Team approaches in palliative care: a review of the literature

GVMC Fernando and Sean Hughes

Abstract

Background: Interdisciplinary team involvement is commonplace in many palliative care settings across the world. Teamwork is perceived by many experts as an indispensable functionality of palliative care teams. Significantly different structural and functional attributes of these teams between regional and organisational contexts could potentially act both as strengths and weaknesses towards their overall productivity. The sustainability and resilience of the team also has an indirect bearing on the team functioning. **Aim:** This article describes international evidence on dynamic palliative care teams with a view of how and when they function efficiently or adversely. Emphasis is also placed on studies that suggest means to mitigate the conflicts and limitations of teamwork in palliative care and related healthcare settings. **Findings:** Evidence strongly suggests that palliative care is best delivered through a multidisciplinary team approach. **Conclusion:** The overall performance of a healthcare team is largely determined by the supportive work environment built through effective communication, leadership skills and mutual respect.

Key words: ☐ Interdisciplinary team ☐ palliative care setting ☐ team functioning ☐ institutional management teams

This article has been subject to double-blind peer review

GVMC Fernando
Palliative Care Lead, National Centre for Primary Care and Allergy Research, University of Sri Jayewardenepura, Sri Lanka

Sean Hughes
Lecturer, Department of Family Medicine, Faculty of Medical Sciences, University of Sri Jayewardenepura, Sri Lanka

Corresponding author:
Chamath Fernando
chemetf@sjp.ac.lk;
chemetf@gmail.com

The founder of the modern palliative care and hospice movement, Dame Cicely Mary Saunders, developed the concept of 'total pain' in 1964 (Saunders, 2001). This concept encompassed not only the physical, but also the psychosocial and spiritual sources of distress experienced by a person who has been diagnosed with a life-threatening illness. The discipline of palliative care aims to address each aspect of total pain among patients faced with life-threatening illnesses, while including their relatives. The spectrum of domains across which palliative care is organised makes obvious the fact that a team of professionals with a range of expertise must be involved with the care of such patients. In its extended definition of palliative care, the World Health Organization (WHO) emphasises the necessity of a 'team approach' to address the complex needs of the patient spanning from the point of diagnosis to the stage of provision of bereavement care to the loved ones following the death of the patient (World Health Organization, 2017).

The International Association for Hospice and Palliative Care (IAHPC) is currently in the process of obtaining stakeholder endorsements for its consensus-based definition of palliative care (International Association for Hospice and Palliative Care, 2019). It reiterated the salience of contributions of multidisciplinary teams (MDT) in palliative care from personnel with basic palliative care training through to those with specialist training. Universities, academia and teaching hospitals are encouraged by the IAHPC to integrate research and multi-professional training related to palliative care at basic, intermediate and advanced levels.

Certain attributes of a palliative care team

Box 1. Features of a team
Structural attributes
● Models for teamwork
● Designated roles in the multidisciplinary team
● Sequelae of 'having many eyes and many hands'
● Teamwork across different care settings
Functional attributes
● Teamwork
● Phases of team development
● Leadership
● Communication
● Multimodal therapeutic options
● Overlap between roles
● Dealing with burnout and compassion fatigue
Economic imperatives of palliative care teams
Means of sustaining satisfactory care

© 2019 MA Healthcare Ltd

determine its effectiveness. Particular characteristics of a team may have beneficial effects and/or detrimental consequences on the quality of care, overall team performance and use of scarce resources, especially in resource-poor settings. The features of a team will be discussed under the headings in *Box 1*.

Structural attributes
Models for teamwork
Team structure and interactions between members vary in relation to the model of teamwork. Three models of healthcare teams have been outlined by Crawford and Price (2003) in an Australian context; multidisciplinary, interdisciplinary and transdisciplinary. A hypothetical, purely multidisciplinary team has clearly defined responsibilities assigned to individuals. Instead of interacting with other members of the team, each professional provides care in isolation. This approach is perceived to have practical limitations, principally due to fragmentation of care. On the other extreme is the transdisciplinary approach where the responsibilities are overlapping to a greater extent between the members. Each member attends to the same set of duties during their shift. There can be specific care needs unattended to, which make this model unsuitable in general for healthcare teams. In an interdisciplinary team, the members interact with each other and work interdependently resulting in augmentation of overall patient care, which is a model suited to palliative care provision (*Figure 1*). In this article, we use the term 'multidisciplinary team'(MDT) to denote 'teamwork' in general.

