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Patients' Experiences of Interprofessional Care: A Narrative Inquiry

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PATIENTS' EXPERIENCES OF INTERPROFESSIONAL CARE: A NARRATIVE INQUIRY

by

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ABSTRACT

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Interprofessional care (IPC) has been discussed in the literature as having the ability to lower health care expenditures, decrease wait times, enhance patient health outcomes and increase healthcare provider satisfaction with care-delivery. To date, limited research has been conducted to develop an in depth understanding of patients' experiences receiving IPC. Using Connelly and Clandinin's Narrative Inquiry qualitative research approach, three participants were interviewed and asked to engage in a metaphor selection drawing exercise. Participants were invited to describe how they experienced IPC and whether or not they believe person-centered care was delivered to them. Collected stories were analyzed as per Narrative Inquiry approach of three dimensional space: temporality, sociality and place. The *National Canadian Interprofessional Competency Framework* provided the theoretical lens through which the stories were examined. Along with giving voice to patients, three narrative threads emerged within this study: communication, patient within interprofessional team and interprofessional team members.

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Lastly, but most importantly, I would like to thank my parents (Oleg and Larysa) and sister (Sophia) for standing by my side through all the difficult moments in my life. To my dear grandparents (Roman, Bronislava, Stephanie and Bogdan), I am who I am today because of each one of them. Additionally, I have to thank my fiancé Anton for continuing to support all of my educational endeavors, being patient with me even though I know it was tough at times and loving me unconditionally. Most importantly, this thesis would not be possible without the participants and their willingness to share their stories of experience receiving interprofessional person-centered care.

DEDICATION

I would like to dedicate this thesis to my parents, Oleg and Larysa, who were both physicians back in Ukraine, but had to give up their professions to ensure my sister and I would have a better future. I hope I have been able to make you proud with all of my accomplishments thus far. I want you both to know that I will be forever grateful for what you have done for me.

As well, I want to dedicate this thesis to both of my uncles (Volodymr and Misha) for leaving us too soon, to all the loved ones who have parted with us, and to babusia Kasia, whose name I bare.

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PROLOGUE

Journey of Discovery

As I begin to unravel the path my thesis has taken me on, I start to envision the process through metaphorical images. Thinking in metaphors allows me to feel a closer connection to my study participants. Additionally, metaphors can illuminate the meanings of experiences (Schwind, 2009). The strongest of all metaphorical images for me, in relations to this thesis, is that of a journey. This metaphor is the most ideal because it encompasses the notion that each and every one of us lives some kind of a past that impacts our present position and will influence our future endeavors. I thread this journey metaphor throughout my entire thesis as evident in titles and introductions of each chapter.

This particular journey that I am embarking on is a multi-stop venture: I will be traveling using multiple modes of transportation before I finally make it to my destination, the seaside hotel. As I pack my bags, I am packing my whole past and taking it along on the trip. Arriving at the airport I am greeted by a travel agent who provides me with my full itinerary for my trip. Having obtained my schedule, I walk to Gate C to board my first method of transportation. As I walk onto the plane, I am completely engulfed by all the new faces and people before me. As I locate my seat, I notice that I am going to be sitting beside a lovely elderly man and for the next couple of hours, our lives would intersect. Immediately I become curious as to where he is heading and what his final destination is. I start up a conversation with a small question only later to find out that we have been deep in discussion for the duration of the flight. Upon landing at my first stop-over, I have to say goodbye to my acquaintance as he is not progressing in the same direction as I am. Running to catch the train, I cannot stop thinking about our conversation and how this complete stranger has trusted me so much to share his experiences.

As I just make it on the train, I realize that there are no empty seats left. I am not looking forward to standing for the next two hours. Just as I am about to succumb to my misery, a young woman, similar in age to me, waves at me and offers her seat. After saying thank you, I end up taking it. I offer to hold her bag on my lap as she stands next to me. These small gestures are like an icebreaker for us to get comfortable in starting a conversation. I learn about her past and what her hopes are for the future and she learns about my present situation and what I want to achieve. As we are talking, although I am invested in the discussion, for the most part my mind cannot help, but think back to the story the elderly man had shared with me on the plane. How can I meet two complete strangers and see a connection between their 'storied' lives? I am startled when the conductor informs us to get our belongings together as we are getting into the station in five minutes. Time flew by. Just like earlier in the morning, I have to say goodbye to another new "friend", knowing that most likely I will never see her again. I cannot help, but wonder who I will encounter on the next leg of my journey.

Strolling through the train station, I am becoming more and more excited with the anticipation of being close to my final destination: I am only a bus ride away. As for most things, I am early for the bus. What surprises me is that there is already someone else there, also waiting for the same bus. Knowing that it will not come for another two hours, I ask the woman if she can watch my bags so that I can grab a bite to eat. I don't know why I am entrusting a complete stranger with my belongings, but something inside tells me she can be trusted. Upon my return, we strike up a conversation about trust as well as talk about some of our life experiences. At this point, I am completely shocked about how quickly my mind is connecting all the conversations I have had during my trip. We talk for a significant amount of time and even sit close to each other

on the bus. As I get off before her stop, we say goodbye as if we have known each other forever. I cannot help, but realize that my life will never be the same after this trip.

Walking to my destination, I realize that my life narrative is ongoing and constantly unfolding, as it is for all three of my travel acquaintances. Their own narratives are also progressing along and will continue to do so after our encounter. At the point of our conversation our life narratives intertwined for a brief period of time, impacting our futures. As I arrive to my hotel room, I quickly sit down and spend some time writing down the experiences my travel companions have shared, so I would not forget about them. I cannot help, but also include my own thoughts within the experiences. Additionally, I now have time to reflect on the stories I heard and consider what I have learned from these conversations.

Like this metaphoric journey, my thesis process has brought me into research encounters with three individuals: Fred, Sasha, and Purple. With each of these participants I enter into a dialogue, through a guided interview and metaphor selection-drawing exercise, to obtain their experiences of receiving care from an interprofessional team. With every subsequent encounter, I draw parallels between the current and previous conversations I have had, exploring any narrative threads that have emerged between them. Throughout the entire process, I reflect on my interactions with each of the participants and address these reflective thoughts during data analysis.

