Interdisciplinary Geriatric and Palliative Care Team Narratives: Collaboration Practices and Barriers

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Abstract

Despite the development and implementation of team training models in geriatrics and palliative care, little attention has been paid to the nature and process of teamwork. Geriatrics and palliative care in the clinical setting offer an interdisciplinary approach structured to meet the comprehensive needs of a patient and his or her family. Fellowship members of an interdisciplinary geriatric and palliative care team participated in semistructured interviews. Team members represented social work, chaplaincy, psychology, nursing, and medicine. A functional narrative analysis revealed four themes: voice of the lifeworld, caregiver teamwork, alone on a team, and storying disciplinary communication. The content-ordering function of narratives revealed a divergence in team members' conceptualization of teamwork and team effectiveness, and group ordering of narratives documented the collaborative nature of teams. The study findings demonstrate the potential for narratives as a pedagogical tool in team training, highlighting the benefits of reflective practice for improving teamwork and sustainability.

Keywords

communication; death and dying; end-of-life issues; families; geriatrics; narrative analysis; older people; palliative care; teaching/learning strategies

One of the core elements of both palliative care and geriatrics is the collaborative practice of the interdisciplinary team (Meier & Beresford, 2008). Geriatrics is a subspecialty of internal medicine or family practice that focuses on the health and illnesses of the aging adult. Likewise, palliative care, also a subspecialty of internal medicine, focuses on pain management and comfort measures. For both geriatrics and palliative care, the focus is on quality of life, the functional status of the patient, and the patient's family. Both approaches to medicine are grounded in an interdisciplinary care model. The interdisciplinary care model is a process of care based on collaboration among health care providers with specialized knowledge from multiple disciplines (Geriatrics Interdisciplinary Advisory Group, 2006). Throughout the last decade, interdisciplinary team training programs have been established to train health care professionals how to work together and collaborate. However, little is known about how team training impacts the detailed, informed critique of team members' actual practices, which are important to effective teamwork (Opie, 1998). In this study we examined narratives collected from interdisciplinary geriatric and palliative care team members to provide a qualitative assessment of interdisciplinary-based care approaches.

Literature Review

There are a number of benefits to providing interdisciplinary-based care, especially with geriatric and palliative care patients. The American Geriatric Society surmises that interdisciplinary care improves health care processes, benefits the health care system and caregivers, and adequately prepares health care providers for better care of older adults (Geriatrics Interdisciplinary Advisory Group,

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2006). In palliative care, improved outcomes regarding patient time spent at home, patient and family satisfaction, symptom control, reduction of days in the hospital, decreased costs, and patients' increased likelihood of dying where they want, can all be attributed to interdisciplinary care (Hearn & Higginson, 1998). Overall, interdisciplinary health care approaches improve client understanding and benefit team members as they are able to expand their knowledge from interactions with other disciplines (Abramson & Mizrahi, 1996).

In 1995, the John A. Hartford Foundation implemented geriatrics interdisciplinary team training to establish and enhance interdisciplinary team training. Ideally, the shared educational experience breaks down discipline-specific barriers and fosters the development of trust and understanding between and across disciplines, and joined learning provides an immediate context for practice and modeling (Mellor, Hyer, & Howe, 2002). Although the program evaluation found that trainees demonstrated improvement in all attitudinal change scores, there was no change on the geriatric care planning measure, and only some change on self-reported team skills (Fulmer et al., 2005). Several factors might explain these findings. First, bureaucracy in the clinical setting determines the amount and type of interaction among team members, inadvertently creating barriers to team effectiveness (Hinojosa et al., 2001). Second, a disciplinary split can result from differing regulatory and accreditation barriers among the disciplines (Reuben et al., 2004). Finally, collaborative efforts can be stymied by varying levels of personal health care experiences, knowledge, and skill among team members, as well as differing languages and discipline-specific jargon, varying philosophies, and discipline-specific codes of ethics (Mellor et al., 2002).

Recent research on interdisciplinary-based care approaches in palliative care has been grounded in naturalistic inquiry and has focused on communication in team meetings (Arber, 2007, 2008; Li & Arber, 2006; Wittenberg-Lyles, 2005; Wittenberg-Lyles & Parker Oliver, 2007; Wittenberg-Lyles, Parker Oliver, Demiris, & Regehr, 2009). Studies have explored how a patient's psychosocial information is addressed in interdisciplinary team meetings (Arber, 2007; Wittenberg-Lyles, 2005). Findings indicate that communication in team meetings is distorted by an emphasis on biomedical information sharing (Wittenberg-Lyles, 2005); however, sharing psychosocial stories helps build a positive relationship among team members (Arber, 2007; Li, 2004, 2005). Additional research on collaboration in team meetings suggests that the team meeting environment is influential (Wittenberg-Lyles & Parker Oliver, 2007), and the strategic use of questions among interdisciplinary team members during meetings can be used to communicate interprofessionality, team identity, collegial decisions, and professional identity (Arber, 2008). Still, improvement in team member support and communication effectiveness are needed (Demiris, Washington, Doorenbos, Parker Oliver, & Wittenberg-Lyles, 2008).