Designated roles in the multidisciplinary team
Healthcare professionals involved with palliative care include doctors, nurses and allied health professionals (AHP). The physicians in a care team include general practitioners, palliative physicians, anaesthetists, psychiatrists, oncologists and other disease-specific specialists, for example nephrologists (National Hospice and Palliative Care Organization, 2019). Nurse practitioners and community nurses play a major role as do AHP (Kirby et al, 2014). AHP also include physiotherapists, occupational therapists, speech and language therapists, dietitians and a range of other therapists (Ramirez et al, 1998; Fleissig et al, 2006; Bowen, 2014; Ramanayake et al, 2016). Psychologists, counsellors, social workers and community volunteers assist patients with their psychosocial wellbeing while priests, chaplains and pastoral care givers provide spiritual guidance to patients (Puchalski, 2002; Hanson et al, 2008; El Nawawi et al, 2012).

Team members whose services are essential on a routine basis constitute permanent members of a team: the core team. Others who offer support on an 'as required basis', form the extended team (Øvretveit, 1996). Extended team members also provide indispensable aspects of care and may include, for example, solicitors who assist patients in advanced care planning, appointing lasting power-of-attorney for welfare/financial affairs (Mullick et al, 2013). Family members and caregivers who play a significant role in care provision also

❛In an interdisciplinary team, the members interact with each other and work interdependently resulting in augmentation of overall patient care, which is a model suited to palliative care provision❜
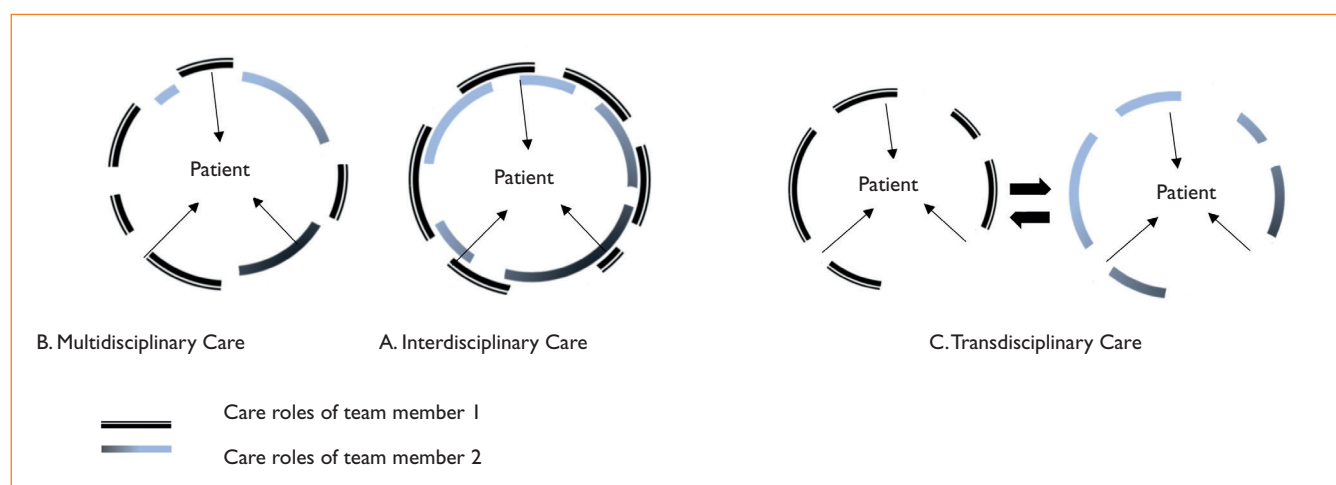

Figure 1: Graphical representation of care models for teamwork; A. Multidisciplinary B. Interdisciplinary C. Transdisciplinary in a team with two members.

