as CNs in this study still found it necessary to use this communication strategy towards GPs, even at the expense of the patient’s comfort. In contrast, all study respondents experienced communication with PHCT nurses to be open. In addition to relying on PHCT nurses for their expertise when the GP was not available or was perceived to be less experienced, CNs also reported that they acted as important mediators when disagreements with the GP arose. As such, the PHCT nurse was relied upon as a coalition partner. Therefore, this study shows that CNs are dedicated to providing quality patient care; however, they often feel hindered to act accordingly for fear of harming the relationship with GPs.

Leever et al. (2010) investigated the ways hospital nurses and physicians cope with frictions. Strategies to overcome these frictions included discussing it with a person other than the one concerned (namely another physician or a staff nurse). Similarly, the results from this study revealed the significance of PHCT nurses in cases of CN-GP disagreements, not only as someone to discuss the situation with but also to lean on as a mediator.

This study highlights the adaptability of CNs within the GP-CN-PHCT nurse triad. The first aspect of this adaptability is related to the temporary team structure, to be considered a fluid team. Today, teams operate in a rapidly changing, dynamic and complex environment. They change and adapt more frequently and operate with looser boundaries than in the past (Tannenbaum et al., 2012). Therefore, professionals adapt to the fact that clinical teams are constituted on an ad hoc basis. Contemporary clinical teamwork then inhabits a place between established routines and improvisation under uncertain conditions (Bleakley, 2013). The second aspect of this adaptability is related to the behavioural style of CNs which, depending on the workplace context and attitude of the GPs, ranges from a more professional relationship-focused style to a more patient-focused approach. This is aligned with the results of a previous study which used PHCT nurses as the target study population (Pype et al., 2014). Although this study demonstrates the adaptability of CNs, the question raised is to what extent hierarchy and lack of open communication affect the provision of quality patient care. Future research, investigating in depth the entire interactions between collaborating professionals, may gain insight into how CNs’ perceptions influence their behaviour during the next interaction and ultimately how it influences the quality of patient care.

7 | LIMITATIONS

It is acknowledged that none of the participants worked in multidisciplinary practices, which therefore influences the generalisability of the results. Furthermore, the Belgian healthcare context and its regulations regarding remuneration may be a limitation. However, we expect our findings to be transferable to CNs in other countries, as the Belgian context is exemplary. It hereby transcends the domestic practice due to similarities to healthcare systems within other developed countries.

8 | CONCLUSION

This study demonstrated the adaptability of CNs during interprofessional collaboration in palliative home care. However, the dynamics described in the doctor–nurse game 50 years ago are still present today and affect the interprofessional communication. Early interprofessional socialisation can ensure that professionals understand their roles in relation to each other. Recognising one’s own role and those of other professionals, interprofessional communication and effective team development are core competencies described by the Interprofessional Education Collaborative (Collaborative, 2016). Interprofessional education (IPE) interventions that enable health professionals to learn about, from and with one another may improve collaborations and healthcare outcomes (Reeves, Pelone, Harrison, Goldman, & Zwarenstein, 2017; Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013). Further research on interventions that aim to improve interprofessional communication in daily practice is recommended. In addition, these study results confirm the need for further IPE development in the curriculum of healthcare professionals with team fluidity being taken into account.

9 | RELEVANCE TO CLINICAL PRACTICE

The study findings shed light on the dynamics between the collaborating ad hoc team members and uncovered critical knowledge gaps in interprofessional collaboration in palliative home care. These insights are relevant for, and relate to, two essential aspects of clinical nursing practice. First, poor interprofessional collaboration is associated with moral distress (Lamiani, Borghi, & Argentero, 2017); conversely, positive interprofessional collaboration may enhance nurses’ professional well-being (Kaiser, Patras, & Martinussen, 2018). Therefore, insights into collaborative experiences are very relevant. A second aspect, being crucial for nurses’ lifelong learning, is workplace learning as an important side effect of interprofessional collaboration (Mertens et al., 2018).
CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.