There is an assumption that interdisciplinary teams operate effectively by virtue of having multiple team members present (O'Connor, Fisher, & Guilfoyle, 2006); however, early work on health care teams found that detailed accounts of teamwork emphasized power and control (Opie, 1998). Cultural patterns, perceived absences of equity and fairness in expectations, and a lack of understanding between team members can contribute to power differentials among team members (Martin, O'Brien, Heyworth, & Meyer, 2008). Especially among physicians, there is a lack of understanding of professional team roles (Martin et al., 2008), and many physicians believe that they have the right to alter patient care plans developed by the team (Leipzig et al., 2002).

Interdisciplinary-based care requires a realignment of traditional power relations within health care (Opie, 1998). One way to assess changes in practice is to examine health care professionals' discourse; stories, in particular, function as a way of constructing identity within the interdisciplinary team (Arber, 2007; Li, 2004, 2005). The reflective practices of team functioning can assist in evaluation of the success of interdisciplinary team approaches (Hall & Weaver, 2001). In this investigation we first explored interdisciplinary geriatric and palliative care team member narratives about dying patients, their families, and team process; and second, employed a functional narrative analysis to identify and interpret themes of content and group ordering to reflect on interdisciplinary collaboration practices and barriers.

Theoretical Lens

This study is situated in a narrative paradigm approach to communication and interaction. The narrative paradigm assumes that all forms of human communication can be seen fundamentally as stories, as interpretations of aspects of the world occurring in time and shaped by history, culture, and character (Fisher, 1987). A team member's experience of caring for someone with illness, like narrative, occurs within context at the same time it reshapes context, within relationships at the same time it reshapes relationships, and within a person's life at the same time that it reshapes that life. One of Fisher's aims was "to account for how people come to adopt stories that guide behavior" (1987, p. 87). These cocreated stories can order and disorder human experience. Fisher's interest centered on how people came to adopt narratives that directed action. He pointed out that many dominant social science

theorists/theories take up an interest in prediction of behavior. Fisher's ideas mark a clear break with rational positivism by naming all people as creators of knowledge that guide action.

Personal narratives serve as building blocks for public knowledge about public performance. The stories of individuals cannot be built and understood separately from public narrative. Critical care issues present a desire and necessity to make sense of health events. Narration is a way to organize, understand, make meaning, and reduce uncertainty; it is a communicative vehicle to perform these tasks. Narration provides those caring for individuals with serious illness a way to interpret, change, understand, manage, and respond to care.

Interdisciplinary team member narratives reveal stories that involve the experience of working with and without other team members, and illuminate our understanding of this specialized care process (Sharf & Vanderford, 2003). These narratives incorporate the team members' humanistic perspectives of disease and illness as they extend beyond biological suffering and include the interdisciplinary team experience with illness as related to changing roles, relationships, and identities (Sharf & Vanderford, 2003). The inclusion of these narratives in research is an approach that challenges the assumptions of existing knowledge, thus enabling us to highlight and focus on the communicative domain of interdisciplinary-based care. Stories of interdisciplinary team approaches demand a shift from a biomedical model to a biospychosocial one that includes a sociocultural, political, and historical understanding of teamwork (Geist & Gates, 1996).

Poirier (2002) discussed the multiplicity of the interdisciplinary team narrative and applied Bakhtin's concept of *heteroglossia*, the many voices in a novel. The voices represented in a novel are relevant to those on an interdisciplinary team (IDT) in that so many disciplinary orientations will profoundly shape decision-making processes and actions (Poirier, 2002). "The conferences . . . are clearly multivocal, with each participant contributing a certain kind of knowledge and skill to planning the patient's care. The multivocality displayed in these staffings reflects part of the ideology of interprofessional teams, which holds that no single health professional can fully assess a patient's condition or needs" (Poirier, 2002, p. 53). A team is without Bakhtin's dialogism if individuals only provide data to the group without reflecting on the impact or meaning of that data, or fail to consider its meaning in light of other disciplinary voices. Moving reflexively from the act of dialogism, in this study we revisited team member stories to identify what French literary theorist Gerard Genette described as *narrative levels* (Genette, 1980). It is in these levels of individualized storying that we can begin to discern the contributors (i.e., patients, family members, other team members) to the current teller's story (Genette, 1980). The notion here is that every retelling of the story places the current narrator at a level further removed from the initial telling. The basic existence of the team meeting predicates the storying of patient/family cases by various team members. In light of Genette's concept, team member narratives about their team experiences are reliant on earlier levels of storying.