B. Multidisciplinary Care   A. Interdisciplinary Care   C. Transdisciplinary Care

▬▬ Care roles of team member 1
▬▬ Care roles of team member 2

form part of the team (Morris et al, 2013), particularly in countries where palliative care is well established, such as the UK and Australia. Team member skill sets can vary significantly across countries and regions based on the loco-regional needs, policies and resources (Crawford and Price, 2003). For example, volunteers have long been part of the hospice workforce in the UK (Crawford and Price, 2003) but are deployed in more extensive community-based roles in other places where the palliative care infrastructure is less well resourced, such as in Kerala, India (Kumar, 2007).

Sequelae of 'having many eyes and many hands'

Integrating the spectrum of expertise of different individuals into the palliative care plan increases the likelihood that patients are managed in a holistic manner. As the number of persons observing the patient increases ('many eyes'), the patient's welfare improves, and the probability that a patient's concerns are overlooked diminishes (Rome et al, 2011; O'Daniel and Rosenstein, 2008). Other proven benefits include expansion of the sources of support, satisfactory symptom control, better opportunities to express concerns, better preservation of autonomy, improved satisfaction and quality of life as reported by care recipients (Hearn and Higginson, 1998). Involvement of care teams lessens the rates of hospitalisation of palliative care patients and allows them to spend more time at home (Higginson et al, 2002; Gade et al, 2008), honouring patients' predominant preference to be cared for at home (De Roo et al, 2014).

An American group of investigators suggested that the number of members in an ideal core palliative care team ranges between five and 10. It is also reported that the efficiency of a team may decline should the number of professionals in a team exceed 20. This study found that contradictory views and opinions, which are inevitable by-products of a functioning enthusiastic team, were better tolerated among members of a relatively larger team (Katzenbach and Smith, 1993).

Teamwork across different care settings

The principle settings of palliative care delivery comprise community/home, hospice and hospital (Wiencek and Coyne, 2014). The composition and the dynamics within these teams vary depending on the availability of resources and expertise in the relevant care setting. The general

practitioner (GP) who practises in the community has considerable understanding of the resources available around the household, neighbourhood and the society in which the patient resides. Therefore, GPs are well equipped to provide generalist palliative care while coordinating care in community settings. Similarly, the palliative care specialist usually delivers care in a hospice or a hospital-based setting (as well as in the community) while solving complex health-related issues (Higginson et al, 2002; Brumley et al, 2003). The same patient may need access to palliative care in different settings owing to constantly reshaping circumstances through the disease trajectory. Therefore, efficient collaboration between the generalist and specialist care settings and the professionals involved is beneficial to ensure continuity of comprehensive care (Quill and Abernethy, 2013).

The models of palliative care provision and professional compositions of teams are continuously evolving. A study that retrospectively evaluated pooled data on community-based specialist palliative care teams concluded that such teams evidently reduced rates of use of acute care and of institutionalised deaths at the end of life (Seow et al, 2014). Macmillan specialist nurses who care for palliative patients in the community are examples.

Higginson and Evans (2010) reviewed the literature assessing the effect of specialist palliative care teams on patients with advanced cancer receiving care at home, hospital and designated inpatient care units. Compared to disease-oriented care models, superior relief of pain-related symptoms and anxiety was apparent with these teams with a reported reduction in hospital admission rates.

Another systematic review looked at the contribution to palliative care by GPs. Patients and relatives expressed mixed perspectives in this regard. They appreciated the accessibility, time dedication and efforts made by their GPs to ease symptoms, while they believed bereavement care was comparatively better provided in other settings. Furthermore, GPs themselves felt less competent to provide palliative care. It was established objectively that they can miss complex and rare symptoms that may lead to delays in diagnosis and the provision of appropriate care. Recommendations that encouraged palliative specialists to refer patients to GPs for palliative care provision were expected to stimulate GPs to develop their competencies (Mitchell, 2002).

Functional attributes

Team work

Healthcare teams have been demonstrated to provide better care in qualitative and quantitative terms than practitioners operating in solitude. Care receiver satisfaction with regards to a team was influenced favourably by collaboration, conflict resolution and functioning in cohesion (Mitchell, 2002). The combined skills and decision-making abilities demonstrated by successful teams comprising diverse experts (Crawford and Price, 2003) have been shown to improve patient outcomes as well as organisational effectiveness (Lemieux-Charles and McGuire, 2006). A group of Norwegian experts suggested that the key objectives expected of an optimally functioning healthcare team are prompt and comprehensive patient assessment combined with appropriate care provision in constructive collaboration with the patients, their loved ones, fellow team members, external individuals and organisations. Evaluating practice on a regular basis to audit practice standards in light of current evidence informs the development of service provision (Cherny et al, 2015).

