

Working Collaboratively in Hospice and Palliative Care: Sharing Time

A Grounded Theory

Christine A. McDonald

A thesis submitted to Auckland University of Technology in partial fulfilment
of the requirements for the degree of
Doctor of Health Science (DHSc)

2017

School: National Centre for Interprofessional Education & Collaborative Practice
(NCIPECP)
Faculty of Health & Environmental Sciences
AUT University

Abstract

Palliative care is the physical, social, emotional, and spiritual care of people with a life-limiting illness (Palliative Care Subcommittee, 2007). As a health care service, palliative care advocates for a holistic multidisciplinary approach. While service delivery is certainly multidisciplinary, whether health professionals working in New Zealand palliative care services practice collaboratively, and in what form that collaboration takes, is unknown. Collaborative practice can be difficult to achieve, as traditionally trained health professionals are more accustomed to working alongside each other, rather than together (Herbert, 2005; Herbert et al., 2007). Gaining further knowledge about what is occurring in practice is important when, driven by international workforce shortages and an increasing complexity of health care, the World Health Organisation (WHO) (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010) has called for interprofessional education and collaborative practice across all areas of health care.

Glaserian grounded theory methodology has been used to examine the area of interest which is, 'What is the main concern of health professionals working collaboratively in palliative care (with colleagues and patients) and how do they manage that?' A total of 25 interviews were undertaken with 23 participants, across professional disciplines, working in palliative care services within the North Island of New Zealand. Through an iterative process of constant comparative analysis and conceptualisation, using memoing, key concepts, and abstracting categories, a theory emerged. The theory of Sharing Time explained the social process of how health professionals working collaboratively in palliative care facilitated collaboration, while managing their main concern. Sharing Time is both an interactive participatory process and an outcome.

The main concern of possessorship, is defined as having possession of a tangible commodity or having a need to have possession of an intangible commodity, that has the potential to impact patient care when not shared. Sharing Time occurs when health professionals purposefully make time, take time, find time, and spend time in their workday for and with each other, to share further, and facilitate collaboration. Sharing Time occurs through purposeful connecting and finding common ground. Integrated by reciprocity this theory is mutually beneficial to all involved as there is an exchange of a commodity, such as equipment or information, which improves patient care.

This research also discovered that health professionals Sharing Time are facilitating collaboration by situating this strategy in a middle ground. Moving outside of this middle ground, where there is too much or too little Sharing Time, continues the main concern of possessorship rather than manages it, which adds barriers to collaboration. The theory of Sharing Time has potential value for all health professionals working in palliative care, as it facilitates collaboration and promotes further sharing.

Collaboration and managing possessorship promotes a safer work environment.

Keywords: Sharing Time, Possessorship, Hospice, Palliative care, Collaboration,

Table of Contents

Abstract	i
Table of Contents	iii
Table of Figures	vii
Table of Tables	viii
Attestation of Authorship	ix
Acknowledgments	x
Chapter One: Introduction	1
Beginning Interest	1
Refining the Substantive Area of Interest	4
Aim and Purpose of this Study.....	6
Methodology	6
Significance of the Research.....	7
Thesis Structure.....	8
Chapter Two: Literature Review	11
Introduction	11
Literature in Glaserian Grounded Theory	12
Literature Search	14
Hospice and Palliative Care	15
Historical beginnings	15
Definitions.....	19
Contemporary hospice and palliative care	22
Summary of palliative care	30
Working Collaboratively.....	31
Background	31
Definitions.....	34
Contemporary collaborative practice	39
The social context	43
Summary of working collaboratively	46
Chapter Three: Research Methodology	48
Introduction	48

Historical Developments	48
Epistemology.....	53
Methodology	57
Theoretical sampling.....	58
Constant comparative analysis.....	61
Glaserian Coding.....	61
Abstracting	64
Conceptualising through memoing	64
Theoretical sensitivity	65
Emergent theory generation	67
Credibility and rigour.....	67
Decision to Use Glaserian Grounded Theory	68
Summary	69
Chapter Four: The Research Process	71
Introduction	71
Approval Processes	71
Pre-requisites.....	71
University approval: Confirmation of candidature	72
Ethical approvals.....	72
Meeting Ethical Principles	75
Participants.....	79
Recruiting.....	79
Eligibility	80
Research participants	81
Data Collection - The Interviews	82
Data Analysis	87
Constant comparative analysis.....	87
Memoing	87
Emergence of the Main Concern.....	90
Emergence of Properties and Categories	91
Emergence of Core category	95
Generating the theory and application of ‘coding families’.....	98
Maintaining Rigour	101

Summary	102
Chapter Five: The Theory	103
Introduction	103
The Main Concern: Possessorship defined	103
The Theory: Sharing Time	105
Overview	105
Sharing Time	107
Purposeful Connecting	112
Communicating	115
Relating	118
Finding Common Ground	119
Participating	121
Negotiating	123
Sharing Time in the middle ground.	125
Summary	132
Chapter Six: Discussion	134
Introduction	134
The importance of time	143
Teams and roles within teams	148
Chapter Seven: Methodological Considerations & Opportunities.....	170
Introduction	170
Opportunities for Further Research.....	172
Summary	173
References	175
Glossary of Terms	198
Appendices	201
Appendix A: Health and Disability Ethics Approvals	202
Appendix B: AUTECH Ethics Approvals	207
Appendix C: Safety Protocol	210
Appendix D: Cultural Support Letter.....	211
Appendix E: Health Professional Information Sheet.....	212
Appendix F: Patient Information Sheet.....	216
Appendix G: Consent Form	220

Appendix H: Potential Interview Questions	221
Appendix I: Memo example September 2013	222
Appendix J: Emerging main concerns	223
Appendix K: Emergence of Possible Core Categories	224
Appendix L: Emerging theory (January 2015)	225
Appendix M: Emerging theory (March 2015)	226
Appendix N: Emerging theory Finding Time (July 2015).....	227
Appendix O: Emerging theory of Sharing Time (June 2016).....	228
Appendix P: Diagrammatical representation of Sharing Time’s mid-ground	229
Appendix Q: Summary of the theory of Sharing Time (with main concern)	230

Table of Figures

Figure 1: Coding definitions (Glaser 1992, p. 38; 1998, p. 135).....	62
Figure 2: Participant demographics	81
Figure 3: Example of early typed memo.....	89
Figure 4: Example of initial open coding.....	92
Figure 5: Example of grouping of codes into categories	93
Figure 6: Example of early core category emergence analysis.....	94
Figure 7: Example of later core category emergence analysis.....	95
Figure 8: Discovering codes and categories example (dated 12.9.14).....	97
Figure 9: Memo example of discovering theoretical code.....	100
Figure 10: Sharing Time situated in the middle ground	126
Figure 11: Communicating in the middle ground.....	128
Figure 12: Relating in the middle ground	129

Table of Tables

Table 1: Conceptual representation of the theory of Sharing Time	112
Table 2: Categories and properties of purposeful connecting.....	113
Table 3: Categories and properties of finding common ground	120

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.



Christine McDonald.
30/04/2018

Acknowledgments

Learning to undertake research as part of a doctoral programme is not an easy endeavour. Many students, like myself, have competing life events with family, work, and study that must be juggled as it is not possible to remove one, to spend more time on the other. Research is also not something that can be done alone. Therefore, I wish to acknowledge and thank those who have helped me. Without you all, this piece of research would not be where it is today.

I want to thank all the participants who willingly agreed to be interviewed. You are this research. Without you, it would not exist.

I wish to acknowledge my supervisors without whom this research would never have been completed: Antoinette McCallin who started this research with me. Strongly encouraging me to research in the interprofessional collaboration field, Antoinette was there as I began learning to do Glaserian grounded theory, giving encouragement as I undertook my first interviews. Rod MacLeod, whose expert knowledge of palliative care is immeasurable. If I can only gain a small portion of the knowledge you have, I would be grateful. Your questions to me were more insightful than you perhaps realised. Marion Jones and David Healee both came on board after Antoinette retired. David, your knowledge of grounded theory that you shared was invaluable, as was your own recent student experiences that enabled you to understand and suggest ways of managing the various aspects of post-graduate research from a student perspective. Marion, your experience and knowledge is immense, and I appreciate you picking up where Antoinette left off. Saying thank you barely seems to be enough, but it is sincere.

Thank you to my Mum for her support; even while verbalising that choosing to do further study “at my age” was crazy. Finally, yet foremost, thanks to the Lord. For I can do all things through Christ who strengthens me (Philippians 4:13).

Ethics approval for this study was initially conferred by the Health and Disability Multi-Region Ethics Committee on November 25, 2011. Approval number MEG/11/EXP/123. Renewals were received through to January 2017.

Ethics approval was initially confirmed by the Auckland University of Technology Ethics Committee (AUTEK) on February 8, 2012. Approval number 11/334. Renewals were received in February 2013 and March 2014.

Ethical approvals and annual renewals can be seen in Appendices A and B.

Chapter One: Introduction

Beginning Interest

Working in clinical practice as a Registered Nurse (RN) for many years, both in New Zealand and internationally, in the specialty area of paediatric oncology, eventually led this researcher to develop an interest in palliative care. Returning to New Zealand, this interest in palliative care subsequently led the researcher to accepting a nursing position at a community hospice when the opportunity arose. Working for an organisation that specialises in palliative care meant the researcher's interest grew into a passion for providing patients with the best palliative care possible. That passion remains today. Palliative care is the physical, social, emotional, and spiritual care of people with a life-limiting illness from diagnosis to death, which includes care for the family caregivers (Palliative Care Subcommittee, 2007).

For some time, prior to the development of this research study, the researcher began listening to stories from staff, patients, and patients' families; stories of the times when the care provided by health professionals went well, and stories of when it did not. While it was important to recognise what worked well, to be able to emulate that behaviour, the researcher, believing that as much, or more, can be learned from what does not work well, began to take note of the stories where care provision was more challenging. One recurring theme, in both the positive and challenging stories related to how health professionals worked together, within and between organisations. The researcher began to question whether these stories, if accurate, were relevant only to the individual hospice where the researcher was employed or were more widespread. This

led to further inquiry about what exactly was occurring when health professionals were working together and whether delivery of care could be improved.

The literature indicates that one way of improving care delivery is through collaborative practice, as recommended by the World Health Organisation (WHO) (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). What this recommendation meant to health professionals currently working in palliative care in New Zealand was unknown. Neither was it known if this recommendation differed from how health professionals currently worked together. The WHO defined collaborative practice as occurring “when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings. Practice includes both clinical and non-clinical health-related work” (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010, p. 13). Following the WHO recommendations for collaborative practice is a laudable goal for palliative care providers. However, before embarking on this challenge, further investigation to examine what was occurring in the work place was considered beneficial, including examining why working together appeared to be effortless at times, but very challenging at other times. What were the basic social processes, both positive and negative, that impacted health professionals working collaboratively?

The researcher began to consider why the definitions of hospice and palliative care include a multidisciplinary, interdisciplinary, or team approach, and what that meant to health professionals working directly with patients, as opposed to asking for a

collaborative approach (Palliative Care Subcommittee, 2007; WHO, 2014; Wittenberg-Lyles & Parker-Oliver, 2007). What is meant by multidisciplinary, interdisciplinary, or team is not further defined in these definitions of palliative care, although these terms have been defined by others. For example, Ovreveit (2009), when discussing parallel working, identified five ways of describing a multidisciplinary team in terms of degree of integration, extent of responsibility, membership, management structures, and patient pathway and decision making. The various definitions and descriptions of teams can be challenging, as health care professionals' interpretation of these terms may not match the intended meaning of the author requesting this type of team, for example, the WHO's definition and expectations. An assumption can be made that this challenge will continue until health care organisations agree on and use the same definition for each term. Adding to the perplexity of multiple terms for describing teams, the term collaboration brings yet another layer of confusion as it describes how teams function. With differing definitions of collaboration, including interprofessional collaboration, it would be surprising if health professionals working in palliative care, while aware of the need to work together, clearly understand the expectations.

Prior to commencing this study, the researcher's informal dialogue with colleagues indicated that few understood what the differences were in relation to the various terms used to describe teams and ways of working together. As these terms appeared to be used interchangeably, the researcher wondered how the influence of these different terminologies impacted on practice and care delivery. This curiosity narrowed the researcher's area of interest to palliative care delivery in New Zealand. These observations and informal questioning inspired the researcher to investigate more formally through research; believing it was important to uncover whether the words

used to describe collaboration influence the basic social processes of health professionals' working together in palliative care and, if so, how.

Refining the Substantive Area of Interest

Palliative care is imbedded in New Zealand's health care system (Ministry of Health, 2001). However, the connection between the practice of palliative care and collaboration was unclear. Collaboration of some description occurred, but this seemed to be assumed rather than stated. Interestingly, when comparing New Zealand palliative care to international palliative care provision, some providers, for example Canada, have clearly stated the need for the hospice and palliative care teams to work collaboratively (Canadian Hospice Palliative Care Association, 2006). In New Zealand, although a multidisciplinary team is asked for, no written requirement for collaboration between health professionals working in palliative care was found (Hospice New Zealand, 2012). Perhaps, to date, it has been assumed that a multidisciplinary team will collaborate and, therefore, this does not need to be stated. Moreover, any lack of clarity around expectations for health professional behaviours, to provide quality palliative care delivery in New Zealand, may influence how collaboration is practiced.

Collaboration is an established term that has been defined by Gray (1989) as "a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go well beyond their own vision of what is possible" (p. 5). Collaboration occurs between health professionals as needed in a moment of time to solve a problem. In contrast, the Canadian Interprofessional Health Collaborative (CIHC, 2010) defined collaborative practice as "a partnership between a team of health professionals and a patient or patient in a participatory, collaborative and coordinated approach to shared decision-making around health issues" (p. 24), thereby

emphasising an interprofessional focus. Interprofessional collaboration requires a change in philosophy, as it is a way of practice that shares decision making and includes the patient in the partnership of care. For the purposes of this research, Gray's (1989) definition was used when discussing moment-in-time collaboration; whereas, the CIHC (2010) definition was used when discussing interprofessional collaborative practice.

Clearly, health professionals working in palliative care do not work in solitude, but how they work collaboratively with colleagues was uncertain. There are multiple palliative care providers in New Zealand, offering the potential for varying influences on how health professionals within those organisations work, such as location, management structure, organisational culture, and professional role mix. Identification of the way of working in one organisation, by some health professionals, does not necessarily translate to other organisations and health professionals. This was considered when choosing the research methodology, as the abstraction that occurs with Glaserian grounded theory removes the spatial and site differences.

Determining how some health professionals work together within and across palliative care organisations identifies a baseline. This becomes a potentially useful beginning for transitioning to increased collaboration, or to the WHO recommended interprofessional collaborative practice (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010), if this is not already occurring. Therefore, lack of clarity around collaboration in palliative care delivery in New Zealand helped to refine this research topic. A decision was made to ask palliative care health professionals about working collaboratively. Using a grounded theory approach allowed participants to define what that term meant for them in their

workplace, as they are considered the experts in the field and have an intimate knowledge of the basic social processes in collaborative practice. While framing the area of interest in the form of a question is uncommon in grounded theory, Glaser accepts that it is more comfortable for some researchers to enter the field with some combination of a clear question, or problem area, in mind. This gives the researcher “a general perspective and a supply of beginning concepts and field research strategies. This is less than being completely open, but still quite receptive to the emergent” (Glaser, 1978, p. 45). Hence, the research area of substantive interest became, ‘what is the main concern of health professionals working collaboratively, with colleagues and patients, in palliative care and how do they manage that?’

Aim and Purpose of this Study

The aim of this study was to generate a substantive theory that explained how health professionals working in palliative care collaborate.

The main purpose of this study was to find a theoretical explanation of the behaviours health professionals use when working collaboratively to manage their main concern, which will also be identified. A second purpose was to provide practical knowledge about how collaboration occurs in palliative care in New Zealand that has application for the professional arena. The proposed explanations contribute to the current knowledge base as original research. In addition, the discussion may also stimulate further research and be transferable to other areas of health care through dissemination.

Methodology

Glaserian grounded theory is a research method that generates theory from data gathered through theoretical sampling. This data is organised and analysed using

constant comparative analysis, coding, and conceptualising through memoing (Glaser & Strauss, 1967). A useful research approach for investigating the social process of collaboration, when the actual research problem is unknown at the beginning of the study, Glaserian grounded theory gives an opportunity to explore how a sample group behaves in a substantive area. Glaserian grounded theory was chosen to support the emergence of a theoretical explanation of how health professionals working in palliative care manage a self-identified concern, rather than the researcher identifying the problem (Glaser, 1992, 1998; Glaser & Strauss, 1967). This participant viewpoint decreases the potential for preconceived assumptions about the problem and resolution, adding another perspective to the knowledge base. According to Glaser (1978, 1998) the participant's main concern motivates the resolution process.

Significance of the Research

While there is no doubt some collaboration is occurring, discovering how palliative care health professionals are currently working collaboratively, along with determining their main concern with collaboration, is significant for the future of palliative care service delivery. As the call for palliative care is increasing, services and organisations providing palliative care are required to plan for future growth, while using finite resources wisely (Palliative Care Council of New Zealand, 2011; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010; Worldwide Hospice Palliative Care Alliance, WHO, & United Nations, 2014). Understanding how health professionals practice, through uncovering and supporting any social processes related to collaboration, can strengthen practice where appropriate, or lead to needed change. Such knowledge can be used to improve and support current forms of collaboration, or preferably the information may be used as a baseline for introducing interprofessional collaborative practice in palliative care.

Recommended as a way of working for all areas of health care, interprofessional collaborative practice is widening (Australian Interprofessional Practice & Education Network, 2015; CIHC, 2015; Centre For The Advancement Of Interprofessional Education, 2014; Ministry of Health, 2001; Ministry of Health New Zealand, 2008; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). However, interprofessional collaborative practice is not the same as collaboration. It is unclear what form of collaboration is happening in the practice of palliative care in New Zealand. In turn, interprofessional collaborative practice in palliative care, were it to occur, has the potential to role model and facilitate the introduction of collaborative practice into other areas of health care in New Zealand.

Thesis Structure

This thesis is presented in seven chapters. Chapter one has introduced an overview of the research by detailing the beginning interest in the research topic. It described how the research topic was refined, the aim and purpose of the study, the methodology, and significance of the research. Finally, this chapter gave an overview of the thesis structure.

Chapter two presents the literature review. The review begins with the place of literature in Glaserian grounded theory study, and is followed by the literature search process.

The literature review is then presented in two parts: part one addresses hospice and palliative care including historical aspects, definitions of palliative care, and an overview of contemporary palliative care. Part two follows a similar format but focuses on collaborative practice. Beginning with the background of working collaboratively, this chapter then reviews definitions before continuing with an overview of

contemporary collaborative practice. The chapter finishes by examining the social context of working collaboratively. These two sections were separated due to the large amount of literature available, and have purposefully been kept broad. At the time of the literature review, only a general area of interest was defined, as the problem itself was not formulated. Therefore, what literature would have specific relevance to this study was unknown.

Chapter three presents Glaserian grounded theory from the researcher's interpretation of the methodology and its underpinnings. Beginning with the historical developments of Glaserian grounded theory, this section reviews where Glaserian grounded theory is situated as a research methodology and includes a discussion on the epistemological and methodological positioning. Methodological processes and procedures, alongside the core methods of Glaserian grounded theory, are included, followed by how rigour is maintained. The chapter is completed with the rationale for using Glaserian grounded theory.

Chapter four presents the method; how the research was undertaken, and the choices and decisions made by the researcher. Starting with ethical approvals and data collection, the process of this research will then be shown through the core methods of grounded theory. These methods of constant comparative analysis, sorting, memoing, generating concepts, theoretical sampling, and theoretical coding, show how the main concern and theory of Sharing Time emerged.

Chapter five presents the proposed explanations. The theoretical explanation of the proposed resolution strategy that participants use to manage their main concern of

possession is Sharing Time. Integrated by reciprocity, Sharing Time is defined through purposeful connecting and finding common ground. Purposeful connecting is defined through communicating and relating, while finding common ground is defined through participating and negotiating. The relationship between Sharing Time and the mid-ground continuum of categories and concepts is introduced.

Chapter six presents a discussion on the theory of Sharing Time situated in the literature on palliative care and collaborative practice. The main concern, possession, is briefly discussed relative to the extant literature. The chapter concludes with a presentation on how the theory and clinical practice interface. This is followed by recommendations for practice.

Chapter seven, the final chapter, begins by discussing methodological considerations, both positive and challenging. This is followed by opportunities for further research and a final summary.

Chapter Two: Literature Review

Introduction

Literature gives a received view of the world, informing readers about what is already known (Glaser, 1992). Literature reviews in research are undertaken for three reasons: to provide the researcher with current theoretical and scientific knowledge about a problem; to identify and refine the research question by finding the gap in knowledge; and to compare research results with current literature (Burns & Grove, 2007).

Regardless of these reasons, the requirement for a literature review prior to beginning a research study is traditionally at odds with Glaserian grounded theory, which has instigated much debate (Glaser, 1992).

This chapter begins by reviewing the place of literature in Glaserian grounded theory, followed by an explanation of the literature search process. The received view of what is known about collaborative care in palliative and hospice care has been presented in two parts. Part one examines literature related to hospice and palliative care. Covering historical beginnings, definitions, and contemporary hospice and palliative care today, examining both the international and New Zealand perspective, gives a general understanding of this specialty health service. Part two explores literature on collaboration, reviewing the background, definitions, contemporary collaborative practice, and collaboration in the social context. As this research study involved exploring participants' interpretations of working collaboratively, the term 'collaboratively' was purposefully not defined by the researcher. Rather, it was left open for participants to define, as either collaboration, interprofessional collaborative practice, or something yet to be named. Although the participants' definition of

working collaboratively was unknown, to begin, the researcher believed it was necessary to review both collaboration and interprofessional collaborative practice.

Literature in Glaserian Grounded Theory

The purpose of literature in Glaserian grounded theory is to assess and place the research outcome within the main body of relevant literature (Glaser, 1998; Glaser & Strauss, 1967). When documenting the grounded theory method, Glaser initially discouraged researchers undertaking a literature review prior to data collection and analysis; writing that this could contaminate the researcher's effort to generate concepts from the data with preconceived concepts that may not fit, work, or were irrelevant to the participants (Glaser, 1998). In addition, during those early years, Glaser felt the researcher misused time by frequently studying the wrong literature, as what was relevant remained unknown until the main concern and core category emerged (Glaser, 1998). Therefore, traditionally in Glaserian grounded theory, the literature review occurs after data collection and analysis, during the sorting and writing phases, when the grounded theory is nearing completion (Glaser, 1998).

Over time, Glaser's stance on the place of the literature review has softened, although not completely reversed. Glaser (1998) acknowledged that most researchers already have substantive knowledge of the literature in their areas before beginning the study. Glaser has also recognised that many researchers undertaking grounded theory studies face grant applications and institutional research requirements that include the need for a literature review prior to data collection. As such, he has recommended that researchers not waste time debating the place of literature reviews in Glaserian grounded theory, but rather do what is required, as the constant comparative process will correct any inaccuracies or preconceptions arising from the literature (Glaser,

1998). Glaser wrote further recommendations to help students overcome the difficulty of meeting institutional requirements, for example, to write the proposal with stated flexibility to allow the unanticipated to emerge (Glaser, 2001). This acknowledgement by Glaser of the need for literature reviews has not resolved the debate of when a literature search should be undertaken in the Glaserian grounded theory research process. Rather than being a clear methodological instruction, it allows for variances.

Variances bring uncertainty, and researchers using Glaserian grounded theory methodology continue to grapple with the literature review issue (Andrew, 2006; Christiansen, 2011; Giles, King, & Lacey, 2013; McCallin, 2006; Nathaniel, 2006; Xie, 2009). Further direction from Glaser (1998) to the researcher, when faced with the necessity of doing a literature review prior to data collection, was to turn the literature review “into data collection to be constantly compared as the review is done” (p. 72). This prevents any preconceiving and grabbing effects the literature may have on the researcher. Whether this constant comparison of the literature being reviewed is vital to the Glaserian grounded theory process or not is unclear. When Glaser noted that the constant comparative process will correct any inaccuracies arising from the literature, he may have been discussing the constant comparison of literature, the constant comparison of participant data, or both. Regardless, a pre-data collection literature review also introduces the researcher to theoretical sensitivity, as reading and previous knowledge sensitises the researcher to what is and is not known (Glaser, 1978). This is a necessary ingredient for finding the gap in knowledge required for doctoral study. In the spirit of Glaser’s “do what the people want” (p. 72), to meet the requirements for student researchers and, importantly, to understand what is already known about the

topic, the literature review was undertaken at the beginning of the research process, but in a purposefully broad manner in line with grounded theory.

Literature Search

For the literature review, search words and terms used included: hospice; palliative care; hospice history; collaboration, collaborative practice, interprofessional collaboration, and team. The library search engines used were Scopus, ProQuest, and EbscoHost. In addition, Google and Google Scholar were employed. To assist with tracking newly published journal articles and research findings, content feed via email was set up for specific peer reviewed journals in both palliative care and interprofessional collaboration. Some journals were searched at the publisher's website using the available table of contents when the journal was not available through the university library. Literature chosen for review fitted into the broad areas of historical aspects, the contemporary situation particularly as it pertains to New Zealand, team work in palliative care, health care delivery recommendations, definitions, and word usage. While many journal articles or book chapters overlapped, covering more than one broad area, literature was sorted manually into categories as part of the search strategy, according to the researcher's view of best fit. As this research study was situated in New Zealand, and due to the sheer volume of literature available, only a general world overview is given.

Starting with literature relating to hospice and palliative care, the review will begin with the historical beginnings. As words may be used interchangeably in health care practice, definitions and terminology will be examined for both hospice and palliative care, and working collaboratively.

Hospice and Palliative Care

Historical beginnings

While the concept of hospice is long-standing, palliative care is, by comparison, a new specialty within healthcare (Allen, Chapman, O'Connor, & Francis, 2008). The word hospice is medieval and originates from the Latin 'hospes' meaning guest (Post, Underwood, Schloss, & Hurlburt, 2002). The documented history of caring for the dying reaches back to ancient and medieval times, when hospices were sanctuaries for the sick and dying, as well as for travellers and religious pilgrims. During these medieval times, hospices were primarily religious centres found along trading routes and the military roads of Europe and the Middle East (Allen et al., 2008; Buck, 2007; Doyle, 2005). Lewis (2007) noted that the Church of Antioch established hospices to house the poor as early as the 340sAD. The aim of people working in these hospices was to comfort those in need whether travelling from one land to another or from one life to another (Post, Underwood, Schloss, & Hurlburt, 2002).

Since those early times, care of the dying has additionally been influenced by two competing models of care that have developed from two different philosophies. The biomedical model, it can be argued, is the science model of care that remains the dominant discourse within health care throughout New Zealand. The second is the Asklepios tradition of care, holding a closer relationship to the original religious or spiritual influences (Davidson, 2004; Randall & Downie, 2006).

The biomedical model has its initial beginnings with Hippocrates (460BC), a Greek physician and teacher, who dedicated himself to investigating the rational scientific basis of medicine (Kaba & Sooriakumaran, 2007; Randall & Downie, 2006). The

rational scientific basis ignored the individuality of patients, while concentrating on what diseases have in common; as every disease or ailment had a cause that could be discovered, treated, and generalised from one patient to another (Randall & Downie, 2006). The scientific belief was supported and expanded during the Cartesian period when René Descartes (1596-1650) introduced the concept of mind-body dualism where the body and mind were independent entities (Robb, 2001).

Major change came again in the 20th century with advances in biology by scientists such as Claude Bernard, Rudolf Virchow, Louis Pasteur, and Robert Koch (Capra, 1982; Wade & Halligan, 2004). Virchow believed that illness and disease involved structural changes at the cellular level; therefore, disease resulted from cellular abnormalities. Pasteur (Capra, 1982) associated specific microbes with specific diseases; while Koch suggested a set of criteria needed to prove conclusively that a microbe caused a specific disease known as Koch's postulates (Capra, 1982). The philosophies of Hippocrates and Descartes merged with the advances of biology, medical technology, and the development of drugs and vaccines has become the basis for the biomedical model of illness and health care as it is practiced today. Therefore, an assumption can be made that this biomedical model of health care is the primary philosophy underlying illness and health care in New Zealand, influencing the design of health and illness care services, structures, and associated government funding (Ministry of Health, 2016).

The second philosophy that has an influence on contemporary hospice and palliative care developed from the Asklepios tradition with the primary emphasis being on internal healing (Randall & Downie, 2006). Within the Asklepios tradition, changes are believed to come from within the patient rather than an external physician. Although

external healing is not excluded, this is not the primary emphasis. Beginning with the Greek physician Asklepios, this tradition spread throughout Greece and the Roman Empire and was the major focus of ancient Greco-Roman medicine, perhaps as early as 1200BC until 500AD (Wilcox & Whitham, 2003). Asklepios, seen as a hero for his gentle humane remedies and humane treatment of the mentally ill, was later deified and worshipped. He became known as the god of medicine and the mythical son of Apollo whose healing power he was thought to have inherited and expanded. During the peak years, many Asklepion hospital-temples called Asklepieions were erected by his followers and, while welcoming all, particularly catered for the poor and disregarded or those considered incurable. Some Asklepieions were extensive and elaborate resembling a cross between a sanatorium and a modern hospital (Wilcox & Whitham, 2003). Mention is made of Asklepios in the traditional Hippocratic oath (U.S. National Library of Medicine, 2012).

Little is recorded about the actual care given; other than when patients entered the fragrant temple they would first bathe for purity and then lay down to rest, encouraged by the priest physicians to be silent and sleep. Patient dreams, either real or suggested by the priests, told of what treatment the patient should receive from the priest (Indiana University, 2000). The temple environment aided spiritual healing while the dreams were a way of ensuring individualised patient care. Assumptions in this model of care include the following: the patient is a whole person and must be treated as such as the body and mind cannot be separated into parts; physical surroundings play a role in healing; individualised patient care is necessary for the healing process; waiting, listening, acceptance, and paying attention to the patient has positive effects on healing; healing comes from within and occurs when the patient gets rid of false beliefs and

accepts his or her state; and the healer's role is to carefully apply his or her knowledge in a way that is unobtrusive to the patient's personality, privacy, integrity, and is not manipulative (Randall & Downie, 2006). The Asklepios tradition stresses healing, but in the context of acceptance of human mortality, and so fits well with palliative care where the focus is on symptom management for physical relief and healing of the total patient spiritually, socially, and psychologically. Healing, in this sense, does not equal cure.

As with the assumption that health and illness care in New Zealand is chiefly influenced by the biomedical model, there is an alternative view that palliative care is influenced by the Asklepios tradition. The Asklepios tradition can be seen in current palliative care delivery in the provision of holistic care for the person, in the provision of person-centred care for each patient based on individual needs, in the belief that the environment is important to healing and that healing can occur, even amid dying. The use of aromatherapy, massage, and other alternative or complementary therapies, rest, quiet space, listening to dreams, focusing on the patient rather than staff (patient centred care), and treating physical symptoms are very much part of hospice care today (Running, Shreffler-Grant, & Andrews, 2008). It is not surprising, therefore, if a clash of competing models occurs when health organisations or health professionals, working from the one philosophy, encounters or challenges another philosophy. If health professionals are practicing from different underlying philosophies, this is likely to affect how they work together. Moreover, the historical development of care philosophies influences how terms are defined.

Definitions

Palliative care is a modern term introduced by the Canadian surgeon, Balfour Mount in 1973; the word being derived from the Latin pallium, meaning to cloak or to cover (Pastrana, Jünger, Ostgathe, Elsner, & Radbruch, 2008). There have been various changes to the definition since 1973 (Pastrana et al., 2008). Currently, palliative care is defined by the WHO (2014) as:

An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. 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. (p. 1)

New Zealand uses the WHO definition as a template and defines palliative care in a similar way, but with a New Zealand cultural flavour:

Care for people of all ages with a life-limiting illness which aims to: 1. optimise an individual's quality of life until death by addressing the persons' physical, psychosocial, spiritual and cultural needs. 2. support the individual's family, whanau, and other caregivers where needed, through illness and after death. Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may be suitable sometimes when treatments are being given aimed at improving quantity of life. It should be available wherever the person may be. It should be provided by all health care professionals, supported where necessary, by specialised palliative care services. Palliative care should be provided in such a way as to meet the unique needs of individuals from particular communities or groups. These include Māori, children and young people, immigrants, refugees, and

those in isolated communities. (Palliative Care Subcommittee, 2007, p. 5)

Of interest, within the preamble of the New Zealand definition is the statement that “Palliative care is best delivered through an integrated approach to care that recognises the roles and responsibilities of both palliative care generalists and specialists in meeting palliative care needs” (Palliative Care Subcommittee, 2007, p. 3). Absent from both the WHO and New Zealand definitions of palliative care are the words collaboration, team, interprofessional, or multidisciplinary. Interestingly, the word integrated has been used. Without further definition, the term integrated could be related to any of the terms previously mentioned, specifically collaboration, team, interprofessional, and multidisciplinary, if these require some integration to occur. Integration may, however, refer to something different altogether. Integrated is defined as “combined to form a whole” (Pearsall, 2002 p. 735). Yet how that fits when health professionals are asked to work collaboratively is equally unclear. For example, is it expected that health professionals maintain their own professionalism within the team, adding their expertise, or are health professionals expected to conform and become homogenous with an overlapping of roles? Overall, having the term integrated in the definition of palliative care has not clarified how health professionals are expected to act when working together. Rather one could assume that this additional word adds to the confusion of having multiple terms used.

The 2001 *New Zealand Palliative Care Strategy* noted that palliative care services are generally provided by a multidisciplinary team and use a multidisciplinary approach (Ministry of Health, 2001). Interestingly, a New Zealand Ministry of Health definition for multidisciplinary team or multidisciplinary approach could not be found, although these terms are used frequently in Ministry of Health documents. The Australian

Northern Territory Ministry of Health states that “A multidisciplinary team (MDT) is composed of members from different healthcare professions with specialised skills and expertise. The members collaborate to make treatment recommendations that facilitate quality patient care (Northern Territory Government of Australia Department of Health, 2016). The New Zealand Palliative Care Glossary also uses an Australian definition to describe a multidisciplinary team as “a team that consists of a mix of health care disciplines. Team members share common goals, collaborate, and work together in planning and delivery of care” (Palliative Care Council, Hospice New Zealand, & Ministry of Health, 2012b, p. 12). While the definitions of multidisciplinary team agree that team members collaborate, these definitions do not include the patient as part of the team. Rather the definitions infer that the multidisciplinary team makes decisions of care for the patient. Oliver, Wittenberg-Lyles and Day (2007) suggested that those providing palliative care need to, and in fact do, work together, which matches palliative care with the definition of a multidisciplinary team. Working together as a multidisciplinary team however, as will be shown further in the literature search, is not the same as working collaboratively. Finding out what kind of collaboration is occurring in palliative care in New Zealand is worthy of further exploration.

Palliative care can be provided by any health professional and should not be confused with palliative medicine, which refers to the work and professional discipline of medical doctors (Doyle, 2005). “Palliative Medicine is the study and management of patients with active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life” (The Australia and New Zealand Society of Palliative Medicine, 2015, p. 1). The term hospice is not used in any definition of palliative care. Internationally, hospice is defined as both a place of care for those who are dying or a

philosophy of care (Doyle, 2005; Hospice New Zealand, 2014c; Lum, 2004; Randall & Downie, 2006). In the French language, hospice is used to describe a nursing home for the poor and destitute, which is why Balfour Mount introduced the term palliative care. Mount needed a different term to be clear for French speaking Canadians (Pastrana et al., 2008). The hospice definition has changed over time and there is now more focus on managing rather than controlling symptoms (Hospice New Zealand, 2014c).

The New Zealand hospice philosophy of care is presented as having a unique whole person approach provided by a multidisciplinary team (Hospice New Zealand, 2014c). This holistic approach and use of a multidisciplinary team in hospice is the same as the definition of palliative care and may explain why these terms are often used interchangeably. Currently, New Zealand has 37 individual hospices throughout the country, each with an associated physical building from which a variety of services are offered or coordinated. Services include inpatient care; but nationally, the majority of hospice care is given in a person's home (Hospice New Zealand, 2014c). Despite many hospices providing inpatient beds at the hospice's physical location, Hospice New Zealand, the national body supporting hospices, is clear that hospice is a philosophy of care and not merely a place (Hospice New Zealand, 2014c). Before investigating the modern hospice movement and palliative care it is important to examine the historical beginnings as history often shapes what is occurring today.

Contemporary hospice and palliative care

As noted previously, apart from the presence of some early institutions, people primarily died at home with family, the community, and clergy providing for the needs of the dying person. This continued despite hospitals becoming more common and offering a range of services. The mid-18th century saw 16 public hospitals in provincial

England, which grew to 38 by 1800 (Lewis 2007). The religious influence in care continued with religious orders, particularly nursing nuns, providing much of the care for the poor, destitute, and dying (Lewis, 2007). The 19th century saw religious orders, such as the Daughters of Charity and St. Vincent de Paul's Ladies of Charity, open hospices. The term hospice continued to be deliberately used, as, while providing food and lodging and care for the body, it also depicted a stopping place for the soul on its journey to God (Lewis 2007). The late 19th century also saw journals, such as the *Lancet* and *British Medical Journal*, begin to publish literature on the needs of terminally ill patients; specifically, well-ventilated rooms, nutritious meals and experienced nurses (Lewis 2007). Despite growing attention on care for the dying, at the same time, in the late 19th century, there was an increasing occurrence of people seeking hospital care, looking for cure, in the United Kingdom (UK). This change occurred for several reasons, one reason being socioeconomic change, where increased income gave more people the opportunity to seek hospital care. Another reason was the rise in modern science and healthcare's commitment to curing, led by advances in surgical progress and the growth of research (Lewis, 2007). By mid-20th century the common location for dying changed, moving from the home to a hospital setting (Randall & Downie, 2006). It was felt that health professionals could offer the dying person more than the family including, for some, the possibility of delaying death. At that time, the community were removed from providing care, while physicians became the central decision makers of the care provided (Allen et al., 2008; Dupere, 2006).

Although concern about improving care for the dying began to re-surface in the 1950s (Clark, 2002), the development of the modern hospice movement is commonly credited to Dame Cicely Saunders who volunteered as a nurse at St. Luke's Hospice in

Middlesex, England, where she developed many of her initial ideas (Saunders, 2015); including, in the 1960s, returning to some of the Asklepios traditions as a reaction to the biomedical model, and opening St. Christopher's Hospice in London, 1967 (Randall & Downie, 2006; Susan & Vincent, 2006). This development was in response to her (and the public's) recognition that people who were dying in hospitals were largely ignored and not cared for well. While Saunders focused on the perceived medical neglect of dying people in the UK, others in the United States of America (USA) began to give attention to futile treatments in the face of suffering and inevitable death (Clark, 2002). At that time, as noted in the previous definitions, the term palliative had not come into use and care of the dying was commonly referred to as terminal care (Charles-Edwards, 1983; Doyle, 1987; Gray & Elder, 1987; Saunders & Baines, 1983). Prior to the opening of St. Christopher's, institutions that committed solely to the care of the dying, offering comfort measures and spiritual care, were in existence in the UK and several countries worldwide, such as Australia, USA, and South Korea (Buck, 2007; Lewis 2007). While these earlier institutions are not typically considered part of the modern movement of hospice care, started by Saunders, they helped to formulate the philosophy of hospice care (Susan & Vincent, 2006).

Favourable to Saunders at that time and helping to put her vision for change in the care of the dying into practice, was that western society in the 1960s was undergoing another change in the perception of death. Clark (2002) noted four innovations that were occurring during this time. These were a shift in literature related to care of the dying from anecdote to observation and research; increased openness about the terminal condition of the patient alongside the need for dignity for the dying; an active approach to finding new ways to continue caring up to death; and growing recognition of the

interdependency of mind and body leading to concepts such as total suffering and total pain. An example of the shift in literature was Elizabeth Kubler-Ross' research on death and dying, published in 1969, which gave people permission to start talking about the subject again. As Saunders and Kubler-Ross were both physicians, this gave them credence within the field that they may not have received if from another profession (Allen et al., 2008). From Saunders and St. Christopher's the modern hospice movement with its ideas on best care of the dying spread internationally to existing hospices, while encouraging the opening of more institutions, including in New Zealand.

Hospice and palliative care in New Zealand is now well established. The first hospice opened in 1979 at Calvary Hospital, Wellington (Mary Potter Hospice, 2014). This was closely followed by the establishment of two other hospices in that same year (MacLeod, 2001; St. Joseph's Mercy Hospice, 2014; Te Omanga Hospice, 2014). Growth continued in the 1980s with several hospices opening around the country; each managed and supported by separate individual community groups and volunteers with local community funding (Hospice New Zealand, 2014a). Hospice growth was driven by staff, volunteers, and community supporters, who believed in the need to provide quality care for people who were dying that the healthcare service at the time could not provide (Davidson et al., 1981; Phillips, Ingham, & MacLeod, 2013). It is reasonable to hypothesise that the grassroots beginnings of hospices by community groups and volunteers had a strong influence on how, and what, palliative care services were delivered. That influence continues today; although it can also be argued that influence is waning, as health care regulations and funding models change. To grow the hospice movement nationally, and to enable hospices to support each other, a committee was

formed to investigate setting up a national hospice body. The outcome was Hospice New Zealand, which officially began in 1986 with the help of funding from the Cancer Society New Zealand (Hospice New Zealand, 2014a). Hospice New Zealand provided a voice for community hospices and a place to gather but did not have input into individual hospice management. This supportive role continues today with Hospice New Zealand providing individual independent hospices with overall guidance, training programmes, fundraising activities, advertising, and political lobbying, while independent hospices continue to self-manage (Davidson et al., 1981; Hospice New Zealand, 2014a, 2014c, 2015; Phillips et al., 2013).

Hospices in New Zealand were developed at the community level offering a mix of home care and inpatient hospice care. The original staffing typically consisted of volunteers and nurses. Today, hospice staff commonly includes nurses, physicians, social workers, counsellors, chaplains, and volunteers (Hospice New Zealand, 2012, 2014c), with other health professionals joining on an as needed basis. While this professional staff mix may be the ideal, hospices of different sizes with different incomes may not be able to employ such a range of professional staff. The literature did not address how hospices choose which professionals to employ when there is not an option to employ all. Alongside the growth of hospices, other palliative care services have arisen, such as palliative care teams within hospitals (MacLeod, 2001). Despite palliative medicine being recognised by the Royal College of Physicians in the UK as a medical specialty in 1987 it was not until 2001, 22 years after the first New Zealand hospice opened, that palliative medicine was recognised by the New Zealand Medical Council as a medical specialty (Doyle, 2005; Yamaguchi et al., 2014). In 2008, the Palliative Care Nurses New Zealand group developed a framework of the competencies

required of all registered nurses providing palliative care. This was revised and updated in 2014 (Palliative Care Nurses New Zealand, 2014); although whether this competency framework is well known and utilised by nurses is yet to be determined. Regardless, in recent times nurses have taken on an advanced practice role of palliative care nurse practitioners (Health Improvement and Innovation Resource Centre, 2012).