Stories are the action of being a member of an interdisciplinary health care team. In essence, team member storytelling is part of the "ongoing struggle to create and maintain a coherent system of meanings" (Langellier & Peterson, 2006). Stories are partial, conflicting, fragmentary, and contradictory; even so, they become a vehicle for sense and meaning making. Some team members share the "same" story, but the performer of the story shapes it very differently than another team member's voice. In all of these performances, team and disciplinary identity is constructed and revealed. Poirier (2002) suggested that the particular individuals composing a health care team radically influence its way of working and communicating. Team identity is embodied and discursive, both performed and performative (Langellier & Peterson, 2006). Narrative analysis allowed us to study this performance of team experience while appreciating the impact of a particular team's dynamic. We explored the narrative function for team members in varying disciplines working together on an interdisciplinary geriatric and palliative care team.

Methodology

Participant Recruitment

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Participants were IDT members in 1-year fellowship placements, working in a combined consultation service in geriatrics and palliative care at a Veterans Affairs (VA) hospital in the southern United States. Each year a fellowship team is assembled to fill positions in the medical center's geriatric and palliative care services. At the start of the 9th month of the 2006-2007 academic fellowship year, the second author personally invited members of the fellowship team to participate in this study and accompanied this verbal invitation with a brief written description of the project, an interview guide, and confidentiality measures. The second author served the IDT in the capacity of a communication specialist, and had cultivated a professional relationship with each fellow during her 6-month presence as an ethnographic researcher. Because of the close working contact between the second author and the participants, they arranged individual meeting times for interviews.

These arrangements were ultimately negotiated utilizing a combination of face-to-face contact, email, and telephone calls. All interviews were conducted during the last 2 months of the fellowship year. At the beginning of each interview session, verbal and written informed consent was obtained from the participant. Participants included a psychologist (P), a social worker (SW), a chaplain (C), a nurse (N), and 2 medical fellows (MF1 and MF2). The original fellowship team included 4 medical fellows, only 2 of whom participated, with the others citing heavy workloads and time commitments.

Setting

The medical director of inpatient interdisciplinary services and the geriatric oncology program oversaw the IDT and their involvement with patients in two hospital programs. Inpatient interdisciplinary services cared for 100 to 150 adults per month, providing geriatric expertise and palliative care consultation to frail elderly patients from other services such as orthopedics, surgery, psychiatry, and medicine. The geriatric oncology program was a not-for-profit, interdisciplinary, outpatient clinic and research center combining geriatrics, palliative medicine, and medical oncology. This program offered newly diagnosed cancer patients aged 70 years and older with optimized geriatric assessment as an integral part of treatment and follow-up.

The culture of the fellows was established through their team meetings and rounds. Here we describe the schedule and presence of team meetings in their work. Interdisciplinary team members rounded (visited patients) each morning, and attended individually to the same patients for the rest of the day. As a team, the fellows held a daily meeting in their conference room, lasting from 20 to 60 minutes, depending on the number of new patient consultations/admissions (a new patient load was between 5 and 12 patients per day). A once-weekly educational session was held for all fellows, lasting 1 hour. During these sessions, fellows might have heard about innovations in palliative care, geriatric care, small group communication, or other applicable topics. Additionally, weekly interdisciplinary evaluations were performed on all patients, and monthly team meetings were held specifically to assess the management of stress and loss for team members.

Research Design and Ethics Review

We designed interview prompts to enable fellows to reflect on their own perceptions about their disciplinary position and function on the team. Semistructured interviews lasted between 35 and 70 minutes, and were conducted face to face in a participant's office or the fellows' conference room at the hospital. Data gathering followed an open-ended interview guide based on 6 months of ethnographic observation of the team and included the following prompts:

1. How did you get involved in the palliative care fellowship?
2. What previous experience did you have working in hospice and palliative care?
3. Describe your most memorable patient during your fellowship.
4. Describe one of your most challenging experiences from this year.
5. Who has taught you the most this year?
6. Who do you turn to when you have a problem?
7. Describe a bad experience as a fellow.
8. Did you enjoy working with medical students as part of their coursework?
9. What advice will you give the next fellow?
10. What do you still feel insecure about in this setting?
11. What are your thoughts on your own death?

Interviews were conducted within 2 months of completing the 1-year fellowship. The second author conducted the interviews and recorded the data. All participants agreed to the recording of data; interviews were audiotaped and transcribed, resulting in 104 typed, double-spaced pages. This study was reviewed and approved by the institutional review board of the medical center site utilized. Our use of data from IDT fellows was reviewed and approved. Team member confidentiality, as well as patient confidentiality, was protected by our coding labels, and family and professional identifiers have been changed. To further protect participant confidentiality, we did not collect demographic identifiers.