Phases of team development

The development of a team progresses through sequential stages through which the members mature while gaining experience (Katzenbach and Smith, 1993; Rickards and Moger, 2002). In the 'forming' stage, inexperienced members attempt to define their roles with the guidance of a formal leader. During the 'storming' stage, conflicts arise as a result of contradicting opinions between different subgroups and in a competition for power. The 'norming' phase is characterised by members coming to terms with their roles and responsibilities. They openly discuss their concerns with fellow members with whom they share a sense of belonging. In the final stage of 'performing', team members support each other to function synergistically and develop in-built algorithms for conflict resolution (Twomey et al, 2014). The notion of a 'phases model' suggests that a team would not function efficiently right from its inception, but will do so through growing together as a functioning group.

Leadership

Among the philosophies of teamwork (directive, integrative, elective), the integrative model is seen to work best with palliative care MDTs. In this model, the value of each professional is weighted equally since their individual expertise together enables the broad spectrum of patient welfare. Frequent discussions among them are also vital to the functioning of the group. A more directive leadership approach exists in order to identify the skillsets of team players, assign suitable tasks, motivate, collaborate with external resources, deal with obstacles and steer the overall performance of the team towards the achievement of set goals (Katzenbach and Smith, 1993). When the roles and responsibilities of team players are well coordinated by directive leadership, patients, practitioners and care givers are all likely to benefit.

In the absence of supportive leadership, teamwork can be frustrating. Poor definition of leadership and conflicts over authority can also impair team functioning. Teams can, on occasions, face problems related to unduly dominant members (Feiger and Schmitt, 1979). The gold standards framework has been instrumental in associating communication with high-quality generalist palliative-care delivery where well-functioning teams have used a mixture of formal and informal meetings (Mahmood-Yousuf et al, 2008). The meetings were meant to be held in relatively a non-hierarchical working style without much emphasis on leadership specifically, although the hierarchy was apparent in the doctor–nurse relationship.

Communication

Communication, whether inter-professional or between the professional and a patient, was described in a Swedish qualitative study as key to both the execution of palliative care and optimal team functioning (Klarare et al, 2013). Satisfactory inter-professional communication is deemed instrumental in arriving at management decisions, conflict resolution, building trust, fulfilling administrative tasks, advocacy, sharing of knowledge and experiences, and thereby enhancing individual and collective competencies (Klarare et al, 2013). A Swiss study shows that lack of formal channels of communication between professionals in different care settings has led to disharmony; for instance between primary and tertiary care levels (Liebig and Piccini, 2017).

Communication challenges faced by healthcare professionals dealing with patients diagnosed with life-threatening diseases include breaking bad news, dealing with collusion, difficult questions, uncertainty and responding to overt emotional reactions (Faulkner, 1998). An individual's team member of preference may vary from one patient to another. A study based in Libya found that the patient's preferred staff

member within the broader team was considered to be better positioned to undertake sensitive information exchange than others (Kurer and Zekri, 2008). With this notion, having staff with varying personality characteristics within the team can be perceived a strength.

Certain team members who are more experienced in leadership, communication skills, development of trust and team-building are well equipped to serve as resourceful intermediaries in dissonance management, while offering valuable feedback and support to the fellow members (Parker Oliver and Peck, 2006; Green, 2017).

Multimodal therapeutic options

The range of members forming the traditional palliative care team continues to evolve over time. Examples from a Taiwanese context include music and art therapists who render services that bring symptomatic relief and enhance the patients' quality of life (Huang et al, 2010; Lin et al, 2012). Fear of adverse effects of drug therapy, for example opiophobia, can contribute to patients' reluctance to accept pharmacotherapy. Patients who receive care in resource-rich settings and who may have access to a range of therapeutic approaches, can provide opportunities to test the benefits of complementary therapies, such as art therapy.