Through this metaphor of a journey, I am able to delve deeper into my experience of working and comprehending each step of the thesis process. Thinking in symbols, images, and pictures, provides me with the ability to enhance the creative aspects of this research. The first chapter is the introduction, the planning for the trip. Here you are briefly introduced to the topic

of interest, the purpose of the research, and provided with an overview of what to expect in subsequent chapters.

CHAPTER 1: INTRODUCTION

Planning the Trip

As I prepare to travel on this journey of discovery, revelations, and new learning, I first reflect on my past experiences. I begin this chapter with discussing one personal life experience that has introduced me to the topic of interprofessional care. I also share a poem I have composed as a result of my interactions with the healthcare providers from an observer, family-member perspective. I then proceed by briefly outlining some of the literature conducted on the topic of interest. Lastly, the remainder of this chapter serves as an overview of the thesis and what is to come in subsequent chapters.

To begin, a dear family member had to be hospitalized for a period of six months, undergoing a battle with a very difficult disease, which was slowly eroding the individual that we knew her to be. She required an extensive level of expertise, care and attention. Remembering the number of care providers involved in her case, I am amazed at how effortlessly they collaborated with each other and my loved one. They all came from different healthcare disciplines and educational backgrounds, yet it seemed as if they were speaking the same language: communication appeared effortless. This unit was different; the care delivery was conducted together by all healthcare providers, not independently of each other as I had seen elsewhere in my professional role of a nurse. When coming to visit my relative, at length I observed the interactions between care providers. This greatly heightened my curiosity about studying interprofessional team work during my graduate education and led to the composition of this poem:

Together, sitting side by side,

They ask what's wrong

And she replies.

Not one, but all combine their thoughts

Including her to see what she prefers and likes.

A plan is drafted, each role defined.

She knows what will happen; there is really no surprise.

Together, working side by side,

They combine their expertise

And help her reach a common goal

For her to heal is all they want

Reflecting on my experiences through a poem has allowed me to find a very personal, meaningful connection with interprofessional and person-centered care as well as inform the research I have undertaken. In addition to my personal experiences with a family member, I also need to examine what is already known by scholars and practitioners on how patients experience interprofessional care.

Through my experiences working with patients and my practicum at a major downtown healthcare institution, it is apparent that today's healthcare system is extremely fast paced, complex, and composed of high-acuity patients. Healthcare providers are coming to realize they are no longer able to individually provide the wide level of expertise needed to effectively care for their patients (Larson et al., 2004; Mulvale & Bourgeault, 2007; Reeves et al., 2009; Svensson, 1996). Additionally, advancements in medical knowledge and technology, which allow for increased life expectancy, place a great demand on knowledge integration between

different disciplines and collaboration amongst healthcare providers (Reeves et al., 2009; Sargeant, 2009). Moreover, the added pressure of preserving resources and cutting down on healthcare costs, as well as the need to efficiently coordinate care, further complicates the care delivery of any healthcare provider.

The Canadian Government (Health Canada, 2003), Canadian Nurses Association (2010), College of Family Physicians of Canada (2000), as well as a number of other healthcare provider professional groups, have called for the establishment of interprofessional healthcare teams as an effective means of coordinating care delivery and providing 'patient-centered care' (Shaw, 2008). Thus, over the past decade Canada and a significant number of other countries have witnessed a rise in interprofessional initiatives (Nolte & Tremblay, 2005), bringing into focus person-centered care. Interprofessional care can be defined as two or more healthcare providers working together to cohesively address the needs of patients/families/communities in their care (D'Amour and Oandasan, 2005). However, literature suggests that healthcare providers may not have had any previous experiences delivering care interprofessionally (Nolte & Tremblay, 2005). Consequently, the challenge is that healthcare providers now have to learn how to work collaboratively, not only with other professionals, but with patients as well. Additionally, within Ontario, Bill 179, *the Regulated Health Professions Statute Law Amendment Act,* came out in 2009. This Bill amended 26 health-related statutes, such as the Nursing Act of 1991, Dietetics Act of 1991, Medical Radiation Technology Act of 1991, Medicine Act of 1991, and Pharmacy Act of 1991(Matthews, 2009). These amended acts have produced a number of significant changes for professional practice such as expanding the scope of practice of selected healthcare professions; pharmacists can now perform vaccinations for influenza, dieticians can order point of care testing for blood glucose for patients under their

care, and a nurse practitioner can cast fractures (Matthews, 2009). Today, more than ever before, professionals are faced with increasing overlap amongst themselves in the services they provide to their patients.

Published research on interprofessional care is developing rapidly (Bianchi-Sand, 2003; D'Amour, Ferrada-Videla, Rodriguez, & Beaulieu, 2005; Reeves et al., 2009; Shaw, 2008; Sidhom & Poulsen, 2006; Zwarenstein & Reeves, 2002). This research identifies barriers to interprofessional collaboration between physicians and nurses (Zwarenstein & Reeves, 2002), evaluates the use of multidisciplinary care meetings for formulating treatment plans for oncology patients (Sidhom & Poulsen, 2006) and presents an overview of an interprofessional interaction on general internal medicine floors (Reeves et al., 2009). Additionally, in the literature significant attention has been paid to the evaluation of interprofessional care (D'Amour et al., 2005; D'Amour & Oandasan, 2005; Kinnaman & Bleich, 2004; Mior et al., 2002; Oandasan et al., 2006) leading to the creation of conceptual frameworks being published on the topic (D'Amour et al, 2005) and providing recommendations on how to promote effective teamwork in healthcare (Oandasan et al., 2006). Despite this significant attention to the topic at hand, there is currently a limited amount of research available on how interprofessional care is experienced from the patient's perspective (Shaw, 2008). This is important to explore as the patient is at the center of care delivery and from an interprofessional perspective should be included in every step of the collaboration among healthcare providers and the decision making process (Shaw, 2008). One of the main components of interprofessional care is person-centered care; thus, the patient is an important source of data for evaluating interprofessional and person-centered care initiatives within the healthcare setting.