With the advancement of health professional roles in palliative care, the New Zealand Government, under the auspices of the Ministry of Health and Palliative Care Council, have become more interested and involved in the planning, provision, and funding of palliative care (Ministry of Health, 2001; Palliative Care Council, Hospice New Zealand, & Ministry of Health, 2012). Hospices are changing from their foundation model of being independent, locally managed, and locally financed services, to being nationally directed through contracts with District Health Boards (DHBs). While increased funding is positive to help maintain and expand services, and perhaps bring some consistency to palliative care services throughout New Zealand, it can also be argued that this comes at a cost. Hospices with contracts take direction from the DHBs and Ministry of Health on what services they must provide to receive funding, so complete independence is lost (Palliative Care Council of New Zealand et al., 2012a). This loss of independence can be viewed as having both positive and negative aspects, but the implications are not addressed in the literature. For example, this shift in control and independence may mean that hospices in New Zealand are able to improve service from a holistic Asklepiion perspective due to this additional support. Alternatively, it can be argued that hospices are becoming, or have become, biomedical health services like other health services and are, therefore, at risk of losing their individual identity. Another option to consider is that hospices may have simply grown without an

associated improvement or change in services. Regardless, hospice and palliative care is recognised through an annual World Hospice and Palliative Care Day on the 9th October (Worldwide Palliative Care Alliance, 2015). The call to include palliative care as a human right has grown (FBX Centre for Health and Human Rights & Open Society Foundations, 2013) while an increasing number of countries are signing declarations to support the provision of palliative care (National Hospice and Palliative Care Associations, 2005; United Nations Department of Economic and Social Affairs, n.d.). The United Nations has shown interest in palliative care (United Nations, 2014) and worked with the WHO and the Worldwide Palliative Care Alliance to publish a report evaluating the availability of and need for palliative care globally (Worldwide Hospice Palliative Care Alliance et al., 2014).

In New Zealand, a series of reports from the New Zealand Palliative Care Council have been recently published (Palliative Care Council of New Zealand, 2013, 2014). An aim of these reports and recommendations is to develop consistency of service throughout the country. Data collected for these reports show that most palliative patients receive care through primary health care services and only a small percentage require specialist palliative care (Palliative Care Council of New Zealand, 2013). While it is believed that supporting primary health care services, including aged residential care services, to provide good palliative care will save the need for many palliative patients to be hospitalised (Palliative Care Council of New Zealand, 2013), this remains to be seen, as data is collected in the future. Regardless, it is not difficult to imagine that any support for primary health care services providing palliative care would be beneficial for the patient.

While the assumption can be made that health professionals working in palliative care strive to provide optimal care, defining optimal care is important. In New Zealand, this has been achieved through the *Hospice New Zealand Standards for Palliative Care* (Hospice New Zealand, 2014b). Initially developed by Hospice New Zealand in 1987, the standards were updated in 2001, prior to a major revision in 2012 to include an associated quality review programme (Hospice New Zealand, 2014b). However, these are not the only standards to guide health professionals in the delivery of palliative care in the western world. The Hospice New Zealand standards were derived from the Australian palliative care national standards. First published in 1994, these Australian national palliative care standards were most recently updated in 2014 as the 5th edition (Palliative Care Australia, 2015). A different type of standard from those written by, and for, specialist palliative care providers, the *Gold Standards Framework* (GSF) for palliative care grew from ‘grass roots’ general medical practice in the UK (National Gold Standards Framework Centre, 2014b).

Originating in 2000, the Gold Standards were developed for community-based primary care providers and use an evidence-based approach to optimise end-of-life care delivery (National Gold Standards Framework Centre, 2014a). Like the *Hospice New Zealand Standards for Palliative Care* (2012), the Gold Standards have been further developed and expanded since their inception (National Gold Standards Framework Centre, 2014a). A notable difference is that the *Hospice New Zealand Standards for Palliative Care* have been developed with and for hospices as specialist palliative care providers. However, this excludes non-hospice primary palliative care providers in New Zealand for whom there are no specific standards. The Gold Standards, in contrast, having been developed for all community palliative care providers, have a wider use. The Gold

Standards framework includes a coordination role and improved communication within the multidisciplinary team but does not specifically require collaboration (Mahmood-Yousuf, Munday, King, & Dale, 2008; Melvin, 2003; National Gold Standards Framework Centre, 2014a). That collaboration will occur seems to be assumed rather than stated. Interestingly, when adopted by Canada, the Gold Standards were modified to suit the Canadian situation and have clearly stated the need for the hospice and palliative care team to work collaboratively (Canadian Hospice Palliative Care Association, 2006). The New Zealand standards for palliative care provide guidelines for individual health professionals working in palliative care; yet is most strongly weighted toward organisations providing palliative care and is used as the guide for quality review (Hospice New Zealand, 2014b).

Summary of palliative care

Palliative care services have grown worldwide since the 1960s with the birth of the modern hospice movement. However, there are countries that remain without palliative services or the service is in its early stages (Lynch, Connor, & Clark, 2013; Worldwide Hospice Palliative Care Alliance et al., 2014; Wright, Wood, Lynch, & Clark, 2008). The literature indicates that the provision of palliative care will continue to grow and change, as it will in New Zealand. Alongside this growth, the number of people requiring palliative care is increasing as the population ages (Palliative Care Council of New Zealand, 2011); and the ageing health workforce is also a concern as expressed by the WHO and the New Zealand Palliative Care Council (2011). However, in contrast to the WHO (2010), neither the New Zealand Palliative Care Council nor hospices through Hospice New Zealand have called for collaboration as a means of providing the care that is, and will be, needed.

Working Collaboratively

Background

Collaborative practice in health care is not a new idea. There are reports of collaborative practice occurring in mission hospitals in India as far back as the early 1900s (Solomon, 2010) during the time of the British Indian Empire and colonial rule. Solomon (2010) observed that these early examples of collaboration occurred in teams, a description that appears to fit with Gray's (1989) definition of collaboration which is "a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go well beyond their own vision of what is possible" (p. 5). Teamwork may have been viewed as a mechanism to balance the needs of those requiring care with the limited resources available at the time. However, developments beginning in the 1970s indicate that some believed that team work, as practiced at the time, was not sufficient to meet new challenges arising in the provision of health care.

In the 1970s, the WHO began hosting meetings, producing documents, and supporting research for collaboration. This was an interesting development as it indicated that the WHO believed health professionals either did not collaborate or did not collaborate well. Whether health professionals had a differing opinion as to whether they collaborated is unknown. In the clinical arena, mental health took the lead in calling for collaboration through publications and research (Gottlieb & Schroter, 1978; Leathard, 2003; Pattison, Hackenberg, Ellis Wayne, & Wood, 1976). The September 1978 *Declaration of Alma-Ata*, signed as part of the International Conference on Primary Health Care, called on participants to collaborate in introducing, developing, and maintaining primary health care (International Conference on Primary Health Care,

1978). A report on working relationships in community health care was released in October 1978 (WHO, 1978). That same year, a study examined communication and collaboration between health professionals. The emphasis was on physicians and nurses working in teams (WHO, 1978). Despite all this attention there was no clear definition of collaborative practice that all agreed on. What seemed clear was that there was a beginning move in health care toward having a planned for, and recognised, collaborative culture in practice and care delivery. The underpinning assumption was that a collaborative culture did not exist.

Interestingly, discussion in the literature changed to define interprofessional development as the term interprofessional was appearing in relation to collaboration. In the UK, a new journal was published in 1986 titled the *Journal of Interprofessional Care*. A year later, the Centre for the Advancement of Interprofessional Education (CAIPE) was formed, which brought the idea of interprofessional education and collaborative practice to the forefront in the western world. The CAIPE talked of interprofessional education and interprofessional practice. Interprofessional education was defined as occurring “when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (Barr, 2002 p. 5). Canada, in comparison, talked about interprofessional education and collaborative practice, defining interprofessional collaboration as “a partnership between a team of health professionals and a patient or patient in a participatory, collaborative and coordinated approach to shared decision-making around health issues” (Canadian Interprofessional Health Collaborative (CIHC) as cited in Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011, p. 2).

Not to be left behind, and following closely behind CAIPE, the WHO (1988) joined in the discussion, issuing a technical report identifying interprofessional education as an important component of primary health care. It appears that these organisations believed that if interprofessional education occurred, then collaborative practice should follow. Again, this assumed that collaborative practice was not already occurring in health care and that health professionals needed to be further educated and educated together rather than education separated by profession. Several years later the CIHC was formed as a national hub for interprofessional education, collaboration in healthcare practice, and patient-centred care. The goal of CIHC is to share knowledge with those who make policy and plan health and education systems, health professionals, and educators. Differing from CAIPE, the CIHC has a greater emphasis on collaborative practice, alongside their interest in interprofessional education and research. For example, there is now sufficient evidence to show that collaborative practice interventions improve workplace quality by creating a collaborative culture (Suter et al., 2012). This, in turn, increases provider satisfaction by improving provider roles and/or quality of care.

In New Zealand, for the past several years, there has been an awareness of, and interest in, interprofessional education and collaborative practice by some health care education and practice providers. The National Centre for Interprofessional Education and Collaborative Practice (NCIPECP) was opened in 2010 at Auckland University of Technology within the Faculty of Health and Environmental Sciences (AUT University, 2014). This is the first centre of its kind in New Zealand. However, the Australasian Interprofessional Practice and Education Network (AIPPEN), involving Australian and New Zealand health professionals, institutions, and organisations was developed prior.

Holding its inaugural conference in April 2006, AIPPEN aims to research, promote, and support interprofessional education and practice across Australia and New Zealand (Moran, Nisbet, & Thistlewaite, 2006).

Amongst these various countries and organisations subtle, but important, differences in terminology and definitions have occurred that have the potential to confuse, as health professionals struggle to understand what they are being asked to do. Therefore, the researcher believes it is important to have a brief overview of the different words used and definitions prior to beginning data collection. Gaining an understanding of these differences will decrease the potential for any researcher confusion that may occur, alongside recognising any possible participant confusion during data analysis.

Definitions

As with the definitions of palliative care, many terms are used to describe health professionals working together and working alongside each other. While each term has its own definition, the difference can at times be unclear. Different terms risk confusion if health professionals delivering care at the bedside are uncertain of what is being asked of them in policies, guidelines, and strategies. There may be confusion by the authors at the point of writing these documents. It is important to examine the words used in the literature that explain how health professionals work together collaboratively.

Clarifying these terms may have relevance to the research explanations proposed and assist in understanding what health professionals are doing in practice.

Several authors have observed that many health professionals believe they are practicing collaboratively when they may simply be working within a group, each agreeing to use their skills individually to achieve a common goal (Barr, 1998; Bliss,

Cowley, & While, 2000; Hall, 2005; Hermsen & Ten Have, 2005; Solomon, 2010; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). What is clear is that collaboration does not occur simply because health professionals work together, or groups are merged (Eloranta, Welch, Arve, & Routasalo, 2010; Goldsmith, Wittenberg-Lyles, Rodriguez, & Sanchez-Reilly, 2010; Wittenberg-Lyles, Parker Oliver, Demiris, & Regehr, 2010; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). While significant effort has gone into defining the broad term of collaboration, there are multiple definitions that cause confusion (Bridges et al., 2011; CIHC, 2010; Gray, 1989; Petri, 2010; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010).

The two main definitions used in the literature reviewed, when discussing collaborative practice, are the previously mentioned WHO definition of collaborative practice (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010) and the CIHC (2015) definition of interprofessional collaboration. Interestingly, when the term collaboration is used alone, without the interprofessional, few define the term. It seems as if there is an expectation that health care professionals will know what collaboration is without further clarification.

Other common terms used that describe health professionals working together are interdisciplinary collaboration and multidisciplinary team. The Palliative Care Council and Hospice New Zealand (2012b) define interdisciplinary collaboration as “a group of individuals with diverse training and backgrounds who work together as an identified unit or system” (p. 7). An earlier definition of interdisciplinary collaboration requires

“team members collaborate to solve problems too complex to be solved by one discipline alone, or several disciplines in sequence” (Drinka & Clark, 2000. p. 178).

The multidisciplinary team is defined as a team that consists of a mix of health care disciplines where:

Team members share common goals, collaborate and work together in planning and delivery of care. Members of a multidisciplinary team might include GPs, surgeons, medical or radiation oncologists, palliative care specialists, pastoral care workers, nurses, social workers, occupational therapists, physiotherapists, dieticians, volunteers, pharmacists or care assistants. (Palliative Care Australia 2008, para.1)

It can be difficult to see significant differences in these definitions, or even why these differences are important, without further scrutiny. The WHO definition of collaborative practice states that “Collaborative practice in health care occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings” (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010, p. 13). The WHO noted that collaborative practice includes both clinical and non-clinical health related work (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). This is useful, as while this research study is investigating health professionals working collaboratively at the bedside delivering palliative care, the explanations proposed may transfer to other areas of health care. Nonetheless, it could be argued that one clear term, with one definition, if used consistently in health care, would benefit all by its clarity. Perhaps returning to simply talking about teamwork, regardless of the mix of health professionals on the team, would suffice if health professionals were trusted to work together. This is clearly not the current trend identified in the literature.

As previously noted, the CIHC (2010) uses the term interprofessional collaboration. When reading the above definitions, the WHO definition of collaborative practice appears to require less of the health professional than interprofessional collaboration. The WHO definition is outcome or goal oriented – simply health workers from different professional backgrounds providing comprehensive care. The CIHC definition of interprofessional collaboration, by comparison, is process oriented, requiring partnership, coordination, and shared decision making by those involved. This takes more work and is a different way to practice.

The WHO and CIHC definitions of collaboration and interprofessional collaboration have appeared within the past decade. Therefore, these two definitions are relatively new in the history of health professionals working together. Regardless of these two definitions being available, terminology remains confusing and concepts are used interchangeably with no common definition within health care today (Fallon & Smyth, 2008; Thannhauser, Russell-Mayhew, & Scott, 2010; Zwarenstein, Goldman, & Reeves, 2009). For example, Meier and Beresford (2008) used the terms palliative care team and interdisciplinary team while discussing identified characteristics of collaborative practice. The WHO and CIHC have taken a stand, making a concentrated effort to use the same terminology within their individual organisation documents to support a common understanding (CIHC, 2010; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). However, these two leaders in collaborative practice do not share the same definition so there is not one universal understanding of interprofessional collaboration or simply

collaboration. Whether this matters to health professionals working in direct patient care at the bedside is unknown.

The characteristics or components of collaborative practice have been identified. Analysis suggests that collaborative practice occurs when there is a need; it is a means of communicating effectively; it involves a shared language, shared purpose or goal, cooperation, trust, respect, and a time frame (San Martín-Rodríguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). In addition, collaborative practice seems to involve balance, equality, choice, adaptability, flexibility, trust, respect, understanding, shared decision making, partnership, power, and lack of professional jealousy (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005; Molyneux, 2001; Sullivan, 1998; Suter et al., 2009). While this is interesting, it is unhelpful because the concepts are broad and differ.

Collaborative practice has been associated with different models of practice, such as patient-centred practice, family-centred practice, and relationship-centred care that advocate for the participation of the patient and family in the collaborative process (Beach, Inui, & Relationship-Centered Care Research Network, 2006; Herbert, 2005; Solomon, 2010). The primary purpose of collaborative practice is to improve the delivery of health care. There is an underlying assumption that improving the delivery of health care using collaboration is beneficial for the recipient of care as well as for the providers, which is evident in the WHO and CIHC definitions. Both include the patient in the process (CIHC, 2010; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). Moving past the initial assumption, there is now increasing evidence that working collaboratively, due to

the partnership with the patient/family, is beneficial to the patient as well as the health professional (Petri, 2010; Schmitt, 2001).

Early documentation on collaboration focused on teams and teamwork, emphasising attitudes, behaviour, and roles of individual team members within a group (Drinka, Miller, & Goodman, 1996; Fleissig, Jenkins, Catt, & Fallowfield, 2006; Mackay, 1992; Meyer, 1993; Thomas & Corney, 1993). From the mid-90s the terms interdisciplinary and later interprofessional were introduced into the mix causing even more confusion to health professionals. The introduction of interprofessional was due to the realisation that health professionals were not behaving collaboratively; therefore, health professionals needed to be educated differently with an interprofessional approach (Barr, 1998, 2007; Fineberg, Wenger, & Lachlan, 2004; Hammick, 1998; Koffman, 2001). The 2010 WHO report *Framework for Action on Interprofessional Education and Collaborative Practice* brought further awareness that professionals cannot be expected to know how to collaborate if they are not taught how to do so (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010).

Contemporary collaborative practice

Today, there is decreased literature about collaboration and collaborative practice alone, as the trend has moved toward interprofessional collaboration. The literature indicates that the need for interprofessional collaboration has become more predominant, driven by international workforce shortages and an increasing complexity of care (Daly, 2004; Elliott, 2004; Jansen, 2008; Kingdon, 1992; Lindhardt, Hallberg, & Poulsen, 2008; Quality End-of-life Coalition of Canada, 2014; San Martín-Rodríguez et al., 2005; Schmitt, 2001; WHO & Health Professions Network Nursing and Midwifery Office:

Department of Human Resources for Health, 2010; Zwarenstein et al., 2009). As interprofessional education and collaboration have been introduced into some areas of health care provision, there has been an associated interest in the outcomes of interprofessional collaboration, to provide evidence of whether it does improve the working environment and associated patient care as predicted (Alberto & Herth, 2009; Bliss et al., 2000; Dewar, 2000; Herbert, 2005). The results are positive as the evidence to date is clear that interprofessional collaboration reduces the cost of patient care, increases provider satisfaction, improves workplace quality, and leads to improvement in patient care (Schmitt, 2001; Suter et al., 2012; Zwarenstein et al., 2009).

As interest in the outcomes of interprofessional collaboration has grown, so too has curiosity about organisational issues and multi-sector, multi-institutional collaboration (Johnson, Wistow, Schulz, & Hardy, 2003; Schmitt, 2001; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010; Zwarenstein et al., 2009). This change in emphasis has occurred due to health care recognising that interprofessional collaborative practice is no longer solely the responsibility of the individual. This is not surprising as the potential for interprofessional collaboration to improve professional relationships, reduce clinical error rates, and improve the quality of health care, benefits organisations by eliminating problems before they occur (Reeves et al., 2009). Clearly, interprofessional collaborative practice is affected by wider social, political, and economic issues (CIHC, 2015; Centre For The Advancement Of Interprofessional Education, 2014; Johnson et al., 2003). How much these wider social, political, and economic issues of palliative care affect interprofessional collaboration in New Zealand remains to be identified. What has been identified is the need for interprofessional education.

It is difficult to find literature on interprofessional collaborative practice without the mention of interprofessional education, due to the belief that health professionals need to learn to work together in a collaborative way. The WHO noted that interprofessional education is a necessary step to prepare a collaborative practice-ready health workforce better prepared to respond to local health needs (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). The assumption being that health professionals cannot collaborate well without being educated together, and therefore have not been doing so up to this point in time. A common definition of interprofessional education is that it “occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care” (Barr, 2002 p. 8). Regardless, the literature on providing interprofessional education does not follow through to how this education translates into practice (Barr, 2007; Centre For The Advancement Of Interprofessional Education, 2014; Cuff, 2013; Hammick, 1998; Thistlethwaite, 2012). Both the WHO and CIHC include interprofessional education in discussions on collaborative practice and interprofessional collaboration.

Health care organisations and training institutions also have a role to play in how interprofessional education and collaborative practice develops, and how it can be developed in conjunction with patients, caregivers, and communities in a variety of settings (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). The need for interprofessional education, as well as some of the challenges of providing it, has been recognised in palliative care due to the service being one that includes multiple health professionals

(MacLeod & Egan, 2007). This is a strong start toward interprofessional collaborative practice, as well as being practical. Educating health professionals together about palliative care makes sense as the best use of education resources, including personnel, while health professionals come to understand each other's roles.

Despite some health professional education providers in New Zealand quietly moving toward interprofessional education and the opening of the NCIPECP in 2010, the overall impact this has on changing health professionals' behaviour in the workplace nationally is yet to be seen (AUT University, 2014). The New Zealand government has yet to set aside specific funding to help with the establishment and growth of interprofessional collaborative practice. This is despite asking for, or even mandating, that collaboration happen in government health care strategies, planning documents, and health professional competency frameworks (Ministry of Health, 2001; Nursing Council New Zealand, 2014; Palliative Care Council of New Zealand, 2011; Palliative Care Nurses New Zealand, 2014; Palliative Care Subcommittee, 2007; Workforce Taskforce, 2008). While it is easy to write something in policy, there is a disconnect in supporting change to happen in practice. This disconnect could be due to several reasons. One potential reason is a lack of understanding by health organisations and associated management personnel that interprofessional collaboration is a complex process and, therefore, requires the commitment of time, education, and often funding.

Interprofessional collaboration rarely happens randomly and may require a change in many organisational structures. On a positive note the NCIPECP, as a national centre, is working toward spreading the message of interprofessional education and collaborative practice through offering conferences and publications (AUT University, 2014).

New Zealand also has a unique and well-recognised framework in the Treaty of Waitangi. The Treaty of Waitangi, signed in 1840, is an agreement between Māori, the previous immigrants to New Zealand, and the British Crown. Today's interpretation of the intent of this document, considered a living document by Māori and government, acknowledges the three principles of partnership, protection, and participation (Chapple, 2015). These principles have many commonalities and shared characteristics with collaborative practice (Kingi, 2007; Ministry of Health New Zealand, 2000, 2002; Palliative Care Subcommittee, 2007). Commonalities and characteristics include trust, respect, cooperation, understanding, partnership, shared decision making, shared power, a shared purpose or goal, equality, and choice (D'Amour et al., 2005; San Martín-Rodríguez et al., 2005; Suter et al., 2009). If the New Zealand government increases support for interprofessional collaboration in health care this will complement the requirements laid down in the Treaty of Waitangi. In return, the principles of the Treaty complement interprofessional collaboration. Interprofessional collaboration becomes a win-win situation for New Zealand health services in general, for hospice and palliative care services and, most importantly, for the patient and family.

The social context

The background of international change and terminological confusion has influenced collaboration as it is known today. Defilippi (2002) noted that, historically, the occurrence of people working collaboratively increased during times of crisis and war. The literature reviewed is not clear whether internationally crises and war continue to influence collaboration. Regardless, the complexity of working relationships has increased in modern times due to significant growth in the number of professions and specialties (Obholzer & Roberts, 2011). In addition, there have been shifts in the

balance of power between professions, and between health professionals and patients. Patients have become consumers (McLauchlin, 2009). In New Zealand, the Health and Disability Services Consumer Rights, initially written in 1996, grants all health consumers clear rights in law while placing corresponding obligations on providers of health services (Health & Disability Commissioner, 2009). These rights give the patient or consumer knowledge and power, with the option of complaining to the Commissioner if the rights are not upheld by the provider (Health & Disability Commissioner, 2009). Previously, the power had been strongly weighted toward the service provider (McLauchlin, 2009). Health care services are now recognised as a right rather than a privilege (Barr, 1998). Taking this idea of rights versus privilege in health care further, there is now, as previously noted, the call for palliative care to be listed as a human right (Brennan, 2007).

The health care environment is dealing with rising health costs and the associated need to manage those costs, along with an increasing complexity of care that includes more community care, early discharge from hospitals, and an aging population (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). People living longer often have more than one underlying chronic condition, requiring new models of care to meet these needs (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). Along with an aging population there is an aging health workforce and an increased need for health care that current services are inadequate to meet (Christensen, Doblhammer, Rau, & Vaupel, 2009; International Council for Human Resources in Nursing (ICHRN), 2007; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). In 2007, the

ICHRN (2007) predicted that there will be more than one billion people aged 60 or over worldwide by 2020. A recent statement from the WHO (2015a) noted that the world's population 60 years or older was 900 million in 2015. Whether this trend of an increasing older population continues, considering the increase in chronic illnesses such as diabetes, remains to be seen. It has been projected that by 2020 chronic diseases will account for almost three quarters of all deaths worldwide (WHO, 2015b). Regardless of age at death, the need for palliative care will remain.

Collaborative practice is proposed by the WHO as an innovative strategy to address these issues of increased need for care and the aging workforce (WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). Palliative care providers in New Zealand are not immune to these world-wide health care challenges. It is expected that New Zealand's aging population will bring an increased need for palliative care services alongside an increasing complexity of care. Without some form of change, current palliative care services will have difficulty meeting this need (Palliative Care Council of New Zealand, 2011, 2013), which supports the assumption that interprofessional education and collaborative practice would be beneficial to the provision of palliative care in New Zealand.

Collaborative practice is considered an important tool in providing improved quality of care delivery, and improving patient health outcomes (Baldwin, 2007; Parker-Oliver, Wittenberg-Lyles, & Day, 2006; Pietroburgo & Bush, 2008; Silver & Leslie, 2009; Suter et al., 2012; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010; Zwarenstein et al., 2009). Benefits identified to date include shorter length of stay, reduced cost of care, reduced mortality,

and an improved workplace culture leading to increased work satisfaction for those who collaborate. This improved workplace culture includes more support and shared responsibility, leading to less isolation and burnout (Safran, Miller, & Beckman, 2006; Pietroburgo & Bush, 2008; Suter et al., 2012; Zwarenstein et al., 2009). However, regardless of how positive collaborative practice may appear it is not easy to accomplish. The many challenges to collaboration include conflict over power and control when trying to protect what health professionals identify as their role and responsibilities, differences in professional values and practice, differences in organisational culture, competition for market share, a lack of understanding of roles, and time issues (Goldsmith et al., 2010; Herbert et al., 2007; Jones, 2007; Pietroburgo & Bush, 2008).

Summary of working collaboratively

As noted at the beginning of this literature review, there is much written about collaboration. Keeping the literature review broad is consistent with the methodological approach. This literature review shows that many studies have focused on health care workers' perceptions of the broad concept of collaboration within their workplace (Parker-Oliver, Bronstein, & Kurzejeski, 2005; Parker-Oliver et al., 2006, 2007; E. M. Wittenberg-Lyles & Parker-Oliver, 2007). What is not known is whether this broad concept matches either of the definitions of collaborative practice from the WHO or CIHC, and whether it is incorporated in palliative care practice in New Zealand. Unknown is whether collaboration, as currently exercised, is a pseudo-collaborative practice more closely related to the team work and multidisciplinary care noted in the definitions of palliative care, rather than the current expectations of interprofessional collaborative practice. Also unknown is whether the concept of collaborative practice has been thwarted by the context of practice in New Zealand, as the literature has

clearly shown that there are social, political, economic and professional influences impacting the delivery of hospice and palliative care. Finally, whether the differences between the terms used to describe working collaboratively are well understood by, or even matter, to health professionals working with patients in New Zealand, delivering palliative care at the bedside could not be found in the literature. This gap in knowledge led to the researcher asking participants about working collaboratively, so that participants could define, for themselves, what collaboration meant to them, alongside their main concern. Specifically, the research area of substantive interest was: What is the main concern of health professionals working collaboratively (with colleagues and patients) in palliative care and how do they manage that? As noted in chapter one, framing the area of interest in the form of a question is uncommon in grounded theory. Regardless, Glaser accepted that it is more comfortable for some researchers to enter the field with some combination of a clear question or problem area in mind. While not being completely open, Glaser (1978) believed this still gives data that is receptive to the emergent.

Glaserian grounded theory has been chosen as the research method to examine health professionals' views of providing palliative care at the bedside, what their main concern is when working collaboratively with other health professionals and patients, and how they manage that. An exploration of the underpinnings of the Glaserian grounded theory methodology follows, culminating with the rationale of why this method was chosen by the researcher.

Chapter Three: Research Methodology

Introduction

Glaserian grounded theory is an inductive research method that generates theory from data gathered through theoretical sampling, organised and analysed using constant comparative analysis, coded, and conceptualised through memoing (Glaser & Strauss, 1967). Holding a neutral position from an epistemological stance is necessary as Glaser (1992) argued that it “is a general methodology. What counts are that grounded theory methods are not bound by discipline or data collection” (p. 18). Initially developed by Glaser and Strauss (1976), the Glaserian version continues to be championed by Glaser as the one-and-only true grounded theory methodology; although today, alternative versions of grounded theory can be found. To understand Glaserian grounded theory methodology, this chapter will begin by reviewing the historical development of grounded theory including the differing interpretations for comparison. This will be followed by a discussion on the epistemology of Glaserian grounded theory. Next will be a review of the methodology including theoretical sampling, coding, conceptualising through memo writing, emergent theory generation, credibility and rigour. The chapter will conclude with the rationale for the decision to use Glaserian grounded theory in this research study.

Historical Developments

The philosophical stance of logical positivism, following on from its beginnings in Europe, was flourishing in the USA of the 1960s as a belief that the only meaningful philosophical statements or problems were those which could be solved by logical analysis and empirical verification (Gartrell & Gartrell, 2002). Logical positivism came about through scientism, which is the belief that the assumptions and methods of

research of the physical and natural sciences are equally appropriate to all other disciplines including the social sciences (Gartrell & Gartrell, 2002). It was during this time, following World War One, the social survey was developed as a means to obtain information from large groups of people in a standardised way, such as questionnaires or structured interviews. There are three major aspects of the social survey process: sampling techniques; data collection techniques; and statistical methods for data analysis (Alasuutari, 2010). Scientism itself was noted to be a particularly American phenomenon as it never took root in British sociology. The reason for this difference is thought to be that universities in the USA fostered a scientific approach to social research. Conversely, leading universities in the UK at the time were reluctant to even acknowledge sociology as a discipline (Gartrell & Gartrell, 2002). Regardless, in the 1950s Lazarsfeld, a social science researcher began undertaking quantitative studies that used specific methodology and related the results to theory (Glaser, 2007c). While positivism was the dominant research approach at the time, it was not without detractors (Gartrell & Gartrell, 2002) and it was in this research environment that the grounded theory methodology arose.

Glaser and Strauss, as the architects of grounded theory, came from different scholarly backgrounds to logical positivism and thus the influences on these two researchers, prior to them working together, differed. Strauss' background in the Chicago School of social research emphasised qualitative, ethnographic research with symbolic interaction and pragmatism perspectives. Strauss' influencers related to the Chicago School include Herbert Blumer, George Mead, and Robert Park (Glaser, 1998; Legewie & Schervier-Legewie, 2004). Glaser studied at Columbia, New York, a school with a strong quantitative orientation to research. While there, Glaser was influenced by

Robert Merton and Paul Lazarsfeld (Glaser, 1998). While acknowledging Merton as a mentor when a doctoral student investigating the sociology of science, Glaser (2007c) admitted that he was more heavily influenced by Lazarsfeld's writings on methodology when developing grounded theory. This mix of qualitative and quantitative approaches helped to form the original Glaser and Strauss grounded theory, a general inductive research method where all data can be used whether from qualitative or quantitative methodologies, and "no matter the implicit theoretical perspective involved" (Glaser, 2005, p. 15). However, while recognised as a general inductive method, Glaser (1998) noted that simply classifying Glaserian grounded theory as either inductive or deductive is over-simplification of the complex thinking required, stating that there is some deduction that occurs. For example, "deductions for theoretical sampling fosters better sources of data, hence better-grounded inductions" (Glaser, year, p. 43). Induction and deduction are different ways of approaching research. When using an inductive method, the researcher begins with broad generalisations in an area of interest, and then, through specific observations of the data, comes to a hypothesis. If using a deductive method, the researcher begins with a hypothesis, which is tested to show how this may work in the generalised area of interest (Burns & Grove, 2007).

Following their seminal work, Glaser and Strauss went separate ways due to disagreement on methodology; the main difference being the approach to data analysis (Glaser, 1978). Glaser remained resolute that the strength of grounded theory is that the inductive process takes precedent over deductive, and analysis requires only two levels of coding, open and selective (Cooney, 2010; Glaser, 1992; Heath & Cowley, 2004). Beginning with specific observations of an event, trend, or social process, the inductive process leads the researcher to progress analytically to broader generalisations, working

up to an abstract level of theory development that explains the initial observations. In contrast, when using a deductive process, the researcher starts at the general abstract level, with a theory or hypothesis. The researcher then works toward a more specific and concrete level to verify whether the beginning theory was correct or needs modification (Heath & Cowley, 2004). In contrast to Glaser, Strauss' approach to data analysis, in collaboration with Corbin, was to add a third level of coding, that is, axial coding (Corbin & Strauss, 2008; Strauss & Corbin, 1990).

Grounded theory has evolved since the initial discovery by Glaser and Strauss (1967) and brought controversy and debate. To distinguish classic grounded theory from other versions of grounded theory that have developed, since Glaser and Strauss' initial work (Glaser & Strauss, 1967), Phyllis Stern coined the term Glaserian grounded theory, which is now in common use (Glaser, 1978, 1992, 1998, 2009; Stern, 2009). Following the publication of Strauss and Corbin's work, Glaser accused Strauss of forcing data, and promoting a method of social research that Glaser (1992) believed was no longer grounded theory. Further, while Corbin and Strauss (2008) willingly accept the qualitative paradigm, Glaser was dismissive of any divide between paradigms, claiming grounded theory is neutral (Holton, 2008). Additionally, Glaser, as noted in the literature review, believed focused reading should only occur once the emergent theory is developed, while Strauss and Corbin begin with a literature review (Corbin & Strauss, 2008; Glaser, 1998). Like Strauss and Corbin, Glaser began to publish further explanations of grounded theory, writing additional books and journal articles to reiterate the original approach, clarify his approach, and counter the evolution that was occurring within and to grounded theory (Glaser, 1978, 1992, 1998). This led to the

Grounded Theory Review: An International Journal being published under the auspices of Glaser's own publishing company, Sociology Press.

The evolution of grounded theory continued with Kathy Charmaz (2006) publishing a constructivist grounded theory approach in 2000, using social constructivism as the epistemological base. The two major differences are that in constructivist grounded theory concepts are constructed, whereas in Glaserian grounded theory concepts are discovered; and constructivist grounded theory begins with a specific question based on a substantive area, whereas Glaserian grounded theory begins with an interest in a substantive area but no specific question (Glaser, 1978, 1998; Glaser & Strauss, 1967). Again, Glaser believed that due to these differences constructivist grounded theory is not truly grounded theory but a different methodology altogether (Glaser, 2007a). A later method, which evolved from the original Glaser and Strauss grounded theory, occurred when Adele Clarke developed her methodology of situational analysis grounded theory with a critical theory perspective. Clark argued that this adds to traditional grounded theory by bringing in a post-modern perspective. Issues of power relations, using maps as tools of analysis, influence how behavioural processes occur (Clarke, 2003, 2005). According to Clarke (2003), there are three kinds of maps: situations that include all the key human and nonhuman elements; social worlds and arenas; and positionality along salient analytic axes.

The multiple versions of grounded theory offer the researcher a choice. Once having decided that a grounded theory method is best for the area of interest, the researcher must review which grounded theory approach offers the most relevant research design

to answer the posed question or explore the substantive area. Investigating the epistemology may help with this decision.

Epistemology

In their initial writings, Glaser and Strauss never fully discussed grounded theory's philosophical foundation from an epistemological stance, relative to methodological underpinnings, thereby leaving others to develop their own interpretations (Bryant, 2009; McCallin et al., 2011). This lack of discussion can be argued to have been deliberate, as Glaser and Strauss preferred to stress that grounded theory was new and different, breaking with existing research methods, traditions, and practices (Bryant, 2009). In later writings, Glaser has gone back to address and explain his position, admitting that there were influences in the roots of grounded theory, particularly that of Paul Lazarsfeld and quantitative methodology (Glaser, 2007c). Lazarsfeld is known for work in several fields, but is primarily regarded for applying scientific methodology to advance social science by investigating the procedures used by other researchers, considering both quantitative and qualitative research approaches (Bryant, 2009). These procedures had not previously been identified as specific ways of researching, that is, methods. Lazarsfeld believed the strengths of both qualitative and quantitative research complemented each other. From this analysis, methodology in research became common, with Glaser being considered by some as one of the key adherents and developers of Lazarsfeld's methodological ideas (Bryant, 2009; Glaser, 2007c).

“Epistemology deals with the nature of knowledge” (Crotty, 1998, p. 8), providing a philosophical grounding for deciding what kinds of knowledge are possible, ensuring it is adequate and legitimate (Crotty, 1998). While understanding the epistemology of a research project can help ensure the soundness of the research, the epistemological

approach that best fits Glaserian grounded theory remains unclear. There has been discussion and speculation in the literature about the underpinning philosophy that guides grounded theory (Artinian, Giske, & Cone, 2009; Christiansen, 2007; Glaser, 2005, 2007c; Holton, 2009; Morse et al., 2009). Much of this has been conflicting. Arguments for the epistemological positioning of grounded theory have included realist, constructivist, critical realist, objectivist, relativist, interactionism, pragmatism, positivist, and post-positivist philosophies (McCallin et al., 2011). Objectivists believe that meaningful reality exists regardless of whether anyone is aware of it. Reality does not, therefore, depend on conscious thought to exist. It is simply there to be discovered. This objectivist belief links grounded theory's focus of discovering hidden social processes. Conversely, constructivists believe that truth or meaning only comes into existence when we unite with the realities of the world. Even when faced with the same phenomenon the unity can be different for each person, so his or her reality will be different. This has commonalities with grounded theory through recognition that reality for participants is not the same reality as that of the researcher, so the theory emerges from the data, not the researcher. In comparison, subjectivists believe that the object being examined or researched does not contribute to the generation of meaning. Rather meaning is imposed on the object by the subject, from the researcher (Crotty, 1998).

Although Glaser and Strauss came from different epistemological backgrounds, it has been more recently argued that the best philosophical fit for Glaserian grounded theory is pragmatism as developed by Charles Sanders Pierce (1839-1914) (Nathaniel, 2011). Moreover, Nathaniel (2011) argues that Piercean Pragmatism has some common elements that fit with the Glaserian grounded theory approach. An American philosophy, pragmatism's emphasis on practice and reality led to judgement by some

European philosophers that this was too optimistic and progressive, not subjected to criticism (Crotty, 1998). It is important to note that while neither Glaser nor Strauss mention pragmatism, Strauss was influenced by Dewey's interpretation of pragmatism through the Chicago School. In contrast, Glaser mentions having an appreciation of perspectivism (Glaser 1998). Perspectivism, explained through the work of Friedrich Nietzsche (1844-1900), considers that truth is a matter of perspective, not fundamental reality (Crosby, 2007). Knowledge is inevitably partial and limited by an individual's perspective.

According to Nathaniel (2011), Pierce's pragmatic views are described through the concepts of reality, latent patterns, and human perspective. Nathaniel contended that pragmatists believe reality is more than people think it is as some aspects of life are hidden from view. While not all can be seen, this does not make what is occurring less real, nor does what is hidden, change by thinking or believing it is something different from what it really is.

In addition, habits or latent patterns evolve over time and acquire their own properties (Nathaniel 2011). Therefore, pragmatists see the realities of life as active and changeable rather than static. Expressed, and in turn affected by actual behaviour, habits are inferential concepts that can be defined and measured by behavioural terms. Furthermore, "Human perspective, the way in which humans understand the natural world and communicate is done through using icons or likenesses; indices, which is something about the object; and symbols, finding meaning through common language" (Nathaniel, 2011, p. 191). That is, every person is a social construction interacting within our society (Crotty, 1998), using language to define the world, as it is known.

The argued similarities with pragmatism and Glaserian grounded theory relate to both focusing on reality, whatever that reality may be; the tendency for the real phenomenon to behave in a certain way regardless of what it is thought to be; and finally, the pragmatist view of hidden realities and social behaviours and the ability of Glaserian grounded theory to uncover these behaviours (Nathaniel, 2011). Although a sound argument has been made for pragmatism as the best philosophical fit for Glaserian grounded theory, there have also been arguments for symbolic interaction as the underpinning epistemology.

Symbolic interaction has been described as pragmatism in sociological attire (Crotty, 1998). Symbolic interactionism sees meaning as deriving from social interactions between people and putting oneself in the place of others (Crotty, 1998). Interestingly, while many have strongly linked symbolic interaction to grounded theory, Glaser (2005, 2007b) called it a takeover, absolutely denying it is the theoretical perspective behind grounded theory. While Glaser is not opposed to symbolic interactionism, it must earn its place in the theory as any other data. Using symbolic interactionism as a theoretical perspective to frame data collection and analysis changes the approach. This change of approach then influences the outcome of the research (Glaser, 2005).

Glaser (2007b) was adamant that the rhetorical wrestle regarding epistemology is unhelpful, a waste of time. The wrestle, therefore, goes nowhere as there are too many different types of data that can potentially be used by the researcher. Moreover, there is no need to have an epistemology to justify grounded theory (Glaser, 1998, 2005). As Glaser (2007b) stated in an interview:

Epistemology. A theory of, or a theoretical perspective. That's all bullshit for grounded theory (*GT*). You can read it in Theoretical

Coding (2005). GT is just a stupid little method. That's all it is. The epistemology is irrelevant. It's how you use it. GT is based on a concept indicating method, which has been used for years in psychology. You get concepts out of indicators and the interchangeability of indicators and you get a theory. That's it. (p. 27)

Grounded theory, being a general inductive methodology that can be used on any kind of data or mix of data (Glaser, 1998), gives space for the researcher to use a full range of theoretical codes, rather than being locked into specific codes related to a specific epistemology (Glaser, 2005).

Regardless of Glaser's strong denials, many authors continue to classify grounded theory as a qualitative research methodology (Burns & Grove, 2003; Corbin & Strauss, 2008; Speziale & Carpenter, 2007), possibly because of the methods and procedures. For example, Burns and Grove (2003) assumed that any methodology that involves induction and theory development is qualitative. Being aware of grounded theory's background helps the researcher when deciding what research method to use in general; and, if grounded theory is chosen, which version of grounded theory. Equally, when deciding on methodology, it is important to have some understanding of the core methods of the research.

Methodology

The grounded theory approach has specific core methods that make it a unique methodology. These core methods are theoretical sampling, constant comparative analysis, coding, memoing and conceptualisation, theoretical sensitivity, emergent theory generation, and determining rigour. These methods can be difficult for the researcher new to grounded theory to understand and practice, particularly if looking for a step-by-step process that can be followed rigorously. Grounded theory does not occur

as a linear process. Rather, these methods occur both sequentially and concurrently. This means that grounded theory appears messy and confusing as well as serendipitous to the researcher, although Glaser (1998) is encouraging when he says to “just do it” (p. 19). While recognising the concurrent nature of Glaserian grounded theory methods, these core methods will be discussed in this chapter in a linear way for convenience of understanding. The first key method to be discussed is theoretical sampling.

Theoretical sampling

Theoretical sampling is the process of data collection “whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them in order to develop his theory as it emerges” (Glaser, 1978 p. 36). This Glaser quote clearly shows the concurrent nature of grounded theory, as constant comparative analysis occurs at the same time as data collection, and the results of that analysis influences further data collection.