Owing to inherent discrepancies in the training, exposure and perspectives of the diverse professionals involved, contradictory views on the best therapeutic modality for a patient given their current status are likely to exist. Silbermann et al demonstrated that this could lead to inter-professional conflict (Silbermann et al, 2013). MDT discussions allow space for the team members to weigh each option and arrive at consensus on the best overall plan of management for a patient. Good palliative care teams respect a patient-centred approach while arriving at care decisions (Bélanger et al, 2016).

Overlap between roles

Designations of distinct personnel imply their primary role in the team. Practically, however, a considerable overlap will exist between roles. For example, multi-faith hospice chaplains can offer spiritual guidance regardless of a patient's religious background or spiritual belief. Dutch experts suggest that other team members, not principally concerned with spiritual care provision, should also have a basic training in assessing spiritual distress and an overview of the nature of care a pastoral care giver provides (Baldacchino, 2015; van de Geer et al, 2018). This understanding ensures that spiritual distress is more likely to be perceived by healthcare professionals, and measures including appropriate referrals will be undertaken to alleviate such distress.

Where there is uncertainty in the specific roles of individual professionals, emergence of dissonance is not uncommon. Disputes can arise between different professionals who claim sole responsibility over a particular facet of an individual's care. There could also be occasions where professionals overlook certain aspects of care having assumed that another colleague is responsible (Green, 2017). Timely communication between team members can prevent such occurrences.

Dealing with burnout and compassion fatigue

Emotionally, and sometimes physically, overwhelming tasks are handled by palliative care providers, while dealing with dying, suffering and uncertainty render them vulnerable to compassion fatigue and burnout (Kamal et al, 2016). Burnout has mental, emotional and physical elements of fatigue, which can undermine a professional's interest and capacity. The proportion of clinicians who suffer burnout mostly due to emotional exhaustion can be as high as 62% in hospice and palliative care settings (Kamal et al, 2016). Recent research found that conflicts within a team can also serve as a source of stress. However, working in a team can positively influence individual members through reinforcing interpersonal relationships, providing opportunities for professional appraisal and sharing of experiences, responsibilities and worries (Penson et al, 2000; Pereira et al, 2011; Kamal et al, 2016).

Economic imperatives of palliative care teams

The labour-intensive nature of team approaches may raise concerns about the costs involved. When community-based multidisciplinary palliative care team members work in collaboration aimed at the best interests of their patients, the need for hospital-based care declines. Hence, the team approach in fact decreases the overall costs of care (Hearn and Higginson, 1998). The cost-effectiveness of palliative care teams was consistently found to be impressive in contrast to comparator groups

in fellow disciplines. The community-based model developed in Kerala, India, where the administrators of care are mostly trained volunteers, is an exemplary cost-effective method of care provision that has been of proven efficacy and hence promoted in other resource-poor countries (Smith et al, 2014).

Means of sustaining satisfactory care

Regular audit of practice is central to the sustenance of the quality of care provision, fair staff contributions and stability within teams. An audit is generally aimed at evaluating the discrepancy between current and best practice recommendations in keeping with the most recent evidence. Organisational structure, processes for service delivery and care outcomes must be audited by palliative care teams on a regular basis. These must be interspersed with necessary revisions and training in order to upgrade and maintain standards and consistency of care (Hunt et al, 2004; Fulmer et al, 2005).

Sufficient room must be provided for each individual in the team to develop and update skills and knowledge. Case discussions, ward rounds and clinical meetings held by the MDT members on occasions with external resource persons are some examples as to means for team development and functioning.

Conclusion

Evidence aligns strongly with the notion that palliative care is optimally delivered through MDT approaches. The inherent attributes of teamwork provide strengths to the quality and extent of care provided to the patients and their loved ones, albeit with minimal yet noteworthy limitations. The dynamics within the team can influence individual members and the team as a whole favourably and on occasions adversely. The net effect of the supportive and maladaptive environments created within healthcare teams largely determines the overall team performance towards achieving the common goal of holistic patient care. The majority of perhaps inevitable drawbacks in an MDT approach are best mitigated through communication, leadership skills and mutual respect. Research, clinical audits and ample opportunities for the team members for continuous professional development are central to the maintenance of the ideal standards of care provided by a multidisciplinary palliative care team. IJPN