Only seven studies, which evaluate interprofessional care from the patient's perspective (Blickem & Priyadharshini, 2007; Hallin, Henriksson, Dalén, & Kiessling, 2011; Howard, Agarwal, & Hilts, 2009; Litaker et al., 2003; Macdonald, Herrman, Hinds, Crowe, & MacDonald, 2002; Shaw, 2008; Zwarenstein, Bryant, & Reeves, 2003), have been located. Three themes have emerged from these articles: satisfaction with care delivery, role confusion and team functioning, as well as variation in care receiving preferences. These will be elaborated on in the literature review section in the next chapter. More importantly two of these studies use quantitative satisfaction questionnaires to elicit information about the encounters patients have with interprofessional care. Although these satisfaction questionnaires show that patients are more satisfied with receiving care from an interprofessional team than from a single provider, they do not allow participants to elaborate on their answers, providing a minimal understanding of patients' perceptions. Thus, this limited view of patients' experiences hinders the full potential of improving healthcare services to more effectively meet patient needs (Edwards, 2002).

Narrative data collection methods provide opportunities for a deeper understanding of patients' experiences than satisfaction questionnaires (Neuberger, 1998; Shaw, 2008). Narrative research allows for stories of experience to be exchanged, bringing forth an abundance of information on patient illness events. Using Clandinin and Connelly's (2000) Narrative Inquiry approach: listening to patient stories, critically reflecting upon them and then reconstructing and re-telling them with new meaning in place, allows for a richer, more complex understanding of how ill persons experience receiving interprofessional care.

Purpose of the Study

The purpose of this study is to give voice, through the use of Narrative Inquiry, to patients' stories of how they experience receiving interprofessional care and thereby gain a

deeper understanding of the relationship between interprofessional care and person-centered care from the patient's perspective. Exploring patients' experiences of the care they received from an interprofessional team, also allows us, as healthcare professionals, to reflect on the care we provide in our respective roles. In writing this research it is my intention to invite you as the readers of these pages to delve into your own narratives, and to reflect on interprofessional healthcare experiences that are meaningful to you as persons and professionals.

Overview of what is to Follow

In order to be able to discuss and situate this study, I first present the background literature on interprofessional care and person-centered care in Chapter 2. Essential connections are drawn between the two concepts and their history, as well as their current position within our healthcare system. The next two chapters discuss the methodology of the study. Chapter 3 begins with an exploration of what Narrative Inquiry is, including its origin and why this is an appropriate method to use for this study. The theoretical underpinnings are also outlined, which later aid in the interpretation of the collected patient stories. Next, Chapter 4 discusses how I recruited the three participants for this study. The data collection methods are presented, including a discussion as to where and when I met with the participants, how I communicated with them, and what information I was seeking to obtain through our meetings. I then provide a step by step outline as to how I conducted my data analysis. The chapter concludes with a discussion on how rigour and reflexivity have been maintained in the study, as well as the ethical considerations I made when dealing with participants who are patients in a hospital.

Chapters 5, 6, and 7 present the unique experiences of each one of the participants (Fred, Sasha and Purple) with receiving care from an interprofessional team during their recent hospitalization. A different font is used for each of the three participants to provide a visual

distinction of these individuals. Additionally, participant illustrations of the metaphors they chose to represent interprofessional care, as they perceived it, are included. Reflection, in-depth analysis, and the exploration of narrative threads that emerged from participants' stories conclude the chapter. Lastly, Chapter 8 presents the social significance of the stories participants have shared. Within this chapter, I include a letter I wrote to members of interprofessional teams on behalf of the three patients. I also provide possible implications for education, practice, policy, and research in relation to interprofessional care.

~

This chapter began with my personal experience of interprofessional care. This was followed by the introduction of the topic through presenting some of the key literature findings.

The next chapter explores the literature in greater detail, examining the concepts of interprofessional care, person-centered care and the studies that have been conducted to date on these two topics. I am closer to embarking on my journey now. I still have to pack all of my bags and make sure I have everything with me before I take off for my trip of new learning and discovery.

CHAPTER 2: BACKGROUND AND LITERATURE REVIEW

Packing the Suitcase

After planning for the trip (which includes taking time off and purchasing the tickets), I am ready to start packing for the journey. Packing is parallel to collecting and deciding on what information is important for me to have in order to study my topic of interest. With numerous definitions and names for interprofessional and person-centered care, it has been a challenge to extract articles for this literature review. What has become evident is how complex the field of interprofessionalism has become, despite being a fairly recent phenomenon. Within this literature review section, it is my intention to first introduce and define interprofessional and person-centered care and how it will be used in my work, and then to review current research that has been done in the field.

Definitional Perspectives

The literature addresses the concept of interprofessional care using a wide variety of terms: interdisciplinary care (Hamman, Beaudin-Seiler, & Beaubien, 2010; Spath, Godfrey, Taylor, & Bell, 2011), multiprofessional care (Humphris, 2007; Junger, Pestinger, Elsner, Krumm, & Radbruch, 2007; Macdonald et al., 2002) transprofessional care (Cherin, Huba, Brief, & Melchior, 1998) and transdisciplinary care (Vyt, 2008). *The National Canadian Interprofessional Competency Framework* discussed in Bainbridge, Nasmith, Orchard, and Wood (2010) is an ideal starting point in exploring interprofessional care as it highlights six competency domains for effective interprofessional healthcare delivery and collaboration. These include role clarification, dealing with interprofessional conflict, team functioning, and collaborative leadership. Additionally, communication and patient/client/family/community-centered care, although they are domains on their own, they also intersect with all the other

competency domains of the framework. This framework identifies the patient at the center of care delivery, defining interprofessional collaboration to be "a partnership between a team of healthcare providers and a client in a participatory, collaborative, and coordinated approach to shared decision-making around health and social issues," (Bainbridge et al., 2010, p. 9). This definition of interprofessional collaboration is congruent with that of interprofessional care as described by D'Amour and Oandasan (2005), and as such the two terms are used interchangeably within this study. According to D'Amour and Oandasan (2005), interprofessional care is defined as "development of a cohesive practice between professionals from different disciplines" (p. 9). It allows professionals to "reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population" (D'Amour & Oandasan, 2005, p.9).