Theoretical sampling begins once the first data has been analysed and concepts begin to emerge. Thus, sampling is guided by the emerging codes and categories, informing the researcher what data to collect next. This adds depth and complexity to the emerging theoretical concepts (Glaser, 1978; Glaser & Strauss, 1967; Coyne, 1997). Theoretical sampling continues until the data is saturated to within the researcher’s sources of time, money, and energy, at which point the researcher moves on to sorting the memos as part of abstracting and conceptualising (Glaser, 1998). “Saturation means that no additional data are being found whereby the sociologist can develop properties of the category” (Glaser & Strauss, 1967 p. 61).

Initial decisions for sampling are based on a general problem area rather than a preconceived hypothesis or framework (Glaser, 1978). This selective sampling occurs in the initial stage of the study when the researcher makes a calculated decision to sample a specific location or group of participants “according to a preconceived but reasonable initial set of dimensions which are worked out in advance for a study” (Glaser, 1978, p. 90). Therefore, when selective sampling at the outset of data collection, the researcher goes to the groups he or she believes will maximise data. Specifically, participants from the substantive field, as these are the experts in the area of interest and the sample is where the phenomenon occurs (Coyne, 1997; Glaser, 1978; Glaser & Strauss, 1967).

There is plentiful data that can be used for theoretical sampling to generate theory. Glaser (1998) acknowledged this range of possibilities by stating that “all is data” (p. 8). There are various ways of collecting that data such as observation and literature review. Another commonly used method is face-to-face interviews with participants. For researchers choosing to use interviews, it is not necessary to obtain a response from each participant to a set of questions and participants do not need to respond to the same questions (Glaser & Strauss, 1967). While Glaser believed all is data to be compared, he specified four distinct types of participant data for the researcher to be aware of during sampling and constant comparative analysis (Glaser, 1998, 2005). These are: baseline data, which are the best description the participant can offer and is therefore the ideal; properline data occurs when the participant tells the researcher what he or she feels the researcher wants to hear rather than whatever the reality is; whereas, interpreted data can occur when the participant is a trained professional who gives data to the researcher that is interpreted through his or her professional lens rather than the

normal way of seeing something; and finally, vaguing out, which occurs when the participant gives vague responses as he or she has no stake in the research (Glaser, 1998). These four types of data are identified by the researcher as the incidences occur. However, regardless of the type of data, any question or observation is considered suitable if this helps the researcher to know what is going on in the participant's situation. Questions are purposefully unstructured to avoid preconceived theory (Glaser & Strauss, 1967).

Situated alongside theoretical sampling field notes are written during or following each episode of data collection and are used to capture additional information (Glaser 1978, 1998). Information collected may include the researcher's observations such as the time of day the data was gathered, the location, the interviewee's body language, words spoken and the general atmosphere, such as any surrounding noise or other distractions. These can later be useful to help the researcher's recall when analysing data. While accepting that many researchers prefer to digitally record interviews, Glaser (1998) preferred that field notes be written in place of the digital recording.

Regardless of the researcher's use of field notes, digital recording, or a mix of both, the research problem is defined in the early stages of theoretical sampling through the constant comparative analysis that simultaneously takes place (Glaser, 1998; Glaser & Strauss, 1967; Kwok, McCallin, & Dickson, 2012). It is important not to force the data; that is, seeing what is expected rather than what is there (Glaser & Strauss, 1967). As constant comparative analysis occurs simultaneously with theoretical sampling, this will be examined next.

Constant comparative analysis

Constant comparative analysis is the concurrent coding and analysis of data, word by word, incident-by-incident (Glaser, 1998; Glaser & Strauss, 1967). Linking to theoretical sampling, the researcher uses constant comparative analysis to decide what data will be gathered next on the way to theory development (Boeije, 2002). The idea of the constant comparative method came from Glaser studying the work of Lazarsfeld at the University of Paris (Glaser, 2007c; Glaser & Strauss, 1967). Lazarsfeld championed “simply studying a work line by line to see exactly what is being said” (Glaser, 2007c, p. 11). Using constant comparative analysis in grounded theory requires that each point of data collected, for example an interview, is compared internally within itself, and compared with different interviews. This occurs whether the data is from the same or different groups of participants. Therefore, a strength is that constant comparative analysis can be applied to any kind of data used within the same study, such as observations, interviews, documents, articles, and books. The initial purpose of constant comparative analysis is to develop categories and label these with the most appropriate codes (Boeije, 2002), then systematically generate theory through the finding of a core category, categories, and properties of those categories until saturation is reached. Saturation occurs when no new conceptual insights are generated, which gives the researcher repeated evidence or conceptual categories (Glaser & Strauss, 1967). While undertaking constant comparative analysis the researcher is also coding and theoretical sampling.

Glaserian Coding

Coding occurs as part of, and an outcome of, constant comparative analysis. The purpose of coding is to “generate an emergent set of categories and their properties

which fit, work and are relevant for integrating into a theory” (Glaser, 1978, p. 56).

Glaser (1992; 1998) defined these terms in Figure 1 below:

Concept	The underlying meaning, uniformity, and/or pattern within a set of descriptive incidents.
Property	A type of concept that is a conceptual characteristic of a category, thus at a lesser level of abstraction than a category. A property is a concept of a concept.
Category	A type of concept. Usually used for a higher level of abstraction.
Subcore Category	The category that relates to much of the core category.
Core Category	Accounts for most of the ongoing behaviour in the substantive area being researched through the relationship with most other categories and their properties.

Figure 1: Coding definitions (Glaser 1992, p. 38; 1998, p. 135)

There are two main types of codes, substantive and theoretical. In substantive coding the purpose is to conceptualise the empirical aspects of the raw data. Substantive coding occurs in two parts; first, open coding, followed by selective coding once the core category has emerged. During open coding, the researcher codes the data in every way possible to identify what fits best. This step brings the researcher to the point where he or she can then begin selective coding, focusing on a core category that has been identified, (Glaser, 1978). Glaser (1978) stipulated several rules for coding that he considered vital. The first rule relates to asking questions to identify what the data is a study of, and what categories and properties of categories does the incident indicate in relation to the emerging theory. The second rule is to analyse data line by line through

constant comparative analysis. For the third rule, Glaser stipulated that the researcher must do his or her own coding, despite the fact it can be laborious and time consuming, as the researcher collecting the data will recognise when new categories emerge, and categories are saturated. The fourth rule is to memo the ideas that come from the coding process, which will, at times, require stopping coding to write – without this, ideas are lost. A fifth rule is that the researcher should not assume any relevance to general variables such as age, sex, race, social class when analysing data unless and until it emerges as being relevant (Glaser, 1978). Following substantive coding, theoretical coding occurs.

“Theoretical codes conceptualise how the substantive codes relate to each other as hypothesis to be integrated into a theory” (Glaser, 1978, p. 72). That is, theoretical codes emerge to weave the story back together, turning fractured concepts back into an organised whole theory (Glaser, 1998). Glaser’s (1978) firm rule for theoretical coding was that the researcher should stay within the confines of the substantive area and the field of study to maintain fit, relevance, and workability. To assist with theoretical coding Glaser identified numerous coding families. For example, one common coding family is “the six C’s: causes, context, contingencies, consequences, covariances and conditions” (Glaser, 1978, p. 74). Glaser noted that this is the most common general code and most studies fit into either the causal model, the consequence model, or the conditions model. Another coding family is the Strategy Family, where the theory developed describes a conscious strategy used by participants to manage their main concern (Glaser, 1978). As an analytic tool, coding families assist the researcher to conceptualise and hypothesise how the codes relate to each other. This is then integrated into a theory (Glaser, 1978).

Abstracting

Abstracting and conceptualising are important steps to generate a grounded theory, so the researcher can rise above description. Abstraction occurs primarily through coding. A lower level abstraction occurs as codes are compared and combined, as they relate to each other. With continued coding and comparing, codes are eventually combined and related to one another, becoming a higher abstraction as categories or concepts are formed (Glaser, 1998). Concepts are related to concepts, as the researcher works toward generating a theory.

Conceptualising through memoing

Conceptualisation is an abstract, simplified view of the world that the researcher wants to represent. In Glaserian grounded theory, “theoretical codes conceptualise how the substantive codes may relate to each other, as hypothesis to be integrated into the theory” (Glaser, 1978, p. 55).

Memo writing and sorting of memos are tools used to assist throughout the process of conceptualising. Memo writing occurs when the ideas about concepts, categories, the properties of categories and their relationships are written up. These ideas can be immediately analysed for patterns of behaviour (Glaser, 1978, 1998, 2013; Glaser & Strauss, 1967). Memo writing begins when first coding data and continues until the very end, becoming a written record of the researcher’s thinking, to preserve what may be easily forgotten over time as theoretical sampling, constant comparative analysis, and coding continues (Glaser, 1978, 1998, 2013). Initially, Glaser stated that there are four basic goals of memo writing: helping the researcher develop ideas, giving the researcher freedom to develop these ideas by the action of writing, compiling the memos into a fund for future use, and having a memo depository that is highly sortable (Glaser,

1978). However, in later writing, Glaser noted that he may have been too formal in setting out these four goals for memo writing as it “will stifle emergence” (Glaser, 1998, p. 179). Memo writing does not have a prescribed structure or format. There are no rules and the researcher will develop his or her own style which Glaser (2013) termed free-style memoing.

Sorting in grounded theory refers to the sorting of memos and accompanying data. The purpose of sorting is to further conceptualisation, leading to theory generation. Sorting is not simply data sorting into a file type system. There is no prescribed way of sorting memos although Glaser (1998) described sorting as beginning by finding a large space, picking a memo from the pile and putting it somewhere. Then, choosing another memo, comparing how it is related to the first and either starting a new pile or adding to the first. Continuing this process of “sorting, comparing, and resorting and the integration of the theory emerges” (Glaser, year, pp. 189-190). The final sort frames the first draft of the write up. If this is not done, there is the risk that thoughts will become lost within the mechanics of data analysis, coding, sorting, and writing. Thus, memo writing is the only way to store ideas as grounded theory constantly generates many ideas (Glaser, 1978). While some literature notes sorting is done manually (Christiansen, 2007; Glaser, 1998), it remains to be seen if Glaserian grounded theorists of the future make use of computer programmes that assist with data analysis. Should these future Glaserian grounded theorists use computer programmes, what impact this will have is unknown.

Theoretical sensitivity

Theoretical sensitivity occurs when the researcher generates concepts from the data and conceptualises those concepts, to enable the theory to emerge (Glaser, 1992).

Specifically, the researcher is using his or her knowledge, understanding, and skill to conceptualise and foster the awareness of the subtleties of meaning within the data so that theory emerges.

Theoretical sensitivity is not an easy feat for the researcher. Glaser noted two essential personal characteristics of the researcher that should be present to have theoretical sensitivity. The first is that the researcher has a personal and temperamental bent to maintain analytic distance, tolerate confusion and regression, while remaining open and trusting the process (Glaser 1978, 1998; Glaser & Strauss, 1967). A crucial step to being theoretically sensitive and assisting the researcher to remain open while avoiding predetermination is by entering the research study without knowing the problem (Glaser, 1978, 1988). The second trait noted is for the researcher to have the ability to develop theoretical insight and make something of that insight while using the constant comparative method (Glaser, 1978, 1988). Glaser's view of the researcher needing specific traits when undertaking a grounded theory study is novel to Glaserian grounded theory rather than being a common feature of other methodologies that rely on the process alone.

While some researchers may have more of a natural ability to be insightful, rigorously following the core methods of grounded theory can help any researcher develop this skill. It does require that the researcher maintain an analytical distance, develop theoretical insight, conceptualise data, and practice (Glaser, 1992; Holton, 2008).

Without the ability to keep this analytical distance, preconception can occur where the researcher forms an opinion about the means of dealing with the main concern, or even

the main concern itself, that does not come from the data. This in turn would affect the credibility and rigour of the theory.

Emergent theory generation

Underpinning emergent theory generation are the core methods of theoretical sampling, constant comparative analysis, coding, memoing and conceptualisation, and theoretical sensitivity, which come together to birth a theory of a social process occurring in the substantive field of interest (Glaser, 1998). The core category is the theory itself that explains the basic social process that has been discovered. Specifically, the theory or core category is a collection of categories brought together to detail the subject of the research (Glaser, 1992; 1998; Glaser & Strauss, 1966; 1967) and integrated through a conceptual or theoretical code. For this theory generation to occur, the researcher avoids descriptive interpretations. Avoidance is achieved by following and trusting, to a sufficient degree, the grounded theory method alongside the researcher's own work of following that process. By trusting the grounded theory method, the researcher assumes that a theory will emerge through abstract conceptualisations (Glaser, 1978, 1998).

Credibility and rigour

The credibility of grounded theory is maintained through fit, workability, relevance, and modifiability, which is distinctly different from other forms of rigour and credibility in other, non-grounded theory research methodologies. It is these four areas that are the criteria for doing and judging grounded theory (Glaser, 1998). Fit equals validity. Fit occurs through the constant comparison method to ensure that the theoretical categories match the data and categories are not preconceived or forced to fit in pre-existing assumptions (Glaser, 1998). Defined by Glaser (1998) as asking "do the concepts and the way they are related into hypothesis sufficiently account for how the main concern of participants is continually resolved" (p. 18), workability occurs when the concepts

and hypothesis of a grounded theory study clearly capture the main concern of the participants and management of that concern. Relevance deals with the main concerns of the participants involved and, therefore, make the research more interesting and important than it may be if it were the researcher's concern (Glaser, 1998). Relevance can be seen through grab, when the researcher's concepts have grab for others and people start to see the concepts everywhere (Glaser, 2010). Glaser noted that modifiability is very significant. In grounded theory, the theory itself is never finished in so much as it can be modified when it is compared to new data. Theoretical development is always evolving (Glaser, 1998). Fit, workability, relevance, and modifiability are indicators of a good grounded theory and should be considered when deciding to use grounded theory as a research method.

Decision to Use Glaserian Grounded Theory

All versions of grounded theory were reviewed, and have merit; however, the researcher decided to use Glaserian grounded theory for the following reasons. First, the researcher had an area of interest, collaboration in palliative care, but no specific question. Glaserian grounded theory is one approach for research when the actual research problem is unknown by the researcher at the beginning of the study; the problem is defined by the participants as it emerges from the data (Glaser, 1998; Glaser & Strauss, 1967). The concerns of the participants rather than those of the researcher being the focus of the research held appeal, possibly because of the researcher's nursing background where the patient comes first. Finding a research method where the participant's voice is heard above the researcher's felt comfortable.

A second reason that Glaserian grounded theory was chosen is that while there is structure in procedure, it allows for creativity in the formation of theory. Such

opportunity for creativity, while not impacting on the theory's relevance, fit, and work (Glaser, 2007b), added appeal.

A third consideration for choosing Glaserian grounded theory related to the potential outcome. When researchers follow the Glaserian grounded theory method, a mid-range theory emerges from participant data, which has strong application to practice (Charmaz, 2006; Glaser 1967, 1978). As the Doctor of Health Science (DHSc) programme, including this 240-point thesis, requires study to be applied to practice, the application of theory to practice was something the researcher appreciated. In contrast, the Corbin and Strauss grounded theory approach has a possible outcome of a low-level abstract description which may be less relevant to practice. Moreover, Charmaz's approach, emphasises a descriptive outcome rather than theory (Cooney, 2010).

Finally, Glaser's assertion that his is the one true version of grounded theory (Glaser, 1998, 2007b) held appeal to the researcher. If grounded theory was the best method for this research, then using the original Glaserian grounded theory rather than a variant gave the researcher more confidence in the process.

Summary

Developed by Glaser and Strauss (1967), Glaserian grounded theory is a methodology useful for studying hidden patterns of social behaviour, such as may occur in a health care environment (Cooney, 2010; Glaser, 1978; Glaser & Strauss, 1967). Initial limited discussion from Glaser and Strauss regarding the underpinning epistemology has left grounded theory open to interpretation, leading to controversy and debate (Bryant, 2009; Glaser, 2007a, 2007b). However, to this end, Glaser (2007b) continued to state that the rhetorical wrestle regarding epistemology is a waste of time. With structure in

procedure and generating theory from data through constant comparative analysis, coding, and abstracting, Glaserian grounded theory is credible as a research methodology. Core methods include theoretical sampling and the use of field notes, constant comparative analysis, abstracting and conceptualising using coding, sorting and memoing; and theoretical sensitivity. Following these methods and procedures ensure the credibility and rigour of this research methodology.

Glaserian grounded theory is the chosen methodology for undertaking this research study as the problem, and how that problem is managed, was unknown to the researcher. A strength of Glaserian grounded theory is its focus on the participants and their perceptions, not the researchers. Therefore, in the substantial area of interest, that of palliative care, the focus is on health professionals. Glaserian grounded theory can identify social processes within palliative care, such as the way participants act to manage collaboration. This focus on participant perceptions prevents the researcher from making assumptions that may end up wasting both the researcher and participants' time by investigating a problem that does not actually exist to the participants. As will be discussed in the following chapter, grounded theory it is not an easy methodology to undertake, particularly for researchers new to this method, as the procedures often occur simultaneously, revolving around each other rather than having a clear linear step-by-step approach.

Chapter Four: The Research Process

Introduction

This chapter documents the researcher's experience of using a Glaserian grounded theory approach to investigate what social processes are occurring in the substantive area of collaboration in palliative care. Decisions made by the researcher will be acknowledged, including the highs and lows, stops and starts of this research journey. Documenting this process gives transparency and the opportunity to demonstrate rigour.

To assist with documenting the core methods undertaken, this chapter is presented in a chronological order; while continuing to recognise that Glaserian grounded theory is not a linear method (Glaser, 1978; 1992; Glaser & Strauss, 1967), therefore some core methods occurred simultaneously. Beginning with obtaining necessary approvals for the research, this chapter will continue with a brief overview of the need for ethical approval in New Zealand, followed by the ethical approval process for this study. Next, participant recruiting, and data collection will be presented. This will be followed by data analysis, using core methods which include constant comparative analysis, memoing, coding, emergence of the categories, conceptualisation and, finally, theory emergence and maintaining rigour.

Approval Processes

Pre-requisites

Prior to the research study itself, three coursework papers were successfully completed as part of the requirements for the Doctor of Health Science (DHSc) degree. The required papers, in the order they were undertaken, are: Practice and Philosophies, which focused on the complex influences, philosophies and assumptions in palliative

care; Health Systems Analysis which led the researcher to critically analyse the New Zealand health and disability system, policy developments, reforms, and relevant health laws; and Research Practice and Methodologies, in which the researcher examined different research methodologies while refining the research question (Auckland University of Technology, 2015). Focusing on the practice area of palliative care, these required papers helped the researcher, in the role of student, investigate the area of palliative care in depth, while developing the direction of the research and gaining a broader understanding of the health system that the specialty of palliative care sits within. Following successful completion of these papers, the thesis process began.

University approval: Confirmation of candidature

In New Zealand, research being undertaken as part of a university degree requirement must be approved by the university at which the student is enrolled, which for this study was the Auckland University of Technology (AUT). The approval process assures the research is relevant, at an appropriate level for the degree being bestowed, and that the student has appropriate support in the way of supervision. There were three steps to gaining initial approval from AUT. An application form detailing the research proposal was completed and submitted for review. The researcher then gave an oral presentation to a group of faculty members, at which time questions were asked by those attending and suggestions for change given. Finally, the AUT Postgraduate Board confirmed candidature, indicating that the next step, obtaining ethical approval, could begin.

Ethical approvals

In New Zealand approval must be obtained before any research involving human subjects can commence to protect participants and reduce potential harm (McCallin, 2010). Prior to applying for ethical approval, it was important to the researcher that she understood the historical background related to this requirement. This awareness and

knowledge helped with the application process itself due to knowing why specific questions were asked. New Zealand's current ethical requirements were developed over many years. Starting after the Second World-War (WWII), the trials of Nazi doctors accused of conducting human experiments in the concentration camps (Nuremberg Trials) resulted in the formulation of the 1947 Nuremberg Code (Shuster, 1997). With the intention of preventing further unethical research, the Nuremberg Code offered guidelines for undertaking ethical research.

Following these guidelines, in 1950 New Zealand set up the National Medical Research Council and, over time, hospitals began to voluntarily establish ethics committees to review research studies (Loveday & Mitchell, 2010; Shuster, 1997). In 1964, the Declaration of Helsinki established more specific guidelines for physicians conducting human research and again New Zealand took guidance (Loveday & Mitchell, 2010; McCallin, 2010). However, this declaration was for guidance only, not firm legal requirements. The New Zealand Committee on Ethics in Research was established in 1984. Following this, an ethics committee under the Health Research Council Act of 1990 was confirmed (Committee of Inquiry, 1988; Loveday & Mitchell, 2010). This was the first time in New Zealand that health research ethics was written into law, requiring regional health authorities to either establish ethics committees or contract to ethics committees to provide ethical review by 1993. Following on from the Health Research Act of 1990, the National Ethics Committee was formed in 2000, taking ethical reviews of research studies from the local level to a national level (Loveday & Mitchell, 2010). Now called the Health and Disability Ethics Committee, under the auspices of the Ministry of Health, this committee consists of various subcommittees based on region, for example, the Northern A and B Health and Disability Ethics

Committees, the Central Health and Disability Ethics Committee, and the Southern Health and Disability Ethics Committee (Ministry of Health, 2015). The primary purpose of these committees is to protect and safeguard research participants and to respect the dignity of persons (Ministry of Health, 2015).

The final ethical consideration for this study related to the researcher's plan to include patients with a palliative diagnosis as participants. These patients are considered a vulnerable population (Alexander, 2010; Nickel, 2006). However, that vulnerability is a contested notion, as some who are considered vulnerable by outsiders do not view themselves as such (Wilson & Neville, 2009). Alexander (2010) argued that while many researchers have avoided research among vulnerable groups because of prevailing preconceptions, such research is unethical and difficult. In fact, it is unethical not to research vulnerable populations. Inclusion in research, if done in an ethical manner, allows vulnerable people to have access to any benefits of research participation (Alexander, 2010). Therefore, the addition of patient participants was included in the ethical application.

For this study, ethical approval was sought, and subsequently obtained, from two ethics committees, the Health and Disability Multi-Regional Ethics Committee (Appendix A), and the Auckland University of Technology Ethics Committee (AUTEK). The process involved completing an application document detailing the study and how participants would be kept safe. Ethical approval for this grounded theory study was challenging, as the researcher did not know at the beginning of the research how many participants would be interviewed or who needed to be interviewed, as this in fact is associated with the methodology (McCallin, 2010). Estimates were made with the understanding that,

if required, a request could be submitted to the ethics committees to make the necessary changes. Once approval was received from the Health and Disability Committee, further ethical approval was applied for, from AUTEK (Appendix B). This second ethics approval is a requirement of the university for any student or staff member conducting research under the auspices of the university. The AUTEK committee had concerns about researcher safety, as interviews were to take place at a location of the participant's choice. A safety protocol was written (Appendix C) and put in place after which approval was given. These ethical approvals included a plan for meeting specific ethical principles.

Meeting Ethical Principles

When applying for ethical approval, in New Zealand, there are specific principles that the researcher must address, to show how these will be met throughout the study. The researcher is then bound to make sure this does, in fact, occur. These principles are validity of research, cultural, and social responsibility to Māori, minimisation of harm, privacy and confidentiality, and informed consent for all participants.

Validity for the purposes of ethical approval is demonstrated through the aim of the research, which is to describe and explain how health professionals collaborate in a palliative care environment; the scientific basis of the project; the study design; and the expected outcomes or impacts of research. The outcome being that the findings of this study will assist with future planning of health services for palliative patients in New Zealand using collaboration at both strategic and operational levels. This knowledge has the potential to be transferrable to other areas.

In regard to the principle of cultural and social responsibility, the New Zealand Health and Disability Ethics Committee states that all health research conducted in New Zealand is of relevance to Māori (Ministry of Health, 2015). Therefore, any researcher undertaking research in New Zealand has a cultural and social responsibility to involve Māori in the research process as full participants. Alongside this, is the need to identify how the research will contribute to improving health outcomes and reducing health inequalities for Māori. Specific guidance documents have been written to help the researcher fulfill these requirements. Two documents available to researchers to assist them to meet these ethical requirements were reviewed by the researcher prior to applying for ethical approval: *Te Ara Tika guidelines for Māori research ethics* (Pūtaiora Writing Group, 2010) and *Guidelines for researchers on research involving Māori* (Health Research Council, 2010). Having read these documents, and as a way to ensure cultural and social responsibility to Māori would be met in this study, the researcher consulted with a local respected Māori elder (Kaumatua) for guidance and advice. The Kaumatua felt this study was culturally appropriate, as any improvement in the delivery of palliative care would benefit Māori requiring those services (Appendix D). Ongoing support was given through informal meetings between the researcher with the Kaumatua, where he was given updates related to participant interviews and, while keeping confidentiality of individual participants, was informed as to whether any participants self-identified as Māori. Participant ethnicity data was not formally collected for this study as this did not seem relevant to the substantive area of interest, or to the methodology where the participant voice is de-identified through abstraction of concept. No participants voluntarily self-identified as Māori.

As noted above, minimisation of harm is the third ethical principal that was required to be met. There was no physical intervention to this study that could cause harm. The

first potential harm was identified as being emotional, should issues arise during the interviews that cause distress through the reliving and relaying of an experience. To manage this, participants were informed that they could stop the interview at any time and interviews were scheduled for a maximum time of 60 minutes. In addition, to provide a measure of openness and comfort during the interview, research participants were informed that the researcher was a nurse working in palliative care. The decision to share this information was made as researchers who have the status of being an 'insider' are "frequently trusted because they possess an understanding of the socio-cultural requirements associated with interacting with these groups" (Wilson & Neville, 2009, p. 77). To prevent any possibility of coercion, a second potential harm, the decision was made to interview participants from the wider region and not recruit from the hospice where the researcher was employed. As the researcher's place of employment changed during this study, the risk of coercion lessened nearer the end of data collection. Regardless, once theoretical sampling got underway, it was found that the researcher was acquainted with a small number of the health professional participants prior to these participants agreeing to take part in this study. This was expected, as the pool of expert palliative care providers in New Zealand is small.

The fourth principle is privacy and confidentiality. Using Glaserian grounded theory for this study meant that hidden social strategies were identified through using the grounded theory method of coding, categories, and conceptualisation. There are no descriptions of individual experiences that could identify the participant. Therefore, the individual participant voice is de-identified through abstraction of concepts. Only the group voice remains. In addition, only the researcher knows individual names and personal identifiers of participants. All data collected, along with individual names and

personal identifiers, have been password protected electronically. Signed consent forms with names and contact details are kept in a locked file cabinet in the principal researcher's office. Individual participants were given a number as an identifier that consisted of the order of the interview and year. Audiotaped interviews were deleted once the interview had been transcribed. Transcribed data is being stored electronically on disc for 10 years after the completion of the study in a locked secure file cabinet. At the end of the 10 years, this disc will be destroyed.

The final ethical principle is informed consent. Informed consent occurs when participants are given full and truthful information about the study in a way they can understand, so that they can make a judgement about whether to participate. To meet this principle, participants were given an information sheet to read that explained the study, how long the interview would take, benefits for the participant, possible risks, and what to do if they changed their minds and wanted to withdraw from the study. Contact details for the researcher and research supervisors were included as part of the information sheet. Two information sheets were written: one for health professionals (Appendix E) and one for patients (Appendix F). Differences between these information sheets are related to the interview length, potential discomforts, and risk minimisation. While health professionals' interviews were up to one hour in length, patients had the opportunity to elect to have two shorter interviews of 20-30 minutes if they tired easily. Patients were advised to speak to a family member or a health professional if they felt upset about anything that came up in discussion and were given the number of their local patient advocacy service. After reviewing the information on the sheet, and being given the opportunity to ask questions, all participants were requested to sign a consent form (Appendix G). Later, participants were given an

updated information sheet and consent form due to changes in the supervision team, as one was leaving the university. The only changes to these updated forms were names and contact details for new supervisors. The plan for meeting ethical principals was accepted by the relevant ethics committees which allowed the researcher to begin recruiting.

Participants

Recruiting

With relevant ethical approvals in place, the researcher began by approaching five Chief Executives of hospices in the North Island of New Zealand to ask permission to advertise the study to staff in their workplace. The initial approach was made via a personal telephone call to introduce the researcher, followed by an email from the researcher containing detailed information specific to this study. Four of the five hospices granted permission. One hospice declined due to the number of research projects they were already participating in, feeling another project would place a burden on staff. With the choice of four hospices, the researcher then decided to start data collection with health professionals at one organisation (name withheld for confidentiality) that had a reputation for being experts at working collaboratively. This decision was made because Glaser advised that the researcher go to the experts (Glaser, 1998). Participant information sheets (Appendices E & F) were emailed to staff to give time for them to review the information, ask questions, and decide whether they would be willing to be interviewed. A date and time was then made for the researcher to visit and interview willing participants. As the months progressed, two health professionals working in palliative care outside of the initial four hospices heard about the study by word of mouth. These two health professionals initiated contact with the researcher to

obtain more information. Both agreed to participate once they reviewed the information and eligibility was established.

As the researcher viewed patients as part of the palliative care team, she believed that patients could bring another voice when examining collaboration in palliative care. Therefore, the original decision to include patient participants was made early in the research process, and prior to the research area of substantive interest being refined. An arrangement was made for a research intermediary at the four participating hospices to identify patients who may be willing to participate. It was felt that having a local intermediary already known to the patient, gave the potential participant an opportunity to decline in a safe familiar environment, before meeting the researcher. This occurred at one hospice.

Eligibility

Inclusion and exclusion criteria were purposefully kept as uncomplicated as possible to allow several health professionals and patients to participate while still enabling enough experience to be able to discuss collaboration. This would give the researcher more data for opening coding. To be eligible, patient participants were to have a palliative diagnosis and experience of palliative care delivery in both community and in-patient settings. For health-professional participants to be eligible, they were to have worked in palliative care for five or more years, although not necessarily employed at a hospice. All participants were required to be over 18 years of age and able to speak conversational English, as the researcher could not speak any other language and did not have research funding to employ an interpreter. Excluded was any patient or health professional who could not meet conversational English, who was under 18 years of age or who did not have the experience of working in palliative care for five or more years.

Research participants

A total of 23 people agreed to participate in this study of collaboration in palliative care. Interviews took place in the North Island of New Zealand at various venues, convenient to the participant. These venues ranged from the participant's workplace (16), to cafés (6), the participant's home (2) and finally, at the researcher's workplace, where a quiet meeting room was utilised for the interview (1). As a sample base, known participant demographics are shown in Figure 2 below.

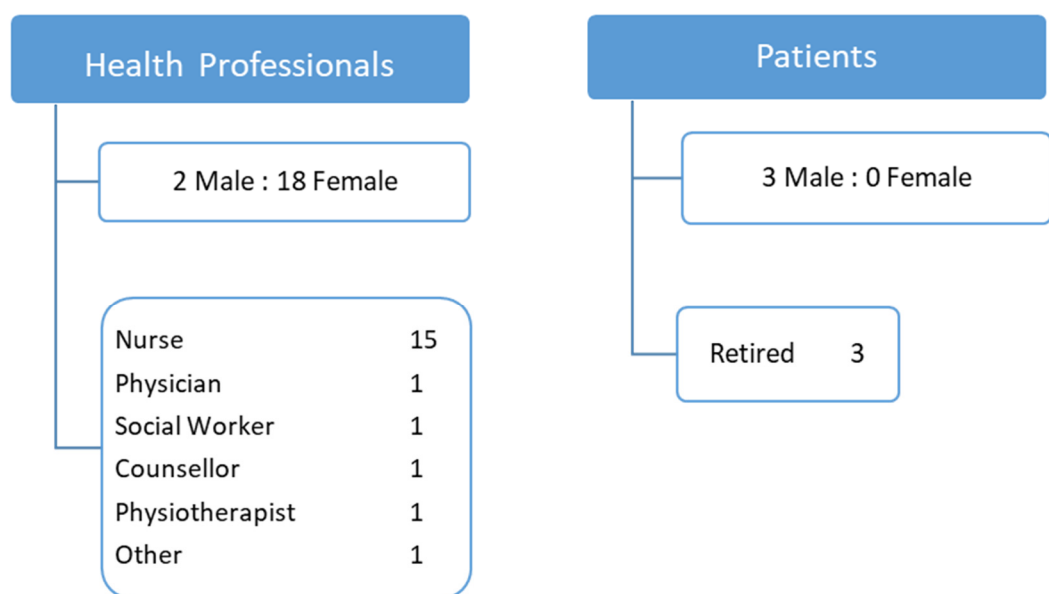


Figure 2: Participant demographics

Of the 23 participants, 20 were health professionals and three were patients receiving hospice care. Five were male and 18 were female. Amongst the health professionals, participant professions were registered nurse (15), physician (1), social worker (1), counsellor (1) physiotherapist (1) and other (1). This range of health professionals interviewed is broadly representative of palliative care teams in New Zealand where, although it is a multidisciplinary service, the majority of health professionals are nurses. The profession categorised as 'other' has been deliberately withheld as the role is very specific and could lead to identification of the participant if disclosed. The three patient participants were retired from paid employment.

From these 23 participants, a total of 25 interviews were undertaken, as two participants had a second interview. Twenty-one interviews took place prior to the emergence of the core category. Four interviews were undertaken after the emergence of the core category. Only four interviews were required following the emergence of the core category as saturation was reached, and no new categories emerged. One additional patient, not included in the above patient number, asked to participate to 'help' the researcher. While conversing, the researcher became aware that this patient, despite his willingness to help, did not meet the eligibility criteria. However, the researcher spent time discussing the study topic with the patient and wrote this discussion up as field notes.

Data Collection - The Interviews

In keeping with theoretical sampling and initial decisions, interviews began at a location where health professionals were reputed to be experts at collaboration and experienced in palliative care. Once participants verbally agreed to take part in the research study, they met with the researcher who offered to answer any further questions and gave participants the written consent form to sign (Appendix G). Once signed, a face-to-face interview between the participant and the researcher began. Time given for each interview was up to one hour (60 minutes). Two interviews with health professionals went over the planned one-hour time allocation as participants wanted to continue talking; however, none went longer than 90 minutes. Other interviews were shorter than one hour. This variation in interview time is common when using Glaserian grounded theory as the researcher begins with open-ended questions about the area of interest and participants differ in the length of their responses (Glaser, 1998).

Interviews were semi-structured as this approach enabled the researcher to gain information and clarify concepts emerging from the data, using the participant's own words. With participant consent, all interviews were digitally recorded. Most were later transcribed. The decision to digitally record interviews was made despite the researcher being aware that using a recorder is contentious within the Glaserian grounded theory approach. Glaser (1998) strongly recommended that the researcher not record, believing that recording produces too much data without distilling the main ideas, is time consuming, and can become a barrier between the researcher and participant. Rationale for the researcher's decision to digitally record was that grounded theory research methodology was new to the researcher, who was subsequently concerned that pertinent data may be forgotten, overlooked, or misinterpreted. Interviewing for a grounded theory study is a learned skill requiring patience and ability. Being able to return to recorded data gave a sense of security to the researcher, by providing the ability to re-immense oneself in the interviews at later stages of theoretical generation and improve confidence in interpretations. The physical barrier of a digital recorder is less in current times. Recorders available today are small in comparison to the older style cassette recorders, making the recording of data less intrusive. During the interviews, all but one participant appeared comfortable with digital recording as the recorder was left visible resting on a table or similar between researcher and participant. With this one exception, who kept glancing at the digital recorder, the researcher found that participants appeared to quickly adapt to the presence of the digital recorder, possibly to the extent of forgetting it was present as the interviews progressed.

The starting point for interviews was to use a broad statement that encouraged the participant to talk freely (Glaser & Strauss, 1967). For this study, participants were informed that the researcher was investigating collaborative practice in palliative care as the substantive area of interest. Participants were then initially asked if they had any concerns working together and, if so, what their concerns were (Appendix H). As each interview progressed the researcher used prompt questions to promote discussion, based on the previous information given. For example, participants were asked to explain more about a situation they described, asked why they did the action they had just described or, alternatively, asked why chose not to act in the situation described. At times, participants were also asked to clarify what they said. Clarification questions included confirming understanding by responding with “so you were saying...” and paraphrasing or asking the participant what he or she thought was going on.

The researcher was aware that time was needed to write field notes during and after each interview. Regardless, this took longer than expected due to the researcher being unsure of what to write, what was important to note, and what was not. Due to travel and participant availability, the need to undertake the first four interviews within an eight-hour work day added a further challenge. The researcher was concerned that some data, important to the emerging theory, would be missed or lost. As noted above, digitally recording these interviews gave the researcher some confidence that all the data would be available later for analysis. Undertaking interviews close together felt mentally exhausting due to the need to closely focus on what each participant was saying. To manage this, the researcher took breaks between interviews to write field notes of the main points discussed. Due to the tight time frame, initial comparative analysis, while starting on day one of data collection, was limited to the researcher’s

memory of what was said at the first interview and comparing to what the participant was saying during the second interview, continuing to the final interview of the day. Comparative analysis was enhanced when transcribing of digital recordings was completed, which also assisted with the researcher's memo writing. Regardless of the initial benefit of transcribing for the researcher, the last five interviews were not transcribed verbatim from the digital recording as previous interviews had been. As the researcher became more confident in analysing data, not transcribing saved time; time that was used for further constant comparative analysis and abstracting.

Initial interviews undertaken allowed the researcher to gather a broad range of data to be sorted. During interviews with patient participants, the patients' stories consistently related to previous health care experiences that occurred either prior to their palliative diagnosis or outside of hospice and palliative care. These stories were therefore, not relevant to the substantive area of interest being asked about at the time. Specifically, giving information on how health professionals collaborate in the palliative care arena. In addition, when conversation was directed by the researcher to the patient participant's palliative care experience of collaboration with health professionals, the patient participants were consistently overly positive, expressing they had no concerns. Properlining appeared to be occurring. Properlining, according to Glaser (1998), occurs when participants tell the researcher what they believe the researcher wants to hear, rather than what is occurring.

The original substantive area of interest that had received research approval was investigating health professionals' main concern with collaboration in palliative care, not the patient's main concern. A distinction the researcher, in an altruistic desire to

include the patient as part of the team, did not note until interviews were underway. Grounded theory allows for constant comparison of interviews from different groups (Glaser, 1998), giving an opportunity to continue by constantly comparing patient data and health professional data separately and then together. However, this was not well understood by the researcher at the time. There was also the possibility that undertaking data analysis from two groups could lead to a study larger than anticipated with two theories emerging, or a theory may emerge that was not relevant to either the health professional or the patient.

Despite the researcher's concerns of proper lining, data from the three patient participant interviews was comparatively analysed with health professional interviews, in the method of grounded theory. Following this initial comparative analysis, discussion occurred between the researcher and her supervisor at which time the decision was made to not recruit any further patient participants, due to the lack of relevance. As the behaviours and concerns from the three patient participant interviews were not reflected in the emerging categories, these concerns and behaviours did not earn a place in the final theory or main concern.

As participant interviews continued, and codes began to emerge through constant comparative analysis, the researcher continued to be guided by theoretical sampling, whereby the data analysis prompts the researcher on where to sample next (Coyne, 1997; Glaser, 1978). Moving to other locations and participants, interview questions became more specific related to the categories and their properties that were emerging during data analysis.

Data Analysis

Constant comparative analysis

Throughout data analysis, the researcher used the constant comparative method. While comparison was assisted by memo writing, the physical act of writing the initial memos on paper did not begin until the day after the first four interviews had taken place. At that time, the researcher began to fully analyse the first interview, comparing word-by-word and line-by-line with itself. This was to identify what the participant was saying in the moment with what he or she said previously. The second, third, and fourth interviews were then analysed over several days, using comparative analysis. This was done prior to any further interviews being conducted, as having the data of four interviews in her possession, but not analysed, made the researcher feel she was falling behind in the research process. As each interview was analysed, new data were compared within itself, and with the previous data. This comparative analysis was helped by further memo writing, as possibilities for concepts and categories were recorded and tested. The initial memos consisted of word or phrases from the data that may have been potential concerns or potential categories, for example, communicating, relating, and adjusting. These were placed alongside the researcher's thoughts, such as harnessing (Appendix I). Using open coding, common words and expressions were found and grouped into categories. This process, repeated constantly, allowed for the emergence of the main concern (Appendix J) and later the emergence of the core category (Appendix K).

Memoing

The process of conceptualising the categories, pre-core categories, and the core category was assisted by memoing. The mechanics of memo writing was initially difficult as the researcher was unsure of what was expected and what a memo should look like. To

assist with this process the researcher preferred to write memos by hand rather than electronically. However, as a doctoral student, the researcher was asked to send the first few memos to one supervisor for review. The mechanics of typing the memos for electronic posting added a formality due to the researcher's concern of grammar, spelling, and formatting and changed the free flow of the ideas being expressed as the researcher tried to make the memos that were understood by her, understandable to the supervisor. An example of a typed memo is given in Figure 3 (p. 90), demonstrating the process of analysis where the possible early main concern, resourcing, can lead to individualising.

Interestingly, Glaser (2013) noted that while many supervisors want to review and guide graduate student's memo writing, it is important that the student researcher "uses autonomy to develop their own style and should not show his memos to anyone" (p. 2). The formality that occurred when typing memos for a supervisor's review, along with the associated stifling of free-flowing ideas, was overcome when the researcher reverted to hand writing memos, which was more natural for her. Hand writing memos helped the researcher with her reflection and review, capturing fleeting thoughts without being concerned about spelling and grammar.

Concerns that came up were resourcing - both lack of resources and over-resourcing where there can be too many agencies/people involved. Timing (it's seldom quick; can take a lot of time). Testing - both the individual person and the professional role. Misbalancing (power imbalance), vulnerability and unequal treatment of health disciplines, patch protecting. Expecting was a problem in that others have expectations of your role. Changing expectations was a solution. Overlapping professional roles can also be a problem and solution.

The main solution to manage these concerns was reframing as in reframing the situation to be able to deal with it. Also understanding, adjusting, educating & training, voicing, unburdening, advocating, communicating, strengthening, processing (information), proximiting (physical proximity), sharing, relating (relationships), referring, unburdening. Feeling safe (versus unsafe) makes professional less defensive.

Commonalities within first nine interviews show it's about people and how people act whether in communicating, their relationships or whatever. This seems pretty obvious and not a unique finding by any means.

Can the problem be people management in all forms whether managing ourselves or managing others and the solution collaboration?

What is the main concern of health professionals working collaboratively (with colleagues and patients) in palliative care and how do they manage that?

Using their words to answer the question

The main problem is individualising. The solution is harnessing.

Sub-contexts are communication, relationships, culture, integrating and adjusting.

Memo
22/11/12

Figure 3: Example of early typed memo

Regardless of the mechanics of memo writing, memos were important for the researcher in the process of conceptualising groups. Initially, memos captured similarities between the interviews and any ideas the researcher had about the data and its potential links and

meaning. During open coding, the researcher's early memos tended to be descriptive in nature. Nevertheless, these memos assisted with the emergence of the main concern.

Emergence of the Main Concern

Despite intense analysis by the researcher, the main concern appeared slow to emerge from the data. Several potential main concerns were considered during the constant comparative process prior to finding the actual main concern. Initial examples that were memoed, to help clarify the emergence of the main concern, included information insufficiency, lack of sharing, and silos (Appendix J).