Baldacchino D. Spiritual care education of health care professionals. Religions. 2015; 6(2):594–613. https://doi.org/10.3390/rel6020594

Bélanger E, Rodríguez C, Groleau D, Légaré F, MacDonald ME, Marchand R. Patient participation in palliative care decisions: An ethnographic discourse analysis. Int J Qualit Studies Health Well-Being. 2016; 11(1):1-15. https://doi.org/10.3402/qhw.v11.32438

Bowen L. The multidisciplinary team in palliative care: a case reflection. Indian J Palliat Care. 2014; 20(2):142–145. https://doi.org/10.4103/0973-1075.132637

Brumley RD, Enguidanos S, Cherin DA. Effectiveness of a home-based palliative care program for end-of-life. J Palliat Med. 2003; 6(5):715–724. https://doi.org/10.1089/109662103322515220

Key points

- Evidence shows that a multidisciplinary team (MDT) approach is best suited to deliver optimum palliative care
- The dynamics within the team can influence individual members and the team as a whole favourably and on occasions adversely
- Many drawbacks of a MDT can be mitigated through effective communication, proper leadership and mutual respect
- Conducting regular clinical audits and providing continuous professional development opportunities for team members are central to maintaining standards of care by multidisciplinary palliative care teams

Continuing professional development: reflective questions

- Have you had a conflict between members of your multidisciplinary healthcare team? What did you learn from this?

- What attributes of yourself and/or the fellow members of your healthcare team affect team dynamics positively? What attributes negatively affect the team?

- Does your healthcare team have effective mechanisms to resolve dissonances as they arise?

Cherny NI, Fallon M, Kaasa S, Portenoy RK, Currow D. Oxford Textbook of Palliative Medicine Oxford: Oxford University Press; 2015

Christensen C, Larson JR, Jr Collaborative medical decision making. Med Decis Making. 1993; 13(4):339–346. 10.1177/0272989x9301300410

Crawford GB, Price SD. Team working: palliative care as a model of interdisciplinary practice. Med J Aust. 2003; 179(6 Suppl):S32–34

De Roo ML, Miccinesi G, Onwuteaka-Philipsen BD et al. Actual and preferred place of death of home-dwelling patients in four European countries: making sense of quality indicators. PLoS One. 2014; 9(4):e93762. https://doi.org/10.1371/journal.pone.0093762

El Nawawi NM, Balboni MJ, Balboni TA. Palliative care and spiritual care: the crucial role of spiritual care in the care of patients with advanced illness. Curr Opin Support Palliat Care. 2012; 6(2):269–274. https://doi.org/10.1097/SPC.0b013e3283530d13

Faulkner A. ABC of palliative care. Communication with patients, families, and other professionals. BMJ. 1998; 316(7125):130–132. https://doi.org/10.1136/bmj.316.7125.130

Feiger SM, Schmitt MH. Collegiality in interdisciplinary health teams: its measurement and its effects. Social science and medicine. Part A: medical psychology and medical sociology. 1979; 13:217–229. https://doi.org/10.1016/0271-7123(79)90031-2

Fleissig A, Jenkins V, Catt S, Fallowfield L. Multidisciplinary teams in cancer care: are they effective in the UK? Lancet Oncol. 2006; 7(11):935–943. https://doi.org/10.1016/s1470-2045(06)70940-8

Fulmer T, Hyer K, Flaherty E et al. Geriatric interdisciplinary team training program: evaluation results. J Aging Health. 2005; 17(4):443–470. https://doi.org/10.1177/0898264305277962

Gade G, Venohr I, Conner D et al. Impact of an inpatient palliative care team: a randomized control trial. J Palliat Med. 2008; 11(2):180–190. https://doi.org/10.1089/jpm.2007.0055

Green S. Making it right in the end: conflict on the hospice interdisciplinary team. 2017. https://sophia.stkate.edu/msw_papers/744 (accessed 10 September 2019)

Hanson LC, Dobbs D, Usher BM et al. Providers and types of spiritual care during serious illness. J Palliat Med. 2008; 11(6):907–914. https://doi.org/10.1089/jpm.2008.0008