Data Analysis and Trustworthiness

In this study we employed a narrative functional analysis that focused on what stories did, the setting in which they were told, and the effects they had (Mishler, 1995). More specifically, "function is defined in a variety of ways both within and across different disciplinary traditions. These differences tend to reflect their primary units of theoretical analysis: persons, cultures, social processes, and institutions" (Mishler, 1995, p. 108). As we sought to locate what these IDT stories were "doing," we integrated two key concepts that identify story function in narrative performance theory: *content ordering* and *group ordering* (Langellier & Peterson, 2006). Content ordering attends to the sense-making of events, the innovations of meanings,

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and the relocating or rejecting of what content has been seminal. Selecting content for narration engages the process of navigating choices about meanings, events, activities, and identities. Group ordering speaks to the identities that are formed, maintained, and reformed as they become visible or invisible in storytelling narratives.

This narrative analysis was conducted by the first three authors, who identified narrative themes within each transcript. Interview dialogue was considered narrative if the participant provided temporally situated information offering an account that revealed specific, unique, and contextualized information (Sharf & Vanderford, 2003). After identifying narrative themes independently, authors reached consensus by discussing areas of divergence. Narratives for each participant were classified by story theme. After categorizing narratives thematically, researchers (the first and second authors) examined stories for frequency as well as absence across participant data. The trustworthiness of the results was established in three ways. First, ethnographic field notes of the team's practices and barriers were collected during the final 6 months of the fellowship year as part of another study. These field notes were reviewed, analyzed, and developed 1 month following the completion of interview collections for this article, to check for accuracy of respondents' interview answers. Second, these field notes were summarized and presented for feedback to the fellowship team for the purpose of identifying and addressing discrepancies. Third, these field notes ultimately were the centerpiece in a manuscript about breaking bad news in the terminal context that was published in a peer-reviewed medical journal in the spring of 2008 (Wittenberg-Lyles, Goldsmith, Sanchez-Reilly, & Ragan, 2008). The final published analysis of field notes also supported some of the interpretative claims made in this article.

Interpretive Claims

Voice of the Lifeworld

The lifeworld perspective (Gadamer, 1998; Heidegger, 1962; Husserl, 1970a, 1970b; Merleau-Ponty, 1962) finds the greatest value in the richness of daily living; it is the meaningful part of the world for us. This meaning can be ignored or taken for granted in the actions of others (Asp & Fagerberg, 2005). Language that addresses the psychosocial experiences of the seriously or chronically ill person, the humanistic side of disease/illness, can be identified as the "voice of the lifeworld" in Mishler's narrative theory (Mishler, 1981). To relieve suffering and ensure quality of life for a patient and his or her family, a geriatric and palliative care team must recognize the four dimensions of pain: physical, emotional, spiritual, and psychological. These dimensions of pain include the multiplicity of losses in a patient's/family's personal life because of a decrease in activities of daily living. Although interdisciplinary team members represented both medical (physician, nurse) and nonmedical (social worker, chaplain, psychologist) disciplines, team members predominantly recalled stories about patients' emotional, spiritual, and psychological pain. Analyzing team members' responses for the lifeworld perspective reveals the value and weight of the psychosocial impact of illness, and allows us to assess how disciplinary members approach their patients' daily living. Despite the first priority in palliative care to provide expert symptom management of physical pain, the voice of medicine was absent among all team members, including team members whose expertise represented a medical specialty. The nurse described a man enduring emotional pain accompanying the loss of his independence:

> There was one gentleman who, was dying and was in denial . . . and he was very cultured. He liked the music, books. That was an important piece of his lifestyle. And so you would go into his room and it was like no other VA room . . . his, uh, sister, um, was supportive, but she drew the line because she didn't, she couldn't take him home . . . and that was a hard one to just sit with because there was nothing you can do with that. You could just feel his pain in not being able to go home, 'cause that's what he really wanted. Those other things were nice, but we couldn't, um, give him what he really wanted.

Also relating a lasting memory of emotional pain, the team psychologist described a discussion with a dying man about euthanasia:

> He . . . he had, for all intents and purposes made a promise to family that he would fight, and he came to a point when he asked me about euthanasia. I mean, he sat there, he looked totally drained of energy, and he said, "I feel like crying," but he couldn't cry because he was so tired from fighting. He just wanted to rest, he wanted to stop fighting but he was struggling against that and the promise he'd made to fight. It was really suffering, uh, emotionally.