During the analysis, some potential main concerns appeared to be similar although different terms were used to express them, for example, information insufficiency (not having enough information), lack of knowing (not having enough information), and information imbalance (one has more information than another). Another potential main concern that appeared during analysis was resource limitations. While information is a resource, there were other resources participants felt were missing, causing concern. However, the data indicated that 'resources' was being defined in different ways. In addition, resource limitations were not considered a concern if obtaining that resource was outside of the participant's role description. Therefore, the concern only occurred when the participant had to do something to obtain that resource. The potential main concerns of individualising, retaining, lack of sharing, and silos were also similar but led to the actual main concern.

Silos had been identified as the main concern by the researcher, but when beginning to write up the research it did not appear to be the best fit, as this had not continued through all the data being analysed. At this point the researcher realised she was doing

what Glaser (1998) called forcing the data due to professional interests and assumptions. Trusting the process and her own insight, the researcher went back to the data and previously written memos. Further comparative analysis indicated that the participants were clear that they wanted to provide what they consider is good palliative care. However, participants were consistently describing barriers or blocks to obtaining a commodity they believed was needed for improved patient care but did not have because it was held by someone else, whether by another health professional or health organisation. Telling this narrative, and retelling in various ways through memo writing, the main concern finally emerged from the data and will be discussed in Chapter Five. According to Glaser (1998) “discovering the main concern or problem of the participants is what socially organizes the behaviour in the substantive area, hence the emerging theory” (p. 117). With the main concern now identified, the researcher could focus on how the health professionals managed this concern and provide a theoretical explanation of these processes.

Emergence of Properties and Categories

Emergence of the properties and categories that led to the core category accompanied the emergence of the main concern. Initial codes, placed into groups of common words and expressions, were plentiful and included, for example, communicating, informing, and sharing (Appendix K). Adding to memoing, large flip-chart sized paper was used as a visualisation tool to document common words and phrases that were appearing, to help identify potential relationships between properties that may lead to concepts and categories. Figure 4 (p. 93) demonstrates how the researcher initially listed the words that were similar in meaning, as defined by the participants, to find potential future properties.

Date: 1.1.14

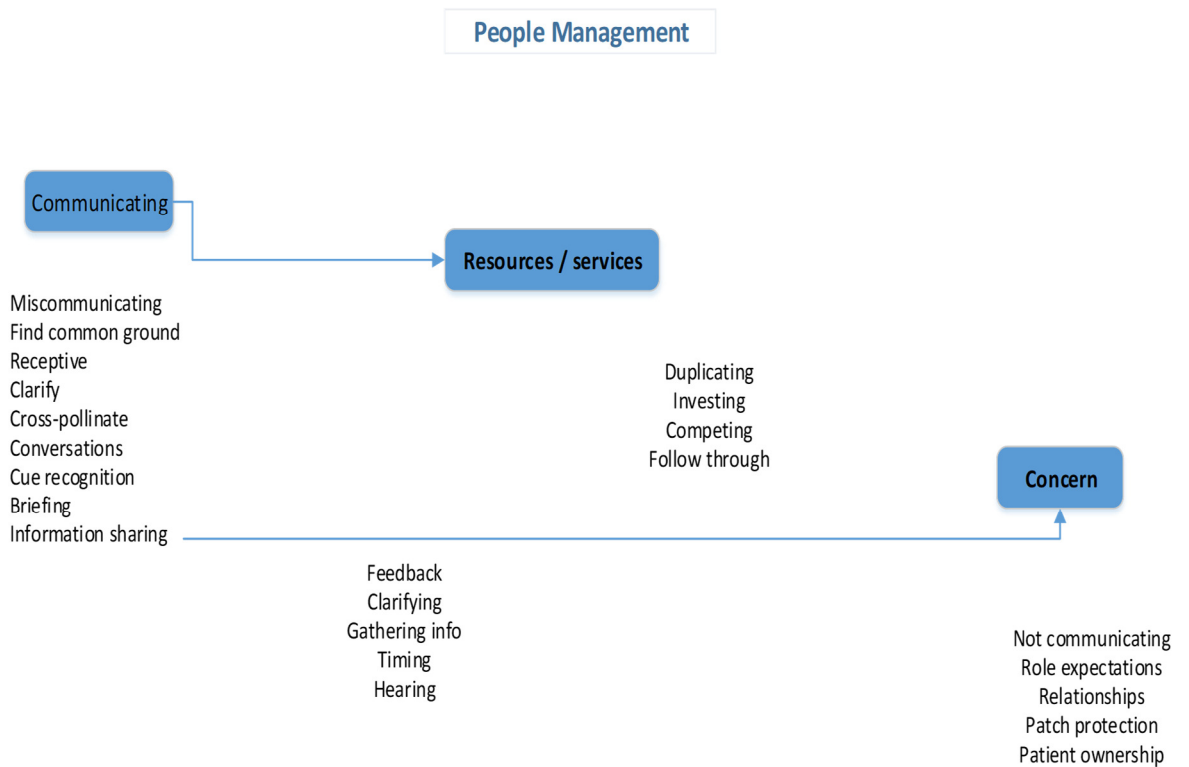


Figure 4: Example of initial open coding

The groupings in Figure 4 were selected by the researcher as these words appeared in the data. During constant comparative analysis, words were moved around frequently so the grouping of codes began to emerge into categories as noted in Figure 5 (p. 94). Memo writing continued to help the researcher identify these groupings by looking at similarities emerging from the data. Some categories identified early in the open coding process eventually became part of the proposed explanation for facilitating collaboration and managing the main concern.

Category - Codes	
	developing , building , connecting , personalities , investing effort /time
	referring , accepting , respecting , understanding , supporting
	culture , goals , needing , intermingling , interrelating . Interacting
	meeting , informing , telling , saying , asking , clarifying , understanding , listening

Figure 5: Example of grouping of codes into categories

Properties became evident early in the constant comparative process and have remained consistent, although there were changes to which category the property best related to (Appendix K). These properties were compared and, together with similar properties, became a category. For example, the properties of speaking, meeting, and giving and receiving information, became the category of communicating. The following Figures 6 and 7 (p. 94) are examples of this early analysis that occurred:

Date 3.3.14 1. Purposeful: <ul style="list-style-type: none"> • Connecting? • Intentional? • Association? 	2. communicating	informing	
		Talking	
	3. relating	Meeting	
		knowing each other	
		trusting	rapport respecting confidence
	Sharing	interacting	
	professional identity	expecting understanding	
Intentional or purposeful? Purposeful = resolute / having a purpose Purpose = the reason for which something is done or for which something exists. Resolve or determination			

Figure 6: Example of early core category emergence analysis

Figure 6 above was written early in the constant comparative analysis process when properties began to emerge from the data. Figure 7 (page 95) is an example from the later stage of comparative analysis.

Main concern	Core category	Pre-core categories	Categories	Properties
Individualising Retaining (+) Keep possession of, hold, keep, secure, maintain, hold onto, keep on (d) Continue to have, keep possession of, derail, alter	Connecting (+) Join, unite, relate, identify, come together, cooperating, collaborating	Communicating	Informing	Telling /saying, asking, clarifying, gathering, finding, sharing
			Talking	Speaking, chatting, conversing, phoning, calling
			Meeting	Coming, attending, visiting
	(d) Bring together as to establish a link. – join, as to provide access and communication,	Relating	Knowing (each other)	Developing, building, connecting
			Trusting	Referring, investing, accepting, respecting, involving
			Sharing	Culture, goals, needs, participating
	Connection – a link or relationship between people or things (seeking to connect)	Role clarifying	Expecting (role expectations)	Advocating, trusting, involving, testing, fitting
			Knowing information	Enhancing, articulating, educating
			Understanding	Sorting, adjusting, reframing, focusing
Story: main concern “retaining” as indicated by different personalities not sharing same goals, same culture, working alone. Role confusion, expectations, ownership.				

Date: 9/6/14

Figure 7: Example of later core category emergence analysis

While the final categories and core category remained unknown at the time, there were some properties and categories that emerged early, such as communicating and relating.

Emergence of Core category

Through continued analysis, coding, memoing, and sorting, the core category finally emerged. As previously noted, the researcher had written memos on paper and kept these in a three-ring binder, in chronological order. Hindering the sorting process was

that the researcher had often written, depending on length of the memo, more than one memo per page and written on both sides of the paper. While keeping a memo file in this manner initially appeared organised, this slowed sorting as it took time to literally cut a page into two where necessary to put each memo in the appropriate pile, or to photocopy a back page when both sides of the page needed to go into different sorting piles. The benefit was that once done, it allowed shuffling of the memos to assist in finding the theoretical outline of the emerging theory. Moving memos out of chronological order into different orders resulted in stacks of memos, on different sized pieces of paper, that got reshuffled frequently and at times seemed overwhelming. At that point in time, the researcher learned that a personality trait of hers was a preference for order and neatness, not what seemed messy and chaotic, adding to the challenge. Regardless, the researcher continued, reviewing these stacks of paper many times over many weeks.

The following Figure 8 (p. 97) is an example, originally drawn on large white paper, of linking categories and properties. As constant comparative analysis continued, the categories and properties changed, as did the main concern.

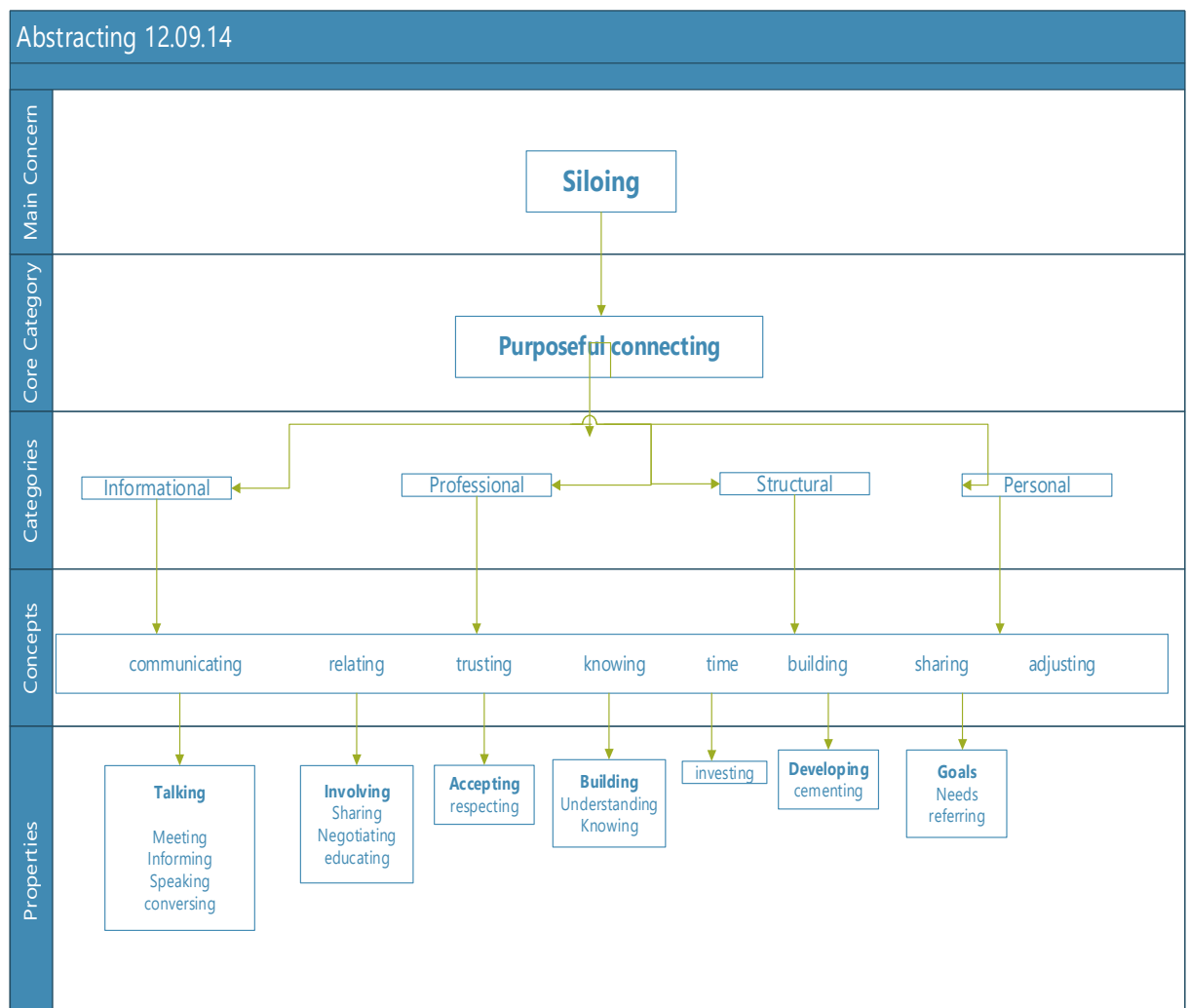


Figure 8: Discovering codes and categories example (dated 12.9.14)

During this phase of analysis, various pre-core and core categories were considered, such as bridging (Appendix L), finding common ground (Appendix M) and finding time (Appendix N). With each consideration memos were sorted and additional memos written to help the researcher begin to conceptualise a potential theory through visualising in words what worked. To the researcher this was like attempting to write a story using given data; a story that needed to theorise how health professionals work together. Memos often became short stories told in a few sentences. Emergence of the core category came about through adjusting the position of categories to find the best fit that made sense according to the data.

After the discovery of the core category, selective coding began, with the researcher focusing only on the core category of Sharing Time and the variables that relate to the core category in significant ways that were used to assist with theory generation. At this point of theoretical sampling, four additional interviews took place using this core category as a guide for data collection. 'Coding families' were then introduced to assist the researcher to discover the integration codes.

Generating the theory and application of 'coding families'

Following the emergence of the core category, the researcher began to further hypothesise how all categories related to each other as an explanation of how health professionals collaborate in palliative care. The complexity of generating theory was a challenge, particularly when trying to understand and explain the relationship between the categories. To assist with this conceptualising, the researcher returned to the literature on theoretical decision making and coding families alongside immersing herself in the data through memos (Glaser, 1978, 1992, 1998). Previously written memos were compared and sorted into piles, while continuing to write new memos. They were then resorted. There were some changes from previous sorting as the memos began to theoretically and substantially fit with other memos and the conceptualisation of the theory emerged.

Throughout this process, the researcher continued meeting with her supervisors and receiving feedback on drafts of the written thesis, which gave the researcher opportunities to practice expressing the proposed explanation of how health professionals managed their main concern and facilitated collaboration. The initial coding family that the researcher attempted to use, to discover what integrated the developing theory, was that of the Six C's – causes, contexts, contingencies,

consequences, covariances, and conditions. This was chosen to begin with as Glaser (1978) noted this is the most commonly used coding family. Continuing with higher level analysis, it became evident that this coding family did not explain how the categories and properties were integrated. One reason being that the **data indicated that what** occurred was purposeful social behaviour rather than an unplanned behaviour leading to an unplanned consequence.

A second coding family, the Strategy Family, was consequently tried, to discover the strategy that integrates the theory; that of uniting (Appendix O). However, further feedback helped the researcher to recognise that uniting was not a strategy. Rather, uniting was a descriptive analysis, not an abstract conceptualisation. This re-confirmed to the researcher the challenge of developing a theory and the importance of letting the conceptualisation of the theoretical code emerge through following the grounded theory method, rather than trying to force a coding family to fit. Revisiting the literature on theoretical coding families yet again (Glaser, 1978, 1992), previously written memos were reviewed as new memos were written to help with the process of moving from conceptual description to conceptual theory. A short example is given in Figure 9 (p. 100).

When speaking, meeting and informing another person there is a mutual but unspoken expectation that communicating will occur/is occurring. When people communicate and relate there is a mutual expectation that there will be purposeful connecting. When purposeful connecting there is a shared expectation that communicating and relating occur

Or

Speaking and meeting and informing are all beneficial for communicating. When health professionals are communicating and relating there is benefit to both as they share and get what they need from the exchange. When purposefully connecting and finding common ground health professionals have an exchange that is beneficial as it leads to sharing. Both get something they want or need. This leads to further communicating, relating, participating and negotiating.

So it is mutual – both sides win – a win-win situation in the social behaviours.. It is purposeful as there is intention, rather than happenstance. There is sharing.

Memo
20/05/17

Figure 9: Memo example of discovering theoretical code

Writing the ‘story’ of the theory through memos led to the discovery of the theoretical code for this theory, the interactive family. Glaser (1978) noted that “this code is an effort to capture the interacting pattern of two or more variables when the analyst cannot say which comes first” (p. 76). Further discussion on how this code links the categories, concepts, and properties together takes place in Chapter Five.

Maintaining Rigour

Methodological strength can be shown through rigour. Rigour was maintained throughout this study in several ways such as fit, workability, relevance, and modifiability (Glaser, 1998). Regular supervisory feedback, along with questioning of the emerging key concepts, assisted the researcher to argue the relevance and fit of these concepts. This process strengthened the rigour of the method. Fit was maintained through the constant comparative method that occurred throughout data collection and analysis, from the first interview to the last. Thus, fit ensured that the concepts of this theory emerged from, and adequately expressed, the data and that emerging concepts were not preconceived or forced by the researcher. Rather data were grounded to and in the theory. Workability occurred as the theory clearly accounts for how participants manage collaboration through using the social process of Sharing Time. Memoing helped the researcher move from conceptual description to theoretical explanation. However, this was a process that remained challenging for the researcher and was questioned by supervisors and again by thesis examiners.

Returning to memo writing and sorting reinforced the workability of the theory but led to a change to the theoretical code. To ensure relevance, the researcher, as concepts emerged, took these to participants in the form of questions to obtain feedback. Either the participant demonstrated instant grab by giving the research an immediate response and talking about the concept with minimal prompts, showing relevance, or response was minimal to none. This ongoing instant grab indicated the relevance of the main concern. Modifiability will be shown in the ability of this theory to withstand modification and reformation as new data emerges in the future.

Summary

This chapter has documented how the researcher generated a theory that explains the social behaviour of health professionals when managing collaboration in a palliative care environment. Briefly noting the pre-requisite papers and ethical approvals helped to situate the study and the researcher's previous knowledge in the substantive area of interest. The remainder of the chapter explained how the researcher applied the core methods of Glaserian grounded theory to identify the main concern of possession and conceptualise how health professionals managed that main concern, through the theory of Sharing Time. These core methods include theoretical sampling, constant comparative analysis, coding, and conceptualising through memoing (Glaser & Strauss, 1967). Using theoretical sampling, open and then selective, data were obtained by interviewing health professionals working in palliative care. Constant comparative analysis, memoing, and sorting, enabled the main concern of possession to emerge, followed by the properties, categories, and core categories of the theory. Following these processes enabled the researcher to maintain rigour. Theoretical coding and conceptualisation identified the interactive family which integrates the theory. This theory and how it manages the main concern will be explained in the following chapter.

Chapter Five: The Theory

Introduction

This chapter introduces the theory of Sharing Time to explain how health professionals working in palliative care manage their main concern of possession. The explanation will begin with defining possession. Next, the theory of Sharing Time will be presented as the core category that explains the actions health professionals take to manage possession. Integrated by reciprocity, Sharing Time is defined through the categories of purposeful connecting and finding common ground; as health professionals purposefully make time, take time, spend time, or find time in their workday for each other. Finally, this chapter will present the emergence of the theory of Sharing Time being situated in a middle ground. This middle ground links the main concern and the theory, as too little or too much of any of the properties and categories moves health professionals outside of Sharing Time and toward possession.

The Main Concern: Possession defined

Possession emerged as the main concern. Defined by the data, possession occurs when health professionals or health organisations possess a commodity that is not shared with other health professionals or organisations. This commodity is defined as something of use, advantage, or value. The commodity itself can be a tangible item or intangible. For example, a tangible item may be information that is part of a patient's health record at a different health service and is, therefore, not accessible to the current provider.

For us as a hospice to get notes out of [name] hospital is a major mission. We have to get consent from the family and patient and it takes weeks. That's if we choose to go down that road. There is also the informal route through our medical or CNS [clinical nurse specialist] palliative care links up there so they will get the person's notes and fax them down. (222014)

Alternatively, an intangible commodity occurs where a health professional's actions indicated he or she felt a certain commodity belonged to him or her, a commodity he or she was unwilling to share. For example, displaying possessorship by protecting what he or she believes is his or her patch [physical work environment] and purposefully excluding other health professionals; or when a health professional wants to maintain his or her strong relationship, real or perceived, with a patient and patient's family, excluding others in the health care team:

I have seen a little bit of wanting to keep the patient to yourself. I've seen a little bit of that and thought we all think we can do the best for this person don't we. (122014)

Whether this commodity is tangible or intangible, another health professional or organisation, who is not in possession of this commodity, believes it is necessary for, or would greatly improve, health care delivery to the patient at the bedside if shared.

Within the data, possessorship was often interpreted as ownership. However, conceptually the term ownership offered too many current definitions, for example, being strongly associated with having the legal right of possession of tangible, material goods. Yet, there was no suggestion of the main concern being specific to legal ownership within this study. In addition, there were several potential reasons for ownership, ranging from a health organisation's policies and procedures, to competition for resources, to an individual health professional's personal choice. Therefore, a term was needed to conceptualise this main concern as it emerged. Possessorship became the best conceptual name to capture the main concern.

Possessorship is recognised as being something others do, whether the possessor is an individual or an organisation. While health professionals may recognise or

acknowledge possessorship in their own behaviour, profession, or places of work, this was rare:

What I bought into when I started was, I bought into the idea of I need to you know, protect my patch and I need to be seen as important and so I can't give away information because otherwise I lose my power. (092012)

Whether it is an individual health professional or health organisation exhibiting possessorship, the act of possessorship introduces difficulties for other health professionals caring for palliative patients and has the potential to impact patient care:

In terms of collaboration if you've got three or four teams going in and each one of them has a sense of ownership, you are going to run into trouble. (072012)

The management of possessorship, therefore, is vital due to the potential negative impact of possessorship on patient care at the bedside. For example, when there is a lack of information:

From my personal point of view, we can find it quite difficult in the way we have limited information. Even though we are all professionals we are limited to what we can do for the patient because we don't have the added information. (052012).

Regardless of who is exhibiting possessorship, this main concern is managed by Sharing Time.

The Theory: Sharing Time

Overview

Sharing Time is the proposed theory that explains the way health professionals manage their main concern of possessorship:

Being able to share and that sort of thing takes time. (022012)

Sharing Time does not occur randomly; rather it is identified as a purposeful action, with a mutual expectation that each party will make the effort and be willing to commit time:

Putting time into building the team. That is really the way forward.
(032012)

In this way, purposeful connections are made. Making connections assists health professionals to find common ground. In return, finding common ground strengthens the connections made. Therefore, the theory of Sharing Time occurs through purposeful connecting and finding common ground:

We were very fortunate because of having a very real connection with
[*name*]. (012012)

You have to find common ground. (012012)

Purposeful connections are defined by communicating and relating. Whereas, finding common ground is defined through participating and negotiating. The order in which social behaviours occur to Share Time is often unidentified. For example, someone sharing time may communicate prior to participating, or participate prior to communicating, or this may occur simultaneously. Although the order of these social behaviours is often unidentifiable, the order of occurrence does not have any impact on the theory of Sharing Time.

Where Sharing Time occurs, reciprocity integrates it. Reciprocity is an exchange of mutual benefit. This mutual benefit may be explicit or an implicit unspoken expectation, where there is a sense that when something is given, something must be given in return. When Sharing Time, all health professionals involved benefit and gain from the exchange. For example, when purposefully connecting through communicating and relating, reciprocity has a beneficial influence for enhancing the

finding of common ground, as the mutual exchange of information between professionals improves collaboration, which can strengthen the delivery of care. If one or more components of the theory of Sharing Time is absent, an exchange may happen, but reciprocity will not occur. Rather, this will be a singular, one-way exchange. The lack of reciprocity means collaboration will either be impeded or will not occur at all.

Sharing Time

The theory of Sharing Time has a clear purpose, which is to facilitate collaboration and manage possession. When collaboration is facilitated and possession is successfully managed, the outcome of Sharing Time is that health professionals share what they have, and what others require, for patient care. Moreover, health professionals are sharing more than time. Sharing itself is considered important in the provision of optimal patient care:

The patient can't be cared for in a medical setting if we don't share.
(062012)

Sharing Time occurs in moments of time where health professionals come together for a common purpose; it is not a continuous strategy. Sharing Time always requires two or more health professionals, otherwise sharing cannot occur. In some instances, Sharing Time may appear to be one-sided to an observer, for example, when information is given from one to another, with no information given in return:

We would like to share with you what it is we do here. (012012)

However, during each occasion, there is a mutual sharing that is beneficial to all participants. Following this first occasion, should the need to collaborate arise again, Sharing Time will be easily repeated as there is now a foundation of communicating, relating, participating, and negotiating. Each occasion of Sharing Time improves the

facilitation of collaboration, so that it becomes a smooth quick strategy that takes little effort.

The two or more health professionals Sharing Time are often considered a team. There is little data about team possession as a concern, although when this does occur, it related to one team of health professionals not including another, such as not referring to another health profession or organisation. Regardless, Sharing Time can occur no matter how the healthcare team is defined. For example, the word 'team' is often used when discussing whom health professionals work with, and to define other professional groups, such as the doctor team or the nursing team:

My experience would lead me to believe that speaking generally there is the doctor team, the nursing team, and the family support team and whether or not they collaborate and work together depends on the personalities involved. (032012)

The team is often considered to be those in the same workplace with the same employer, therefore, a designated team. There is recognition that all of those involved in a patient's care, regardless of varying employers, are a palliative care team; however, there is no absolute consensus as to the definition of team:

I guess it depends on peoples' interpretation of what they think a multidisciplinary team and collaboration is. (212014)

Nor does the theory of Sharing Time require such a consensus to occur. Collaboration is facilitated through Sharing Time regardless of whether health professionals are in a designated team or considered outside of the team, as Sharing Time recognises participants as being a community of practice. However, the make-up of teams was viewed as a potential concern that could affect the way palliative care is delivered. Teams are often built by employment, rather than being built to meet the desired outcomes for individual patient care:

We don't build our teams with the outcomes we want and then we crisis manage along the way. (102012)

The reason health professionals choose to Share Time, and thereby facilitate collaboration, include meeting a shared goal or having a common purpose. This goal or common purpose is most often some aspect of delivering good palliative care. In the following example, the common purpose is the patient and preventing the need for the patient to be repetitious in telling his or her story to various health professionals:

She contacted me and said look, I've been visiting the patient weekly but clearly, it's going to be too much. So, let's work out a schedule and make sure we are sharing information so that we don't need to be asking (the patient) the same questions. (072012)

Adding to Sharing Time is time itself. The general busyness of the workday or aspects of work can take what is perceived to be a lot of time. For example, the time it can take to organise the care being provided:

You can spend hours trying to get coordination. (212014)

When delivery of care takes a longer time than it is believed it needs to be this becomes frustrating and potentially, in the view of some health professionals, misrepresents the palliative service:

So not only do you get misinterpretation, but you get frustration. It holds up the speed of delivery of care to that patient. (252014)

This frustration with time can be an outcome of possession, rather than ownership itself and, an outcome of not Sharing Time and collaborating. When ownership occurs, it takes time for health professionals when attempting to obtain what they want or need from the possessor. For example, the time needed to search for, and hopefully obtain, information being held or possessed by another health professional or organisation:

For us we have patients going from one DHB to another... so for us to extract information out of either of them is really challenging and time consuming. (222014)

Interestingly, concern is exhibited for the other health professional, recognising that many of these professionals are also busy:

Sometimes people in other organisations are just hindered by time constraints and you know, overloaded at times as the rest of us. (082012)

The recognition that others are busy does not prevent Sharing Time from occurring to facilitate collaboration; rather it enhances Sharing Time. Health professionals want to use what time they have well. There is an understanding of the importance of Sharing Time but not wasting time. Therefore, when Sharing Time, health professionals are managing time. When time is not shared by health professionals, time itself becomes a part of the main concern of possession, obstructing collaboration. For example, the physical presence of health professionals in the same room does not mean that Sharing Time is occurring as defined in this theory. Rather, these health professionals are sometimes seen to be wasting time, causing frustration for those who were trying to Share Time:

You go to a meeting and it takes about half the meeting time for people to get down to business. Either people are late, not prepared, they are not there to work. (202014)

Therefore, Sharing Time occurs in a middle ground, where there is neither too little or too much time spent, to facilitate collaboration, and manage possession.

When lack of sharing occurs, there is a corresponding lack of reciprocity. For example, a health professional choosing to work alone to provide care to a palliative patient, when the patient may clearly benefit from the input of other health professionals, is not

sharing and there is decreased benefit to the patient. This is described as patient ownership:

One of the key factors is ownership of the patient. (032012)

In these solitary possession behaviours sharing is not facilitated. Although there may be a small degree of sharing that occurs within possession, it occurs for short periods due to an employment or role requirement, rather than being voluntarily sought by the health professional aiming to improve patient care over and above the minimum required to meet employment or role expectations. Thus, Sharing Time as defined in this theory is not occurring.

Table 1 (p. 112) depicts the researcher's conceptualisation of the proposed explanation of the theory of Sharing Time. This table includes categories and the properties of those categories which will be discussed further in this chapter.

Table 1: Conceptual representation of the theory of Sharing Time

Core Category	Sub-corecategories	Categories	Properties
<p>SHARING TIME (Theory of)</p> <p>“collaborating”</p> <p>Periods of time when health professionals purposefully make time, take time, find time, and spend time in their workday for and with each other, in order to share ‘commodity’ required, facilitating collaboration and managing possessorship. Time shared is in the middle ground – neither too much nor too little.</p> <p>Sharing Time is integrated by reciprocity – the practice of exchanging things with others for mutual benefit.</p>	<p>PURPOSEFUL CONNECTING</p> <p>is the uniting of health professionals through communicating and relating. Purposeful connecting is the means of finding common ground and Sharing Time.</p>	<p>COMMUNICATING</p> <p>is purposeful speaking, meeting and informing about a particular matter or subject.</p>	<p>Speaking: phoning, calling, talking, listening, hearing, saying, chatting, articulating</p> <p>Meeting: visiting, popping in, seeing, attending</p> <p>Informing: <i>giving</i> – telling, educating, writing, documenting, passing on, enhancing (knowledge) <i>receiving</i> – finding, asking, seeking, accessing, follow-up, clarifying, gathering</p>
		<p>RELATING</p> <p>is the active process of developing a professional relationship by involving self and others.</p>	<p>Involving: <i>self</i> – join in, intermingling, interacting, follow through</p> <p><i>others</i> – inviting, referring, building rapport, contacting, trusting</p>
	<p>FINDING COMMON GROUND</p> <p>is the finding of a common interest or goal through participating and negotiating. Finding common ground gives reason to connect and Share Time</p>	<p>PARTICIPATING</p> <p>is voluntarily and purposefully taking part (in finding common ground) through building and investing.</p>	<p>Building: developing, improvising, cross-pollinating</p> <p>Investing: commitment, willingness, resourcing</p>
		<p>NEGOTIATING</p> <p>is the purposeful act of working to achieve a mutual agreement (in order to find common ground)</p>	<p>Adjusting: changing, placating, reframing, compromising, integrating, merging, buying in</p> <p>Role clarifying: understanding, awareness, recognising, knowing, valuing, respecting, testing, advocating, learning</p>

Purposeful Connecting

In this study, purposeful connecting is defined as communicating and relating, which in turn explains how health professionals Share Time through reciprocal actions to minimise possessorship. Regardless of which occurs first, communicating and relating

are reciprocal and mutually beneficial. Specifically, communication is enhanced when relating is occurring and relating occurs more effortlessly with good communication.

When purposeful connecting occurs, it is easily recognised:

We were fortunate initially because of having a very real connection.
(012012)

Purposeful connecting is depicted in Table 2.

Table 2: Categories and properties of purposeful connecting

Sub-core category	Categories	Properties
Purposeful connecting	Communicating	<p>Speaking – phoning, calling, talking, listening, hearing, saying, chatting, articulating</p> <p>Meeting – visiting, popping-in, seeing, attending</p> <p>Informing: giving – telling, educating, writing, documenting, passing-on, enhancing (knowledge)</p> <p>Informing: receiving – finding, asking, seeking, accessing, follow-up, clarifying, gathering (information)</p>
	Relating	<p>Involving self – joining, intermingling, interacting, follow-through</p> <p>Involving others – inviting, referring, building rapport, contacting, trusting</p>

While purposefully connecting, health professionals Share Time and information through communicating and relating:

So, it's that real sharing of knowledge to the benefit of the patient and avoiding distress. Doing all that stuff, that communication and taking the burden off the patient so that they are free to try to get well or be comfortable. (092012)

This sharing is a reason to purposefully connect as well as an outcome of purposeful connecting:

Its sharing isn't it! It's to have the information so there's some purposeful connecting. (212014)

When purposefully connecting, there is a beneficial mutual exchange owing to the reciprocal relationship between the health professionals, with communicating and relating. Each helps the other to occur, which in turn helps to manage the solitary activity resulting in possession. As previously noted, when a health professional or organisation practices possession there is no or limited connecting occurring, which means that there is not the opportunity for reciprocity to occur. Interestingly, a lack of time, specifically the busyness of the workplace, is cited as one reason for not purposefully connecting. For example, if communication is lacking, purposeful connecting is not occurring:

People are busy because of staff shortages and sickness and often the thing missed is communication because the doing of the work is the core thing. (072012)

While communicating and relating frequently occur in the workplace between health professionals, simply communicating and relating does not automatically ensure purposeful connecting will occur. Alone, communicating and relating can be superficial or poor, affected by or affecting the culture of the working environment and the health professionals working in that environment:

It can be quite distracting if there is a lot of negative talk and you're trying to be there for the patient, but you've got colleagues unhappy you know. (172013)

Without a purposeful connection, it is less likely that health professionals will want to Share Time and, thereby, collaborate. There is no reciprocity, no beneficial mutual exchange occurring as an intangible reward to encourage further connecting. Health professionals may connect and share some time due to work and/or role requirements but not with the same willingness that those Sharing Time use. This leads to feelings of

frustration and making assumptions about other health professionals one works with, for example, that they will not understand:

Sometimes it doesn't matter how many times you tell somebody, it still goes over their head. So, from my point of view it's giving them just the information they need and no more. (052012)

However, when reciprocity occurs during and between communicating and relating, this encourages health professionals to connect, leading to Sharing Time, facilitating collaboration and minimising possessorship. In the following example, this reciprocity has been expressed as having respect for each other:

It's about creating awareness, it's about education, communication, information sharing and respect I think, for each other. (072012)

Communicating

In this study, communicating is defined as the purposeful strategy of health care professionals speaking to, meeting with, and informing each other about a matter or subject. Communicating is viewed as a key factor in patient care and collaboration:

Communication is always a key factor and continuing the communication you know so it's all ongoing. (082012)

When communicating within the theory of Sharing Time, there is reciprocity regardless of who is the giver and receiver in the communication, which leads to further sharing, and enhanced reciprocity. The commodity shared may be a tangible physical resource or an intangible non-physical resource such as information and knowledge.

Various ways of communicating occur which lead to purposeful connecting and Sharing Time. Speaking is the verbal means of communicating and includes phoning, calling, talking, listening, hearing, contacting, saying, chatting, and articulating:

You know you just ring up and have a chat before discharge. It just all helps a smooth discharge. (172014)

Speaking occurs when there is a physical meeting but can also occur without a physical meeting such as phoning or calling and assists with information giving and receiving. When speaking takes place within the theory, it is beneficial to other modes of communication such as listening, meeting, and informing. Likewise, listening, meeting, and informing are beneficial to speaking. Regardless of the order of occurrence when communicating, for example, whether one member of the party Sharing Time speaks first or listens first, this social behaviour, as with all the theory, has reciprocity. Each enhances the other and is mutually beneficial to health professionals providing patient care. Importantly, regardless of the form of communication used, this helps to manage possession, a solitary behaviour, when sharing through communication is occurring. However, this does not always require a physical presence.

Meeting is the physical component of communicating whereby health professionals are physically present in the same location while communicating. Meeting and speaking also have reciprocity, each benefitting the other, while both benefit communicating and purposeful connecting. Recognising this reciprocity, many health professionals are cognizant that meeting made communication easier:

I find it much easier if I actually front up in person. (092012)

Described as visiting, popping-in, seeing, and attending, meetings can be formally planned or informal. While different ways of communicating occur when Sharing Time, as discussed above, a physical meeting is often preferred, when location allowed:

Nothing like that face-to-face meeting. (092012)

I prefer a face-to-face conversation even with my colleagues at the other end. (132013)

Communicating involves informing. Two complementary aspects of informing occur when Sharing Time. The first being 'receiving' where information comes in or to the health professional. This is expressed as finding, asking, seeking, accessing, follow-up, clarifying, and gathering. The second aspect of informing that emerged is 'giving', where information is given to others through telling, education, writing, documenting, passing-on, and enhancing (knowledge). Both giving and receiving information are reciprocal as health professionals give or receive a commodity between them that is needed to improve patient care, thus overcoming possession. Not giving or receiving information, regardless of reason, is possession, as the holder of the information maintains possession. Interestingly, one reason given for not informing was maintaining confidentiality:

People are so protective of information because of the confidentiality and stuff like that. I think unless someone knows you they are not going to give you... and your new nurses don't know me either and some of our staff, so they don't realise. (052012)

Communicating within the theory of Sharing Time has been shown to be purposeful; therefore, some effort is applied to communicate effectively:

It's become apparent to me that I can't control everybody else's communication, but I need to make sure that my communication is constant. (072012)

This differs from communication that occurs frequently throughout the workday, whether personal or professional, which occurs without effort. Within the theory of Sharing Time both communicating and relating are necessary and are interactive. That is, communication is enhanced when relating is simultaneously occurring. Conversely, relating is enhanced when simultaneously communicating. Both are needed for purposeful connecting to occur. Communicating and relating, regardless of what occurs first or whether they occur simultaneously, have reciprocity.

Relating

Relating is defined as the active strategy of developing a professional relationship by involving oneself and involving others, to connect:

Everything is about relationships. (021012)

Occurring through involving-self and involving-others, there is reciprocity as the health professional involving his or herself is increasingly likely to involve others, for the benefit of the patient. For example, through a referral between different health professions:

So, I refer to them and they refer to me. (022012)

Showing further reciprocity, the health professional receiving a referral is more inclined to refer to the other health professional when appropriate.

Involving-self occurs when health professionals choose to join in, intermingle, and interact with other health professionals on behalf of patients. As the following example demonstrates, interacting with the team can mean involving oneself more than what may have occurred if practicing possession through not interacting. Reciprocity benefitting health professionals is extended to benefitting the patient. The patient gains through receiving improved care when the health professional becomes more involved and the health professional gains through participating in providing that improved care:

If I feel strongly about something, I will not hesitate to speak up even if it's not received, because I am here for the patient, and they can't speak in MD meetings so I am here to represent them. (172013)

Involving-others occurs when a health professional actively seeks out another health professional, asking him or her to join in or participate in some way through inviting, referring, building rapport, trusting, and contacting. The following example of trusting demonstrates how involving others when relating and Sharing Time requires trust but is

reciprocal in that not only do those Sharing Time give trust to another, they gain trust in return:

I think trust is probably one of the things there and I know when we go in anywhere we have to gain their trust. People have to trust that you're a good organisation, that you're going to arrive on time, that your nurses are educated and all that. (232014)

Generally, health professionals invite others to participate in a patient's care based on their perception of the clinical situation and patient requirements. This may be through, for example, a formal referral process or a casual verbal discussion. The choice to involve others expedites Sharing Time, while not involving others promotes possessorship. Reasons for not involving others can vary, such as a lack of confidence in the other health professional as shown in the following example:

My only concern is when I have to work collaboratively with someone I don't have professional confidence in. (032012)

As discussed above, purposeful connecting occurs through communicating and relating. Communicating in turn occurs through speaking, meeting, and informing, while relating occurs through involving self and others. Each has a reciprocal relationship with the other and is beneficial for the health professionals Sharing Time by sharing what is needed to improve patient care. Purposeful connecting also has a reciprocal relationship with finding common ground.

Finding Common Ground

In this study finding common ground is defined as participating and negotiating, which supports the health professional to find a common interest, purpose, or goal:

You have to find common ground. (012012)

The common interest, purpose, or goal when finding common ground is frequently the desire to provide the best quality palliative care that health professionals could:

If they have that common goal, they both want to do what's right for the patient. (242014)

Participation is voluntarily and purposefully taking part in finding common ground, which includes building and investing. Whereas, negotiating is the purposeful act of working to achieve an agreement and includes adjusting and role clarifying. Finding common ground is represented in Table 3.

Table 3: Categories and properties of finding common ground

Sub-core category	Categories	Properties
Finding common ground	Participating	Building – developing, improvising, cross-pollinating Investing – commitment, willingness, resourcing
	Negotiating	Adjusting – changing, placating, reframing, compromising, integrating, merging, buying-in Role clarifying – understanding, awareness, recognising, knowing, valuing, respecting, testing, advocating, learning.

Finding common ground, being reciprocal with purposeful connecting, leads to Sharing Time. Showing reciprocity, Sharing Time in return gives health professionals the opportunity, in terms of time and space, to find common ground. For example, one common ground often stated is that of wanting to provide the best palliative care possible. However, the way this is accomplished varies, and common ground may be recognised by health professionals as being a more specific goal:

And now because of the personalities involved we all seem to be working toward a common goal. But before, there were just some different agendas altogether. (042012)

The negotiation and reason for participation may be, for example, to obtain specific information or obtain equipment. Reciprocity also occurs between participating and negotiating. For example, health professionals voluntarily participating will approach

the interaction with an attitude of willingness to negotiate. Achieving an agreement through negotiating will encourage further participation. If participation is not occurring, negotiating between health professionals is difficult and may not occur.

Likewise, if negotiating is not occurring, willingness to participate may wane or not exist. Participating and negotiating, are further identified in Table 3 (p. 120).

Participating includes building and investing while negotiating includes adjusting and role clarifying.

Participating

Participating is voluntarily taking part in finding common ground through building and investing. The willingness of health professionals to participate is an important feature of finding common ground and Sharing Time. The voluntary participating within the theory of Sharing Time differs from the required participation that can occur in the workplace. That is, if the employment, professional, or organisational role requirement to participate were removed, participation may cease, so it is not truly voluntary and leads to additional challenges as shown in the following example:

The challenge is that we cannot impose it on another service. That service has to decide for themselves that it is worthwhile. (222014)

Participating is indicated through building and investing. Building includes developing, improvising, and cross-pollinating. Cross-pollinating refers to the interchange of knowledge or ideas, which is reciprocal.