Hearn J, Higginson IJ. Do specialist palliative care teams improve outcomes for cancer patients? A systematic literature review. Palliat Med. 1998; 12(5):317–332. https://doi.org/10.1191/026921698676226729

Higginson IJ, Evans CJ. What is the evidence that palliative care teams improve outcomes for cancer patients and their families? Cancer J. 2010; 16(5):423–435. https://doi.org/10.1097/PPO.0b013e3181f684e5

Higginson IJ, Finlay I, Goodwin DM et al. Do hospital-based palliative teams improve care for patients or families at the end of life? J Pain Symptom Manage. 2002; 23(2):96–106

Huang ST, Good M, Zauszniewski JA. The effectiveness of music in relieving pain in cancer patients: a randomized controlled trial. Int J Nurs Stud. 2010; 47(11):1354–1362. https://doi.org/10.1016/j.ijnurstu.2010.03.008

Hunt J, Keeley VL, Cobb M, Ahmedzai SH. A new quality assurance package for hospital palliative care teams: the Trent Hospice Audit Group model. Br J Cancer. 2004; 91(2):248–253. https://doi.org/10.1038/sj.bjc.6601945

International Association for Hospice and Palliative Care. Palliative care definition. 2019. https://tinyurl.com/y33mr2zq (accessed 10 September 2019)

Kamal AH, Bull JH, Wolf SP et al. Prevalence and predictors of burnout among hospice and palliative care clinicians in the US. J Pain Symptom Manage. 2016; 51(4):690–696. https://doi.org/10.1016/j.jpainsymman.2015.https://doi.org/10.020

Katzenbach JR, Smith DK. The wisdom of teams creating the high-performance organization Harvard, MA: Harvard Business School Press; 1993

Kirby E, Broom A, Good P. The role and significance of nurses in managing transitions to palliative care: a qualitative study. BMJ Open. 2014; 4(9):e006026. https://doi.org/10.1136/bmjopen-2014-006026

Klarare A, Hagelin CL, Furst CJ, Fossum B. Team interactions in specialized palliative care teams: a qualitative study. J Palliat Med. 2013; 16(9):1062–1069. https://doi.org/10.1089/jpm.2012.0622

Kumar SK. Kerala, India: a regional community-based palliative care model. J Pain Symptom Manage. 2007; 33(5):623–627. https://doi.org/10.1016/j.jpainsymman.2007.02.005

Kurer MA, Zekri JM. Breaking bad news: can we get it right? Libyan J Med. 2008; 3(4):200–203. https://doi.org/10.4176/080825

Lemieux-Charles L, McGuire WL. What do we know about health care team effectiveness? A review of the literature. Med Care Res Rev. 2006; 63(3):263–300. https://doi.org/10.1177/1077558706287003

Liebig B, Piccini C. Inter-professional communication in palliative care: general practitioners and specialists in Switzerland. Clin Case Rep Rev. 2017; 3(2):1–5. https://doi.org/10.15761/CCRR.1000311

Lin MH, Moh SL, Kuo YC et al. Art therapy for terminal cancer patients in a hospice palliative care unit in Taiwan. Palliat Support Care. 2012; 10(1):51–57. https://doi.org/10.1017/s1478951511000587

Mahmood-Yousuf K, Munday D, King N, Dale J. Interprofessional relationships and communication in primary palliative care: Impact of the Gold Standards Framework. Br J Gen Pract. 2008; 58(549):256–263. https://doi.org/10.3399/bjgp08X279760

Mitchell GK. How well do general practitioners deliver palliative care? A systematic review. Palliat Med. 2002; 16(6):457–464. https://doi.org/10.1191/0269216302pm573oa

Morris S, Wilmot A, Hill M, Ockenden N, Payne S. A narrative literature review of the contribution of volunteers in end-of-life care services. Palliat Med. 2013; 27(5):428–436. https://doi.org/10.1177/0269216312453608

Mullick A, Martin J, Sallnow L. An introduction to advance care planning in practice. BMJ. 2013; 347f6064. https://doi.org/10.1136/bmj.f6064