Similarly, the medical fellows demonstrated an acute awareness of the patient's life beyond the disease. Both doctors frequently framed their stories of patient loss by talking about the impact this would have on their own

lives were they in the position of their patients. They were aware of their specific team role of managing physical pain, but in their patient reflections they spoke most often about the emotional pain of terminal illness—demonstrating the dominance of the lifeworld in their narrative reflections through empathy, which palliative care physician James Tulsky simply defined as, "I could be you" (Tulsky, 2009):

> I mean the high impact is seeing yourself, I mean, that can happen to you. And how prepared will you be if somebody comes and tells you exactly the same news, and uh, I mean, during that interview with him [patient] you notice that it was not physical that the guy had, it was the morphine that would relieve that pain. It's the pain that all your plans you have made out won't happen. You have now left behind a wife and a child. (MF2)

The team chaplain shared stories that reveal acute attention to patients' spiritual pain and strength in the face of loss. In this passage she described her assessment of how that spiritual pain is produced:

> The saddest moments are to know that they [patients] have no security in what's next, and I have to stand quiet and let them pass . . . and it's not my place, you know, you [a dying patient] haven't invited me to do that, or maybe the time hasn't been developed for you to trust me, or for whatever reason. You know, you're angry, you're bitter, your life is up and you're leaving quickly and you just haven't had time to sort those things out.

Each of the 6 team members recalled several stories centered on the voice of the lifeworld, and had come to know patients through their lives beyond the illness. The team members' disciplinary roles established a lens through which they could appreciate the lifeworlds of their patients. The nurse and psychologist content ordered patients' pain concerning their worldly life and losses (jobs, home comforts, identity, family). As patients realized they were dying, the chaplain primarily narrated sense-making efforts about life beyond earthly living, removed from the trappings of a patient's accomplishments, family, or job. The social worker's content ordering addressed systems affecting the patient: the organizations of health care, finances, and family. The two medical fellows revealed a clear empathic function in their narrative, identifying strongly with the loss in patients' lifeworlds. Team members were in consonance with the common goal of improving patient quality of life; their narratives revealed this practice.

Caregiver Teamwork

Health care workers practicing an interdisciplinary care approach consider the patient and family as the unit of care. Involvement of the family is necessary when making decisions about day-to-day care, living arrangements, follow-up care, and advance directive communication. The narratives captured in this study reveal that family members and caregivers are often the primary focus of work for a team. Reflective narratives shared by team members did not focus on discipline-specific team roles, but rather on the team's efforts as a whole.

The social worker recounted the story of a family who wanted the patient to be "full code" (which means that the patient would be resuscitated if his or her heart were to stop beating). Typically, when patients are dying, their status is "do not resuscitate." The patient endured head and neck cancer with a poor prognosis, and had already received his lifetime radiation limit:

> They [family] were still trying to possibly do these experimental procedures with him, and he was clearly declining. The staff was very upset . . . we were all worried that the tumor was going to impinge on his airway. He was going to suffocate to death . . . she wanted him to be full code . . . I remember [the doctor] saying to her, "They're gonna push on his chest and they could break all his ribs, and it's gonna be really painful for your father," and she was saying, "Oh yes, I've broken people's ribs before." Some people thought that they were trying to keep him alive longer maybe to get the wife more money, because they get more income when the veteran is alive. Just the thought of him having to suffocate to death was horrible. Of course he ended up coding, and then half way through the code they called the daughter, and she did stop it.

Similarly, team members shared narratives in which their tasks were eased by caregivers who had already prepared for transitional health care situations. The social worker recalled a patient under her care who was not able to communicate, but had previously made end-of-life plans with his daughter:

> She knew exactly what he wanted and . . . he had done it all with his family, and we just felt like we had gotten to know him so well even though he couldn't talk to us. . . . She was terribly upset, but . . . it was so interesting to see someone very sad, but also very at peace with it.

In both instances, the SW described caregiver choices that revealed not only what was meaningful to each of

those families, but how those caregiver choices affected the team and the care of the dying patient. Caregiver decisions are identified as vitally important to this SW through narrative, especially how it related to the team. Note that in both narrative accounts the SW reflected on the team's experience of the caregiver's role in facilitating care, highlighting that caregiver choices impacted the entire team. Her narrative account did not depict her role, but rather the team's role in these stories.

Family meetings with the health care team are an important part of facilitating the role of the family/caregiver. By meeting together, the health care team is able to support the family's goals of care by providing information and assisting in their decision-making process. Family meetings are especially important when patients are not able to communicate. A medical fellow recalled a family meeting about transitioning goals of care for a patient who was demented:

> I don't know if they [family] didn't want to know what's going on . . . but it's like every time we explained they came with a different story about what's going on. And at the end of the meeting they are able to explain back what's going on with the patient and the patient is dying. And at the next meeting it's like that never took place, never happened. Finally, after three or four meetings the family decided they don't want any hospice. . . . I don't think we got across the message. . . . I couldn't pinpoint our failure. (MF2)

The medical fellow attempted to identify the failure of the team—the ways in which they were unable to create meaning for the family and effect positive change in the dying experience. Not only does this narrative reveal content ordering in function, but also group ordering as the team's purpose and role is called into question in the medical fellow's story. The focus is once again on the impact to the team, as he references "we" and "our" rather than positioning himself as solely responsible for the interaction.