They see us as people with resources that they can utilise and we can cross-pollinate. (012012)

Examples emerged in the data to indicate that building can occur in a physical sense such as building up a service or resources, or embedding these:

I do think that formalised agreements between services are, while they can be challenging to create, once they're embedded it becomes the norm. This is how we behave in this area. (222014)

Building also occurs in other non-physical way such as building relationships:

So, it's that kind of relationship building. (012012)

Investing includes commitment, willingness, and resourcing. Investing, like building, is an action of choice. When choosing to invest there is an associated commitment and willingness:

So, I think it begs the question, is this sort of collaboration possible without an investment by the particular hospice organisation in team building and really intentionally building of relationships. (032012)

Interestingly, while health professionals invest in different ways to participate, the main investment required is time:

This hospice works at creating a team. There is time and energy. Once a year there is a day set aside for team building purely and simply. (032012)

I find my work is quite..., it can be quite time intensive you know. It can take a lot of time. (092012)

Regardless of the order of occurrence, building and investing have reciprocity. When building occurs, investing in that building through commitment or resourcing will enhance that building. Conversely, should investing occur first, the commitment or resourcing will enhance the building and developing, helping it become stronger. A lack of resources is a recognised reason to collaborate, to acquire those resources:

Because we have very limited resources here, there is a real need to collaborate. (012012)

This encourages health professionals to build, invest, participate, and negotiate –
Sharing Time facilitates collaboration.

Negotiating

In this study, negotiating is defined as adjusting and role clarification which assists health professionals to achieve an agreement, specifically a common goal. Including adjusting and role clarification, negotiating helps health professionals to find common ground. Negotiating has reciprocity with participating. Through health professionals voluntarily participating, negotiating is enhanced as health professionals work to achieve an agreement on interventions related in some way to patient care. This agreement may be informal between health professionals employed in the same organisation or formal between two different organisations, such as when negotiating a challenging patient's admission to another service.

Yes! Negotiation. It wouldn't have happened with the previous lot. They would have just said no and not participated. (042012)

Likewise, negotiating encourages further participation either in the current situation or in future situations:

There has got to be a win-win situation for everybody doesn't there? At the end of the day, whatever you invest comes back. (012012)

Adjusting is expressed through changing, placating, reframing, compromising, integrating, merging, and buying-in:

Sometimes it can be a bit messy. We are just trying to have that buy-in you know, for them, the referrers to realise that there is certain, not restrictions but certain considerations when they refer people here. (042012)

Much of the adjusting is identified as occurring when negotiating between different organisations:

I think probably the biggest thing for us is that we learn we have to adjust because each area, whether its hospice or the district nurses, are quite different. With different expectations, so quite different. (052012)

However, there is also adjusting that occurs in the workplace between different health professionals, when an aspect of the workplace is not as expected, for example, when the expectation of a full multidisciplinary meeting becomes a handover between doctors and nurses. The health professionals not actively participating in the meeting reframe their expectations of that meeting:

I have to do a bit of reframing so sometimes I'll go to a morning meeting and quite often I will reframe that it had to be a hand over meeting and I will think of it being a handover meeting from the nurses to the doctor who has just come on shift. (092012)

Role clarifying occurs through understanding, awareness, recognising, knowing, valuing, respecting, testing, advocating, and learning:

You have to have respect and understanding of what the person's role is within the team. And that takes the time factor and the commitment to it. (202014)

This occurs in both organisational and professional roles. Health professionals not understanding their own, or others' professional roles, increases the difficulty of negotiating and contributes to possession. Where professional roles were not clarified, participant data described situations that hinted at a lack of trust:

So, he challenged me personally and professionally on what I was doing. That's probably the most I have ever struck anyone throwing up a barrier on my credibility. (102012)

Role clarification, whether individual, professional, or organisational, has reciprocity with adjusting and negotiating. Health professionals clearly understanding their own, and others' roles is beneficial to any negotiation, as is making adjustment to those roles when required, to Share Time. This will in turn facilitate collaboration and potentially improve patient care. This occurs whether it is a professional role or a role within the team with others of the same profession. Roles being clearly understood is viewed as

beneficial, but this does not mean roles are unbending. The ability of roles to bend or be cloudy is also viewed as beneficial as shown in the following quote:

But the roles are slightly..., which is another thing that's quite nice about the job, the roles are slightly cloudy. (112013)

Adjusting and negotiating is in turn beneficial to clarifying roles in patient care, which can prevent a double up of services:

I've stabilised on one person but they were sending four at one stage and I just couldn't cope with it. (162013)

Interestingly, negotiating demonstrates the reciprocity that occurs throughout Sharing Time to facilitate collaboration. When collaborating, negotiation is enhanced as health professionals willingly Share Time. In return, negotiating strengthens collaboration:

Collaboration and negotiation. Yeah, I suppose the negotiation aided the collaboration didn't it? There wouldn't have been any collaboration without negotiation. (042012)

When health professionals are finding common ground through participating and negotiating there is reciprocity. As this mutual exchange occurs, health professionals gain a commodity they believe is required to improve patient care, for example, information, and are further encouraged to continue to participate and negotiate, to find common ground and Share Time. In this way, a 'win-win' situation occurs, meaning the outcome is favourable and satisfactory to all involved. While the theory has been presented, where this theory is positioned is important and links the theory of Sharing Time with the main concern of possession.

Sharing Time in the middle ground.

Adding further to the complexity of the theory of Sharing Time, is the discovery that this theory occurs in the middle ground of a continuum (Appendix P). Maintaining Sharing Time in the middle ground ensures that the time shared is the appropriate

amount of time to facilitate collaboration and manage possessorship. This appropriate amount of time is defined by the health professionals Sharing Time and can differ with each occasion Sharing Time occurs. The middle ground has reciprocity with Sharing Time. Being situated in the middle ground is beneficial to health professionals not wanting to waste time in their practice, while understanding that some time needs to be spent working together, to enable sharing and provide optimal patient care. Being outside of this middle ground, to the left, occurs when too little time is shared and is not mutually beneficial. Too little time shared means health professionals are unable to connect and discover common ground, therefore collaboration is inhibited and possessorship occurs. Moving to the right of the middle ground indicates that when too much time is spent, it becomes a waste of time, which inhibits collaboration and is not mutually beneficial as seen in Figure 10 below.

Too little or no sharing of time	Sharing Time in the middle ground	Too much time shared
<p>Unable to purposefully connect and discover common ground Collaboration not occurring</p> <p>Encourages or reinforces possessorship</p> <p>No reciprocity (no mutual benefit) occurring</p>	<p>Managing Possessorship</p> <p>Facilitating collaboration</p> <p>Reciprocity occurs as the strategy and outcome is beneficial for all health professionals partaking and for patient care</p>	<p>Unbalanced Wasting time Collaboration not facilitated</p> <p>Little to no reciprocity</p>

Figure 10: Sharing Time situated in the middle ground

Time is finite in the palliative care workplace, due to health professionals being employed to work a set number of hours with an expectation that specific tasks will be completed within those hours. Often health professionals feel as if they do not have enough time to meet these expectations:

Before we had time, we had time to slowly articulate what we want.
Now we don't, so we have to get better at it and better at
understanding what our roles are. (202014)

Wasting time is consequently commonly perceived as being negative and unwanted.

While sharing too much time may help manage the main concern of possession, this is not seen as an efficient or effective use of time. For example, while communicating, is needed for purposeful connecting and Sharing Time to occur, over-communicating leads to wasting time in a busy workplace:

Although communication is important timing of it is important. Over communication needs to be managed and people need to have time to get on with their job and not just report back and be, you know, on the phone. (072012)

Health professionals' awareness of the need to practice in the functional and professional middle ground is enhanced by the expectations of health professional behaviours and ethics learned as part of their professional education. This knowledge is part of the strategy of Sharing Time, in that once learned, this information cannot be unlearned. Stepping out of this functional middle ground can lead to or reinforce possession, making Sharing Time and collaboration difficult if not impossible.

The discovery of Sharing Time occurring in the middle ground, as discussed above, continues with communicating, relating, participating, negotiating, and their associated properties. For example, Figure 11 (p. 128) depicts communicating in the middle ground alongside what occurs when outside of the middle ground.

Little to no communication occurring Unable to Connect and Share Time	Communicating within the middle ground leading to purposeful connecting and Sharing Time	Over communicating leads to wasting time
Collaboration not occurring No reciprocity occurring	Reciprocity occurring	Little to no reciprocity occurring




Figure 11: Communicating in the middle ground

Both under and over communication can occur. This inhibits collaboration and subsequently has the potential to impact patient care:

The communication, that was it really. It was very hard to communicate with them or have any sort of collaboration. It was very taxing shall we say. (042012)

Too little communicating means that health professionals are unable to purposefully connect and Share Time; thereby hindering collaboration whether between health professionals in the same organisation or between different organisations. Reciprocal relationships in which there is a favourable or satisfactory outcome are therefore minimised or non-existent. Over communicating, whether in the form of speaking, meeting, or informing, took time that could be better spent, so became a waste of time:

But then again how much [information] is enough? Because quite often when I get on the phone I always say, and someone is throwing me stuff on the phone, information and that, I tend to say look that's fine and it's enough. (052012)

Therefore, this situation of over communicating also lacks a mutually satisfactory outcome for all parties. When information or other resources are held rather than shared, too little communication becomes part of the main concern of possession rather than the solution.

Like communicating, relating requires health professionals to situate this social behaviour when Sharing Time, in the middle ground (Figure 12).

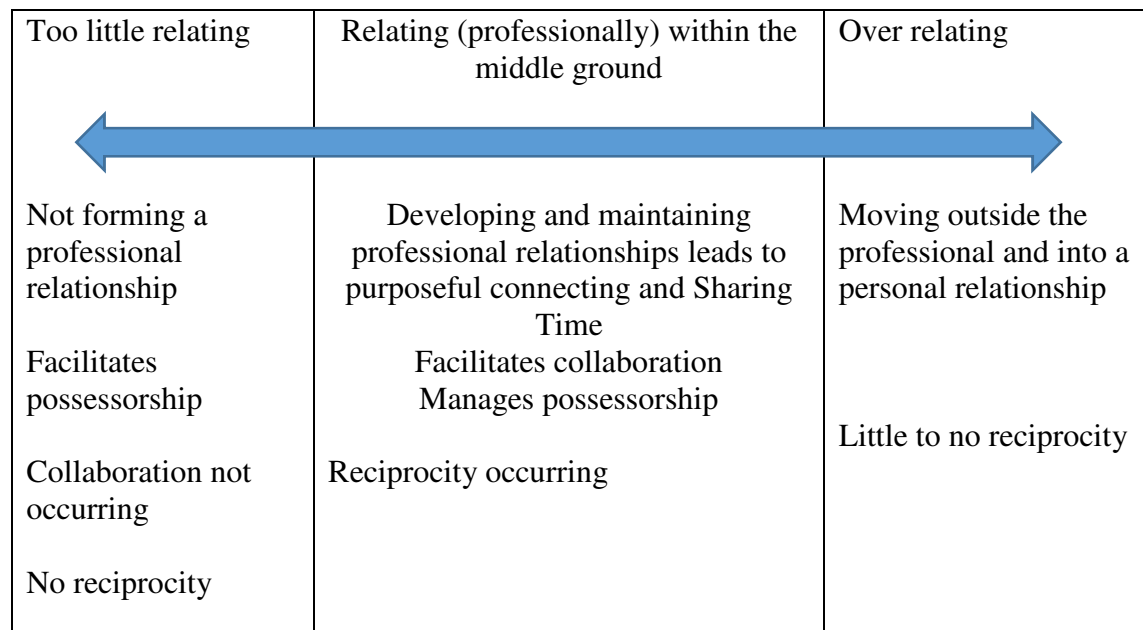


Figure 12: Relating in the middle ground

Not relating assists in maintaining possessorship as Sharing Time is less likely to occur when there is very limited or no professional relationship. Too little relating impairs and supports the main concern of possessorship, often involving a lack of trust in fellow health professionals:

I wouldn't ask any old doctor. I would ask a doctor that I trusted had the capacity to deal with the situation. (032012)

This lack of trust means there is no mutual benefit to the exchange. Too little relating may also lead to the health professional believing he or she needs to participate in all aspects of the patient care, whether appropriate or not, rather than trusting another health professional's knowledge and skills. This is often due to one health professional not being aware of another's professional skills and abilities:

If you don't know each other well enough as a team, then you will feel that you have to have power by being represented. (102012)

Over relating risks health professionals moving outside of their professional boundaries as defined by their professional associations or licensing bodies. This can also maintain, or lead to, further possessorship:

It's about that professional boundary and knowing what's important and I know we often talk about that at work. So, it's not who sees the patient. It's about the patient needs and who is best served to actually deal with that need and it can be anybody within that collaboration. (072012)

Either party could show a lack of or minimal involving for several reasons. Some reasons are controllable by the health professionals and, as demonstrated in the quote below, there are some outside of the health professional's individual control such as the situation with the GP involving other organisations:

The GPs are always saying they miss out. They feel that once their patient goes into a facility or into hospital they are actually rubbed out until suddenly, the patient is dumped back home again and then the poor GP is trying to find out (what happened) because it (receiving discharge information) takes too long and I think it has to be better. (062012)

Not involving, or minimal involving, may occur by unintentional omission or it may be a deliberate choice to not involve others. Regardless there is clearly no reciprocity:

There are two district nurses in (name withheld) who control all of the district nurses including the manager. Trying to get through the barrier of them, they protect everything. (232014)

Moving outside of the middle ground can occur when health professionals over-involve themselves, or over-involve other health professionals, which can disrupt the work or reinforce possessorship:

Over communication needs to be managed and people need to have time to get on with their job and not just report back or be, you know, on the phone. (072012)

Participating and negotiating, within the theory of Sharing Time, are situated in the middle ground. Too little participating and negotiating between health professionals

takes time, however this does not lead to a beneficial mutual exchange as that time used is not shared. Rather time is used to practice possessorship, which can itself be time consuming, or used trying to overcome someone else's possessorship behaviours. For example, the time taken trying to locate a commodity needed or working alone:

Trying to get all the information before that and the forms and you know, I find my work's quite um... it can be quite time intensive you know... it can take a lot of time. (092012)

Over participating and over negotiating wastes time and risks health professionals moving outside of professional boundaries, as defined by their professional associations or licensing bodies, into the personal. This supports possessorship and eliminates reciprocity. For example, one form of possessorship occurs when a health professional over participates with patients but under participates with other health professionals. There is a perceived ownership of the patient or work area, often called a patch and described as patch protection. This can be identified through the behaviours of those possessing, such as being defensive when asked to share:

They are quite intensive relationships you have with patients here and perhaps have a good relationship with a patient and are a bit on the defensive or protect their patch. (112013)

In this situation, some reciprocity may occur between the patient and health professional practising possessorship. However, this reciprocity is limited as other health professionals, who may be able to positively add to the patient's care are kept at a distance. The exchange between patient and health professionals could have a greater mutually beneficial outcome.

Building and investing are also situated in the middle ground. Not building or investing, regardless of reason or cause, has an impact on collaboration and the service provided to patients:

We realised we had to give something up because we were not being funded for it all so we lost the liaison nurse role between here and rest homes and here and the hospital and we are starting to see the impact now. (222014)

While data did not identify over-building, this may have been because of an understanding that there are limitations in resources and thus over-building is unlikely to occur:

Some of the rural areas, the resources are just not there. (072012)

However, there were hints of the possibility of overbuilding where there was doubling up of services offered by different health professionals or organisations, rather than these services and health professionals collaborating. Sharing Time can help to prevent doubling up of services.

Summary

The theory of Sharing Time, defined as periods of time when health professionals purposefully make time, take time, spend time, or find time in their workday for each other, staying in the middle ground, facilitates collaboration and manages possession. Sharing Time enables the further sharing of other tangible and intangible commodities that are required by another health professional in the provision of optimal palliative care. This sharing brings reciprocity as all parties involved benefit. The benefit to health professionals then extends to the benefit of improved patient care. Occurring in the middle ground, Sharing Time is beneficial to all involved whether individual health professionals or organisations. Moving outside this middle ground, too little of any of these actions moves health professionals out of the strategy of Sharing Time, making collaboration difficult and fostering possession.

Facilitating collaboration as moments in time rather than being a continuous process, Sharing Time has value in resolving and managing possession in palliative care. The social strategy of Sharing Time can be used within one interaction between health professionals, such as in a single scheduled meeting, or it may occur continuously over several interactions between individuals. Health professionals can choose to use Sharing Time as individuals who want to find a way to collaborate with each other, to improve patient care in some way. Alternatively, those Sharing Time may be representing a health care organisation, for example, negotiating and participating on behalf of the organisation. Possession cannot be managed without health professionals Sharing Time. Sharing Time begets additional sharing, such as the sharing of time, resources, words, roles, and information. Therefore, Sharing Time is both an active strategy and an outcome. The strengths of Sharing Time as a strategy for improving patient care in the palliative care setting will be discussed in the following chapter.

Chapter Six: Discussion

Introduction

This chapter will locate the theory of Sharing Time in the extant literature and knowledge base to determine how the social behaviours emerging as a theory will influence practice. Sharing Time is a social process that has not previously been identified in the literature. Recognition that this research has made an original contribution to the knowledge base, through the examination and explanation of how collaboration occurs in the New Zealand context of palliative care, will be included.

This discussion will be presented in three segments. The first explores how health professionals facilitate collaboration through the theory of Sharing Time, including how and why they collaborate. This segment will also include the finding that health professionals collaborate in moments-in-time and not as continuous practice. What is already known about collaboration in moments-in-time will be made evident and the theory of Sharing Time will be located in this space to add to that understanding of moments-in-time collaboration. The second segment begins the exploration of time as it relates to the theory of Sharing Time and palliative care. This segment will include what is known about the interpretation of time in healthcare and how the theory of Sharing Time adds additional knowledge to the interpretation of time in practice. The third segment begins the exploration of teams and roles related to the theory of Sharing Time, focusing on the complexity and confusion that can occur in team work, including the effect of the historical religious background of hospice care on health professional behaviours. This discussion will compare what is known with what has been discovered in this research to add further understanding of teams. Where appropriate, discussion

on the main concern of possession will be included throughout. This chapter will then explore how the theory of Sharing Time influences current palliative care in practice, concluding with recommendations for practice.

How and why health professionals collaborate

Prior to undertaking this study, the researcher's professional judgement was that health professionals working in palliative care in New Zealand do collaborate in some form. This opinion came about through a mix of observation in clinical practice and the literature defining palliative care as a multidisciplinary team practice. Yet, how that collaboration took place, what that collaboration looked like, or even why health professionals collaborated was unknown.

The literature presented in Chapter Two identified collaboration as “a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go well beyond their own vision of what is possible” (Gray, 1989, p. 5). That is, the collaboration process, while often multidisciplinary, occurs as a moment-in-time to solve a specific problem. This definition supports the finding of this study that health professionals are practising moments-in-time collaboration in response to problems encountered, rather than continuous collaboration. Once a solution is reached, health professionals return to working individually, until the next problem occurs. In this way, health professionals are practicing intermittent collaboration such as that facilitated by Sharing Time. Roberts (1994) noted that “the word ‘collaboration’ is often used interchangeably with ‘cooperation’, to denote harmoniously working together” (p. 191). One potential reason for this moment-in-time collaboration is that this way of working is problem oriented, rather than practice oriented. Ovretveit (2009) has described this way of

working as multidisciplinary, linking it specifically to the practice area of palliative care which, as discussed in the literature review (Chapter Two), often uses a multidisciplinary team and multidisciplinary way of working. Therefore, the rhetoric of palliative care as a continuously collaborative service and actual practice do not match.

Sullivan (1998) gave an early definition of collaboration, describing it as being high in both assertiveness and cooperation. When this changes something else happens and it is no longer collaboration:

High assertiveness plus high cooperation equals collaboration.
Moderate assertiveness plus high cooperation equals compromise.
Low assertiveness plus low cooperation equals avoidance.
High assertiveness plus low cooperation equals competition.
Low assertiveness plus high cooperation equals accommodation.
(Sullivan, p. 28)

Sullivan's summary of what is and is not collaboration has similarities with Sharing Time, particularly as Sullivan's discussion notes levels of the components of assertiveness and cooperation as being high, medium, or low. While Sullivan required collaboration to be in the high ground, this is similar to the need for Sharing Time to occur within a middle ground. Both Sharing Time and Sullivan's definition recognise that moving outside of this ground, albeit different grounds, affects collaboration.

One category of the theory of Sharing Time is purposeful connecting. A review of the health literature for purposeful connecting found this to be a commonly used term (Ciemins, Brant, Kersten, Mullette, & Dickerson, 2015; Currow & Hegarty, 2006; Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2014; Gallagher & Carey, 2012; Penz & Duggleby, 2011). Eriksen et al. (2014) defined purposeful connecting as being a process with levels that can begin with being detached, through to being cautious, to finally being open and trusting. Trusting was identified as a property of Sharing Time,

occurring when involving others, relating, and purposeful connecting. If trust is absent, health professionals will be less likely to want to Share Time. However, the theory of Sharing Time, when communicating, relating, participating, and negotiating can grow trust.

Although purposeful connecting is a term commonly used when discussing communicating with patients or other health care professionals, there is little in the literature about how purposeful connecting occurs (Currow & Hegarty, 2006; Penz & Duggleby, 2011). One exception was Penney's (2013) doctoral work that found purposeful connecting in community rehabilitation occurs through the categories of liaising, forming-reforming, and guarding. Liaising occurs through interacting, networking, and referring. Forming-reforming refers to practice adaptations undertaken to manage complexity such as forming teams within teams and flexible practice. Guarding occurs through professional shielding, protecting, and negotiating. Interestingly, guarding appears to have some similarities with the main concern of possession. Health professionals may possess to protect what they believe to be their professional patch, which hinders collaboration. While Penney's connecting differs from the purposeful connecting as a category of Sharing Time, some overlap occurs in other areas of the theory of Sharing Time; specifically, the need for negotiating and referring appear in both theories.

Another similarity in Penney's (2013) work, was found in connecting as an essential process used by health care professionals to enhance collaboration in community work. Penney discussed connecting in correlation to relational complexity, that is, the multiple relationships and interactions that are managed through connecting with others. While

it could be argued that both the theory of Sharing Time and possession have relational complexity, there was no clear identification of possession behaviours in her study.

Human-to-human purposeful connecting was revealed in another study on end-of-life care (McCallin, 1999). Despite the same word being used in both research studies there are obvious differences in definition. In McCallin's (1999) study, purposeful connecting was defined by empathy, giving of self, safeguarding, detachment, self-protection, and letting go. Purposeful connecting assisted the process of facilitating. However, amongst these differences there is also similarity. In the theory of Sharing Time, the category of purposeful connecting, through the concept of relating, involves the self and others. As noted above, McCallin's study also identifies the self.

Alongside purposeful connecting, finding common ground, is a well-used term in health care literature (Chan et al., 2010; Haigler, Bauer, & Travis, 2010; Long-Suthehall et al., 2010; Masso, McCarthy, & Kitson, 2013; Politi & Street, 2011; Tan & Manca, 2013). The term is used to describe relationships between health professionals and patients and/or their family members (Haigler et al., 2010; Politi & Street, 2011; Tan & Manca, 2013) or as a foundation for change, such as having a mutual understanding (Masso et al., 2013). Finding common ground in the literature is noted to be both a process and an outcome. A process being an action or activity undertaken to achieve an objective, while an outcome is the result of a process, the objective itself (Mainz, 2003). The process of finding common ground could be difficult at times and reaching the outcome of finding common ground is not guaranteed (Shaw, 2008).

While identifying how health professionals are collaborating, it is important to note that the type of collaboration that is facilitated through Sharing Time differs from interprofessional collaboration although, as argued in the literature review in Chapter Two, the different types of collaboration and terms are not always well understood by health professionals in practice. Shaw (2008) noted that interprofessional collaboration is a strategy that can be initiated to help health professionals who struggle to find common ground with patients. Regardless, it may be assumed the more traditional moment-in-time collaboration occurring in the theory of Sharing Time will assist health professionals who struggle to find common ground with patients. For this to occur, a provision may be that collaboration must be between the patient and health professional, rather than one health professional collaborating with another health professional.

Finding common ground, as a term, leads to the assumption that there is common ground to be found, as opposed to being made or created. Kristjanson and Chalmers (1990) described a process of nurses creating common ground in their interactions with patients, rather than finding common ground. Kristjanson and Chalmers' finding differed from this study as participants, working in palliative care, when Sharing Time along with participating and negotiating, discovered that the patient, or a shared goal, was their common ground. Common ground was there to be discovered, it did not need to be created. This is interesting in comparison with finding common ground in the theory of Sharing Time. Using the theory of Sharing Time, health professionals working in palliative care find common ground, defined as a common interest, purpose or goal, by participating and negotiating. This common ground was most often a shared goal related to the patient and family, and desire of health professionals to provide the best palliative care possible. There was no need to create common ground, rather health

professionals were recognising or finding what was already assumed to be there. Other literature used the term finding common ground but did not define what finding common ground was or how it occurred (Chan et al., 2010; Haigler et al., 2010).

Tan and Manca (2013) looked at how physicians working with a patient's substitute decision makers overcame conflict and noted it occurred by finding common ground through building mutual trust and support, understanding one another and making informed, shared decisions. This is interesting in its similarity to the current study, adding support to the theory of health professionals Sharing Time through purposeful connecting and finding common ground, to meet a goal or need and facilitate collaboration. Differences between the studies include how Tan and Manca looked at the physician working with a patient's decision maker to overcome conflict rather than how different health professionals worked together. Conflict as the main concern was identified by Tan and Manca, whereas this study found it was possession that concerned participants and needed to be overcome.

The term finding common ground has also been linked to finding consensus (Bern-Klug, Gessert, Crenner, Buenaver, & Skirchak, 2004; Koch & Rowell, 1999; Margerum 2011). Consensus is found through sharing a common perspective and knowledge base, then reaching agreement through discussion. Conversely, consensus is inhibited when approached through different perspectives and knowledge bases (Koch & Rowell, 1999). Further, consensus may be inhibited by economic factors, government regulations and intervention, institutional characteristics, or changes to group members (McCourt, Power, & Glackin, 2013; Margerum, 2011). These factors inhibiting consensus may also inhibit collaboration, giving further rationale for why health

professionals, when the need arises, collaborate in moments-in-time rather than continuously. Moment-in-time collaboration may be practiced simply because this is considered more manageable by health professionals in comparison to practising continuous collaboration; health professionals who are affected by what else may be happening in the workplace, such as possession. Choosing an easier way to gain consensus leads to collaboration. While health professionals Sharing Time are discovering common ground rather than creating it, there is risk in making a further assumption that, because some common ground is there to be discovered, everything is similar (Margerum, 2011). For example, assuming there is always consensus within a palliative care team, and that all team members share common values and a common palliative care philosophical paradigm. Any differences that exist prior to Sharing Time remain.

Possession has not previously been identified in the literature as a concern in palliative care in New Zealand. However, when substituting the word possession for ownership, a term initially used by participants, the literature interestingly identified ownership as a positive virtue in health care rather than a concern (Ding, 2014; Gould, Hale, Waters & Allen, 2016; King & Clarkson, 2015; Tye & Dent, 2017). In contrast to findings in this research study, the literature notes that health professionals feeling ownership within their area of practice are often considered more diligent leading to service improvement, have an improved attitude toward their work, and feel self-empowered. Regardless, possession as defined in this study needs to be considered as a behaviour that can interfere with collaboration by obstructing or inhibiting the sharing that is required. While possession may not completely prevent collaboration, any level of obstruction and inhibition of sharing will increase the effort required. For

example, collaboration in this environment may increase the time required for it to occur, which is an adverse outcome in any environment where time is a precious commodity in a busy workday. If health professionals, including managers of health services, can gain an understanding of possessorship as it is identified in this study and subsequently acknowledge this is occurring, it may help to explain why resistance to collaboration occurs. Such understanding can then be considered when introducing or supporting methods to increase collaborative practice within and between palliative care and other health care services.

If health professionals are using different philosophical paradigms to guide their clinical practice, such as either the biomedical model or Asklepios tradition (Randall & Downie, 2006), finding common ground may be more challenging. Where values and philosophies are not shared these were often identified as personal or personality differences, or as structural and professional barriers. Health care professionals come from different knowledge foundations; have different philosophies, different cultures, different language, and different previous experiences (Herbert et al., 2007). Regardless of differences, health professionals need to find a way to work together, often in a short space of time. Consensus implies general agreement of opinion and decision making, which is, finding common ground (Margerum, 2011). It is an end-product of participating and negotiating. Therefore, the theory of Sharing Time is both a process and an outcome. When Sharing Time, common ground is discovered, collaboration is facilitated; possessorship can be acknowledged and then eliminated. Sharing Time, enables health professionals to connect and discover common ground. Integrated by reciprocity, health professionals working in palliative care can move beyond possessorship, to collaborate in a way that meets their shared need or goal.

The importance of time

Time is a major factor within the theory of Sharing Time. When collaboration occurs, it takes time (Bagshaw, Lepp, & Zorn, 2007; Lindeke & Sieckert, 2005). Prioritising time is a skill used by health professionals in their workplace when caring for palliative patients (Waterworth, 2003; West, 2001). Such prioritising may be difficult to do if health professionals, patients, and family members, consider that all tasks are important for patients with, by definition, a limited life time (Palliative Care Subcommittee, New Zealand Cancer Treatment Working Party, 2007). Alongside the desire to meet patient needs and complete required tasks, health professionals have limited time in their work day in which to do so, time which is imposed by employment contracts. Prioritisation of care for each individual health professional becomes easier when collaboration occurs through Sharing Time, as the responsibility for meeting patient care requirements is shared.

Time as a concept appears in the health literature, particularly in discussions on time management skills, and behaviours related to time in the workplace (Marquis & Huston, 2015; Mishra, 2014). However, Sharing Time with other health professionals, as described by participants in this study, was not found in the literature. Within the general health literature, the primary focus related to time appears to be on the individual managing his or her own work within a certain time frame (Marquis & Huston, 2015). In contrast, the palliative care literature has a strong focus on time being perceived in a negative sense, as time being short for the patient (Ellingsen et al., 2015; Totman, Pistrang, Smith, Hennessey, & Martin, 2015). Robertson, (2015) has divided patients' experiences of time into three periods. The first being a brief time where patients became aware of their palliative diagnosis and knew their life span was

shortened; this time also had heightened value. The second was waiting time, the experience of waiting for desired outcomes such as appointments or for a symptom to be managed. The third, transcendental horizon was future time where patients contemplated living toward death, and life after death. Health professionals Sharing Time and collaborating may have an impact on these identified patient time periods by shortening or lengthening how patients perceive these time periods.

Waiting time was found to be the period that most involved health care personnel. Robertson (2015) noted that the outcome patients waited for “occurred according to the time priorities of health care professionals” (p. 71). While Robertson’s study has shown that palliative patients clearly notice time spent waiting, there is no discussion on why patients wait for health professionals, and whether there is a relationship to collaboration occurring or not occurring during this waiting period. Interestingly, this waiting may link to health professionals’ behaviours, as Sharing Time and facilitating collaboration may decrease waiting time. However, as there are likely to be other reasons why there is a need to wait, that are not addressed in this research study, waiting time is not expected to be removed completely. When not Sharing Time, or in the presence of possession, then the assumption is that waiting time would be increased.

Another study which discovered that the perception of time being short for the patient had an impact on health professionals was that of Glaser and Strauss’s (1968) research. Collaborating on a research study investigating dying patients in various settings, and from which they consequently developed their grounded theory research method, time was found to be an important factor. Unsurprisingly, some of these same variables of time remain in palliative care today (Robertson, 2015). Glaser and Strauss argued that

there can be: certain death at a known time; certain death at an unknown time; uncertain death at a known time; and uncertain death at an unknown time (Glaser & Strauss).

These changing times impact health professionals by changing their expectations on how long a patient may live, which can be positive or negative. For example, believing a patient has a short time to live may positively alter the health professionals' motivation to collaborate (McCourt, Power, & Glackin, 2013). If a health professional feels the patient has a very limited life-time or is actively dying, that health professional may feel urgency and an increased motivation to collaborate, to obtain what he or she believes the patient or family needs. Alternatively, a negative impact may be that the health professional feels it is too late to collaborate, providing care without, or with very little, collaborative input. However, health professionals using the theory of Sharing Time to facilitate collaboration will have a positive impact regardless of what the patient's actual lifetime will be, as collaboration, even though occurring as a moment in time rather than continuously, assists health professionals in meeting a patient or family need.

Time is discussed in respect of the busyness of health professionals, feelings of not having enough time in which to complete what the health professional is required to do, or wants to do, to meet the needs of the dying patient and family (Brown et al., 2011; Di Leo et al., 2015; Groot, Vernooij-Dassen, Verhagen, Crul, & Grol, 2007; Tan & Manca, 2013; Totman et al., 2015; Weber & Grohmann, 2004). What was not found in the literature was any discussion about the possibility that this perceived lack of time can enhance possession, as participants feel like they do not have enough time to collaborate. As previously discussed, when possession is occurring, it takes time for health professionals to try to obtain what they want or need from the possessor. It may

also take time and effort for the possessor to maintain what is in his or her possession, time that could be spent collaborating, but this is currently unknown.

Time as a concept is viewed as being manageable (Mishra, 2014). Time is perceived as moving; such as moving too slowly, often spoken of as passing time, killing time, moving too fast, and a lack of time. Time can also be perceived as too short or too long (Pestinger et al., 2015; Rittman et al., 2004). Time is spoken of as an item to be possessed such as 'my' time, something current as in 'real' time, or may have a spiritual dimension, for example, when spoken of as 'eternal' time. In the Western world, time is generally separated into areas of activity such as work time, home time, personal time, and family time (Dijkers et al., 2007; Wight & Raley, 2008). Time is finite when measured in 24-hour blocks, but perception of time within those 24 hours can vary widely for several reasons, including emotion (Yamada, & Kawabe, 2011) or cultural differences (Becker, 1965; Ellingsen, Roxberg, Kristoffersen, Rosland, & Alvsvåg, 2015; Glaser & Strauss, 1968; Gronau, 1977; Kujala, Lillrank, Kronström, & Peltokorpi, 2006). Cultural differences can vary depending on where and how one lives (Reinecke, Nguyen, Bernstein, Naf, & Gayos, 2013). For example, the perspective of time for those living in a modern city with access to services 24-hours per day differs from time in an agricultural environment completing activities between dawn and dusk (Lande, 2000). Due to the focus of time in Western culture (Levine, 2008), it is not surprising that time has a strong focus when health professionals are collaborating. Health professionals when collaborating must do so within a timed but variable time work day, hours of which often depend on profession as well as employer.

While this study focused on the health professional, it is difficult to exclude any reference to the patient in discussion. As noted above, there is a focus on the remaining life time of the patient, simply because the patient is defined as palliative and known to be dying. The literature reviewed is clear that time is perceived as short, by both health professional and patient. However, whether this perception has an impact on health professionals' perception of time and collaboration can only be speculated. It may be that the perception of time for health professionals working in palliative care simply reflects a busy health care system and is, therefore, no different from health professionals working in other areas of health care. Hence, busyness as a concept of time in the palliative care health professional's working day is likely to be unrelated to the theory of Sharing Time. More conceivable is that health professionals working in palliative care, having acknowledged that patient life-time is very limited, have been influenced by this as one reason to develop a means of managing collaboration within, what is deemed to be, an acceptable timeframe by Sharing Time.

Contributing further to the knowledge base of collaboration in New Zealand is the identification of health professionals working within a middle ground, as discussed in chapter five, (pages 124-131), for collaboration to successfully occur. An acceptable timeframe requires health professionals to maintain Sharing Time in the middle-ground of a continuum. Time cannot literally be made but perceptions of the time available can be altered, along with changing how the available time in the workplace is used (Failing & Theeuwes, 2016; Schirmer, Meck, & Penney, 2016; Yamada & Kawabe, 2011). Health professionals may be required to attend a meeting, for example, but how they spend their time within that meeting regarding communicating, relating, negotiating, and participating, all concepts of Sharing Time, relies on the individual health

professional. The concept of time as a resource is supported by Thulesius, Hakansson and Petersson (2003), who noted that in end-of-life cancer care, health professionals' time is a limited resource and, therefore, tasks are prioritised. When tasks cannot be prioritised, time is stretched, which means staff work overtime perhaps with little or no remuneration. In the theory of Sharing Time, how health professionals choose to spend their time while sharing is purposefully managed to make the best use of time as a resource while not wasting time. Making the best use of time will benefit not only the individual health care professional but also the team and, ultimately, the patient.

Teams and roles within teams

Multidisciplinary teams in palliative care are complex due to numerous variations.

Speck (2006b) noted that potential team members could include nursing staff, medical staff, chaplain, dietician, counsellor/psychologist, social worker, pharmacist, physiotherapist, occupational therapist, volunteers, and the patient and family.

Considerable written work is available on palliative care teams (Davidson, 2004; Egan & Labyak, 2006; Hermsen & Ten-Have, 2005; Speck, 2006b; Vickridge, 1998). The concept of a multidisciplinary or interdisciplinary team in palliative care is central to the philosophy of palliative care and a foundational precept (Randall & Downie, 2006; Saunders, 1996; Saunders & Baines, 1983; Weissman, 2015). This can be seen in both the New Zealand and WHO definitions of palliative care (Palliative Care Subcommittee, 2007; WHO, 2014).

With a strong expectation that palliative care teams in New Zealand will be multidisciplinary or interdisciplinary, evidenced through the definitions of palliative care and the Hospice New Zealand Palliative Care standards (Hospice New Zealand, 2012; Palliative Care Subcommittee, 2007), there is an increasing number of health

professions included in the team. However, some team members are transitory, joining the team when needed and then exiting the team until their services are required again later (Davidson, 2004; Meier & Beresford, 2008; Speck, 2006b).

Bleakley (2013) noted that the term 'team' although used frequently "as if it had a transparent, single meaning" (p. 18) is imprecise, can be contested, and does not have a single meaning. Overall, there is little consensus on who and what constitutes a palliative team; other than participants being aware of the need for a multidisciplinary team as outlined in the definition of palliative care (Palliative Care Subcommittee, 2007; Speck, 2006b; WHO, 2014). Although complex, this wide range of potential team members is needed if the palliative care team is to meet the individual and varied needs of patients and families (Speck, 2006b). This mix of team members may cause confusion, particularly if there is not a good understanding of each professional role involved and its place within the team. Confusion or lack of trust in team members can encourage a team member to practice possessorship. Interestingly, Penney (2013) found that teams formed and reformed, so that teams occurred within teams. There is potential that this may also occur in the substantive area of palliative care, having both positive and negative effects. Teams reforming within teams may encourage possessorship, particularly if these teams are divided by, for example, profession. Teams reforming could also be positive if done to be inclusive of the community of practice and is worthy of further study. Regardless, the theory of Sharing Time assists team members to make closer connections and find common ground within the team through communicating, relating, trusting, participating, negotiating, and role clarifying regardless of the team make-up. Sharing Time assists all team members, whether permanent or transitory, thereby facilitating collaboration.

Adding to team complexity in New Zealand are specialist palliative care teams that differ from generalist or primary palliative care teams (Palliative Care Subcommittee, New Zealand Cancer Treatment Working Party, 2007). Specialist palliative care teams consist of a central group of health care professionals (Randall & Downie, 2006) brought together by employment in the same organisation. The makeup of the palliative care team is defined by the need to be multidisciplinary, to conform to the definition and philosophy of palliative care (Palliative Care Subcommittee, 2007), and by management making employment decisions related to staffing. Employment decisions can be made for many reasons including management's personal views of palliative care teams and funding (Meier & Beresford, 2008; Speck, 2006a, 2006b). Staff working at the bedside often have little input into the make-up of the team, whether specialist, generalist, or primary. Generalist palliative care teams consist of healthcare professionals who are not part of a specialist palliative care team and may, for example, consist of members of a general practice team, Māori health providers, district nurses, residential care staff, general hospital ward staff, and allied health. (Palliative Care Subcommittee, New Zealand Cancer Treatment Working Party, 2007). Further complexity has been added in the literature where the term generalist palliative care team has been superseded by the term primary palliative care providers or team (Ministry of Health, 2012).

Roles and responsibilities within specialist palliative care teams can become complex as palliative patients are typically referred to the team rather than to one specific health profession within the team and the reason for referral may not always be clear (Speck, 2006b). Studies have been undertaken investigating reasons for referral to palliative

care teams (De Korte-Verhoef et al., 2012; Johnson, Girgis, Paul, & Currow, 2011; Olden, Holloway, Ladwig, Quill, & van Wijngaarden, 2011). Until recent times, limited research had been undertaken on who to refer to. To assist with referrals to palliative care teams in New Zealand, and decrease complexity as to who should be referred, adult referral guidelines have been published by the Palliative Care Council of New Zealand (2014). This guideline is clear that not every palliative patient needs to be referred to a specialist palliative care team. Many patients can receive palliative care in the community, with care provided by their usual health care providers. This speaks to the fluidity of the palliative care team, as the team may potentially differ for each patient, requiring a need for good collaboration between team members who may not work together on a regular basis. Community palliative care teams can be formed by employees in different organisations. These teams, rather than being continuous, are often intermittent and informal; for example, a General Medical Practitioner (GP) from a community health centre, a hospice nurse from the local hospice, and a dietician from the local DHB. This team comes together until a specific need or goal is met for a specific patient and family, then the team disbands, which is clearly multidisciplinary working and demonstrates the complex nature of how teams come together for specific purposes. By facilitating collaboration, Sharing Time removes potential burden on the patient and family that may be caused by team complexity. Through collaboration, health professionals share, discuss, and plan the delivery of care. When collaboration is absent, it becomes increasingly likely that patients become their own care coordinators to manage their own care delivery amongst various palliative care team members.

Increasing the complexity of palliative care teams is the recognition that palliative care delivery can be crisis driven (Stocker & Close, 2013; Weissman, 2015). Ideally,

palliative care should be proactive, planning for any potential patient crises before they occur (Canadian Hospice Palliative Care Association, 2006; Egan & Labyak, 2006; Hospice New Zealand, 2012; Ministry of Health, 2001; Stocker & Close, 2013). One reason given for palliative care being or becoming crisis driven is the rise in demand for both inpatient and outpatient clinical services (Weissman, 2015). Growing clinical demands related to an increasing older population, alongside an increasing complexity of patient care needs, such as patients having multiple comorbidities, require teams to increase their clinical workload, which comes at the expense of other areas including team health:

An early warning sign is when teams abandon teaching opportunities and provision of interdisciplinary care. Increasingly, I visit teams where each staff member has their own panel of patients with no cross-disciplinary engagement, violating a foundational precept of palliative care. (Weissman, 2015, p. 204)

While Weissman's observations are international, his remarks cannot be discounted for New Zealand. A national health needs assessment undertaken for palliative care found that there is a growing call for palliative care services in New Zealand, which is not expected to slow due to an aging population alongside a growing awareness of palliative care services among the public. With this increasing need came acknowledgement that specialist palliative care providers alone would be unable to cope with that growing demand (Palliative Care Council of New Zealand, 2011, 2013). From this, it can be assumed that there will also be an impact on palliative care teams in New Zealand. Study participants support this assumption of an, at times, crisis driven service influencing teams and collaboration.