Since the patient/client/family/or community is seen as the center of the care delivery (Bainbridge et al., 2010), the main goal of interprofessional care is to provide person-centered care. Person-centered care can be referred to by a number of other names such as person-focused care (Starfield, 2011), patient-centered care (Bainbridge et al., 2010; Greene, Tuzzio, & Cherkin, 2012; Wolf, Lehman, Quinlin, Zulio, & Hoffman, 2008), client-centered care (Bosman, Bours, Engels, & de Witte, 2008; Kirkpatrick, Ford, & Castelloe, 1997), consumer-centered care (Macdonald et al., 2002) and whole-person care (Hayes & Hodson, 2011; Safran, 2003). These terms are often used interchangeably. In this thesis I aim to more specifically explore patients' experiences of receiving interprofessional care through the qualitative research approach of Narrative Inquiry (Clandinin & Connelly, 2000) coupled with Narrative Reflective Process (Schwind, 2008) data collection strategy. From the Narrative Inquiry standpoint participants are considered from a holistic perspective, with their life story taken into consideration. To that end

participants, who are patients within a healthcare institution, are viewed as persons in this thesis; this notion, thus, aligns well with person-centered care and will be the term used in this study.

Literature Search Strategy

Currently, there is an abundance of literature focused on interprofessional care, especially when all its synonyms are searched within databases. When retrieving articles for this study, first a general search was performed and used to introduce the terms interprofessional care and person centered care. These are the articles that can be found in the first two sections of this literature review. Thus, the following databases CINAHL, Ovid, Medline, and Proquest Nursing, as well as Google Scholar, and the 'search everything' function of the Ryerson University library website were searched. Then, these same databases were searched again, but now specifically locating articles that examined interprofessional care and person-centered care together in one article. The following key terms were used: interprofessional/disciplinary practice/care/teams, transdisciplinary/professional practice/care/teams, and multidisciplinary/professional practice/care/teams. This yielded over 500 results. These results were then further narrowed to English language, scholarly peer-reviewed articles, and written within the last ten years, for a total of 356 articles. The titles and/or the abstracts of all of these 356 articles were read in order to deem their relevance to the topic of interprofessional care. Of these, 349 articles were excluded because they were either letters to the editor/opinion/commentary pieces, focused on one aspect of interprofessional care such as interprofessional communication, discussed how professionals should be educated together or did not mention interprofessional care and person-centered care together in one article. Only seven articles that discussed interprofessional care delivery centered on the patient were selected for the next stage of review and relevance.

Thus, another search was performed for the concept of person-centered care, which included examining the same databases with search terms such as: patient-centered care, person-centered care, client-centered care, consumer-centered care and whole-person care. The results showed over 3,000 articles, which were also narrowed to English language, peer-reviewed, within the last ten years. This yielded a total of 1,107 articles. Since, a large volume of articles was retrieved, first only the titles and the aim/purpose of the studies were reviewed in terms of relevance to topic. This produced fifty-nine articles; abstracts of these articles were reviewed and selected for inclusion based on the article being a research study and its major focus was person/patient/client/consumer/whole person care. Lastly, the databases were also searched for any studies conducted examining the patient's perspective of being the recipient of interprofessional care. The same seven articles were retrieved as before, that discussed interprofessional care delivery centered on the patient/person. However, none of these articles discussed patient narratives as a way to elucidate interprofessional care from the patient's perspective. Due to the paucity of research available on this topic, further rigorous search strategies were performed. A digital facilitator called Highwire was used, but this only yielded one study on patient narratives and evaluation of interprofessional care. The reference lists of the seven articles were also reviewed to see if further studies could be found on the topic. No additional articles were retrieved.

Literature Review

Within this literature review section, the two concepts of interprofessional care and person-centered care are first presented separately. Then, more specifically, the seven studies found on patients' perspective of interprofessional care are reviewed. Following, the need for further studies exploring patients' experiences within this field is articulated.

Interprofessional Care

Interprofessional care occurs when two or more healthcare providers from different disciplines come together to share their expertise during care delivery to enhance patient health outcomes (D'Amour & Oandasan, 2005). Interprofessional care itself has shown to not only increase the healthcare providers' satisfaction with the care being delivered, but contributes to the capacity of providing "patient-centered care" and ensuring the sustainability of the healthcare system (Borrill et al., 2002; D'Amour et al., 2005; Mickan & Rodger, 2005). Specifically, Borrill et al. (2002) state that when healthcare providers collaborate with each other, learn from one another and engage in producing innovations to practice and service delivery, the most optimal outcome is achieved for patients. As well, Mickan and Rodger (2005) identify that "with the increasing costs and technological complexity of providing healthcare, and the resultant growth in specialization of professionals, there is a need to co-ordinate scarce human and financial resources to maximize patient outcomes" (p. 358). When healthcare providers collaborate from across professions, interprofessional care has the ability to enrich the quality of provided care (Reeves et al., 2009).

National initiatives by the Canadian Government, such as the *First Minister's Accord on Health Care Renewal* and the Romanow (2002) report, entitled *Building on Values: The Future of Health Care in Canada*, have strongly outlined interprofessional care as the preferred clinical practice model (Côté, Lauzon, & Kyd-Strickland, 2008; Health Canada, 2003). The Canadian Nurses Association (CNA, 2010) and the College of Family Physicians of Canada (2000) have called for "patient-centered interprofessional primary care" as an effective means of improving patient health outcomes. As well, the World Health Organization recognizes the significance of interprofessional care as an innovative strategy that will help mitigate the worldwide health

workforce crisis. Canada, along with many countries worldwide, has witnessed a great rise in interprofessional collaborations and initiatives over the last decade (Nolte & Tremblay, 2005). Despite increased emphasis on interprofessional collaboration, the effectiveness of interprofessional person-centered care from the patient's perspective has not been well evaluated.

Studies on Interprofessional Care

Research conducted on evaluating interprofessional care is steadily growing. A large volume of this research centers on administering quantitative questionnaires to healthcare providers and/or students. The aim is to find out about their experiences with either being members of an interprofessional team or participating in interprofessional initiatives on their unit (Anderson, Manek, & Davidson, 2006; Beatty, 1987; Carpenter & Hewstone, 1996; Harward, Tresolini, & Davis, 2006; Larkin & Callaghan, 2005; Law, MacDonald, Weaver, Lait, & Pauzé, 2009; Lewandowski & GlenMaye, 2002; Parsell, Spalding, & Bligh, 1998; Thannhauser, Russell-Mayhew, & Scott, 2010). Anderson et al. (2006) undertook a study where a questionnaire was administered to over 126 students and eleven tutors, asking about their satisfaction with partaking in an interprofessional workshop series. The questionnaire evaluation identified that "interprofessional competencies were understood and valued" (p. 182), however "student behaviors in practice were not measured" (p. 191). Questionnaires as an evaluation method fell short as they did not show whether the interprofessional workshop series intervention had a lasting impact or made any change in student practice (Anderson et al., 2006). A positive aspect of this study was that it did utilize a questionnaire style that provided room for participants to write in their comments.