In addition to providing information and facilitating decision making, family meetings were also primary opportunities for the health care team to provide emotional support for family. The nurse recalled a family meeting that shifted the team's role as information providers to supportive carers for the family:

> They had the awareness of what they'd [family] done, and . . . it was all the things he [patient] hadn't wanted, but they had done 'em well intended. But to see their awareness of what they had done and how it wasn't what he wanted. . . . The family had their "aha" . . . in the family meeting. And then . . . your role switches in that moment. . . . Your overall goal is to journey with the family and the patient for the patient's best outcome. . . . And, our role went from basically bringing knowledge and options to comforting the family, you know . . . which it typically does. (N)

The chaplain was the only 1 of the 6 participants who did not mention family in a developed narrative; the other 5 team members did include family heavily in their stories. The social worker's data included the highest frequency of family stories, with the nurse and psychologist close behind. Our data trustworthiness process confirms that the chaplain interacted frequently with family members/caregivers.

Alone on a Team

Reflecting on their year and patient/family interactions, the 6 participants readily incorporated narratives about team structure and role performance challenges/successes. These role narratives were revealing in terms of how each team member viewed himself or herself, their personal agency, and guidance that was or was not available to them in light of their disciplinary specialty. Also included in this thematic section are ideas participants shared about implementing educational training components for future IDT members—specifically physicians. A common subject for nonphysician team members was a desire for mentoring. Below are extracts of the psychologist and the nurse describing their preceptor desires:

> You have to create your own structure. You have to go out there and just do things independently, um, which can be, have a lot of advantages 'cause that's essentially what allowed me to go up to the ICU. It makes it harder to, to get mentoring . . . there is no palliative care staff member in my discipline. (P)

> I need a strong mentor here and I, and I don't have one, you know. I have people who are wonderful in different areas, um, but I don't have a strong nurse mentor, and I need that. (N)

One of the medical fellows clearly articulated the strong guidance/cohort he had available to him in this fellowship process:

> If you have a problem with the system I will go straight to [names a person] and she will tell me how. . . . If it's um, knowledge-wise a problem, I go straight to [names a different person]. She will

> either have the answer right away, or she will direct you how to get the answer. . . . You always have somebody that you can come to, to ask any doubt, any question. In this case I have [names a person], I have some of the other, uh, attending that you always just call and say, "Well, you know, this patient has this, this, and that. What should I do?" (MF2)

Some team members expressed a desire for more team time. Their individual responsibilities seemed to pull them away from cohesiveness that might ideally be found in an IDT. The implication in the talk of the psychologist, nurse, and chaplain shown below is that a more unified team approach might improve the holistic care effort for patients, also decreasing frustrations and prejudices produced by disciplinary differences. The medical fellows were the only 2 participants who did not remark on team cohesion/time in narrative:

> It's difficult to not be able to work with the other disciplines more because of the nature of how they work, um, of how busy they are, of how hard it is to, to find time for kind of team-building . . . types of experiences. Um, and kind of the misunderstandings of each other in, in how we work. Um, like I can't just drop my patients and move to another rotation. That's unethical according to my discipline's ethics code . . . they work differently. Um, but it makes it more difficult to work together. (P)

> So my appointment at the school, even though it was at half time, I was on eleven committees. I was chair of one, I ran a course, I had all the lectures for that course, I had clinical instructors under the course that were doing different things, um, and I was, I was on some big committees. I think all the other fellows are full time. So to be half time to begin with and then to be overextended as well, my role, I'm not as, I'm not as visually seen, and, and, uh, I had a lot of late nights. (N)

> I've learned that, uh, doctors are, um, not all-knowing in all areas, that they are specific to the field that they go into, and just like every other profession in the world, they can get in a rut and not look outside the box for the answers. . . . doctors are too busy, they don't have time. . . . I've learned there's a lot of ego. (C)

Team members expressed in detail how they wanted physicians to understand and utilize their particular disciplinary role, and the benefits they brought to the end-of-life challenge with a patient and family. These narratives reveal that disciplinary team members did not believe they were fully integrated and valued in their participation with patient cases. Group ordering serves as the vehicle to understand how the following stories function in reflecting role identities on the team:

> Well the nurse is often the eyes and ears . . . we're [physicians and nurses] all in the same boat. You know, um, and that it's a partnership . . . and that we're a, a good resource, so they [physicians] don't have to reinvent the wheel every time . . . our role is to facilitate. (N)