The crisis driven palliative care delivery that study participants spoke of may be heightened by the complexity of care required, and provided, by multiple team members

with various levels of experience (Speck, 2006b). To feel safe, secure, and have certainty in their roles within the team, some health professionals may resort to possessorship type behaviours, which can be discipline focused as well as individually focused. The number of health professionals involved in the palliative care team may also bring an unspoken need for individualism and separation that is expressed through possessorship in an attempt for a member of a profession to show his or her professional worth (Speck, 2006b). With the reality of this increasing complexity of care and health professionals' various levels of experience, Sharing Time has potential to increase support for each health professional and thereby decrease the incidence of possessorship. Less experienced team members will gain support from more experienced staff through improved communicating, relating, participating, and negotiating. Sharing time by facilitating collaboration acknowledges the palliative care definitions of a team approach while supporting individual team members who may be less experienced or feeling unsure when delivering bedside care.

While there is benefit of having a stable, focused, palliative care team (Speck, 2006b), one potential solution to managing these uncertainties is not to stipulate who should be in the palliative care 'team' by definition, employer, or profession; rather create flexible patient-centred teams whose makeup changes regularly depending on the patient and family needs at that time. For a traditional team to exist, it can be assumed that this also requires exclusions as not every health professional can be a member of the same team. Some of those health professionals excluded may in fact have the solution to a need or goal. Sharing Time can involve any health professional, inviting them in by purposeful connecting and discovering common ground, to meet the need or goal, and subsequently improve patient care.

From data emergence, the main common ground that is found in Sharing Time is the desire of health professionals to provide good palliative care and meet patient needs. While this is admirable, there is no indication in the data that patients and their families are viewed as part of the palliative care team. This may be due to the research focus on health professionals. Participants were not directly asked who they considered were members of the palliative care team, so inclusion of the patient and family was possibly assumed or simply not considered. However, Glaser (1978, 1998) noted that participants will talk about what is relevant for them, so an assumption can also be made that the patient as part of team was not relevant to participants. This lack of inclusion is consistent with much of the literature about palliative care teams. Palliative care teams are formed to provide care to, rather than with, the patient and family (McDonald & McCallin, 2010; Wittenberg-Lyles et al., 2010). Whether the patient and family are considered a part of the palliative care team adds further to the complexity of teams (McDonald & McCallin, 2010). While it can be assumed that health professionals do consider the palliative patient as part of the team, this may not be evidenced by the actions taken in the workplace; actions that if undertaken may require some planning and effort (Ahmann & Dokken, 2012). If a health professional views the patient as someone to do things for and to, rather than an equal member of the team, it is likely easier to move away from collaboration and into possessorship. While the theory of Sharing Time facilitates collaboration and helps health professionals to overcome possessorship when it arises, this will not be enough to stop it from occurring to begin with, due to Sharing Time and collaboration being an intermittent, moment-in-time strategy.

Teams in palliative care are most frequently defined as sharing the same employer (Bleakley, 2013; Meier & Beresford, 2008; Parker-Oliver et al., 2007; Wittenberg-Lyles et al., 2010) or sharing the same profession, such as the medical team, nursing team or family services team which normally includes social workers and counsellors (Kobayashi & McAllister, 2014). To further add to team complexity, palliative care teams may consist of health professionals employed by different organisations (Speck, 2006b). Health professionals from different, and potentially competing, organisations forming a team likely bring together different organisational cultures that may influence the way each of the involved health professionals work together to deliver patient care. This influence may be positive or negative. Sharing the same positive culture can make working together as a team seem effortless, where all work to meet the shared goal. However, when an organisational culture is viewed to have negative aspects, for example, where staff feel bullied or fearful, and is introduced to a multi-organisational team, this can impact the overall team functioning and outcomes. Different cultures, whether organisational or health professional cultures, can lead to difficulties with terminology within the team which may again add to team complexity (Gott, Seymour, Ingleton, Gariner, & Bellamy, 2012).

While not a complete panacea, Sharing Time helps to overcome the challenge of different organisations, with different cultures, coming together as one team. Sharing Time may lead to further benefits for palliative care organisations due to facilitating collaboration. Health professionals from different organisations collaborating often mean the goals and outcomes for patient care delivery are reached economically (Speck, 2006a). Economically, in relation to time saved, means health professionals can use that saved time in the workplace for other activity. Organisations collaborating and

sharing employees to form a team to meet patient palliative care delivery needs, often share other resources outside of the human resource. An assumption can be made that this sharing is a saving to each organisation as individual organisations are not required to provide all the resources needed alone, whether this be, for example, employing additional staff or purchasing specific equipment. Therefore, the theory of Sharing Time transfers across employers, and the make-up of the team. This theory can be used by health professionals within the same organisation or health professionals employed by different organisations whenever there is a need to collaborate or to overcome possessorship.

When two health care organisations collaborate for some reason, sharing occurs (Sullivan, 1998; Vickridge, 1998; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010). Sharing can then lead to further collaboration. It may be argued that organisations can illustrate the theory of Sharing Time, to facilitate collaboration, by communicating through meeting and informing, involving each other, participating through building and investing, and negotiate through adjusting and role clarifying. However, it may be unclear whether this is at the instigation of the organisation, as a management strategy or simply health professionals working within the organisation choosing to Share Time. It can be said, however, that Sharing Time has a positive impact on overall team functioning.

Regardless of the positive benefits of Sharing Time, it is important to acknowledge that Sharing Time is not a panacea and challenges can remain within teams unrelated to collaboration or possessorship (Speck, 2006a, 2006b).

Due to the number of health professionals that can be involved in a patient's care, and the lack of clarity around the ingredients of a palliative team, it is not surprising if some become uncertain of their role and where they fit (Speck, 2006b); particularly as roles within teams in palliative care can be fluid and overlap, regardless of individual job descriptions (Speck, 2006a; Gott et al., 2012). This overlap can be either positive or negative. Having a degree of flexibility and overlap in a role may allow health professionals to meet patient needs sooner or without having to introduce additional people into the mix. However, this relies on health professionals being aware of their own professional limitations and their ability to recognise when to invite in another health professional. Sharing Time can help health professionals balance this through relating when they involve themselves and others in negotiating, which brings role clarity.

Alongside the potential for health professionals working in palliative care to become uncertain of the roles within their own team, Peters et al. (2012) reported that other professionals, for example, GPs, had differing expectations of the palliative care role, adding to the complexity of the palliative care team and roles within that team. There is clearly a need for health professionals to find a way to collaborate so that all are aware of what each is doing and what skills each health professional brings. The theory of Sharing Time illustrates how to facilitate collaboration through negotiating, participating, relating, and communicating. When negotiating, roles are clarified.

Current literature on roles in palliative care has a strong focus on how the individual profession fits within the palliative care team (Adler, Simader & Nieland, 2013; Keane, Bellamy & Gott, 2017; Peters et al., 2012). This is helpful to decrease complexity

around these individual roles. For example, how the role of the speech and language therapist (O'Reilly & Walshe, 2015), or the chaplain's role (Lyndes et al., 2012), or the role of practice nurses, fit in providing palliative care (Raphael, Waterworth, & Gott, 2014). However, this literature is generally authored by a member of the specific profession being written about, which may not represent the views or understandings of other health professions. Therefore, the complexity of each palliative care team, and variability in how the team functions within that complexity, may have an impact on health professionals' understanding of the roles within the team.

With roles, come responsibilities. Depending on specific professional responsibilities, competencies, and job descriptions, this may include a responsibility to collaborate. For example, the Nursing Council New Zealand (NCNZ, 2012) competencies for registered nurses include collaboration and the act of counselling. While counselling is also a separate profession, a small overlap of roles begins at this point, bringing complexity. Both nurses and counsellors are commonly members of palliative care teams, which potentially increases blurring or overlap of roles and competition between health professionals rather than collaboration. A possible reason for this blurring and overlap occurring in palliative care is that health professionals want to provide optimal care for their patients. As such, it is not as important who meets the needs of the patient, only that those needs are met. However, it is also possible that blurred and overlapping roles in palliative care occur when a health professional does not have trust or confidence in a colleague, leading to possession as he or she does as much for the patient as he or she can his or herself rather than collaborating and sharing. The theory of Spending Time can help to manage any confusion that arises from the complexity of blurred or overlapped roles. Role clarifying amongst health professionals builds awareness,

respect, and understanding (Orchard, Curran & Kabene, 2005; Robinson & Cottrell, 2005). Interestingly, role clarification in the theory of Sharing Time matches the role clarification noted in the CIHC (2010) interprofessional collaborative practice competency, particularly when “recognising and respecting the diversity of other health and social care roles, responsibilities and competencies” (p. 12).

Adding to the complexity of roles in palliative care is the relationship between health professionals and patients, and the possible impact of those relationships on other health professionals. As discussed in Chapter Two, the modern palliative care movement began with Dame Cicely Saunders in the 1960s (Allen et al., 2008; National Hospice and Palliative Care Organisation, 2015; Phipps, 1988; Saunders, 2015). The aim of palliative care as envisioned by Saunders, and practiced today, and as evidenced in the current definition of palliative care, is to see the patient as a unique individual. Sitting alongside his or her family, the patient will be given physical, social, spiritual, and emotional care (Palliative Care Subcommittee, 2007; Randall & Downie, 2006). While attempting to provide this level of care, a close relationship is often formed with the patient and family. According to Ferrell and Coyle (2006) health providers gather a lot of information, thereby learning about the patient and family in detail. When these close relationships form, they may, intentionally or unintentionally, exclude other health professionals, which can then impact on that other health professional’s expected role within the team. For example, if they have difficulty accessing the patient as a referral is not made.

The complexity of close relationships between health professionals and patient may be amplified if that relationship becomes negative in some way. The forming of close

relationships in palliative care is supported by Melvin (2012) who investigated professional compassion fatigue. Although there is no identified link between collaboration and developing compassion fatigue there is a commonality with professional boundaries. Vorizavali et al. (2011) examined nurse patient relationships in critical care, finding that nurses developed deep intense relationships that, for some, led to the perception of ownership in the relationship. “Nurses perceived patients as if they ‘belonged’ to them. The nurses seemed to claim ‘their’ patients from other nurses, doctors, even from family members” (Vouzavali et al., 2011, p. 144). This supports the emergence of possessorship from the data, as the ownership seen in critical care was also described by participants in this research as occurring in palliative care.

Possessorship adds to role complexity.

An additional influence on the complex nature of roles within the palliative care team is that of the historical religious background of hospice care. Due to this religious influence those who care for palliative patients are often described in positive semi-religious terms by the public, such as that of being special and being angels (Buck, 2007; Maddocks, 2006; Randall & Downie, 2006). While some health professionals are not influenced by this, others may find this perception of themselves rewarding, bringing feelings of self-importance in what may otherwise be a difficult job of facing death daily, while simultaneously dealing with the patient and family members’ concerns and stressors across all aspects of their lives. Maddocks (2006) described these feelings of self-importance as having “incestuous self-satisfaction” (p. 146). Wanting to continue or grow these positive feelings could lead the health professional to a need for possessorship. Possessorship of the role, the patient, or even the field of

practice that is 'palliative care' must impact on the team and add to role complexity.

Sharing Time manages this situation when it arises, so that collaboration can then occur.

As discussed above, neither the process of Sharing Time nor the main concern of possessorship has been previously identified in the literature, although individual categories of Sharing Time could be found, such as finding common ground. Sharing Time takes time but is manageable for health professionals who are choosing to work in a moment-in-time collaborative manner, rather than being continuously collaborative.

Reasons for this moment-in-time collaboration may include the complexity of teams and how they function. It is important that these factors be considered when discussing recommendations for practice.

Recommendations for Practice

To overcome any potential resistance to collaboration amongst health professionals, two recommendations for practice have emerged. First and foremost, that health professionals need to be aware of the theory of Sharing Time and how it can maximise moment-in-time collaborative practice. Second, that should palliative care providers in New Zealand decide to follow WHO recommendations and transition to an interprofessional collaborative practice environment in the workplace, this should be considered favourably, regardless of the benefits of Sharing Time.

Recommendation one: Awareness of the theory of Sharing Time

The first recommendation, encouraging health professionals to recognise and use the process of Sharing Time to maximise collaboration, has merit. Recognition can be achieved through journal articles, education sessions, and role modelling. That is, learning by example. There is value in recognising how health professionals work together to facilitate collaboration and manage their main concern of possessorship,

alongside value in the potential to improve patient care due to the additional sharing of resources that occurs and preventing wasting time. Sharing Time allows health professionals from different professions to clarify and maintain their professional roles while sharing knowledge and skills to provide optimal patient care delivery. Using the theory of Sharing Time to facilitate collaboration means health professionals are supported to work together, even if only for a moment-in-time, rather than separately.

The delivery of health care, including palliative care, is a social process that does not occur in isolation. Sharing occurs between health care workers, both professional and non-professional, and with the patient and patient caregivers as an element of teamwork. However, the degree and quality of sharing can vary greatly, leading to concerns about how health professionals work collaboratively (Bleakley, 2013; Davidson, 2004; Drinka & Clark, 2000; Speck, 2006b). To review, the theory of Sharing Time is a group social strategy and is how health professionals participating in this study facilitate collaboration and manage possession. Possession is about individualism, a solitary process where sharing is not occurring or is minimal. This lack of sharing can, at any stage, increase the difficulty of work for other health care professionals and potentially impact patient care. Those practicing possession, whether intentional or unintentional, are acting individually at the time the possession is occurring. Whether an individual health professional, or an individual health care organisation, there is no sharing.

There is no conflict between professional role expectations of behaviour and Sharing Time. The theory of Sharing Time and professional expectations, such as ethical codes of practice, is in fact, very compatible (Medical Council of New Zealand, 2011; New

Zealand Medical Association, 2014; Nursing Council of New Zealand, 2012, 2014).

One reason for this compatibility is due to the theory of Sharing Time taking place in the middle-ground of a continuum, where expectations of professional behaviour sit, including the expectation of some collaboration between health professionals. Sharing Time, being relevant for all health professionals, leading to, or enhancing, collaborative practice in its most common form, that of moment-in-time, goal-oriented collaboration.

In addition to not having conflict with professional roles, Sharing Time is not reliant on roles and responsibilities in the work place, which by necessity will always be different. For example, there will always be a need for a manager, team leader, or coordinator.

One strong benefit of Sharing Time not being reliant on roles is that this way of working is beneficial to all, supporting equality for health professionals by bringing the opportunity to achieve an equal voice through communicating, relating, participating, and negotiating. Therefore, no one is disempowered by Sharing Time. An assumption can be made that this opportunity to have a voice will enhance how health professionals work together, view each other, and how they treat each other as human beings.

As Sharing Time may help alter individual organisational cultures from within, it is clear there is relevance of this theory to palliative care organisations regardless of whether health professionals and organisations can be considered different entities and separated. This study discovered that the main concern of possession occurred between organisations, as well as at the individual health professional level. Therefore, with modification, it is likely that Sharing Time can assist all health care organisations and facilitate collaboration between organisations, bringing reciprocal benefits on a larger scale outside of palliative care.

Whether it is individual health professionals Sharing Time in the workplace, or at an organisational level between health care organisations, palliative care organisations can support their staff in Sharing Time by, for example, clearly allowing time in the work day for this to occur and extending the principle of Sharing Time into organisational values. This will help to change, if necessary, organisational and individual health profession values and cultures, leading to further uniting and sharing. Increased sharing will in turn lead to a heightened understanding, amongst Sharing Time participants, of each other's organisation and health profession.

The theory of Sharing Time is a strategy that health professionals are easily able to use as needed. Sharing Time potentially brings a safer work environment. When purposeful connecting, finding common ground, communicating, relating, participating, and negotiating are enhanced, health professionals feel safe to continue to share, so the theory is self-perpetuating as well as having reciprocity, being mutually beneficial. Health professionals sharing information and resources may improve patient care delivery and potentially prevent errors or omissions of care that may occur, for example, through lack of information or misinformation (Bittner, Gavlin, Hansten, & Kalisch, 2011; Institutes of Medicine, 2000). These positive aspects for health professionals, health organisations and most importantly clinical practice, plus a lack of any negative aspects, give rationale for the first recommendation to encourage health professionals to continue to use this strategy to purposefully unite, leading to additional sharing.

The theory of Sharing Time does not include all the criteria of interprofessional collaborative practice. However, knowing that health professionals are Sharing Time to

overcome possessors can be built upon to help change to a more collaborative work culture. Building on to Sharing Time can occur because several of the concepts and properties of Sharing Time are like those needed for interprofessional collaboration, such as communicating, relating, participating, and negotiating. If New Zealand palliative care providers ignore recommendations from the WHO and other organisations to move to an interprofessional collaborative environment, having awareness of possessors will still help staff manage this concern by Sharing Time. Discourse on this concern may help prevent possessors from occurring or, at least, decrease the frequency. When possessors does occur, purposefully Sharing Time will move health care professionals past this barrier so that collaboration occurs.

Recommendation two: An interprofessional collaborative environment

Sharing Time with its moment-in-time collaboration has much value and is currently meeting the needs of health professionals in palliative care. However, as previously discussed, the recommendations by the WHO et al. (2010) to move to an interprofessional collaborative practice environment cannot be ignored. Therefore, the second recommendation for practice, should New Zealand palliative care providers choose to follow the WHO recommendation, is to support the move from the moment-in-time collaboration that occurs with Sharing Time to an interprofessional collaborative practice environment.

Interprofessional collaborative practice, due to the change in philosophy it brings, and the continuous nature of the collaborative workplace environment, can help palliative care teams, who are often complex, manage the predicted increase in workload through improved team functioning (CIHC, 2010; WHO, & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010).

The team functioning that interprofessional collaboration brings includes establishing and maintaining trust, shared decision-making, mutual respect, availability, open communication, and attentive listening (CIHC, 2010). While some of these factors are improved when health professionals are Sharing Time, for example communication, these are transitory benefits that come with moment-in-time collaboration.

Interprofessional collaborative practice brings an improved team dynamic that is continuous (CIHC, 2010).

In addition, while Sharing Time manages possessorship, an interprofessional education and collaborative practice could help to prevent possessorship from occurring in the future by removing some of the issues that cause or encourage possessorship; for example, role confusion and mistrust of other professions (CIHC, 2010). Along with the prevention of possessorship, international experience and research strongly indicates that developing New Zealand palliative care services into an interprofessional education and collaborative practice environment would improve service delivery and benefit everyone involved; health professionals, patients, and their families (Dewar, 2000; Herbert, 2005; Prins, 2010; Zwarenstein et al., 2009). This can happen through further interprofessional education programmes within the palliative care community, expanding on the interprofessional education now being offered, and through palliative care working with other education facilities, particularly those offering palliative care related education. Further benefits of an interprofessional education and collaborative practice environment include: the continuous process of collaboration and a collaborative environment, improved workplace practices and productivity; increased patient satisfaction; improved patient outcomes; raised staff morale; decreased tension and conflict; reduced health care costs; and evokes a true patient/family centred ethic in

practice (Cuff, 2013; Suter et al., 2012; Thannhauser et al., 2010; WHO & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health, 2010; Zwarenstein et al., 2009).

Moving to an interprofessional collaborative practice environment will require effort and support in the form of education, commitment, and resolve, from both individual health professionals and at organisational levels. Interestingly, during the time of this research being undertaken, the transition to interprofessional education in New Zealand palliative care has already begun with some interprofessional education programmes developed and delivered (MacLeod & Egan, 2007). Examples are the collaboration between Hospice New Zealand and gerontology services to produce the *Fundamentals of Palliative Care* education programme (Morgan, MacLeod, & Schumacher, 2015) and the *Foundations of Spiritual Care* education programme (Morgan, MacLeod, Schumacher, & Egan, 2015). Aside from increased knowledge on spirituality for health professionals, evaluation of the interprofessional education, the *Foundations of Spiritual Care* programme has shown benefits to the team that include increased confidence, increased collegiality, positive team building and relationships, and the development of a common language (MacLeod, 2016).

Should this second recommendation be adopted, it is still expected that, for some, change will be challenging. Recognising that the delivery of palliative care can be, and perhaps needs to be, improved may be threatening to health professionals who have dedicated their careers to caring for patients who are palliative, believing that the care provided is already of a high standard. A few health professionals may resist change altogether (Obholzer & Roberts, 2011; Sargent, 2009), which could lead to an increased

possession of this area of health care practice and their own role within. Beginning with palliative care, role modelling interprofessional collaborative practice will change work cultures and draw in others (Thistlethwaite, 2012). If changes are made soon, palliative care can potentially lead the way for interprofessional collaborative practice in many areas of health care (Prins, 2010). Conversely, if changes are not made soon, palliative care may be left behind, as other areas of health care move forward into interprofessional collaborative practice.

Summary

The data clearly indicate that moment-in-time collaboration is occurring, being strongly facilitated by Sharing Time, as health professionals aim to provide optimal care for palliative patients. There are similarities and links to literature but the theory of Sharing Time, not being previously identified, adds to the current body of knowledge. Sharing Time helps practice by facilitating moment-in-time collaboration and managing the main concern of possession. Also added to the current body of knowledge is that health professionals in palliative care are working within a middle ground of a continuum. Having reciprocity with Sharing Time, the amount of time shared facilitates collaboration and manages possession. This middle ground neither wastes time nor spends so little time that collaboration cannot occur.

Sharing is significant as the theory of Sharing Time also facilitates further sharing of other tangible or intangible commodities held by one but needed by another to provide what is considered as optimal palliative care. While there are potential barriers to, and influences on, collaboration in palliative care, such as the structure of the team, role confusion, and possession, Sharing Time is the way health professionals manage these barriers and influences to facilitate collaboration. Collaboration in turn, when it

occurs, encourages further Sharing of Time. Regardless of the many positive aspects of the theory of Sharing Time, there are further recommendations for practice that can be made.

Time itself is an identified factor that influences collaboration as participants described the need to Share Time but not waste time, particularly as it is recognised that health professionals are busy in their work day. Time can be saved through Sharing Time, regardless of the individual health professional's responsibilities and role within the team. Sharing Time can be used by both individuals and organisations. While Sharing Time has many positive benefits, it is important that consideration is given toward an interprofessional collaborative environment should palliative care providers decide to follow WHO et al. (2010) recommendations. To close, the following chapter will consider the methodological advantages and disadvantages; specifically, what worked and what did not from the researcher's perspective. The chapter will also look at what benefit was gained from using this methodology to examine the area of interest.

Chapter Seven: Methodological Considerations & Opportunities

Introduction

To conclude this thesis, methodological strengths and limitations of this research will be examined beginning with the mix of health profession participants. This section will also include discussion on the exclusion criteria and location of the research. Following this is a discussion on opportunities for further research, concluding with a final summary.

Methodological Considerations

As many participants in this research were registered nurses, there is potential for the study to have minimised the voice of other health professions working in palliative care within the theory. However, this limitation may have minimal effect on the proposed explanation of facilitating collaboration by Sharing Time for the following reasons. Firstly, an argument can be made that this is representative of hospice and palliative care services in New Zealand; there is a higher proportion of nursing professionals than any other profession. In 2012, there were 1432 nurses who reported that palliative care was one of their practice areas. Of these, 914 nurses listed palliative care as their main practice or employment setting. This contrasts with a 2010 survey by the Medical Council of New Zealand that reported 84 doctors who indicated they were working in palliative medicine. Of these, 54 said palliative medicine was their main work type (Palliative Care Council of New Zealand, 2013). Secondly, applying grounded theory methodology (Glaser, 1998; Glaser & Strauss, 1967) meant that data were abstracted and conceptualised, resulting in a proposed explanation of a group social process used by participants to manage a main concern.

The criterion which excluded participants with less than five years' experience working in palliative care is another potential limitation. The five-year limit was intended to capture health professional participants experienced in palliative care, but choosing a number becomes irrelevant if further detail is not addressed; for example, whether the health professional has worked in palliative care full time or part time for five years. The need to be more explicit was not understood by the researcher until participant recruitment and data analysis were underway. Therefore, health professionals who may have valuable insight and experience to contribute to the data, but did not meet the timeframe required, were excluded. Lowering the criteria to two or three years' experience would have allowed for increased recruitment.

The geographic location for participant recruitment in this study, the North Island of New Zealand, may be a limitation. As there were only 37 specialist palliative care providers nationally at the time this research was undertaken, there will always be national limitations. How collaboration is facilitated and the main concern of possession may differ internationally, due to differences in culture and health systems, which includes how palliative care is delivered. Regardless, this research investigated palliative care delivery in a uniquely diverse country. The abstraction that occurs as part of Glaserian grounded theory removes the spatial and site differences and is a strength of the methodology. Only further research will indicate if this theory is modifiable and relevant internationally.

The final limitation to be considered is the lack of patient voice when inclusion of patients had originally been planned. As discussed in Chapter Four, the original

rationale to include patients as participants was due to the researcher's belief that the patient is part of the team. How this limitation may be addressed is discussed as opportunities for further research below.

Opportunities for Further Research

There are opportunities for further research resulting from this study. Acknowledging that health professionals can choose to share time in other ways, such as socially, there is an opportunity to discover whether Sharing Time can be modified with data from the social context unrelated to the work of palliative care and patient care. Another opportunity is to investigate whether Sharing Time can be modified to be relevant to other non-palliative health care areas or in non-healthcare social situations.

Another area worthy of investigation is the meaning of time to health professionals working in palliative care in New Zealand, and the influence, if any, of the patient having a short time to live on health professionals. This research could investigate if and how the meaning of time to the health professional influences clinical practice.

As discussed in Chapter Four, the area of interest for the current research was found to be challenging when wanting to include patient participation. Another opportunity for further research, therefore, would be to ask what the patients' main concern is when receiving palliative care, and how they manage that. There is also an opportunity to ask patients their main concern of collaboration in health care, rather than specifying palliative care.

An opportunity for further research is to ask the same question to those providing primary palliative care, to examine if the theory of Sharing Time is modifiable to the

wider palliative care health professional community. Finally, there is an opportunity to study Sharing Time as a means of conflict resolution because of its relationship to purposeful connecting and finding common ground, which includes negotiating.

Overall, there is an opportunity for further research into interprofessional collaboration and palliative care in New Zealand, particularly if the recommendation to move to an interprofessional collaborative practice culture is adopted. Much of the literature to date is international, which does not take into consideration differences in the New Zealand culture and health care delivery systems, although this is beginning to change as more New Zealand researchers are investigating interprofessional collaboration both in practice and within education curricula.

Summary

This final summary reminds the reader that the theory of Sharing Time, previously unidentified, occurs within a middle-ground, also previously unidentified, adding to the body of knowledge on how health professionals in the palliative care arena in New Zealand are currently collaborating in moments-in-time to manage their main concern. This main concern of possession, again previously unidentified, further adds to the body of knowledge. Awareness of Sharing Time will support health professionals in their need to collaborate, to meet the needs of patients and improve patient care at the bedside. Should palliative care organisations choose to move to a more continuous interprofessional collaborative model of practice, this transition will be supported by the awareness of Sharing Time, as health professionals will have been practiced at collaboration, albeit in moment-in-time collaboration rather than continuous.

As has been shown, this research study, culminating in the theory of Sharing Time, has both methodological strengths and limitations. Strengths include the rigour of the method itself with fit, workability, and the potential for this theory to be modifiable, as discussed in Chapter Four. Potential limitations include the mix of health professionals, the exclusion criteria of less than five years' experience, location of the research, and no patient voice. Moving forward, there are opportunities for further research that stem from this original study. One opportunity is to investigate whether the theory of Sharing Time is relevant to the wider health care arena in general. A second opportunity is to investigate whether the theory of Sharing Time will continue to be relevant if interprofessional practice, as recommended by the WHO, develops further.

References

- Adler, S., Simader, R., & Nieland, P. (2013). (Eds). *Potential and possibility: Rehabilitation at end of life. Physiotherapy in palliative care*. London, UK: WB Saunders Co.
- Ahmann, E., & Dokken, D. (2012). Strategies for encouraging patient/family member partnerships with the health care team. *Pediatric Nursing*, 38(4), 232-235.
- Alasuutari, P. (2010). The rise and relevance of qualitative research. *International Journal of Social Research Methodology*, 13(2), 139-155. doi: 10.1080/13645570902966056
- Alberto, J., & Herth, K. (2009). Interprofessional collaboration within faculty roles: Teaching, service, and research. *OJIN: The Online Journal of Issues in Nursing*, 14(2). doi:10.3912/OJIN.Vol14No02PPT02
- Alexander, S. (2010). 'As long as it helps somebody': Why vulnerable people participate in research. *International Journal of Palliative Nursing*, 16(4), 173-178.
- Allen, S., Chapman, Y., O'Connor, M., & Francis, K. (2008). The evolution of palliative care and the relevance to residential aged care: Understanding the past to inform the future. *Collegian*, 15(4), 165-171. doi:10.1016/j.colegn.2008.09.001
- Andrew, T. (2006). The literature review in grounded theory: A response to McCallin (2003). *The Grounded Theory Review*, 5(2/3). Retrieved from <http://groundedtheoryreview.com/2006/06/30/1421/>
- Artinian, B., Giske, T., & Cone, P. (2009). *Glaserian grounded theory in nursing research: Trusting emergence*. New York, NY: Springer Publishing Company.
- Auckland University of Technology. (2015). *Doctor of Health Science: Postgraduate papers and qualification study information*. Retrieved from <https://www.aut.ac.nz/study-at-aut/study-areas/health-sciences/postgraduate-study/doctor-of-health-science>
- Australian Interprofessional Practice & Education Network. (2015). *AIPPEN Australian* Retrieved from <http://www.aippen.net/> *Interprofessional Practice & Education Network*.
- AUT University. (2014). *AUT Interprofessional Education and Collaborative Practice*. Retrieved November 19, 2014, from <http://www.aut.ac.nz/study-at-aut/study-areas/health-sciences/interprofessional-health-studies/autipecp>
- Bagshaw, D., Lepp, M., & Zorn, C. (2007). International research collaboration: Building, learning and managing conflicts. *Conflict Resolution Quarterly* 24(4), 433-446. doi:10.1002/crq.183

- Baldwin, D. C. (2007). Some historical notes on interdisciplinary and interprofessional education and practice in health care in the USA. *Journal of Interprofessional Care*, 21(s1), 23-37. doi:10.1080/13561820701594728
- Barr, H. (1998). Competent to collaborate: Towards a competency-based model for interprofessional education. *Journal of Interprofessional Care*, 12(2), 181-187. doi:10.3109/13561829809014104
- Barr, H. (2002). *Interprofessional education: Today, yesterday & tomorrow*. London, UK: Learning & Support Network Centre for Health Sciences & Practice.
- Barr, H. (2007). Interprofessional education: The fourth focus. *Journal of Interprofessional Care*, 21(s2), 40-50. doi:10.1080/13561820701515335
- Beach, M., Inui, T., & Relationship-Centered Care Research Network. (2006). Relationship-centered care: A constructive reframing. *Journal of General Internal Medicine*, 21(Suppl 1), S3-S8. doi:10.1111/j.1525-1497.2006.00302.x
- Becker, G. (1965). A theory of the allocation of time. *The Economic Journal*, 75(299), 493-517. doi:10.2307/2228949
- Bern-Klug, M., Gessert, C., Crenner, C., Buenaver, M., & Skirchak, D. (2004). Getting everyone on the same page. Nursing home physicians' perspectives on end-of-life care. *Journal of Palliative Medicine*, 7(4), 533-544.
- Bittner, N., Gavlin, G., Hansten, R., & Kalisch, B. (2011). Unraveling care omissions. *Journal of Nursing Administration*, 41(12), 510-512. doi:10.1097/NNA.0b013e3182378b65
- Bleakley, A. (2013). Working in "teams" in an era of "liquid" healthcare: What is the use of theory? *Journal of Interprofessional Care*, 27, 18-26. doi:10.3109/13561820.2012.699470
- Bliss, S., Cowley, A., & While, J. (2000). Interprofessional working in palliative care in the community: A review of the literature. *Journal of Interprofessional Care*, 14(3), 281-290. doi:10.1080/jic.14.3.281.290
- Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality & Quantity*, 36, 391-409.
- Brennan, F. (2007). Palliative care as an international human right. *Journal of Pain and Symptom Management*, 33(5), 494-499. doi:10.1016/j.jpainsymman.2007.02.022
- Bridges, D., Davidson, R., Odegard, P., Maki, I., & Tomkowiak, J. (2011). Interprofessional collaboration: Three best practice models of interprofessional education. *Medical Education Online*, 16. doi:10.3402/meo.v16i0.6035
- Brown, J., Lewis, L., Ellis, K., Stewart, M., Freeman, T., & Kasperski, M. (2011). Conflict on interprofessional primary health care teams - can it be resolved? *Journal of Interprofessional Care*, 25(1), 4-10. doi:10.3109/13561820.2010.497750

- Bryant, A. (2009). Grounded theory and pragmatism: The curious case of Anselm Strauss. *Forum: Qualitative Social Research*, 10(3). Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/1358/2850>. doi:10.17169/fqs-10.3.1358.
- Buck, J. (2007). Reweaving a tapestry of care: Religion, nursing, and the meaning of hospice, 1945-1978. *Nursing History Review*, 15, 113-145.
- Burns, N., & Grove, S. (2007). *Understanding nursing research* (4th ed.). St. Louis, MO: Saunders Elsevier.
- Canadian Hospice Palliative Care Association. (2006). *The Pan-Canadian Gold Standards for palliative home care: Towards equitable access to high quality hospice palliative and end-of life care at home*. Ottawa, ON, Canada: Author.
- Canadian Interprofessional Health Collaborative. (2010). *A national interprofessional competency framework*. Vancouver, Canada: Author.
- Canadian Interprofessional Health Collaborative (CIHCpis). (2015). *AIPHE definitions*. Retrieved from <http://www.cihc.ca/aiphe/about/faq/definitions>
- Capra, F. (1982). *The biomedical model. The turning point: Science, society and the rising culture*. London, UK: Harper Collins.
- Centre for the Advancement of Interprofessional Education (CAIPE). (2014). *Centre for the Advancement Of Interprofessional Education (CAIPE)*. Retrieved from <http://caipe.org.uk/>
- Chan, B., Perkins, D., Wan, Q., Zwar, N., Daniel, C., Crookes, P., & Harris, M. (2010). Finding common ground? Evaluating an intervention to improve teamwork among primary health-care professionals. *International Journal for Quality in Health Care*, 22(6), 519-524. doi:10.1039/intqhc/mzq057
- Chapple, R. (2015). The twin fictions of partnership and principles. In H. Barr, D. Brash, M. Butler, R. Chapple, P. Cresswell, B. Moon...D. Round (Eds.), *One treaty, one nation* (pp.57-75). Wellington, New Zealand: Tross Publishing.
- Charles-Edwards, A. (1983). *The nursing care of the dying patient*. Beaconsfield, UK: Beaconsfield Publishers.
- Charmaz, K. (2006). *Constructing grounded theory*. Thousand Oaks, CA: Sage Publications.
- Christensen, K., Doblhammer, G., Rau, R., & Vaupel, J. (2009). Ageing populations: The challenges ahead. *The Lancet*, 374(9696), 1196-1208. doi:10.1016/S0140-6736(09)61460-4
- Christiansen, O. (2007). A simpler understanding of classic GT: How it is a fundamentally different methodology. *The Grounded Theory Review*, 6(3), 39-61.
- Christiansen, O. (2011). The literature review in classic grounded theory studies: A methodological note. *The Grounded Theory Review*, 10(3), 21-26.

- Ciemins, E., Brant, J., Kersten, D., Mullette, E., & Dickerson, D. (2015). A qualitative analysis of patient and family perspectives of palliative care. *Journal of Palliative Medicine, 18*(3), 282-285. doi:10.1089/jpm.2014.0155
- Clark, D. (2002) Between hope and acceptance: The medicalisation of dying. *British Medical Journal, 324*(7342), 903-907.
- Clarke, A. (2003). Situational analysis: Grounded theory mapping after the postmodern turn. *Symbolic Interaction, 26*(4), 553-576.
- Clarke, A. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: Sage Publications.
- Committee of Inquiry. (1988). *The report of the Cervical Cancer Inquiry*. Auckland, New Zealand: New Zealand Government.
- Cooney, A. (2010). Choosing between Glaser and Strauss: An example. *Nurse Researcher, 17*(4), 18-28.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Coyne, I. (1997). Sampling in qualitative research. Purposeful and theoretical sampling: merging or clear boundaries? *Journal of Advanced Nursing, 26*, 623-630.
- Crosby, D. (2007). Two perspectives on metaphysical perspectivism: Nietzsche and Whitehead. *The Pluralist, 2*(3), 57-76. doi:10.2307/20708915
- Crotty, M. (1998). *The foundations of social research*. Crows Nest, NSW, Australia: Allen & Unwin.
- Cuff, P. (2013). *Interprofessional education for collaboration: Learning how to improve health from interprofessional models across the continuum of education to practice: Workshop summary* (pp. 150). Washington, D.C.: Institutes of Medicine (IOM).
- Currow, D., & Hegarty, M. (2006). Suffering. At the bedside of the dying. *Journal of Religion, Spirituality & Aging, 18*(2/3), 123-136. doi:10.1300/J496v18n02•10
- D'Amour, D., Ferrada-Videla, M., San Martin Rodriguez, L., & Beaulieu, M. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care, 19*(s1), 116-131. doi:10.1080/13561820500082529
- Daly, G. (2004). Understanding the barriers to multiprofessional collaboration. *Nursing Times, 100*(9), 78-79.
- Davidson, G., Evans, H., Gray, A., Kiddle, G., Lancaster, M., & Shepherd, M. (1981). The development of a hospice for the continuing care of cancer patients. *New Zealand Medical Journal, 94*(688), 52-54.

- Davidson, G. (2004). Palliative care teams and the contingencies that impact them: A background. *Progress in Palliative Care*, 14(2), 12-19. doi: 10.1179/096992606X93399
- Defilippi, K. (2002). Collaboration: A critical challenge. *International Journal of Palliative Nursing*, 8(2), 56. doi:10.12968/ijpn.2002.8.2.10238
- De Korte-Verhoef, M., Pasman, H., Schweitzer, B., Francke, A., Onwuteaka-Philipsen, B., & Deliens, L. (2012). End-of-life hospital referrals by out-of-hours general practitioners: A retrospective chart study. *BMC Family Practice*, 13(89). Retrieved from <https://bmcfampract.biomedcentral.com/articles/10.1186/1471-2296-13-89>. doi: 10.1186/1471-2296-13-89.
- Dewar, S. (2000). Collaborating for quality: The need to strengthen accountability. *Journal of Interprofessional Care*, 14(1), 31-38. doi:10.1080/jic.14.1.31.38.
- Dijkers, J., Geurts, S., Dulk, L., Peper, B., Tous, T., & Kompier, A. (2007). Dimensions of work-home culture and their relations with the use of work-home arrangements and work-home interaction. *Work & Stress*, 21(2), 155-172.
- Di Leo, S., Romoli, V., Higginson, I., Bulli, F., Fantini, S., Sguazzotti, E., & Constantini, M. (2015). Less ticking the boxes, more providing support: A qualitative study on health professionals' concerns towards the Liverpool Care of the Dying pathway. *Palliative Medicine*, 29(6), 529-538. doi: 10.1177/0269216315570408
- Ding, D. (2014). The effect of experience, ownership and focus on productive efficiency: A longitudinal study of U.S. hospitals. *Journal of Operations Management*, 32(1-2), 1-14. doi:10.1016/j.jom.2013.10.002
- Doyle, D. (1987). *Domicillary terminal care*. New York, NY: Churchill Livingstone.
- Doyle, D. (2005). Palliative medicine: The first 18 years of a new sub-speciality of general medicine. *Journal of the Royal College of Physicians Edinburgh*, 35, 199-205.
- Drinka, T., & Clark P. (2000). *Health care teamwork: Interdisciplinary practice and teaching*. Westport, CT: Auburn House.
- Drinka, T., Miller, T., & Goodman, B. (1996). Characterizing motivational styles of professionals who work on interdisciplinary healthcare teams. *Journal of Interprofessional Care*, 10(1), 51-61. doi:10.3109/13561829609082682
- Dupere, D. (2006). Palliative care. *The encyclopedia of aging* (Vol. 2, pp. 3). New York, NY: Springer Publishing Company. Retrieved from https://networkservices.aut.ac.nz/ezproxy.cgi?url=http%3A%2F%2Fsearch.oreference.com.ezproxy.aut.ac.nz%2Fcontent%2Fentry%2Fspencage%2Fpalliative_care%2F0.