Studies by Beatty (1987), Harward et al. (2006) and Parsell et al. (1998) also administered a questionnaire to a group of students to evaluate an interprofessional intervention,

but only Parsell et al. (1998) had a small part of its questionnaire composed of open-ended questions; the remainder was close-ended or true or false statements. The results of the study showed that a two-day pilot course composed of students from seven different health professions raised students' knowledge and comprehension of the roles of the other healthcare professions, as well as brought to the awareness the importance of multiprofessional communication and team work (Parsell et al., 1998).

The other studies by Beatty (1987) and Harward et al. (2006) used Likert scale type questionnaires, which did not provide participants, who were healthcare profession students, an opportunity to elaborate on their answers and more fully evaluate the learning that occurred from an interprofessional intervention. Beaty sought to understand whether or not there was a difference in attitudes and perceptions between baccalaureate and associate degree program students about healthcare teams. The study found that students viewed healthcare teams for the most part the same regardless of where they received their education. The key differences were that the baccalaureate program provided more cognitive experiences than the associate, and in the healthcare team concepts that were taught: group dynamics and problems and obstacles were not consistently taught. In Harward et al., two decades later, the results were similar. Medical students who took part in an interdisciplinary case conference also identified that they experienced an increase in attitude and knowledge about the role interdisciplinary healthcare teams can play within the healthcare system.

In articles by Carpenter and Hewstone (1996), Larkin and Callaghan (2005), and Lewandowski and GlenMaye (2002), satisfaction questionnaires were administered to a group of healthcare providers to evaluate an interprofessional intervention. Within these questionnaires a very limited number of open-ended questions were asked, with the majority requiring a yes/no

answer (Larkin & Callaghan, 2005) or use Likert scale type of responses (Carpenter & Hewstone, 1996; Lewandowski & GlenMaye, 2002). In Carpenter and Hewstone the article evaluated a shared learning program that was delivered to last year social work and medicine students. Results showed that through shared learning students identified an increased understanding of the roles, attitudes, skills and duties of the other profession and how they can work together more closely. As for Larkin and Callaghan results demonstrated that, although professionals working within community mental health teams were aware of their own role, they felt that other team members knew little about them. Additionally, the presence of meetings and operational policy had a minimal effect on perceptions of interprofessional team members. Lewandowski and GlenMaye, who looked at teams within child welfare settings, found that respect and coming together for a purpose both predicted team satisfaction.

Of all the studies reviewed on evaluation of interprofessional care it appears that satisfaction questionnaires are most commonly used forms of data collection both with patients and with healthcare providers/healthcare students. Although satisfaction questionnaires contribute valuable information on interprofessional care, they do not provide in-depth qualitative data of patients' experiences receiving interprofessional person-centered care.

Law et al. (2009) and Thannhauser et al. (2010) evaluate some of the instruments that have been used in studies to evaluate interprofessional care delivery. They have found that although there is a significant number of available surveys and questionnaires for assessing and evaluating interprofessional care, a large number of these "lack sufficient information about their psychometric properties" (Thannhauser et al., 2010, p. 338) and were not validated (Law et al., 2009).

Only one study was found that was qualitative (ethnographic) in nature conducted by Sinclair, Lingard, and Mohabeer (2009). Within it, 40 healthcare providers and 6 students in a rehabilitation center, who were from a variety of health professions (nursing, social work, chaplains, physiatry, occupational therapy, physiotherapy, and pharmacy, amongst others), were observed and interviewed to explore "team structures, team relationships and elements of organizational culture that constitute IPC [interprofessional care]" (Sinclair et al., 2009, p. 1196). Findings show that in order for interprofessional care to occur and be supported, a number of clinical, cultural, and organizational factors need to be taken into consideration. However, no patients were interviewed or observed in this study in order to obtain their perspectives or opinions about interprofessional care. In fact, on the whole, patients very rarely have been asked about their experiences of receiving interprofessional care (Shaw, 2008).

Person-Centered Care

Examining patients' experiences seems to be a suitable starting point in exploring person-centered care in an interprofessional context. This is because one of the key reasons interprofessional care was brought to the forefront in the healthcare agendas around the world was the patient and how to improve her/his health outcomes (D'Amour et al., 2005). Care centered on the person promotes collaboration among staff, reduces anxiety for the patient and healthcare providers, and improves patient satisfaction with care received (Binnie & Titchen, 1999; D'Amour et al., 2005; Shaw, 2008). McCormack and McCance (2010) have presented a person-centered nursing framework that discusses person-centered care as being all encompassing, including focusing not only on the patient, but the healthcare provider, and all members of the interprofessional team.

Although there is significant literature available on interprofessional care, very few studies have been undertaken from the patient's perspective (Cott, 2004; D'Amour et al., 2005). There is increasing recognition in the literature that patient perspective is required for effective evaluation of delivered healthcare (Blickem & Priyadharshini, 2007; Haddad, Potvin, Roberge, Pineault, & Remondin, 2000; Hayes & Hodson, 2011; Macdonald et al., 2002; Shaw, 2006, 2008). Specifically, Blickem and Priyadharshini present the importance of hearing from the patients about the type of care they would like to receive in the stroke rehabilitation unit before delivering it. Additionally, in Hayes and Hodson the discussion centers on the importance of considering whole-person care, in order to provide the best pain management services to patients.