> Our expertise in working with families . . . a systems approach. . . . I think it's very important for them [physicians] to understand. Actually this is a specific thing that, um, that I always found myself talking to doctors about, and other team members. . . . Research has shown there's a lot of conflict in the discharge planning process, and sometimes the other team members don't understand if the, if the patient wants to go home, the social worker is kind of advocating for the patient to go home. . . . They're [physicians] very anxious because they feel responsible for all these things. . . . I think it's important to train them early on how to use social workers and what they can do, and that they're an important part of the team . . . and that they're not just case managers. We're not there just to set up the transportation. (SW)

> I want them [physicians] to see us as a real and valid resource to caring for their patients. . . . If there's conflict, the chaplain can, um, come in and, and help maybe address the conflict, can give, uh, help, solicit trust toward the medical team, toward the doctor, can help s-, 'cause a lot of times, uh, and we can clarify. (C)

> I would've liked to do more educational interventions with the residents. . . . A lot of it is family support, um, talking with family about hospice, end-of-life issues, uh, palliative care, explaining that. . . . They're [medical residents] either avoiding certain patients 'cause it brings up certain feelings for them, or they're doing interventions badly, um, because they have their own difficulties dealing with those kinds of issues. (P)

Group-ordering narratives reveal which team members had a more-or-less positive experience with their role on the team in relationship to preceptor guidance, and how

that role was maintained and/or performed. The medical fellows were the only team participants who noted a strong sense of support and guidance from their disciplinary preceptor, and described multiple modalities of support. The lack of preceptor support within all other disciplines was confirmed in the field notes, as other area preceptors were functioning as such with one of the following deficits: no formal preceptor training, overloaded preceptor, uninterested preceptor, no preceptor. In addition, a variance in the need for team "together time" and its purpose gave rise to stories about time, combining the function of content and group ordering. Nonphysician team members felt that time (content ordering) was essential to creating a collaborative, cohesive (group ordering) team, whereas physician team members were stressed by the team meeting demands.

Storying Disciplinary Communication

With dialogism and expertise at play in the illness context, each participant made discipline-specific observations about communication failures in their time with the geriatric palliative care program. In their descriptions they expressed seeing opportunities for the team to improve in its service to patients, and communication with one another. The chaplain articulated her ability to intercede on behalf of a physician when a terminal prognosis communication encounter was unsuccessful between doctor and patient:

> A doctor came in and gave him an explanation that they couldn't do any more chemo [chemotherapy] on him. . . . The patient didn't hear it, just didn't hear it . . . because I was the chaplain I said pretty much the same thing as the doctor said, but I think because I was just a normal person . . . he could hear me. I don't think the doctor appreciated, in that particular instance, what I did, but I know the patient did. (C)

In the next exemplar, the psychologist recalled a terminal prognosis communication in which his intercession was valuable. In both prognosis communication examples, a team member other than the physician participated to support and comfort the patient and family:

> A resident had just observed their attendee communicating bad news to a family in an excellent way . . . and not an hour or two later, I observed this resident doing it terribly, just a horrible way of, of almost smashing the family over the head with this information. I was there and I worked to modify the situation. The attending's not by any means there all the time, um, so the residents are the primary person working with the patient. The resident chose to stand in the hallway right outside the patient's room, so everybody's standing. . . . I thought he might, you know, "Let's go to another room, let's sit down," um. No, he just plunged into it . . . in front of other staff, other families, you know. And without really . . . a lot of empathy apparent on his face, um, just repeatedly hammering them over the head. I was able to say, "Why don't we move into a private room. Let's sit down." (P)

Narratives about discipline-specific communication articulated the heart of IDT strength, though the stories were told with an air of derision and disappointment. Both of these two exemplars were successes in terms of the goals of interdisciplinary care. Team membership was meant to ensure that patient/family needs were met, as the needs at the end of life are too enormous for one individual. In these stories, the content ordering of communication was identified as what was important by the participants. We interpret this theme as unique in that content ordering becomes group ordering; each team member's communication was their identity in these stories.

Conclusion

Reflective narratives from their fellowship year on a geriatric palliative care team described how IDT members interpreted, analyzed, and valued an interdisciplinary-based approach to care. The unique positioning of each IDT member required that they filter stories of dying patients and their families through their professional/ethical lens, and in this process they identified collaborative practices and barriers. The telling of a story and its performance is as important as the narrative elements, because the actual process and expression of communicating a story reveals the implicit values of the teller (Sharf & Vanderford, 2003). These narratives have the potential to become a source of knowledge for other health care providers and future patients and families (Geist-Martin, Ray, & Sharf, 2003).

When examining the functionality of the narratives—described by Mishler (1995) as a combination of cognition, memory, and self—the narratives in this study document the interdependence of content and group ordering. That is, the stories collected function as a means to understand what was important in the realm of meaning and sense making for team members (content ordering), as well as collective identity (group ordering). Moreover, the reflective process of storytelling provided each IDT member with a means for greater understanding of his or her own role in the care process. Teams engage in storytelling as a

way of interpreting their teamwork experiences. Stories are embodied and contextualized, with discursive acts providing a depth of information that allows us to truly examine disciplinary perspectives as opposed to simply assuming interdisciplinary collaboration.