- Egan, K., & Labyak, M. (2006). Hospice palliative care: A model for quality end-of-life care. In B. Ferrell & N. Coyle (Eds.), *Textbook of palliative nursing* (2nd ed., pp. 33). Oxford, UK: Oxford University Press.
- Ellingsen, S., Roxberg, Å., Kristoffersen, K., Rosland, J., & Alvsvåg, H. (2015). The pendulum time of life: The experience of time, when living with severe incurable disease—a phenomenological and philosophical study. *Medicine, Health Care and Philosophy*, 18(2), 203-215. doi:10.1007/s11019-014-9590-9
- Elliott, E. (2004). Building a partnership through collaboration, reflection, dialogue. *Journal of Early Childhood Teacher Education*, 24(4), 247-255. doi:10.1080/1090102040240405
- Eloranta, S., Welch, A., Arve, S., & Routasalo, P. (2010). A collaborative approach to home care delivery for older patients: Perspectives of home care providers. *Journal of Interprofessional Care*, 24(2), 198-200. doi:10.3109/13561820903078272
- Eriksen, K., Arman, M., Davidson, L., Sundfør, B., & Karlsson, B. (2014). Challenges in relating to mental health professionals: Perspectives of persons with severe mental illness. *International Journal of Mental Health Nursing*, 23(2), 110-117. doi:10.1111/inm.12024
- Failing, M., & Theeuwes, J. (2016). Reward alters the perception of time. *Cognition* 148, 19-26. doi:10.1016/j.cognition.2015.12.005
- Fallon, M., & Smyth, J. (2008). Terminology: The historical perspective, evolution and current usage – room for confusion? *European Journal of Cancer*, 44(8), 1069-1071. doi:http://dx.doi.org/10.1016/j.ejca.2008.02.034
- FBX Centre for Health and Human Rights, & Open Society Foundations. (2013). *Palliative care and human rights, Health and human rights resource guide* (5th ed., pp. 11), Boston, MA: Harvard School of Public Health.
- Ferrell, B., & Coyle, N. (2006). *Textbook of palliative care nursing* (2nd ed.). Oxford, UK: Oxford University Press.
- Fineberg, I., Wenger, N., & Lachlan, F. (2004). Interdisciplinary education: Evaluation of a palliative care training intervention for pre-professionals. *Academic Medicine: Journal of the Association of American Medical Colleges*, 79(8), 769-777.
- Fleissig, A., Jenkins, V., Catt, S., & Fallowfield, L. (2006). Multidisciplinary teams in cancer care: Are they effective in the UK? *The Lancet Oncology*, 7(11), 935-943. doi:10.1016/S1470-2045(06)70940-8
- Gallagher, P., & Carey, K. (2012). Connecting with the well-elderly through reminiscence: Analysis of lived experience. *Educational Gerontology*, 38(8), 576-582. doi:10.1080/03601277.2011.595312

-
- Gartrell, C., & Gartrell, J. (2002). Positivism in sociological research: USA and UK (1966-1990). *British Journal of Sociology*, 53(4), 639-657. doi: 10.1080/0007131022000021521
- Giles, T., King, L., & Lacey, S. (2013). The timing of the literature review in grounded theory research: an open mind versus an empty head. *Advances in Nursing Science*, 36(2), 29-41. doi:10.1097/ANS.Ob013e3182902035
- Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.
- Glaser, B. (1992). *Basics of grounded theory analysis*. Mill Valley, CA: Sociology Press.
- Glaser, B. (1998). *Doing grounded theory*. Mill Valley, CA: Sociology Press.
- Glaser, B. (2001). *The grounded theory perspective: Conceptualization contrasted with description*. Mill Valley, CA: Sociology Press.
- Glaser, B. (2005). The impact of symbolic interaction on grounded theory. *The Grounded Theory Review*, 4(2), 1-22.
- Glaser, B. (2007a). Constructivist grounded theory? *Historical Social Research*, 19(Supplement), 93-105.
- Glaser, B. (2007b). Forty years after discovery: Grounded theory worldwide. *The Grounded Theory Review*, (Special Issue November), 21-41.
- Glaser, B. (2007c). The history of grounded theory based on quantitative methodology. *The Grounded Theory Review*, (Special Issue November), 9-20.
- Glaser, B. (2009). *Jargonizing using the grounded theory vocabulary*. Mill Valley, CA: Sociology Press.
- Glaser, B. (2010). The future of grounded theory. *Grounded Theory Review*, 9(2), 1-14.
- Glaser, B. (2013). Introduction: Free style memoing. *Grounded Theory Review*, 12(2), 1-10.
- Glaser, B., & Strauss, A. (1966). *Awareness Of dying*. London, UK: Weidenfeld & Nicolson.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New Brunswick, IL: Aldine Transaction.
- Glaser, B., & Strauss, A. (1968). *Time for dying*. Chicago, IL: Aldine Publishing Company.
- Goldsmith, J., Wittenberg-Lyles, E., Rodriguez, D., & Sanchez-Reilly, S. (2010). Interdisciplinary geriatric and palliative care team narratives: Collaboration practices and barriers. *Qualitative Health Research*, 20(1), 93-104. doi: 10.1177/1049732309355287

- Gott, M., Seymour, J., Ingleton, C., Gardiner, C., & Bellamy, G. (2012). That's part of everybody's job: The perspectives of health care staff in England and New Zealand on the meaning and remit of palliative care. *Palliative Medicine*, 26(3), 232-241. doi:10.1177/0269216311408993
- Gottlieb, B., & Schroter, C. (1978). Collaboration and resource exchange between professionals and natural support systems. *Professional Psychology*, 9(4), 614-622. doi:10.1037/0735-7028.9.4.614
- Gould, D., Hale, R., Waters, E., & Allen, D. (2016) Promoting health workers' ownership of infection prevention and control: using normalisation process theory as an interpretive framework. *Journal of Hospital Infection*, 94(4), 373-380. doi:10.1016/j.jhin.2016.09.015
- Gray, A., & Elder, P. (1987). Hospice care, whose responsibility? *New Zealand Medical Journal*, 100(2), 679-680.
- Gray, B. (1989). *Collaborations: Finding common ground for multiparty problems*. San Francisco, CA: Jossey-Bass.
- Gronau, R. (1977). Leisure, home production and work - The theory of the allocation of time revisited. *Journal of Political Economy*, 85(6), 1099-1123. doi:10.3386/w0137
- Groot, M., Vernooij-Dassen, M., Verhagen, S., Crul, B., & Grol, R. (2007). Obstacles to the delivery of primary palliative care as perceived by GPs. *Palliative Medicine*, 21, 697-703. doi:10.1177/0269216307083384
- Haigler, D., Bauer, L., & Travis, S. (2010). Finding common ground of family and professional caregiving; The education agenda at the Rosalynn Carter Institute. *Educational Gerontology*, 30(2), 95-104. doi:10.1080/03601270490266266
- Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care*, 19(s1), 188-196. doi:10.1080/13561820500081745
- Hammick, M. (1998). Interprofessional education: Concept, theory and application. *Journal of Interprofessional Care*, 12(3), 323-332. doi:10.3109/13561829809014123
- Health & Disability Commissioner. (2009). *The Code of Rights*. Retrieved January 10, 2015, from <http://www.hdc.org.nz/the-act--code/the-code-of-rights>.
- Health Improvement and Innovation Resource Centre. (2012). *Nurse practitioner palliative care role appointed for Waikato*. Retrieved from <http://www.hiirc.org.nz/page/32703/nurse-practitioner-palliative-care-role-appointed/?tag=advancednursingpractice&contentType=27&tab=2618§ion=8959>
- Health Research Council of New Zealand. (2010). *Guidelines for researchers on health research involving Māori*. Wellington, New Zealand. Author.

- Heath, H., & Cowley, S. (2004). Developing a grounded theory approach: A comparison of Glaser and Strauss. *International Journal of Nursing Studies*, 41(2), 141-150. doi:10.1016/S0020-7489(03)00113-5
- Herbert, C. (2005). Changing the culture: Interprofessional education for collaborative patient-centered practice in Canada. *Journal of Interprofessional Care*, 19(s1), 4.
- Herbert, C., Bainbridge, L., Bickford, J., Baptiste, S., Brajtman, S., Dryden, T., Solomon, P. (2007). Factors that influence unity in collaborative practice: How 8 health professionals became advocates. *Canadian Family Physician*, 53(8), 1318-1325.
- Hermesen, M., & Ten-Have, H. (2005). Palliative care teams: Effective through moral reflection. *Journal of Interprofessional Care*, 19(6), 561-568. doi:10.1080/13561820500404871
- Hogh, A., Hoel, H., & Carneiro, I. (2011). Bullying and employee turnover among healthcare workers: A three-wave prospective study. *Journal of Nursing Management*, 19(6), 742-751. doi:10.1111/j.1365-2834.2011.01264x
- Holton, J. (2008). Grounded theory as a general research methodology. *The Grounded Theory Review*, 7(2), 26.
- Holton, J. (2009). Qualitative tussles in undertaking a grounded theory study. *The Grounded Theory Review*, 8(3), 13.
- Hospice New Zealand. (2012). *Standards for palliative care*. Wellington, New Zealand: Hospice New Zealand.
- Hospice New Zealand. (2014a). *History*. Retrieved from <http://www.hospice.org.nz/about-hospice-nz/history>
- Hospice New Zealand. (2014b). *National Standards*. Retrieved from <http://www.hospice.org.nz/our-education-amp-standards-project/national-standards>
- Hospice New Zealand. (2014c). *What is hospice?* Retrieved from <http://www.hospice.org.nz/>
- Indiana University. (2000). *The Asclepion*. Retrieved from <http://www.indiana.edu/~ancmed/intro.HTM>
- Institutes of Medicine. (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.
- Institutes of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century executive summary*. Washington, D.C.: National Academies Press.
- International Conference on Primary Health Care. (1978). *Declaration of Alma-Ata*. Geneva, Switzerland: World Health Organisation.

- International Council for Human Resources in Nursing (ICHRN). (2007). *Fact Sheet: An aging nursing workforce*. Geneva, Switzerland: Author.
- Jansen, L. (2008). Collaborative and interdisciplinary health care teams: Ready or Not? *Journal of Professional Nursing*, 24(4), 218-227.
doi:10.1016/j.profnurs.2007.06.013
- Johnson, C., Girgis, A., Paul, C., & Currow, D. (2011). Palliative care referral practices and perceptions: The divide between metropolitan and non-metropolitan general practitioners. *Palliative & Supportive Care*, 9(02), 181-189.
doi:10.1017/S1478951511000058
- Johnson, P., Wistow, G., Schulz, R., & Hardy, B. (2003). Interagency and interprofessional collaboration in community care: The interdependence of structures and values. *Journal of Interprofessional Care*, 17(1), 70-83.
doi:10.1080/1356182021000044166
- Jones, I. (2007). The theory of boundaries: Impact on interprofessional working. *Journal of Interprofessional Care*, 21(3), 355-357.
doi:10.1080/13561820701257383
- Kaba, R., & Sooriakumaran, P. (2007). The evolution of the doctor-patient relationship. *International Journal of Surgery*, 5(1), 57-65. doi:10.1016/j.ijsu.2006.01.005
- Keane, B., Bellamy, G., & Gott, M. (2017). General practice and specialist palliative care teams: An exploration of their working relationship from the perspective of clinical staff working in New Zealand. *Health and Social Care in the Community* 25(1), 215-223.
- King, R., & Clarkson, P. (2015). Management control system design, ownership, and performance on professional service organisations. *Accounting, organisations and Society*, 45, 24-39. doi:10/1016/j.aos.2015.06.002
- Kingdon, D. G. (1992). Interprofessional collaboration in mental health. *Journal of Interprofessional Care*, 6(2), 141-147. doi:10.3109/13561829209014928
- Kingi, T. (2007). The Treaty of Waitangi: A framework for Maori health development. *New Zealand Journal of Occupational Therapy*, 54(1), 4-10.
- Kobayashi, R., & McAllister, C. (2014). Similarities and differences in perspectives on interdisciplinary collaboration among hospice team members. *American Journal of Hospice & Palliative Medicine*, 31(8), 825-832.
doi:10.1177/1049909113503706
- Koch, T., & Rowell, M. (1999). The dream of consensus: Finding common ground in a bioethical context. *Theoretical Medicine and Bioethics*, 20, 261-273.
- Koffman, J. (2001). Multiprofessional palliative care education: Past challenges, future issues. *Journal of Palliative Care*, 17(2), 86-92.

- Kristjanson, L., & Chalmers, K. (1990). Nurse-patient interactions in community-based practice: Creating common ground. *Public Health Nursing, 7*(4), 215-223.
- Kubler-Ross, E. (1969). *On death & dying*. New York: Simon & Schuster.
- Kujala, J., Lillrank, P., Kronström, V., & Peltokorpi, A. (2006). Time-based management of patient processes. *Journal of Health Organization and Management, 20*(6), 512-524. doi:10.1108/14777260610702262
- Kwok, K., McCallin, A., & Dickson, G. (2012). Working through preconception: Moving from forcing to emergence. *The Grounded Theory Review, 11*(2), 13-23.
- Lande, D. (2000). *Revolution in time: Clocks and the making of the modern world*. Boston, MA: Belknap Press of Harvard University Press.
- Leathard, A. (Ed.). (2003). *Interprofessional collaboration: From policy to practice in health and social care*. Hove, UK: Brunner-Routledge.
- Legewie, H., & Schervier-Legewie, B. (2004). Research is hard work, it's always a bit suffering. Therefore on the other side it should be fun. Anselm Strauss in conversation with Heiner Legewie and Barbara Schervier-Legewie. *Forum: Qualitative Social Research, 5*(3). Retrieved from <http://www.qualitative-research.net/index.php/fqs/article/view/562/0>. doi:10.17169/fqs-5.3.562
- Levine, R. (2008). *A geography of time: On tempo, culture and the pace of life*. New York, NY: Basic Books.
- Lewis, M. (2007). *Medicine and care of the dying: A modern history*. Oxford, UK: Oxford University Press.
- Lindeke, L., & Sieckert, A. (2015). Nurse-physician workplace collaboration. *Online Journal of Issues in Nursing, 1*(4). Retrieved from www.nursingworld.org/ojin/topic26/tpc26_4.htm
- Lindhardt, T., Hallberg, I., & Poulsen, I. (2008). Nurses' experience of collaboration with relatives of frail elderly patients in acute hospital wards: A qualitative study. *International Journal of Nursing Studies, 45*(5), 668-681. doi:10.1016/j.ijnurstu.2007.01.010
- Long-Sutehall, T., Willis, H., Palmer, R., Ugboma, D., Addington-Hall, J., & Coombs, M. (2010). Negotiated dying: A grounded theory of how nurses shape withdrawal of treatment in hospital critical care units. *International Journal of Nursing Studies, 48*, 1466-1473. doi:10.1016/j.ijnurstu.2011.06.003
- Loveday, S., & Mitchell, E. (2010). Getting tangled in red tape: The challenges of doing clinical research in New Zealand. *The New Zealand Medical Journal, 123*(1321), 54-58.
- Lum, K. L. (2004). Palliative care behind bars. *Journal of Pain and Palliative Care Pharmacotherapy, 17*(3-4), 131-138. doi:10.1080/J354v17n03_19

- Lynch, T., Connor, S., & Clark, D. (2013). Mapping levels of palliative care development: A global update. *Journal of Pain and Symptom Management*, 45(6), 1094-1106. doi:10.1016/j.jpainsymman.2012.05.011
- Lyndes, K., Fitchett, G., Berlinger, N., Cadge, W., Misasi, J., & Flanagan, E. (2012). A survey of chaplains' roles in pediatric palliative care: Integral members of the team. *Journal of Health Care Chaplaincy*, 18(1/2), 74-93. doi:10.1080/08854726.2012.667332
- Mackay, L. (1992). Working and co-operating in hospital practice. *Journal of Interprofessional Care*, 6(2), 127-131. doi:10.3109/13561829209014926
- MacLeod, R. (2001). A national strategy for palliative care in New Zealand. *Journal of Palliative Medicine*, 4(1), 69-74. doi:10.1089/109662101300052068
- MacLeod, R. (2016). Personal communication, August 3.
- MacLeod, R., & Egan, T. (2007). Interprofessional education. In B. Wee & N. Hughes (Eds.), *Education in palliative care: Building a culture of learning* (pp. 235-250). New York, NY: Oxford University Press.
- Maddocks, I. (2006). Communication - an essential tool for team hygiene. In P. Speck (Ed.), *Teamwork in palliative care: Fulfilling or frustrating* (pp. 137-152). Oxford, UK: Oxford University Press.
- Mahmood-Yousuf, K., Munday, D., King, N., & Dale, J. (2008). Interprofessional relationships and communication in primary palliative care: Impact of the Gold Standards Framework. *The British Journal of General Practice*, 58(549), 256-263. doi:10.3399/bjgp08X279760
- Mainz, J. (2003). Defining and classifying clinical indicators for quality improvement. *International Journal for Quality in Health Care*, 15(6), 523-530. doi:10.1093/intqhc/mzg081
- Margerum, R. (2011). *Beyond consensus: Improving collaborative planning and management*. Mass, MN: MIT Press.
- Marquis, B., & Huston, C. (2015). *Leadership roles and management functions in nursing* (8th ed.). Philadelphia, PA: Wolters Kluwer
- Mary Potter Hospice. (2014). *History of Mary Potter Hospice*. Retrieved November 26, 2014, from <http://www.marypotter.org.nz/about-us/our-history/>
- Masso, M., McCarthy, G., & Kitson, A. (2013). Mechanisms which help explain implementation of evidence-based practice in residential aged care facilities: A grounded theory study. *International Journal of Nursing Studies*, 51, 1014-1026. doi: 10.1016/j.ijnurstu.2013.11.010
- McCallin, A. (1999). *Humanistic guiding: A grounded theory of end of life care*. Doctoral thesis, Auckland University of Technology, Auckland, New Zealand.

- McCallin, A. (2006). Grappling with the literature in a grounded theory study. *The Grounded Theory Review*, 5(2/3), 18-28.
- McCallin, A. (2010). International perspectives of ethical approval: The New Zealand scene. *The Grounded Theory Review*, 9(3), 43-49.
- McCallin, A., Nathaniel, A., & Andrews, T. (2011). Learning methodology minus mentorship. In V. Martin & A. Gynnild (Eds.), *Grounded theory: The philosophy, method and work of Barney Glaser* (pp. 69-84). Boca Raton, FL: Brown Walker Press.
- McCourt, R., Power, J., & Glackin, M. (2013). General nurses' experiences of end-of-life-care in the acute hospital setting: A literature review. *International Journal of Palliative Nursing*, 19(10), 510-516.
- McDonald, C., & McCallin, A. (2010). Interprofessional collaboration in palliative nursing: What is the patient-family role? *International Journal of Palliative Nursing*, 16(6), 286-289. doi:10.12968/ijpn.2010.16.6.48832
- McLauchlin, H. (2009). What's in a name: 'patient', 'customer', 'consumer', 'expert by experience', 'service user' What's next? *British Journal of Social Work*, 39(6), 1101-1116. doi:10.1093/bjsw/bcm155
- Medical Council of New Zealand. (2011). *Resources*. Retrieved from <https://www.mcnz.org.nz/support-for-doctors/resources/>
- Meier, D. E., & Beresford, L. (2008). The palliative care team. *Journal of Palliative Medicine*, 11(5), 677-681. doi:10.1089/jpm.2008.9907
- Melvin, C. (2012). Professional compassion fatigue: What is the true cost of nurses caring for the dying. *International Journal of Palliative Nursing*, 18(12), 606-611.
- Melvin, J. (2003). Gold standard palliative care in the community. *Primary Health Care*, 13(7), 39-41.
- Meyer, J. (1993). Lay participation in care: A challenge for multidisciplinary teamwork. *Journal of Interprofessional Care*, 7(1), 57-66. doi:10.3109/13561829309014959
- Ministry of Health. (2000). *The New Zealand health strategy*. Wellington, New Zealand: Author.
- Ministry of Health. (2001). *The New Zealand palliative care strategy*. Wellington, New Zealand: Author.
- Ministry of Health. (2002). *He Korowai Oranga: Māori health strategy*. Wellington, New Zealand: Author.
- Ministry of Health. (2008). *Health and disability services (general) standard*. Wellington, New Zealand: Author.

- Ministry of Health. (2009). *Gap analysis of specialist palliative care in New Zealand: Providing a national overview of hospice and hospital-based services*. Wellington, New Zealand: Author.
- Ministry of Health. (2012). *Resource & capability framework for integrated adult palliative care services in New Zealand*. Wellington, New Zealand: Author.
- Ministry of Health. (2015). *Health and disability ethics committee*. Retrieved from <http://ethics.health.govt.nz/>
- Ministry of Health. (2016). *New Zealand health system*. Retrieved from <https://www.health.govt.nz/new-zealand-health-system>
- Mishra, S. (2014). Time management: A critical analysis. *Social Science International*, 30(1), 11.
- Molyneux, J. (2001). Interprofessional teamworking: What makes teams work well? *Journal of Interprofessional Care*, 15(1), 29-35.
doi:10.1080/13561820020022855
- Moran, M., Nisbet, G., & Thistlethwaite, J. (2006). Making it AIPPEN. Sharing a vision for collaborative practice: the formation of an Australasian interprofessional practice and education network. In Proceedings of AIPPEN. Interprofessional Learning for Interprofessional Practice: Interprofessional Learning Conference. *AIPPEN. Interprofessional Learning for Interprofessional Practice: Interprofessional Learning Conference*, University of South Australia, Adelaide, Australia. Retrieved from <https://espace.library.uq.edu.au/view/UQ:172272>
- Morgan, A., MacLeod, R., & Schumacher, A. (2015). Providing palliative care education to staff in elderly care settings in New Zealand. *European Journal of Palliative Care*, 22(6), 296-298.
- Morgan, A., MacLeod, R., Schumacher, M., & Egan, R. (2015). Delivering spiritual care: A resource to train hospice staff in New Zealand. *European Journal of Palliative Care*, 22(3), 130-132.
- Morse, J., Stern, P., Corbin, J., Bowers, B., Charmaz, K., & Clarke, A. (2009). *Developing grounded theory: The second generation*. Walnut Creek, CA: Left Coast Press.
- Nathaniel, A. (2006). Thoughts on the literature review and grounded theory. *The Grounded Theory Review*, 5(2/3), 35-41.
- Nathaniel, A. (2011). An integrated philosophical framework that fits grounded theory. In V. Martin & A. Gynnild (Eds.), *Grounded theory: The philosophy, method and work of Barney Glaser* (pp.187-200). Boca Raton, FL: Brown Walker Press.
- National Gold Standards Framework Centre. (2014a). *The Gold Standards Framework*. Retrieved from <http://www.goldstandardsframework.org.uk/home>

- National Gold Standards Framework Centre. (2014b). *The Gold Standards Framework: History*. Retrieved from <http://www.goldstandardsframework.org.uk/history>
- National Hospice and Palliative Care Associations. (2005). *Declaration on hospice and palliative care*. Paper presented at the 2nd Global Summit of Hospice and Palliative Care Associations, Seoul, Korea.
- National Hospice and Palliative Care Organisation. (2015). *History of hospice care*. Retrieved from <http://www.nhpco.org/history-hospice-care>
- New Zealand Medical Association. (2014). *Code of ethics for the New Zealand medical profession*. Wellington, New Zealand: Author.
- Nickel, P. (2006). Vulnerable populations in research: The case of the seriously ill. *Theoretical Medicine and Bioethics*, 27(3), 245-264. doi:10.1007/s11017-006-9000-2
- Northern Territory Government of Australia Department of Health. (2016). *Multidisciplinary teams (MDTs)*. Retrieved from http://www.health.nt.gov.au/Cancer_Services/CanNET_NT/Multidisciplinary_Teams/index.aspx
- Nursing Council of New Zealand. (2012). *Guidelines: Professional boundaries*. Wellington, New Zealand: Author.
- Nursing Council of New Zealand. (2014). *Competencies for the registered nurse scope of practice*. Wellington, New Zealand: Author
- Obholzer, A., & Roberts, V. (Eds.). (2011). *The unconscious at work*. New York, NY: Routledge.
- Olden, A., Holloway, R., Ladwig, S., Quill, T., & van Wijngaarden, E. (2011). Palliative care needs and symptom patterns of hospitalized elders referred for consultation. *Journal of Pain and Symptom Management*, 42(3), 410-418. doi:10.1016/j.jpainsymman.2010.12.005
- Oliver, D., Wittenberg-Lyles, E., & Day, M. (2007). Measuring interdisciplinary perceptions of collaboration on hospice teams. *American Journal of Hospice & Palliative Care*, 24(1), 49-53. doi:10.1177/1049909106295283
- Orchard, C., Curran, V., & Kabene, S. (2005). Creating a culture for interdisciplinary collaborative professional practice. *Medical Education Online*, 10(11). Retrieved from <http://www.med-ed-online.org>.
- O'Reilly, A., & Walshe, M. (2015). Perspectives on the role of the speech and language therapist in palliative care: An international survey. *Palliative Medicine*, 29(8), 756-761. doi:10.1177/0269216315575678
- Øvretveit, J. (2009). Five ways to describe a multidisciplinary team. *Journal of Interprofessional Care*, 10(2), 163-171. doi:10.3109/13561829609034099

- Palliative Care Australia. (2015). *The national standards*. Retrieved from <http://palliativecare.org.au/the-national-standards/>
- Palliative Care Australia. (2008). *Palliative and end of life care. Glossary of terms* (1st ed.). Deakin West, ACT: Palliative Care Australia, 24. Retrieved from www.palliativecare.org.au/portals/46/pca%20glossary.pdf
- Palliative Care Council of New Zealand. (2011). *National needs assessment for palliative care: Phase 1 report: Assessment of palliative care need*. Wellington, New Zealand: Ministry of Health.
- Palliative Care Council of New Zealand. (2013). *National health needs assessment for palliative care phase 2 report: Palliative care capacity and capability*. Wellington, New Zealand: Ministry of Health.
- Palliative Care Council of New Zealand. (2014). *Referral criteria for adult palliative care services in New Zealand*. Wellington, New Zealand: Ministry of Health.
- Palliative Care Council of New Zealand, Hospice New Zealand, & Ministry of Health. (2012a). *Palliative care national joint work programme 2012*. Wellington, New Zealand: Ministry of Health.
- Palliative Care Council of New Zealand, Hospice New Zealand, & Ministry of Health. (2012b). *New Zealand palliative care glossary*. Wellington, New Zealand: Ministry of Health.
- Palliative Care Nurses New Zealand. (2014). *A national professional framework for palliative care nursing practice in Aotearoa New Zealand*. Wellington, New Zealand: New Zealand Nurses Society.
- Palliative Care Subcommittee, & New Zealand Cancer Treatment Working Party. (2007). *New Zealand palliative care: A working definition*. Retrieved from <https://www.health.govt.nz/system/files/documents/publications/nz-palliative-care-definition-oct07.pdf>
- Parker-Oliver, D., Bronstein, L., & Kurzejeski, L. (2005). Examining variables related to successful collaboration on the hospice team. *Health & Social Work, 30*(4), 279-286.
- Parker-Oliver, D., Porock, D., Demiris, G., & Courtney, K. (2005). Patient and family involvement in hospice interdisciplinary teams. *Journal of Palliative Care, 21*(4), 270-276.
- Parker-Oliver, D., Wittenberg-Lyles, E., & Day, M. (2006). Variances in perceptions of interdisciplinary collaboration by hospice staff. *Journal of Palliative Care, 22*(4), 275-280.
- Parker-Oliver, D., Wittenberg-Lyles, E., & Day, M. (2007). Measuring interdisciplinary perceptions of collaboration on hospice teams. *American Journal of Hospice & Palliative Medicine, 24*(1), 49-53. doi:10.1177/1049909106295283

- Pastrana, T., Jünger, S., Ostgathe, C., Elsner, F., & Radbruch, L. (2008). A matter of definition - key elements identified in a discourse analysis of definitions of palliative care. *Palliative Medicine*, 22(3), 222-232. doi:10.1177/0269216308089803
- Pattison, E., Hackenberg, D., Wayne, E., & Wood, P. (1976). A code of ethics for a community mental health program. *Psychiatric Services*, 27(1), 29-32. doi:10.1176/ps.27.1.29
- Pearsall, J. (Ed). (2012). *Integrate. Concise Oxford English Dictionary* (10th ed.). Oxford, UK: Oxford University Press.
- Penney, P. (2013). *Collaborative practice: A grounded theory of connecting in community rehabilitation*. Doctoral thesis, Auckland University of Technology, Auckland, New Zealand.
- Penz, K., & Duggleby, W. (2011). Harmonizing hope: A grounded theory study of the experience of hope of registered nurses who provide palliative care in community settings. *Palliative & Supportive Care*, 9(3), 281-294. doi: 10.1017/S147895151100023X
- Pestinger, M., Steil, S., Elsner, F., Widdershoven, G., Voltz, R., Nauck, F., & Radbruch, L. (2015). The desire to hasten death: Using a grounded theory for a better understanding “When perception of time tends to be a slippery slope”. *Palliative Medicine*, 29(8), 711-719. doi:10.1177/0269216315577748
- Peters, L., Cant, R., Sellick, K., O’Connor, M., Lee, S., & Burney, S. (2012). Is work stress in palliative care nurses a cause for concern? A literature review. *International Journal of Palliative Nursing*, 18(11), 561-567.
- Petri, L. (2010). Concept analysis of interdisciplinary collaboration. *Nursing Forum*, 45, 73-82. doi:10.1111/j.1744-6198.2010.00167.x
- Phillips, J., Ingham, J., & MacLeod, R. (2013). *The development of palliative care in Australia and New Zealand*. New South Wales, Australia: Unpublished.
- Phipps, W. E. (1988). The origin of hospices/hospitals. *Death Studies*, 12(2), 91-99. doi: 10.1080/07481188808252226
- Pietroburgo, J., & Bush, R. (2008). Coming to terms: A case study of hospice collaboration challenges. *American Journal of Hospice & Palliative Care*, 24(6), 487-492. doi: 10.1177/1049909107306625
- Politi, M., & Street, R. (2011). The importance of communication in collaborative decision making: Facilitating shared mind and the management of uncertainty. *Journal of Evaluation in Clinical Practice*, 17, 579-584. doi:10.1111/j.1365-2753.2010.01549x
- Post, S., Underwood, L., Schloss, J., & Hurlburt, W. (2002). *Altruism and altruistic love: Science, philosophy and religion in dialogue*. Retrieved from

www.oxfordscholarship.com/view/10.1093/acprof.oso/9780195143584
doi:10.1093/acprof:oso/9780195143584.001

- Prins, S. (2010). From competition to collaboration: Critical challenges and dynamics in multiparty collaboration. *The Journal of Applied Behavioral Science*, 46(3), 281-312. doi:10.1177/0021886310369885
- Pūtaiora Writing Group (2010). *Te Ara Tika Guidelines for Māori research ethics: A framework for researchers and ethics committee members*. Health Research Council of New Zealand. Retrieved from <http://www.hrc.govt.nz/sites/default/files/Te%20Ara%20Tika%20Guidelines%20for%20Maori%20Research%20Ethics.pdf>
- Quality End-of-life Coalition of Canada. (2014). *Quality end-of-life coalition of Canada*. Retrieved from <http://www.qelccc.ca/>
- Randall, F., & Downie, R. (2006). *The philosophy of palliative care*. Oxford, UK: Oxford University Press.
- Raphael, D., Waterworth, S., & Gott, M. (2014). The role of practice nurses in providing palliative and end-of-life care to older patients with long-term conditions. *International Journal of Palliative Nursing*, 20(8), 373-379. doi:10.12968/ijpn.2014.20.8.373
- Reeves, S. (2012). The rise and rise of interprofessional competence. *Journal of Interprofessional Care*, 26(4), 253-255. doi:10.3109/13561820.2012.695542
- Reeves, S., Rice, K., Conn, L. G., Miller, K.-L., Kenaszchuk, C., & Zwarenstein, M. (2009). Interprofessional interaction, negotiation and non-negotiation on general internal medicine wards. *Journal of Interprofessional Care*, 23(6), 633-645. doi:10.3109/13561820902886295
- Reinecke, K., Nguyen, M., Bernstein, A., Naf, M., & Gayos, K. (2013). Doodle around the world: Online scheduling behaviour reflects cultural differences in time perception and group decision-making. In *Proceedings of the 2013 conference on Computer supported cooperative work, CSCW '13*, (pp. 45-54), New York, NY. doi:10.1145/2441776.2441784
- Rittman, M., Faircloth, C., Boylstein, C., Gubrium, J., Williams, C., Van Puymbroeck, M., & Ellis, C. (2004). The experience of time in the transition from hospital to home following stroke. *Journal of Rehabilitation Research & Development*, 41(3A), 259-267.
- Robb, J. (2001). *The beginnings of modern philosophy. The emergency of social theory*. Wellington, New Zealand: J. H. Robb.
- Roberts, V. (1994). Conflict and collaboration: Managing intergroup relations. In A. Obholzer & V. Roberts (Eds.), *The unconscious at work* (pp. 187-196). New York, NY: Routledge.

- Robertson, M. (2015). Experiences of time: A qualitative inquiry into experiences of time as described by palliative care inpatients. *Palliative & Supportive Care*, 13(01), 67-73. doi:10.1017/S1478951513000886
- Robinson, M., & Cottrell, D. (2005). Health professionals in multi-disciplinary & multi-agency teams: Changing professional practice. *Journal of Interprofessional Care*, 19(6), 547-560. doi:10.1080/13561820500396960
- Running, A., Shreffler-Grant, J., & Andrews, W. (2008). A survey of hospices use of complementary therapy. *Journal of Hospice & Palliative Nursing*, 10(5), 304-312. doi:10.1097/01.NJH.0000319177.25294.e5
- Safran, D. G., Miller, W., & Beckman, H. (2006). Organizational dimensions of relationship-centered care. *Journal of General Internal Medicine*, 21(S1), S9-S16. doi:10.1111/j.1525-1497.2006.00303.x
- San Martín-Rodríguez, L., Beaulieu, M., D'Amour, D., & Ferrada-Videla, M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care*, 19(s1), 132-147. doi:10.1080/13561820500082677
- Sargent, J. (2009). Theories to aid understanding and implementation of interprofessional education. *Journal of Continuing Education*, 29(3), 178-184. doi:10/1002/Chp.20033
- Saunders, C. (1996). Hospice. *Mortality*, 1(3), 317-322.
- Saunders, C. (2015). *Dame Cicely Saunders: A brother's story*. Retrieved from <http://cicelysaundersinternational.org/dame-cicely-saunders/>
- Saunders, C., & Baines, M. (1983). *Living with dying: The management of terminal disease*. Oxford, UK: Oxford University Press.
- Schirmer, A., Meck, W., & Penney, T. (2016). The sociotemporal brain: Connecting people in time. *Trends in Cognitive Sciences*, 20(10), 760-772. doi:10.1016/j.tics.2016.08.002
- Schmitt, M. (2001). Collaboration improves the quality of care: Methodological challenges and evidence from US health care research. *Journal of Interprofessional Care*, 15(1), 47-66. doi:10.1080/13561820020022873
- Shaw, S. (2008). More than one dollop of cortex: Patients' experiences of interprofessional care at an urban family health centre. *Journal of Interprofessional Care*, 22(3), 229-237.
- Shuster, E. (1997). Fifty years later: The significance of the Nuremberg code. *New England Journal of Medicine*, 337(20), 1436-1440. doi:10.1056/NEJM199711133372006

- Silver, I., & Leslie, K. (2009). Faculty development for continuing interprofessional education and collaborative practice. *Journal of Continuing Education in the Health Professions*, 29(3), 172-177. doi:10.1002/chp.20032
- Solomon, P. (2010). Inter-professional collaboration: passing fad or way of the future? *Physiotherapy Canada*, 62(1), 47-55. doi:10.3138/physio.62.1.47
- Speck, P. (2006a). Maintaining a healthy team. In P. Speck (Ed.), *Teamwork in palliative care: Fulfilling or frustrating?* (pp. 95-116). Oxford, UK: Oxford University Press.
- Speck, P. (Ed.). (2006b). *Teamwork in palliative care: Fulfilling or frustrating?* Oxford, UK: Oxford University Press.
- Speziale, H., & Carpeter, D. (2007). *Qualitative research in nursing: Advancing the humanistic imperative*. New York, NY: Lippincott Williams & Wilkins.
- St. Joseph's Mercy Hospice. (2014). *Mercy heritage*. Retrieved from <https://www.mercyhospice.org.nz/about/heritage.asp>
- Stern, P. (2009). In the beginning Glaser and Strauss created grounded theory. In J. Morse (Ed.), *Developing grounded theory: The second generation* (pp. 24-29). Walnut Creek, CA: Left Coast Press.
- Stocker, R., & Close, H. (2013). Assessing the uptake of the Liverpool Care Pathway for dying patients: A systematic review. *BMJ Supportive and Palliative Care*, 3(4), 399-404. doi:10.1136/bmjspcare-2012-000406
- Strauss, A., & Corbin, J. (1990). *15-116* Newbury Park, CA: Sage Publications.
- Sullivan, T. (1998). *Collaboration: A health care imperative*. New York, NY: McGraw Hill Professional.
- Susan, A., & Vincent, M. (2006). *Hospice. The encyclopedia of aging* (4th ed.; Vol. 1). New York, N.Y: Springer Publishing Company. Retrieved from <http://%3A52F%2Fsearch.credreference.com%2Fcontent%2Fentry%2Fspencage%2Fhospice%2F0>.
- Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *Journal of Interprofessional Care*, 23(1), 41-51. doi:10.1080/13561820802338579
- Suter, E., Deutschlander, S., Mickelson, G., Nurani, Z., Lait, J., Harrison, L., . . . Grymonpre, R. (2012). Can interprofessional collaboration provide health human resources solutions? A knowledge synthesis. *Journal of Interprofessional Care*, 26(4), 261-268. doi:10.3109/13561820.2012.663014
- Tan, A., & Manca, D. (2013). Finding common ground to achieve a "good death": family physicians working with substitute decision-makers of dying patients. A qualitative grounded theory study. *BMC Family Practice*, 14(14), 11.

- Te Omanga Hospice. (2014). *How it all began*. Retrieved from <http://www.teomanga.org.nz/Article.aspx?ID=458>
- Thannhauser, J., Russell-Mayhew, S., & Scott, C. (2010). Measures of interprofessional education and collaboration. *Journal of Interprofessional Care*, 24(4), 336-349. doi:10.3109/13561820903442903
- The Australia and New Zealand Society of Palliative Medicine. (2015). *About*. Retrieved from <http://www.anzspm.org.au/c/anzspm?a=da&did=1002205>
- Thistlethwaite, J. (2012). Interprofessional education: A review of context, learning & the research agenda. *Medical Education*, 46(1), 58-70. doi:10.1111/j.1365-2923.2011.04143.x
- Thistlethwaite, J., Lee, A., Dunston, R., Nisbet, G., Matthews, L., & Pockett, R. (2009). Interprofessional developments in Australia – L-TIPP (Aus) and the way forward. *Journal of Interprofessional Care*, 23(4), 315-317. doi:10.1080/13561820903028251
- Thomas, R., & Corney, R. (1993). Teamwork in primary care: The practice nurse perspective. *Journal of Interprofessional Care*, 7(1), 47-55. doi:10.3109/13561829309014958
- Thulesius, H., Håkansson, A., & Petersson, K. (2003). Balancing: A basic process in end-of-life cancer care. *Qualitative Health Research*, 13(10), 1353-1377. doi:10.1177/1049732303258369
- Totman, J., Pistrang, N., Smith, S., Hennessey, S., & Martin, J. (2015). You only get one chance to get it right: A qualitative study of relatives' experiences of caring at home for a family member with terminal cancer. *Palliative Medicine*, 29(6), 596-507. doi:10.1177/0269216314566840
- Tye, J., & Dent, B. (2017). *Building a culture of ownership in healthcare: The invisible architecture of core values, attitude, and self empowerment*. Indianapolis, IN: Sigma Theta Tau International.
- United Nations. (2014). *New UN report identifies unmet need for palliative care worldwide*. Retrieved from <http://www.un.org/apps/news/story.asp?NewsID=47024#.VPKA7pUcRIb>
- United Nations Department of Economic and Social Affairs. (n.d.). *Palliative care and standards on the rights of older people: Recommendations for new legal instruments*. New York, NY: United Nations.
- United States (U.S.) National Library of Medicine. (2012). *Greek medicine*. Retrieved from https://www.nlm.nih.gov/hmd/greek/greek_oath.html
- Vickridge, R. (1998). Collaborative working for good practice in palliative care. *Journal of Interprofessional Care*, 12(1), 63-67. doi:10.3109/13561829809014088

- Vouzavali, F., Papathanassoglou, E., Karanikola, M., Koutroubas, A., Patiraki, E., & Papadatou, D. (2011). 'The patient is my space': Hermeneutic investigation of the nurse-patient relationship in critical care. *Nursing in Critical Care*, 16(3), 140-151. doi:10.1111/j.1478-5153.2011.00447.x
- Wade, D., & Halligan, P. (2004). Do biomedical models of illness make for good healthcare systems? *British Medical Journal*, 329(7479), 1398-1401.
- Waterworth, S. (2003). Time management strategies in nursing practice. *Journal of Advanced Nursing*, 43(5), 432-440. doi:10.1046/j.1365-2648.2003.02740.x
- Weber, M., & Grohmann, L. (2004). Time expenditure in patient-related care provided by specialist palliative care nurses in a community hospice service. *Palliative Medicine*, 18(7) 719-725. doi:10.1191/0269216304pm943oa
- Weissman, D. (2015). Improving care during a time of crisis: The evolving role of specialty palliative care teams. *Journal of Palliative Medicine*, 18(3) 204-207. doi:10.1089/jpm.2015.1014
- West, E. (2001). Management matters: The link between hospital organisation and quality of patient care. *Quality in Health Care*, 10(1), 40-48. doi:10.1136/qhc.10.1.40
- Wight, V., & Raley, S. (2008). When home time becomes work: Work and family time among workers at home. *Social Indicators Research*, 93, 197-202. doi:10.1007/s11205-008-9377-6
- Wilcox, R., & Whitham, E. (2003). The symbol of modern medicine: Why one snake is more than two. *Annals of Internal Medicine*, 138(8), 673-677.
- Wilson, D., & Neville, S. (2009). Culturally safe research with vulnerable populations. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 33(1), 69-79.
- Wittenberg-Lyles, E., Parker-Oliver, D., Demiris, G., & Regehr, K. (2010). Interdisciplinary collaboration in hospice team meetings. *Journal of Interprofessional Care*, 24(3), 264-273. doi:10.3109/13561820903163421
- Wittenberg-Lyles, E. M., & Parker-Oliver, D. (2007). The power of interdisciplinary collaboration in hospice. *Progress in Palliative Care*, 15(1), 6-12.
- Workforce Taskforce. (2008). *Working together for better primary health care: Overcoming barriers to workforce change and innovation*. Wellington, New Zealand: Ministry of Health.
- World Health Organisation. (1978). *Working interrelationships in the provision of community health care (medicine, nursing and medicosocial work): Report of a working group*. Geneva, Switzerland: Author.
- World Health Organisation. (1988). *Learning together to work together for health. Report of a WHO study group on multiprofessional education for health*

- personnel: The team approach*. World Health Organisation Technical Report Series. Geneva, Switzerland: Author.
- World Health Organisation. (2014). *WHO definition of palliative care*. Retrieved from <http://www.who.int/cancer/palliative/definition/en/>
- World Health Organisation. (2015a). *Aging and health. Fact sheet 404*. Geneva, Switzerland: Author.
- World Health Organisation. (2015b). *Background: The global burden of chronic diseases*. Geneva, Switzerland: Author.
- World Health Organisation, & Health Professions Network Nursing and Midwifery Office: Department of Human Resources for Health. (2010). *Framework for action on interprofessional education & collaborative practice (WHO/HRH/HPN/10.3)*. Geneva, Switzerland: World Health Organisation.
- Worldwide Hospice Palliative Care Alliance, World Health Organisation, & United Nations. (2014). *WHO global atlas on palliative care at the end of life*. London, U.K.: Author.
- Worldwide Palliative Care Alliance. (2015). *About World Hospice and Palliative Care Day 2015*. Retrieved from <http://www.thewhpc.org/about>
- Wright, M., Wood, J., Lynch, T., & Clark, D. (2008). Mapping levels of palliative care development: A global view. *Journal of Pain and Symptom Management*, 35(5), 469-485. doi:10.1016/j.jpainsymman.2007.06.006
- Xie, S. (2009). Striking a balance between program requirements and GT principles: Writing a compromised GT proposal. *The Grounded Theory Review*, 8(2), 35-47.
- Yamada, Y., & Kawabe, T. (2011). Emotion colors time perception unconsciously. *Consciousness & Cognition* 20(4), 1835-1841. doi:10.1016/j.concog.2011.06.016
- Yamaguchi, T., Kuriya, M., Morita, T., Agar, M., Choi, Y. S., Goh, C., . . . Yen-Phi Nguyen. (2014). Palliative care development in the Asia-Pacific region: An international survey from the Asia Pacific Hospice Palliative Care Network (APHN). *British Medical Journal Supportive and Palliative Care*, vol 7(1), 23-31. doi:10.1136/bjmspcare-2013-000588
- Zwarenstein, M., Goldman, J., & Reeves, S. (2009). Interprofessional collaboration: Effects of practice-based interventions on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews* (3). doi:10.1002/14651858.CD000072.pub2.

Glossary of Terms

Health Professionals: Nurses, doctors, social workers, paid health care assistants or any other health care employee who works with palliative patients regardless of age, ethnicity or race.

Hospice: Hospice is not only a building; it is a philosophy of care. The goal of hospice care is to help people with life-limiting and life-threatening conditions make the most of their lives by providing high quality palliative and supportive care (Palliative Care Council of New Zealand et al., 2012b). For the purposes of this research the terms hospice and palliative care will be used interchangeably unless otherwise specified.