Studies on Interprofessional Care from Patients' Perspectives and Their Themes

In line with the above, very few studies evaluate interprofessional care by examining the patient's perspectives. Only seven articles have been extracted from the literature that explore patients' experiences of being recipients of interprofessional care (Blickem & Priyadharshini, 2007; Hallin et al., 2011; Howard et al., 2009; Litaker et al., 2003; Macdonald et al., 2002; Shaw, 2008; Zwarenstein et al., 2003). Similar to the studies, which explore healthcare providers' and students' perceptions of interprofessional care, two of these studies utilize satisfaction questionnaires as their main data collection method and do not provide room for patients to elaborate on their experiences (Hallin et al., 2011; Howard et al., 2009). The rest of the studies are either grounded theory (Shaw, 2008), ethnography (Blickem & Priyadharshini, 2007), transcript review from a symposium on interprofessional care (Macdonald et al., 2002), designed intervention evaluation (Litaker et al., 2003) or controlled-before-and-after trial design (Zwarenstein et al., 2003).

The findings of the seven studies on patients' experiences with interprofessional care (Blickem & Priyadharshini, 2007; Hallin et al., 2011; Howard et al., 2009; Litaker et al., 2003; Macdonald et al., 2002; Shaw, 2008; Zwarenstein et al., 2003) are discussed under the following three themes: satisfaction with care delivery, role confusion and team functioning, and variation in care receiving preferences.

Within the theme of satisfaction with care delivery, overall patients are generally more satisfied with the care they receive from an interprofessional team than from a single provider (Hallin et al., 2011; Howard et al., 2009; Litaker et al., 2003; Macdonald et al., 2002; Shaw, 2008; Zwarenstein et al., 2003). This satisfaction occurs because of the availability of more information provided to patients on their condition (Hallin et al., 2011; Howard et al., 2009), perceived better quality of care (Hallin et al., 2011; Litaker et al., 2003; Zwarenstein et al., 2003), interpersonal care (Howard et al., 2009), effective communication with the patient and among members of an interprofessional team (Macdonald et al., 2002; Shaw, 2008), and increased availability of services (Shaw, 2008). Also, patients like being given the opportunity to participate in decision making in relation to their health outcomes (Hallin et al., 2011) and receive coordinated care (Macdonald et al., 2002; Shaw, 2008; Zwarenstein et al., 2003). Lastly, patients identify good care as being interprofessionally focused (Shaw, 2008) since they feel that within this caring approach their goals, stories, and histories are considered more fully by the team (Hallin et al., 2011; Howard et al., 2009; Shaw, 2008; Zwarenstein et al., 2003).

Although patients feel that they have received comprehensive care from an interprofessional team, they do discuss some problems with the care delivery (Shaw, 2008). Thus, in relation to the second theme, patients express that within interprofessional care there can be role confusion between healthcare providers (Blickem & Priyadharshini, 2007; Macdonald et

al., 2002; Shaw, 2008). This role confusion is centered around the need for each healthcare provider's goals to be fulfilled, lengthening the discharge process (Blickem & Priyadharshini, 2007), and miscommunication between team members (Blickem & Priyadharshini, 2007; Macdonald et al., 2002).

Lastly, patients have expressed the desire to be able to have variation in the care they are receiving. They identify that they would not like to receive care from an interprofessional team all the time; sometimes they prefer to establish relationships with one healthcare provider (Blickem & Priyadharshini, 2007; Shaw, 2008). There is also the notion that what patients want from an interprofessional caring model varies amongst patients; some patients want to hear the same message from different healthcare providers in relation to their condition, while others want to hear different opinions of the varied healthcare providers (Blickem & Priyadharshini, 2007; Shaw, 2008).

Conclusion: The Need for Patient Narratives of Receiving Interprofessional Care

Although all the studies discussed thus far do contribute to the field of interprofessional care by increasing the amount of knowledge available, they provide a minimal or an incomplete picture of the topic. The studies presented in the section on interprofessional care and the two studies presented on interprofessional care from patients' perspective utilize satisfaction questionnaires. Utilizing satisfaction questionnaires as a data collection method, although informative, does not provide a complete understanding of patients' and healthcare providers' perceptions of interprofessional care, and so bring limited value to improving or creating healthcare services that more effectively meet patient needs (Edwards, 2002).

More specifically, even though the number of studies conducted from the patients' perspective are growing, no studies could be located that utilize the Narrative Inquiry (Clandinin

& Connelly, 2000) approach as a method to elicit stories of patients' experiences with this topic. Narrative Inquiry (Clandinin & Connelly, 2000) allows for shared stories to impact future experiences and bring forth a wealth of information on the patient's experience of interprofessional care (Shaw, 2008).

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This chapter presented a conceptual and an empirical overview of the study topic. The paucity of research on interprofessional care from the patient's perspective is evident, presenting the need for further research into patients' narratives of experience receiving interprofessional care.

The next two chapters will discuss the methodology of this study. Chapter 3 introduces you, as the reader, to Narrative Inquiry in greater depth and identifies the data collection tool that has been used. As well, the theoretical framework used for data analysis, the *National Interprofessional Competency Framework*, is presented and connections are made as to how this framework aligns with Narrative Inquiry. Chapter 4 provides a detailed account of how participants have been recruited and data collected and analyzed. As well, ethical considerations and how rigour and reflexivity have been maintained are also outlined. The methodology is separated into two chapters to provide a more in-depth description of the relatively new, to healthcare, qualitative research approach of Narrative Inquiry.

CHAPTER 3: METHODOLOGY 1:

METHOD, DESIGN AND THEORY

Designing the Itinerary

As I have collected all the information I need to begin my journey; I am now creating a detailed itinerary of how I want my travels to unfold. Arranging the trip can be as exciting as the actual travel; everything seems so unpredictable, yet exhilarating. At this stage in the research process, it is important to start with the discussion of the method and design, as well as the theory employed in the study. A review of Narrative Inquiry is provided first in order to help situate this section, as there are many forms that narrative research can take. Then, a brief account is provided on the Narrative Reflective Process, the chosen data collection tool. The chapter ends with the introduction of the theoretical framework used to make meaning of participants' stories.