The content-ordered function of team members' narratives reveals a divergence in team members' conceptualization of teamwork and team effectiveness. Team members content ordered their care experiences by focusing on the voice of the lifeworld through stories about euthanasia requests, family meeting situations, and stories of managing patients' pain and loss of life. The content ordering of experiences in the field reflects a clear understanding of team goals and measures of team effectiveness. However, the content ordering of stories about disciplinary communication reveal that team members do not easily recognize their role in achieving or producing successful teamwork. Narratives told as stories about disciplinary communication functioned to highlight each team member's role as separate from the team, especially in light of communication failures. For example, there were specific criticisms and points of conflict described by nonphysician team members concerning the matter of breaking bad news about terminal prognosis matters. The sense making of these events by content ordering the narrative established team member identity in terms of discipline, rather than a team identity.

In contrast, the group-ordering function of narratives demonstrated team members' abilities to engage in the reflective process of teamwork. Narratives about caregiver teamwork revealed team member attention to how caregiver decision making impacts the team process and the team as a whole. Team members expressed strong ownership of team identity by group ordering work with caregivers. Through group ordering, narratives documented the visible identity of the team (as they intervened with caregivers), yet also revealed the invisible collaborative performance of team members. In concert with other findings, autonomy and competency in individual roles among team members was valued as part of interdisciplinary collaboration (Hinojosa et al., 2001). Although group ordering of the narrative did not pinpoint discipline-specific interventions, the presence of the team was apparent in the reflective process and understanding of team success and failures. The absence of chaplain's narratives about caregivers suggests that the chaplain did not share this enacted identity as an aspect of teamwork.

The reflective process of teamwork was also group ordered in narratives about being alone on the team. Nearly all participating team members described a desire to draw together as a group and communicate role-specific challenges. Narratives depicted a strong desire for reformed identity in terms of team structure and role, including more mentorship and more time. The themes of role differences and communication, in particular, included clear descriptions from team members about their lack of utilization or agency in relationship to the case physician. This discovery is consonant with previous research revealing that physicians typically dominate interprofessional decision making, leaving other team members feeling less engaged (Abramson & Mizrahi, 1996). Although group-ordered narratives revealed needs for team improvement, these narratives also demonstrated that team member identity was clearly formed, as they had an understanding of what was needed to be a successful team.

Guided interviews of one team's stories and the absence of demographic measures comingle to present limitations for this work. It is not possible to generalize the themes collected across other interdisciplinary health care contexts. This study was limited by the number of participants involved and the particular setting of a VA hospital. Additionally, the structure of the system in which they worked impacted their experiences. For example, this team was situated at a VA hospital where more than 95% of their patients were men. However, we make no claim that this data set is representative of IDTs in palliative care or geriatric consult services, and we make no claims about gender, class, or race beyond those that were integrated into the interview responses of our participants.

These IDT narratives unveil both the practice of an innovative model for patient care, and formidable communication challenges for those training to work as part of a care team. This study reveals aspects of collaboration and separation among team members as shared in their reflective accounts of teamwork. A key aspect of effective interdisciplinary care is to be knowledgeable about other team members' disciplines, as well as to recognize and understand each discipline's perspective about patient care plans and goals. The professional filters that each individual brought to the care process, even if conflict was a part of building a care plan, strengthened the collaborative work of the team. Each fellow shared narratives consistent with their disciplinary involvement in the care process, and denoted their specific role in this environment. The narratives demonstrate the strength of the interdisciplinary care model and give evidence to the importance of narrative reflection of team experiences.

Interdisciplinary team training is still in its infancy. A recent project modeled the pedagogical power of narratives and professionals in training by sharing patient narratives with an interdisciplinary care team. In this work, patient-centeredness was problematized in the analysis of narrative responses by team members. There was increased recognition of the need for different professionals to work closely together, to connect more directly

to the patient/family, and most of all to better understand the patient's context via the help of other team members (Blickem & Priyadharshini, 2007). Future interdisciplinary team training should incorporate the concept of Bakhtin's dialogism; the study and discussion of narratives for team members in training could bring an awareness to care professionals about their discipline-specific approaches, biases, and identities, and how these might advance or obstruct good patient/family care. As revealed here, narratives by other team members provide a demonstration of disciplinary perspectives and responsibilities and document aspects of teamwork and divergence (Wittenberg-Lyles, Greene, & Sanchez-Reilly, 2007). By hearing each other's stories, team members can identify and evaluate team processes. Practice and reflection can lead to positive team building and future successes in teamwork.

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