Interprofessional Collaboration: A partnership between a team of health providers and a patient in a participatory, collaborative, and coordinated approach to shared decision-making around health and social issues (Canadian Interprofessional Health Collaborative, 2010).

Palliative Approach: A palliative approach embraces the World Health Organisation definition of palliative care. It incorporates a positive and open attitude toward death and dying by all service providers working with patients and their families and respects the wishes of patients in relation to their treatment and care (Palliative Care Council of New Zealand et al., 2012b).

Palliative Care: An approach that improves the quality of life of patients and their families facing the problems associated with life-limiting or life-threatening conditions,

through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten nor 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 patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- enhances 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 symptoms (World Health Organisation, 2014).

Patient: Someone with a life-limiting palliative diagnosis who is receiving a palliative health care service.

Primary Palliative Care: Palliative care that is provided by all healthcare professionals or organisations that deliver palliative care as a component of their

service, but their substantive work is not in the care of people who are dying. For example, general practice teams, Māori health providers, allied health teams, district nurses and residential care staff.

Specialist palliative care: Care that is “provided by those who have undergone specific training and/or accreditation in palliative care/medicine, working in the context of an expert interdisciplinary team of palliative care health professionals” (Palliative Care Subcommittee New Zealand Cancer Treatment Working Party, 2007, p. 2).

Sharing Time: The mechanism whereby health professionals purposefully make time, take time, or find time in their work day, to connect with other health professionals and discover common ground while sharing.

Appendices

Appendix A: Health and Disability Ethics Approvals



Multi-region Ethics Committee Ministry of Health
No. 1 The Terrace
PO Box 5013
Wellington 6145
Phone (04) 816 2403
(04) 816 2646
Fax (04) 496 2343
Email: multiregion_ethicscommittee@moh.govt.nz

25 November 2011

Amended 28 November 2011

Ms Christine McDonald
12 Reuben Place
Nawton
Hamilton 3200

Dear Ms McDonald –

Ethics ref: MEC/11/EXP/123 (please quote in all correspondence)

Study title: Collaborative practice in palliative care: A grounded theory study

This expedited study was given ethical approval by the Chairperson of the Multi-region Ethics Committee on 25th November 2011.

Approved Documents

- Completed National Application Form
- Signed Part 4 declaration dated 28 October 2011
- Signed Locality Assessment dated 27 October 2011 for North Shore Hospital

- Signed Locality Assessment dated 20 October 2011 for Waipuna Hospice, Tauranga
- Signed Locality Assessment dated 2 November 2011 for Eastern Bays Hospice - Dove House, Auckland
- Consent Form - Version 1, 28 October 2011
- Participant Information Sheet for Health Professionals - Version 1, 10 October 2011
- Participant Information Sheet for Patients - Version 1, 10 October 2011
- Evidence of Māori Consultation - Letter dated 21 September 2011 signed by Koroneihana Cooper
- Typist Confidentiality Agreement - Version 1 dated 10 October 2011

This approval is valid until 25th November 2013, provided that Annual Progress Reports are submitted (see below).

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due on the 25th November 2012. The Annual Report Form is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

We wish you all the best with your study.

Please do not hesitate to contact me should you have any queries.

Yours sincerely

Laura Jayne Burlison
Administrator
Multi-Region Ethics Committee
Email: Multiregion_ethicscommittee@MOH.govt.nz

08 January 2013

Ms Christine McDonald
12 Reuben Place
Nawton, Hamilton 3200

Dear Ms McDonald

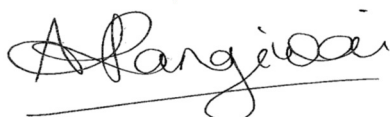
Re: Ethics ref:	MEC/11/EXP/123
Study title:	Collaborative practice in palliative care: A grounded theory study

This letter is to confirm receipt of the annual progress report for this study, submitted on 7 January 2013. HDEC approval for the study is re-confirmed for the period 7 January 2013 to 7 January 2014.

The Northern B Health and Disability Ethics Committee will be in contact with you within 15 days of this date if it requires further information on any matter relating to this annual progress report, or if it wishes to reconsider its approval for the study. In the absence of such contact you should assume that the annual progress report has been accepted and approved without comment. No separate letter will be sent confirming this.

Please don't hesitate to contact us for further information.

Yours sincerely,



Awhina Rangiwai
Administrator
Health and Disability Ethics Committees
hdec@moh.govt.nz



Health and Disability Ethics Committees
1 the Terrace
PO Box 5013
Wellington
0800 4 ETHICS
hdccs@moh.govt.nz

24 January 2014

Ms Christine McDonald
12 Reuben Place
Newton
Hamilton 3200

Dear Ms McDonald

Re: Ethics ref: MEC/11/EXP/123/AM02
Study title: Collaborative practice in palliative care: A grounded theory study

This letter is to confirm approval of the annual progress report for this study, reviewed by the Chairperson of the Northern B Health and Disability Ethics Committee on 23 January 2014. Existing approval remains valid.

Your next progress report is due by 8 January 2015.

Please don't hesitate to contact us for further information.

Yours sincerely,

A handwritten signature in cursive script, appearing to read "R. Sporie".

Mrs Raewyn Sporie
Chairperson
Northern B Health and Disability Ethics Committee

Encl: appendix A: documents submitted



Health and Disability Ethics Committees
20 Aitken Street
PO Box 5013
Wellington
0800 4 ETHICS
hdec@mh.govt.nz

26 May 2016

Ms Christine McDonald
12 Reuben Place
Nawton, Hamilton 3200

Dear Ms McDonald

Re:	Ethics ref:	MEC/11/EXP/123/AM03
	Study title:	Collaborative practice in palliative care: A grounded theory study

This letter is to confirm approval of the annual progress report for this study, reviewed by the Chairperson of the Northern B Health and Disability Ethics Committee on 24 May 2016. Existing approval remains valid.

Your next progress report is due by 7 January 2017.

Please don't hesitate to contact us for further information.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Kate O'Connor'.

Kate O'Connor
Chairperson
Northern B Health and Disability Ethics Committee

End: appendix A: documents submitted

Appendix B: AUTECH Ethics Approvals



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTECH)

To: Antoinette McCallin

From: Dr Rosemary Godbold Executive Secretary, AUTECH

Date: 8 February 2012

Subject: Ethics Application Number 11/334 Collaborative practice in palliative care: A grounded theory study.

Dear Antoinette

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by a subcommittee of the Auckland University of Technology Ethics Committee (AUTECH) and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTECH's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTECH's meeting on 27 February 2012 .

Your ethics application is approved for a period of three years until 8 February 2015.

I advise that as part of the ethics approval process, you are required to submit the following to AUTECH:

A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 8 February 2015;

A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 8 February 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEK is notified of any adverse events or if the research does not commence. AUTEK approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEK grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEK Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at <http://www.aut.ac.nz/research/research-ethics/ethics>).

On behalf of AUTEK and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Christine McDonald cmcdonald@xtra.co.nz

7 April 2014

Marion Jones
Faculty of Health and Environmental Sciences

Dear Marion

Ethics Application: 11/334 Collaborative practice in palliative care: A grounded theory study.

At their meeting of 31 March 2014, the Auckland University of Technology Ethics Committee (AUTEK) received the report on your ethics application. AUTEK noted your report and asked me to thank you.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902.

On behalf of AUTEK, I congratulate the researchers on the project and look forward to reading more about it in future reports.

Yours sincerely



Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Christine McDonald cmcdonald@xtra.co.nz

Appendix C: Safety Protocol

Researcher Safety Protocol

It is expected that risk to the researcher is minimal as the researcher is an experienced palliative care nurse who has knowledge of and experience in recognising patient and family stressors that can occur near the end of life.

To maintain safety and minimise risk when the researcher is conducting interviews in a participants home the following will occur:

1. All visits will occur in daylight hours
2. The researcher will carry a fully charged mobile telephone
3. The researcher will dress in appropriate business attire and wear a name tag identifying her as a doctoral student researcher.
4. The primary supervisor will be kept informed of travel plans and interviewing schedules including the name of person being interviewed, time of interview and location of interview (i.e. participant's address).
5. The researcher's family will be made aware of travel plans and planned time of return. The researcher's family will also be given a contact number for the primary supervisor in case there are any concerns. To maintain confidentiality, family members will not be given names of research participants or the location of the interview (i.e. participant's address).
6. Should the researcher feel concerned about her physical safety at any time, she will excuse herself and leave immediately regardless of whether the interview has been concluded or not.

Appendix D: Cultural Support Letter



21 September 2011

To whom it may concern,

He Maunga rongo
Ki runga te mata o te whenua
He Whakaaro pai ki nga tangata Katoa

I am happy to support Christine McDonald's research for her doctoral studies and act as the Cultural Advisor. I am comfortable that the grounded theory methodology doesn't trespass culturally, as the concerns are asked from the participants point of view to obtain a group perspective. The nature of how this research is going to be conducted is appropriate.

Regards,

Koroneihana Cooper
Kaumatua



Koroneihana Cooper QSM, JP
Waikato Police District Kaumatua
Mobile: 027 233 7582

telephone 07 859 1260
fax 07 859 1266

PO Box 325
Waikato Mail Centre
Hamilton 3240

www.hospicewaikato.org.nz
0800 HOSPICE (0800 467 742)



Appendix E: Health Professional Information Sheet

Participant Information Sheet



For Health Professionals

Date Information Sheet Produced: 30 September 2011

Project Title: Collaborative practice in palliative care

An Invitation

My name is Christine McDonald. I am undertaking a research study as part of the Doctor of Health Science programme at Auckland University of Technology (AUT). I want to look at how health professionals and patients collaborate (work together) in hospice/palliative care. I am inviting you to participate in this study.

Your participation is voluntary. You may change your mind at any stage prior to all of the information being collected from participants. Once all of the information (data) is collected and analysed it will not be possible to recognise and remove individual people's information.

What is the purpose of this research?

Current knowledge of collaborative practice in hospice/palliative care is limited. Along with adding to the current knowledge, the explanations proposed in this study will be helpful to assist with the collaboration of health services for hospice/palliative patients in New Zealand. It may also contribute to the education of health professionals.

How was I identified and why am I being invited to participate in this research?

You have been identified and invited to participate in the research study because you are a health professional with over 5 years' experience working in hospice/palliative care. You are over 18 years of age and speak conversational English.

What will happen in this research?

I will make an appointment to visit with you at a place of your choosing to explain the study and confirm that you are willing to participate. You will be interviewed for up to one hour to find out what you understand about collaborative practice and any experiences you may have had. The information from your interview will be merged with the interviews of other participants to obtain a group perspective. This group perspective will then be used to produce an explanation of what is happening

With your agreement, the interview will be taped to ensure accuracy. The tape recording will be transcribed (typed up word-for-word) and the information will be examined and used to contribute

to the research findings. I may also make some hand written notes during the interview to help me remember what we are discussing if that is acceptable to you.

A second voluntary interview may be requested from you to help clarify the information collected. If a second interview is requested, I will contact you to make another appointment to visit. Therefore, the maximum number of interview visits for this study will be two and the maximum time of involvement will be up to 90 minutes (1 ½ hours).

What are the discomforts and risks?

A potential discomfort is the length of the interview. You may also become upset in recalling your participation in the care of a hospice/palliative patient

How will these discomforts and risks be alleviated?

You can decide to stop at any time during the interview. If, for any reason, you are unable to talk for the time required for me to obtain information for this study, another convenient time will be agreed upon to finish the interview, if you wish to continue. If you feel upset, you may want to talk with a colleague about whatever is upsetting you. At your request I can make the initial telephone call on your behalf to whomever you would like to talk to.

What are the benefits?

If you choose to participate you will not receive any advantages or financial rewards. Neither will you be disadvantaged in any way if you decide not to participate or if you change your mind and withdraw from the study. While there is no direct benefit to you, your participation may influence how collaboration occurs and may affect future care of hospice/palliative patients.

How will my privacy be protected?

You will not be identifiable by name and the research results will be a consolidation of all of the participant's information rather than individual information. You may choose a false name if you wish for the interview data. The audiotapes will be destroyed at the end of the study. Transcribed information will be stored electronically on disc for 10 years after the study has finished. This disc will be kept in a secure locked cabinet.

What are the costs of participating in this research?

The cost of participating in this research is the time required for the interview(s).

What opportunity do I have to consider this invitation?

Following initial contact you may take up to one week to consider your involvement, or longer by negotiation.

How do I agree to participate in this research?

You will need to sign a consent form that will be given to you when you feel you have completely understood your participation in the project and all your questions have been satisfactorily answered.

Will I receive feedback on the results of this research?

Final results from this research will not be available for approximately two to three years following the interview. However, if you wish, you will be sent a preliminary summary of the findings after the first phase of the study is complete. You may also request a copy of the transcript of the interview to keep.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisors,

Associate Professor Antoinette McCallin, antoinette.mccallin@aut.ac.nz or phone (09) 921 9999 extension 7884 or Professor Rod MacLeod, rd.macleod@auckland.ac.nz or phone (09) 373 7599 extension 86082

Concerns regarding the conduct of the research should be notified to the Executive Secretary, Multi-Region Health and Disability Ethics Committee, Telephone (04) 470 0655

Email: multiregion_ethicscommittee@moh.govt.nz

Whom do I contact for further information about this research?

Researcher Contact Details:

Christine McDonald, cmcdonald@xtra.co.nz or phone 027 464 8333

Project Supervisor Contact Details:

Associate Professor Antoinette McCallin, antoinette.mccallin@aut.ac.nz or phone 09 921 9999 extension 7884

Professor Rod MacLeod, rd.macleod@auckland.ac.nz or phone 09 373 7599 extension 86082

Approved by the Multi-Regional Health and Disability Ethics Committee on 25 November, 2011, AUTEK Reference number 11/334 .

Approval for further contact

I am interested in the research study described on this participant information sheet and agree to having the researcher (Christine McDonald) contact me directly to explain the study further and answer any questions I may have.

This form is to help with communication between myself and Christine. Giving approval for further contact does not obligate me to take part in the study.

If I do decide to take part in the research study I will sign a separate consent form. This contact form will be destroyed when the study is completed after I (or my nominated person) have been sent a summary of the study findings. If I decide not to participate in the research study this form will be destroyed immediately and my personal details will not be kept.

Name:.....

Contact telephone number

Address;.....
.....
.....

Preferred means of contact e.g. telephone call, letter, through another family member (state name and contact details if different)

.....
.....

Appendix F: Patient Information Sheet

Participant Information Sheet



For Patients

Date Information Sheet Produced: 30 September 2011

Project Title: Collaborative practice in palliative care

An Invitation

My name is Christine McDonald. I am undertaking a research study as part of the Doctor of Health Science programme at Auckland University of Technology (AUT). I want to look at how health professionals and patients collaborate (work together) in hospice/palliative care. I am inviting you to participate in this study.

Your participation is voluntary. You may change your mind at any stage *prior* to all of the information being collected from participants. Once all of the information (data) is collected and analysed it will not be possible to recognise and remove individual people's information.

What is the purpose of this research?

Current knowledge of collaborative practice in hospice/palliative care is limited. Along with adding to the current knowledge, the findings of this study will be helpful to assist with the collaboration of health services for hospice/palliative patients in New Zealand. It may also contribute to the education of health professionals.

How was I identified and why am I being invited to participate in this research?

You have been identified and invited to participate in the research study because you have a palliative diagnosis. You have had experience of hospice/palliative care in both community and in-patient settings. You can speak English well enough to hold a conversation. You are over 18 years of age.

What will happen in this research?

I will make an appointment to visit with you at a place of your choosing to explain the study and confirm that you are still willing to participate. You will be interviewed for up to one hour to find out what you understand about collaborative practice and any experiences you may have had. The information from your interview will be merged with the interviews of other participants to obtain a group perspective. This group perspective will then be used to produce an explanation of what is happening

With your agreement, the interview will be taped to ensure accuracy. The tape recording will be transcribed (typed up word-for-word) and the information will be examined and used to contribute to the research findings. I may also make some hand written notes during the interview to help me remember what we are discussing if that is acceptable to you.

A second voluntary interview may be requested from you to help clarify the information collected. If a second interview is requested, I will contact you to make another appointment to visit. If the first interview was divided into two shorter portions the maximum number of interview visits for this study will be three and the maximum time of involvement will be 90 minutes (1 ½ hours).

What are the discomforts and risks?

A potential discomfort is the length of the interview which you may find tiring. You may also become upset in recalling the care that you received as a hospice/palliative patient.

How will these discomforts and risks be alleviated?

If, for any reason, you are unable to talk for the time required for me to obtain information for this study because you get tired, you may elect to have two shorter interviews of 20 to 30 minutes. You can decide to stop at any time during the interview and another convenient time will be agreed upon to finish the interview, if you wish to continue. You may want to talk with a family/whanau member or a hospice staff member about whatever is upsetting you. You will also be given the telephone number of the patient advocacy service. At your request I can make the initial telephone call on your behalf to whomever you would like to talk to.

What are the benefits?

If you choose to participate you will not receive any advantages in the care you receive or financial rewards. Neither will you be disadvantaged in any way if you decide not to participate or if you change your mind and withdraw from the study. While there is no direct benefit to you, your participation may influence how collaboration occurs and may affect future care of hospice/palliative patients.

How will my privacy be protected?

You will not be identifiable by name and the research results will be a consolidation of all of the participant's information rather than individual information. You may choose a false name if you wish for the interview data. The audiotapes will be destroyed at the end of the study. Transcribed information will be stored electronically on disc for 10 years after the study has finished. This disc will be kept in a secure locked cabinet.

What are the costs of participating in this research?

The cost of participating in this research is the time required for the interview(s).

What opportunity do I have to consider this invitation?

Following initial contact you may take up to one week to consider your involvement, or longer by negotiation if you wish to consult with family/whanau.

How do I agree to participate in this research?

You will need to sign a consent form that will be given to you when you feel you have completely understood your participation in the project and all your questions have been satisfactorily answered.

Will I receive feedback on the results of this research?

Final results from this research will not be available for approximately 2 – 3 years following the interview. However, if you wish, you will be sent a preliminary summary of the findings after the first phase of the study is complete. You may also request a copy of the transcript of the interview to keep.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisors,

Associate Professor Antoinette McCallin, antoinette.mccallin@aut.ac.nz or phone (09) 921 9999 extension 7884 or Professor Rod MacLeod, rd.macleod@auckland.ac.nz or phone (09) 373 7599 extension 86082

Concerns regarding the conduct of the research should be notified to the Executive Secretary, Multi-Region Health and Disability Ethics Committee, Telephone (04) 470 0655

Email: multiregion_ethicscommittee@moh.govt.nz

Whom do I contact for further information about this research?

Researcher Contact Details:

Christine McDonald, cmcdonald@xtra.co.nz or phone 027 464 8333

Project Supervisor Contact Details:

Associate Professor Antoinette McCallin, antoinette.mccallin@aut.ac.nz or phone 921 9999 extension 7884

Professor Rod MacLeod, rd.macleod@auckland.ac.nz or phone 09 3737599 extension 86082

**Approved by the Multi-Regional Health and Disability Ethics Committee on 25 November, 2011, AUTECH
Reference number 11/334 .**

Approval for further contact

I am interested in the research study described on this participant information sheet and agree to having the researcher (Christine McDonald) contact me directly to explain the study further and answer any questions I may have.

This form is to help with communication between myself and Christine. Giving approval for further contact does not mean I have to take part in the study.

If I do decide to take part in the research study I will sign a separate consent form. This contact form will be destroyed when the study is completed after I (or my nominated person) have been sent a summary of the study findings. If I decide not to participate in the research study this form will be destroyed immediately and my personal details will not be kept.

Name:.....

Contact telephone number

Address;.....

.....>>.....

.....

Preferred means of contact e.g. telephone call, letter, through another family member (state name and contact details if different)

.....

.....

Appendix G: Consent Form

Consent Form



Project title: **Collaborative Practice in Palliative Care**

Project Supervisors: **Associate Professor Antoinette McCallin**
Professor Rod MacLeod

Researcher: **Christine McDonald**

- I have read and understood the information provided about this research project in the Information Sheet dated August 30, 2011
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews.
- I agree for the interview to be audiotaped and transcribed: Yes No
- I wish to receive a copy of the transcript: Yes No
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I have been allowed sufficient time to discuss this project with family/whanau BEFORE SIGNING THE CONSENT FORM (where applicable).
- I agree to take part in this research.
- I wish to receive a summary of the findings from the research (please tick one): Yes No

Participant's signature:.....

Participant's name:.....

Participant's Contact Details (if appropriate):

.....
.....

Date:

Approved by the Multi-Region Health and Disability Ethics Committee on 25 November, 2011

AUTEC Reference number 11/334

Note: The Participant should retain a copy of this form.

Appendix H: Potential Interview Questions

Potential interview questions

Interview questions may include:

- Perhaps we might begin with you talking about your impressions of collaboration and how it occurs in palliative care....
- That is interesting. Can you tell me more...?
- Can you describe any situations where you have worked collaboratively perhaps with colleagues and/or patients and their families? What happened? Can you tell me more about that please?
- What are some of the problems that come up when you are working collaboratively?
- What would be your main concern of working collaboratively with colleagues and/or patients and their families?

As the interview progresses and once the main concern is identified along with key concepts, questions may be asked about

- the causes of collaboration,
- the conditions it occurs under,
- the interactions that take place during collaboration, and
- the consequences of collaboration (Glaser, 1998).

General questions to promote discussion may include:

- Can you tell me more about...?
- So, you are saying...?
- Why did you do that?
- What do you think was going on there?

Appendix I: Memo example September 2013

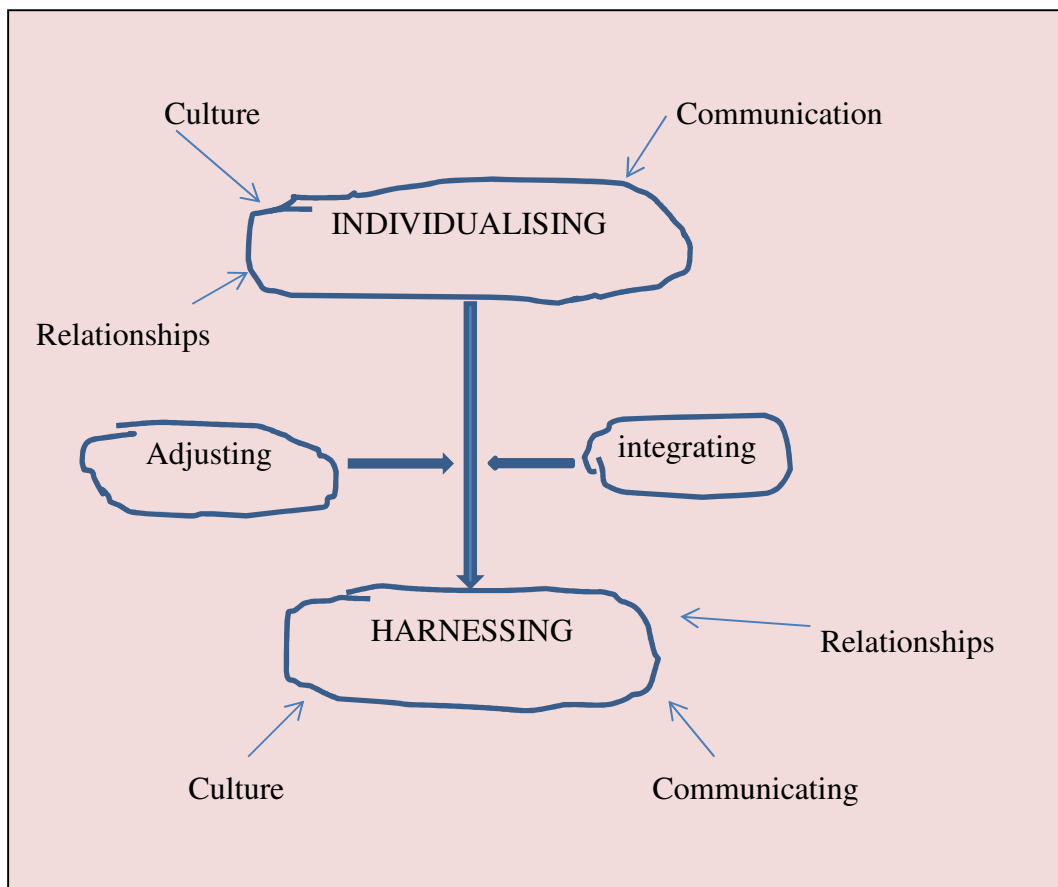
Commonalities within first nine interviews show it's about people and how people act whether in communicating, their relationships or whatever. This seems pretty obvious and not a unique finding by any means.

Can the problem be people management in all forms whether managing ourselves or managing others and the solution collaboration?

What is the main concern of health professionals working collaboratively (with colleagues and patients) in palliative care and how do they manage that?

Using their words to answer the question

The main problem is individualising. The solution is harnessing. Sub-contexts are communication, relationships, culture, integrating and adjusting.



Culture, communication and relationships when done poorly can all have a “negative” impact and support the problem of individualising. When done well they can all have an impact and assist harnessing to occur. In turn harnessing ensures that the culture is amenable to working together, that communication is good and relationships good between people and organisations.

Adjusting and integrating are necessary steps to move from individualising to harnessing.

Appendix J: Emerging main concerns

Communication

Resource limitations

Individualizing

People management (managing others/managing self)

Failure to communicate

Information imbalance

Forsaking

Needing to know/ lack of knowing

Information insufficiency

Retaining information

Lack of sharing

Silos

Barriers

Confronting Barriers

Possessorship

Appendix K: Emergence of Possible Core Categories

Potential core category in chronological order	Sub-core categories/ categories /properties
Goal sharing	Relating Meeting Talking
People management	Adjusting integrating Culture Resourcing Relationships Communication
Harnessing	Adjusting integrating Culture Relationships Communication
Cementing relationships	Relating Talking Role clarification Communicating Meeting
Purposeful connecting	Relating Communicating Adjusting
Information balance	Share Communication Role complexity Relationships
Opportunising –making/taking	Purposeful connecting relating Communicating Role complexity Resourcing
Seeking	Relating Clarifying Communicating Personalising
Opportunising	Purposeful connecting Relating Goal sharing Regaining Communicating Seeking
Purposeful connecting	Communication Relating Role clarifying
	Communicating Knowing Sharing Talking Relating Trusting Informing Meeting
Bridging	Communicating – informing / talking / meeting Relating – role clarifying / sharing / making time
Finding Common Ground	Communicating – informing / talking / meeting Relating – role clarifying / sharing / making time
	Relating – communicating / role clarifying Participating – making time / purposeful connecting
	Purposeful connecting – communicating / informing Participating – making time / relating
	Purposeful connecting – communicating/ relating Making/taking time – participating / negotiating
Finding Time	Purposeful connecting – communicating / relating Finding Common Ground – participating / negotiating
Spending Time	Purposeful connecting – communicating / relating Finding common ground – participating / negotiating
Sharing Time	Purposeful connecting – communicating / relating Finding common ground – participating / negotiating

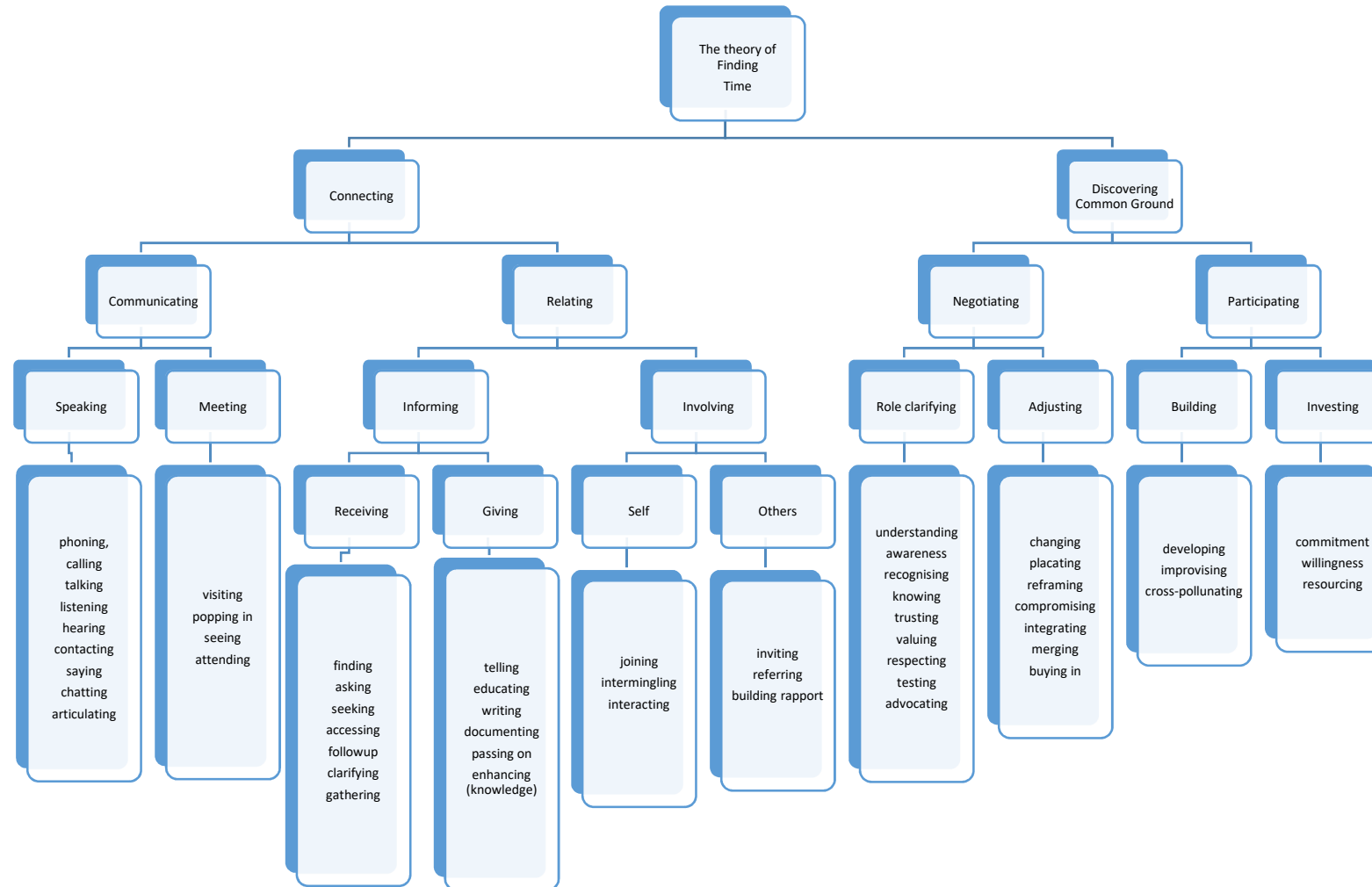
Appendix L: Emerging theory (January 2015)

Theoretical Code	Core Category	Sub-core categories	Categories	Properties
<p>FINDING COMMON GROUND</p> <p>(theoretical code)</p> <p>This occurs constantly when health professionals collaborate</p> <p>Common ground is necessary to stabilise the bridge. Without common ground the bridge cannot be built. If common ground is removed from a bridge in place, that bridge becomes unstable and falls over.</p>	<p>BRIDGING</p> <p>(Theory of)</p> <p>“structuring connections”</p> <p>Main concern:</p> <p>SILOS</p> <p>This is the prime issue of health professionals working together in palliative care.</p>	Relating	Communicating	<p><i>Informing</i> - telling , educating, writing, asking, seeking, finding, accessing</p> <p><i>Talking</i> - phoning, calling, chatting, speaking, conversing, listening</p> <p><i>Meeting</i> - visiting, pop-in, seeing, gathering</p>
			Role clarifying	<p><i>Trusting</i> - feel safe, respecting, valuing, confidence, faith</p> <p><i>Understanding</i> - awareness, recognising, knowing</p> <p><i>Adjusting</i> - changing, placating, re-framing</p>
		Participating	Making Time	<p><i>Building</i> - developing, improvising</p> <p><i>Investing</i> - commitment, willing, resourcing</p>
			Connecting	<p><i>Involving</i> - referring, negotiating, buy-in, inviting, sharing</p> <p><i>Joining</i> - integrating, intermingling, merging, cross-pollenating,</p>

Appendix M: Emerging theory (March 2015)

Theoretical Code	Core Category	Sub-core categories	Categories	Properties		
<p>Enabling? To make able. Give power, means, competence, ability to... Finding common ground enables HPs to collaborate by moving past barriers.</p> <p>or</p> <p>Balancing? There's an imbalance due to/caused by barriers. To correct these HPs find common ground & return to balance for that moment. Collaboration occurs in that moment.</p> <p>For IPC to occur barriers need to be removed so that Pall care becomes balanced</p>	<p>FINDING COMMON GROUND (Theory of) "collaborating in palliative care"</p> <p>Main concern: BARRIERS</p> <p>Professional</p> <ul style="list-style-type: none"> - Role misunderstanding (professional and organisational) - Lack of trust - silos <p>Individual</p> <ul style="list-style-type: none"> - Patient ownership - Personalities - Patch protection - silos <p>Structural</p> <ul style="list-style-type: none"> - Location challenges - Technological - IT systems not talking - Resources / time poor - Hierarchies & power discrepancies - silos <p>Informational</p> <ul style="list-style-type: none"> - Too much info - Too little info – No info - Incorrect/wrong info - One way info flow 	<p>Connecting</p>	<p>Communicating</p>	<p><i>Speaking</i> - phoning, calling, talking, chatting, listening, hearing, contacting, saying, articulating <i>Meeting</i> - visiting, pop-in, seeing, attending</p>		
			<p>Relating</p>	<p><i>Informing</i> - finding, asking, seeking, accessing, follow-up, clarifying, gathering (info), telling, educating, writing, documenting, passing-on, enhancing (knowledge) <i>Involving (self & others)</i> - referring, inviting, sharing, joining, intermingling, interacting</p>		
				<p>Participating</p>	<p>Time (making / taking)</p>	<p><i>Building</i> - developing, improvising, cross-pollinating <i>Investing</i> - commitment, willing, resourcing</p>
					<p>Adapting</p>	<p><i>Role clarifying (professional & organisational)</i> - understanding, awareness, recognising, knowing, trusting, valuing, respecting, testing, advocating, rapport <i>Adjusting</i> - changing, placating, reframing, compromising, negotiating, integrating, merging, buying-in</p>

Appendix N: Emerging theory Finding Time (July 2015)

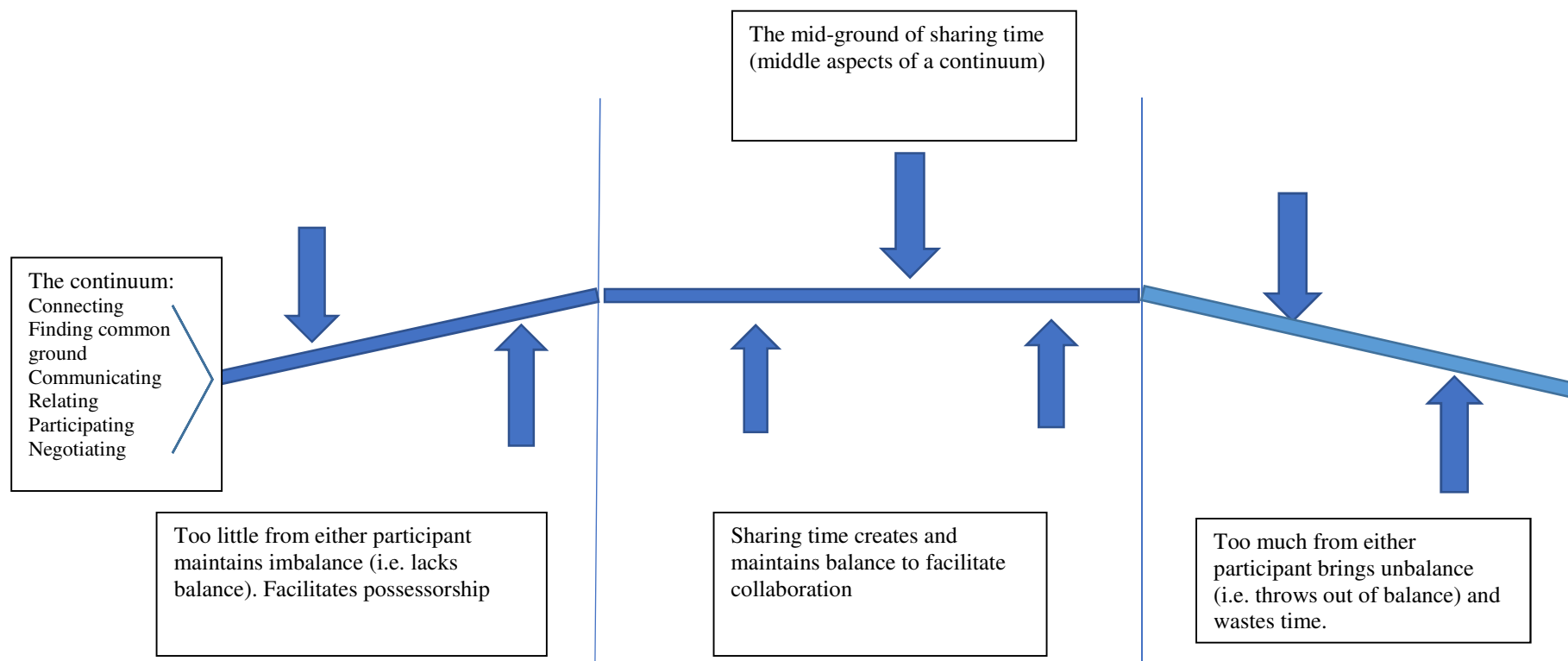


Appendix O: Emerging theory of Sharing Time (June 2016)

Theoretical Code	Core Category	Sub-core Categories	Categories	Properties		
<p>UNITING</p> <p>This interactive strategy occurs constantly in the behaviour patterns of health professionals Sharing Time</p> <p>Uniting is the strategy that integrates Sharing Time with its categories, concepts and properties.</p> <p>This interactive strategy of uniting, defined as ‘coming together with positive intention’ requires tactical management as not uniting or limited unity facilitates possessorship, while over uniting is a waste of time</p> <p><i>Uniting in order to share time without wasting time.</i></p>	<p>SHARING TIME (Theory of)</p> <p>“collaborating”</p> <p>Occurs when health professionals purposefully make time, take time, find time and spend time in their workday for and with each other, in order to share a commodity required, facilitating collaboration.</p> <p>Main concern: POSSESSORSHIP</p> <p>is defined as having possession of a commodity (tangible) or need to have possession of a commodity (intangible) that has the potential to impact patient care when not shared.</p> <p>Possessorship is the main concern that hinders or obstructs collaboration between health professionals – individually or organisationally.</p>	<p>PURPOSEFUL CONNECTING</p> <p>is the uniting of health professionals through communicating and relating. Purposeful connecting is the <u>means</u> of finding common ground and Sharing Time.</p> <p>FINDING COMMON GROUND</p> <p>is the finding of a common interest or goal through participating and negotiating. Finding common ground gives <u>reason</u> to connect and Share Time</p>	<p>COMMUNICATING</p> <p>Is the purposeful process of speaking, meeting and informing about a particular matter or subject.</p>	<p>Speaking: phoning, calling, talking, listening, hearing, saying, chatting, articulating</p> <p>Meeting: visiting, popping in, seeing, attending</p> <p>Informing: <i>giving</i> – telling, educating, writing, documenting, passing on, enhancing (knowledge) <i>receiving</i> – finding, asking, seeking, accessing, follow-up, clarifying, gathering</p>		
			<p>RELATING</p> <p>is the active process of developing a professional relationship by involving self and others.</p>	<p>Involving: <i>self</i> – join in, intermingling, interacting, follow through <i>others</i> – inviting, referring, building rapport, contacting, trusting</p>		
			<p>PARTICIPATING</p> <p>is voluntarily and purposefully taking part (in finding common ground) through building and investing.</p>	<p>Building: developing, improvising, cross-pollinating Investing: commitment, willingness, resourcing</p>		
			<p>NEGOTIATING</p> <p>is the purposeful act of making adjustments and clarifying roles (in order to find common ground)</p>	<p>Adjusting: changing, placating, reframing, compromising, integrating, merging, buying in Role clarifying: understanding, awareness, recognising, knowing, valuing, respecting, testing, advocating, learning</p>		

Appendix P: Diagrammatical representation of Sharing Time's mid-ground

The mid-ground of Sharing Time occurs in the middle aspects of a continuum. Balance is required to remain in the middle aspects of a continuum. Remaining in the middle aspects of the continuum maintains balance.



Appendix Q: Summary of the theory of Sharing Time (with main concern)

Core Category	Sub-core Categories	Category	Properties
<p>Theory of SHARING TIME</p> <p>Occurs when health professionals purposefully make time, take time, find time and spend time in their workday for and with each other, in order to share a commodity required, facilitating collaboration and managing possessorship.</p> <p>Occurs within the middle ground on a continuum, providing balance.</p> <p>Main concern: POSSESSORSHIP</p> <p>is defined as having possession of a commodity (tangible) or need to have possession of a commodity (intangible) that has the potential to impact patient care when not shared.</p> <p>Possessorship is the main concern that hinders or obstructs collaboration between health professionals – individually or organisationally.</p>	<p>PURPOSEFUL CONNECTING</p> <p>is the uniting of health professionals through communicating and relating. Purposeful connecting is the <u>means</u> of finding common ground and Sharing Time.</p>	<p>COMMUNICATING</p> <p>Is the purposeful process of speaking, meeting and informing about a particular matter or subject.</p>	<p>Speaking: phoning, calling, talking, listening, hearing, saying, chatting, articulating</p> <p>Meeting: visiting, popping in, seeing, attending</p> <p>Informing: <i>giving</i> – telling, educating, writing, documenting, passing on, enhancing (knowledge) <i>receiving</i> – finding, asking, seeking, accessing, follow-up, clarifying, gathering</p>
		<p>RELATING</p> <p>is the active process of developing a professional relationship by involving self and others.</p>	<p>Involving: <i>self</i> – join in, intermingling, interacting, follow through <i>others</i> – inviting, referring, building rapport, contacting, trusting</p>
	<p>FINDING COMMON GROUND</p> <p>is the finding of a common interest or goal through participating and negotiating. Finding common ground gives <u>reason</u> to connect and Share Time</p>	<p>PARTICIPATING</p> <p>is voluntarily and purposefully taking part (in finding common ground) through building and investing.</p>	<p>Building: developing, improvising, cross-pollinating</p> <p>Investing: commitment, willingness, resourcing</p>
		<p>NEGOTIATING</p> <p>is the purposeful act of working to achieve a mutual agreement (in order to find common ground)</p>	<p>Adjusting: changing, placating, reframing, compromising, integrating, merging, buying in</p> <p>Role clarifying: understanding, awareness, recognising, knowing, valuing, respecting, testing, advocating, learning</p>
<p>Theoretical Code: Reciprocity – the practice of exchanging with others for mutual benefit This interactive family coding strategy occurs in the behaviour patterns of health professionals Sharing Time</p>			