Narrative Inquiry

All narrative research methods aim to provide a deeper understanding of individual experiences (Blickem & Priyadharshini, 2007; Clandinin & Huber, 2002; Frank, 1995, 2002; Haddad et al., 2000; Hayes & Hodson, 2011; Holloway & Freshwater, 2007; Macdonald et al., 2002; Shaw, 2006, 2008; Woodring et al., 2004). Narrative research in healthcare settings allows for stories to be exchanged, bringing forth a wealth of information on patients' illness experiences. Generally, all forms of narrative research begin with a researcher becoming interested in exploring a particular phenomenon and people having experiences and stories about that phenomenon they are willing to share. The collected stories are then analyzed, that is to say, critically reflected upon and reorganized into a framework or new way of making sense of the presented information (Creswell, 2007; Josselson & Lieblich, 2003).

In this particular study, Narrative Inquiry is utilized as the research method. Using Clandinin and Connelly's (2000) Narrative Inquiry approach: listening to participant stories, critically reflecting upon them and then reconstructing and retelling them with new meaning in place facilitates the co-construction of knowledge, between me, the researcher, and the participants. Additionally, the letter I wrote in chapter 8 to members of interprofessional teams using patients' voice further exemplifies the co-construction of knowledge between me and the study participants.

Narrative research began in the social sciences in the late 1960s with intensified discussions on stories and the roles they play in people's lives (Chase, 2005). The idea of Narrative Inquiry, which was developed by Connelly and Clandinin (1990), has captured the attention of people from a variety of disciplines, especially since it shares commonalities with other forms of qualitative research: use of story in phenomenology and the focus on the social in ethnography (Connelly & Clandinin, 2006). It has been used for studies in: teaching (Fenton, 2002); curriculum (Hwang, 2011); multiculturalism (Conle, 2004; Phillion, 2002); and more recently in community (Caine, 2010); counseling (Patsiopoulos & Buchanan, 2011); health and nursing (Chan, Cheung, Mok, Cheung, & Tong, 2006; Lindsay, 2008, 2011; Schwind, 2003, 2008, in press); psychology (Smith & Sparkes, 2006); social work (Gola, 2009); and women's studies (Sanders, 2011).

The originators of Narrative Inquiry, Connelly and Clandinin (1990), provide the most widely used definition of this qualitative research approach:

> People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a person entered the world and by which their experience of the world is interpreted and made personally meaningful. Narrative Inquiry, the study of experience as story, then, is first and foremost a way of thinking about experience. Narrative Inquiry as a methodology entails a view of a phenomenon. To use Narrative Inquiry methodology is

> to adopt a particular view of experience as phenomenon under study (Connelly & Clandinin, 2006, p. 477).

In relation to experience, the key concept of Narrative Inquiry, Clandinin and Connelly draw on John Dewey's (1938/1963) pragmatic philosophy. He identified the two criteria of experience being interaction and continuity. For interaction, it is important to comprehend that "people are individuals and need to be understood as such, but they cannot be understood only as individuals. They are always in relation, always in a social context" (Clandinin, 2006, p. 46). For continuity, all of our stories arise from previous experiences, and these present experiences influence how future stories will happen (Clandinin, 2006). These experiences do not only alter the individual, but they also alter the "external environment under which subsequent experiences take place" (Chan & Schwind, 2006, p. 304). Working from Dewey's theory of experience, Clandinin and Connelly (2000) put forth the idea that Narrative Inquiry provides a way for experiences to be understood through the researcher-participant relationship that occurs in a particular place over a specified time period.

To develop this idea further, Connelly and Clandinin (1990, 2006) developed the metaphorical three dimensional Narrative Inquiry space, or three commonplaces: temporality, sociality, and place, which serve as the conceptual framework of the Narrative Inquiry research approach, used in this study. Temporality discusses that every individual has a particular past which informs their present situation, which will impact their choices for the future (Connelly & Clandinin, 2006). This means that events, objects, people, relationships can and most likely all are in a temporal transition (Connelly & Clandinin, 2006). Sociality refers to personal and social conditions. It takes into consideration the relationship we have with ourselves, as well as the relationships we share and form with others. This includes acknowledging the relationship between the participant and the researcher as being significant; there is no subtracting or

omission of the researcher from the relationship (Connelly & Clandinin, 2006). Together the researcher and the participant decide on the outcomes of the research including the purpose, next steps, results, and any other components that come along with an inquiry relationship (Connelly & Clandinin, 2006). The researcher describes who s/he is within the relationship and who s/he is in relation to the participant (Connelly & Clandinin, 2006). Lastly, place is where the experience unfolds or the inquiry takes place (Connelly & Clandinin, 2006). The impact the place can have on the study needs to be acknowledged and it is important to remember that place can change as the inquiry delves into temporality (Connelly & Clandinin, 2006). All of these commonplaces need to be explored when undertaking an inquiry into an experience, as they allow researcher to be able to study the "complexity of the relational composition of people's lived experiences both inside and outside of an inquiry and, as well, to imagine the future possibilities of these lives" (Clandinin & Huber, n.d., p.3).

To explore an experience, narrative inquirers working within the three dimensional space described above, can begin by either asking participants to tell them their stories or come alongside the participants to live out the stories (Clandinin 2006; Connelly & Clandinin, 2006). Whatever starting point is chosen, the inquirer is entering into a relationship with the participant to co-compose every part of the inquiry (Clandinin & Huber, n.d.). For this study, participants are asked to tell their story through a one-to-one conversational narrative interview and metaphor selection-drawing exercise. The information generated through these two sessions is made into a story of participant's experiences, which is critically reflected upon, incorporating the three common places of Narrative Inquiry, and then reconstructed and retold with new meaning in place in chapter 8 in a form of a letter to members of interprofessional teams.

Through reflecting upon and telling and re-telling of personal stories, the direction for the future can become clearer (Chan & Schwind, 2006; Clandinin & Connelly, 2000). As Clandinin and Connelly (1998) have stated, "stories are the closest we can come to experience as we and others tell of our experience" (p. 155). The key component of Narrative Inquiry, as previously noted, is experience as articulated through stories (Schwind & Lindsay, 2008). Thus, in order to understand patients' experience of receiving interprofessional care, Narrative Inquiry is an ideal research method to use; it allows for participant voice to be heard so that healthcare providers can hear how interprofessional care actually looks from the receiving end.