National Hospice and Palliative Care Organization. Updated edition of hospice facts and figures report—NHPCO. 2017. https://www.nhpco.org/nhpco-releases-updated-edition-of-hospice-facts-and-figures-report/ (accessed 14 September 2019)

O'Daniel M, Rosenstein AH. Professional communication and team collaboration. In: RG Hughes. Patient safety and quality: an evidence-based handbook for nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008

Øvretveit J. Five ways to describe a multidisciplinary team. J Interprof Care. 1996; 10(2):163–171. https://doi.org/10.3109/13561829609034099

Parker Oliver D, Peck M. Inside the interdisciplinary team experiences of hospice social workers. J Soc Work End Life Palliat Care. 2006; 2(3):7–21. https://doi.org/10.1300/J457v02n03_03

Penson RT, Dignan FL, Canellos GP, Picard CL, Lynch TJ. Burnout: caring for the caregivers. Oncologist. 2000; 5(5):425–434

Pereira SM, Fonseca AM, Carvalho AS. Burnout in palliative care: a systematic review. Nurs Ethics. 2011; 18(3):317–326. https://doi.org/10.1177/0969733011398092

Puchalski CM. Spirituality and end-of-life care: a time for listening and caring. J Palliat Med. 2002; 5(2):289–294. https://doi.org/10.1089/109662102753641287

Quill TE, Abernethy AP. Generalist plus specialist palliative care—creating a more sustainable model. N Engl J Med. 2013; 368(13):1173–1175. https://doi.

org/10.1056/NEJMp1215620

Quinn B, Thomas K. Using the Gold Standards Framework to deliver good end of life care. Nurs Manag (Harrow). 2017; 23(10):20–25. https://doi.org/10.7748/nm.2017.e1581

Ramanayake RP, Dilanka GV, Premasiri LW. Palliative care; role of family physicians. J Family Med Prim Care. 2016; 5(2):234–237. https://doi.org/10.4103/2249-4863.192356

Ramirez A, Addington-Hall J, Richards M. ABC of palliative care. The carers. BMJ. 1998; 316(7126):208–211. https://doi.org/10.1136/bmj.316.7126.208

Rickards T, Moger S. Creative leadership processes in project team development: an alternative to Tuckman's stage model. Br J Manag. 2002; 11(1):273–283. https://doi.org/10.1111/1467-8551.00173

Rome RB, Luminais HH, Bourgeois DA, Blais CM. The role of palliative care at the end of life. Ochsner J. 2011; 11(4):348–352

Saunders C. The evolution of palliative care. J R Soc Med. 2001; 94(9):430–432. https://doi.org/10.1177/014107680109400904

Seow H, Brazil K, Sussman J et al. Impact of community based, specialist palliative care teams on hospitalisations and emergency department visits late in life and hospital deaths: a pooled analysis. BMJ. 2014; 348g3496. https://doi.org/10.1136/bmj.g3496

Silbermann M, Pitsillides B, Al-Alfi N et al. Multidisciplinary care team for cancer patients and its implementation in several Middle Eastern countries. Ann Oncol. 2013; 24 (S7):41–47. https://doi.org/10.1093/annonc/mdt265

Smith S, Brick A, O'Hara S, Normand C. Evidence on the cost and cost-effectiveness of palliative care: a literature review. Palliat Med. 2014; 28(2):130–150. https://doi.org/10.1177/0269216313493466

Twomey C, Byrne M, Leahy T. Steps towards effective teamworking in community mental health teams. Ir J Psychol Med. 2014; 31(1):51–59. https://doi.org/10.1017/ipm.2013.62

van de Geer J, Veeger N, Groot M et al. Multidisciplinary training on spiritual care for patients in palliative care trajectories improves the attitudes and competencies of hospital medical staff: results of a quasi-experimental study. Am J Hosp Palliat Care. 2018; 35(2):218–228. https://doi.org/10.1177/1049909117692959

Wiencek C, Coyne P. Palliative care delivery models. Semin Oncol Nurs. 2014; 30(4):227–233. https://doi.org/10.1016/j.soncn.2014.08.004

World Health Organization. Palliative Care. 2017. https://www.who.int/cancer/palliative/definition/en/ (accessed 10 September 2019)

© 2019 MA Healthcare Ltd