Narrative Reflective Process

The Narrative Reflective Process (NRP) (Schwind, 2008) is a creative self-expression data collection tool. It encompasses storytelling, metaphors, drawing and creative writing. NRP finds its theoretical underpinnings in Narrative Inquiry qualitative research approach (Connelly & Clandinin, 1990, 2006). It is informed by the premise that we know more than we can say, and that this tacit knowing can be accessed through creative self-expression process (Polanyi, 1967; Schwind, 2003). In this study I use aspects of NRP, namely, storytelling, metaphor selection and drawing. These activities guide the participants to a deeper level of self-awareness, self-discovery, and co-construction of knowledge (Schwind et al., 2011).

Having participants take part in a creative exercise of metaphor selection and drawing, really allows for their ideas to be presented on a more personal level. Guillemin (2004) stated that participant drawings can offer an insightful way into exploring how people make sense of their world. The act of drawing alone necessitates knowledge production (Guillemin, 2004). More specifically, metaphors can illuminate the meanings of experiences and can facilitate examination of the topic of interest in a new and unique way (Schwind, 2009). They can be used

to provide structure to the data and more importantly to evoke emotion in participants that conversational data collection methods are not always able to do (Carpenter, 2008). At their worst though, metaphors can obscure the meanings of experiences, thus they should be carefully applied and discussed (Carpenter, 2008, Schwind, 2009).

Theoretical Framework

In qualitative research, theory can enter and leave a research study at multiple points in the exploration (Sandelowski & Barroso, 2010). Within this Narrative Inquiry study, the theoretical framework is used when stories are being deconstructed and critically reflected upon, which is throughout the data collection and analysis processes (Clandinin & Connelly, 2000). Thus, the chosen theoretical framework provided the lens through which the stories were examined, guiding the creation of the narrative threads that emerge from participants stories.

The overarching theoretical framework that is used is *The National Interprofessional Competency Framework (*Bainbridge, Nasmith, Orchard, & Wood, 2010). The main reason why this framework was selected over other interprofessional and person-centered care frameworks is because of its encompassing nature; it not only discusses interprofessional collaboration within the caregiver team, but also patient-centered care. This framework has been created because there currently is a lack of a "commonly agreed upon interprofessional competency framework" (Bainbridge et al., 2010, p. 7). Thus, the Canadian Interprofessional Health Collaborative Interprofessional Competency Working Group "was mandated to develop a pan-Canadian competency framework for interprofessional collaboration" (Bainbridge et al., 2010, p. 7). The group applied the integrative approach to competency creation, as discussed by Roegiers (2007); the framework describes "the complex integration of knowledge, skills, attitudes, values and judgments that enables interprofessional collaboration by guiding effective performance of

activities required in a given occupation" (Bainbridge et al., 2010, p. 8). The framework also "focuses on a common approach to competencies [shared between a number of professions] to inform [...] practice across professions" (Bainbridge et al., 2010, p. 7). The elements that serve the basis of this framework are: interprofessional communication; patient-centered collaborative working relationships; teamwork; shared leadership; self awareness; and evaluation (Bainbridge et al., 2010). These were obtained through the commonalities observed among the interprofessional competency documents each jurisdiction in Canada developed between 2005 and 2008.

As previously described in Chapter 2, the *National Interprofessional Competency Framework* presents six interconnecting interprofessional competency domains: role clarification, dealing with interprofessional conflict, collaborative leadership, team functioning, patient/client/family/community-centered care, and interprofessional communication. The main goal of the framework is interprofessional collaboration where a partnership occurs "between a team of healthcare providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues" (Bainbridge et al., 2010, p. 9). To begin, the competency domain of role clarification is met when healthcare providers are cognizant of the role they and other members of the team play, and are able to use this knowledge effectively to meet the goals of patients/families/community. Dealing with interprofessional conflict discusses the healthcare providers' ability to engage self, others and patients/family in dealing with conflict that may arise as a result of collaboration. Collaborative leadership is the healthcare provider's ability to work in partnership with all participants and patients/families to produce enhanced health outcomes through the evaluation, implementation and formulation of care/services. Next, team functioning is defined as the healthcare provider

being able to comprehend "the principles of team dynamics and group processes to enable effective interprofessional team collaboration" (Bainbridge et al., 2010, p. 9). Patient/client/family/community-centered care refers to the healthcare providers incorporating, seeking out and placing importance on the engagement and integration of patient/family input in implementing and putting together care/services. Lastly, interprofessional communication discusses healthcare providers from different professions being able to communicate amongst each other in a responsive, responsible and collaborative manner.

Having defined what each of six competency domains mean, it is also important to point out that although the competencies don't change their descriptions, they are "flexible and individualized based on the […] practitioners experience, as well as their […] practice context" (Bainbridge et al., 2010, p. 8). Thus, this framework can be integrated and used in all types of practice settings, giving healthcare providers the ability to achieve these competencies at different levels and in different ways (Bainbridge et al., 2010). Additionally, there are three concepts that underpin the six competency domains: quality improvement, complexity of the situation, and context of practice. For quality improvement, it is a "process for addressing patient safety, quality of care and system-wide resources in order to facilitate interprofessional collaboration" (Bainbridge et al., 2010, p. 10). Complexity of the situation refers to the number of healthcare providers that is required to address patient's needs; if the patient presents with a case that requires extensive care there is greater chance that a larger number of different health professionals will be involved and vice versa. In relation to the context of practice, it is important to keep in mind the unit on which the patients are on, as it "influences the type and nature of interprofessional collaboration" (Bainbridge et al., 2010). To conclude and as the authors have stated, this framework is "an evolving concept that will continue to change over time as

educators, practitioners, and researchers become more familiar with the domains and descriptors" (Bainbridge et al., 2010, p. 8).

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In this chapter, the study method and design, as well as the theoretical perspective were discussed. In the next chapter I present a detailed account of how the three participants were recruited for the study. Also, the data collection and analysis methods are outlined, as well as how the rigour of the study is maintained, and what ethical considerations were made.

CHAPTER 4: METHODOLOGY 2:

STUDY PROCESS

Finalizing the Itinerary

Heading to the airport, I have a list of the modes of transportation I need to take and their scheduled departure times in order to reach my final destination. I read through the entire itinerary one more time to make sure everything adds up and I am happy with how my trip will unfold. I know exactly what I will do and where I need to go. This chapter begins with describing the recruitment process in terms of what units are used to obtain participants, what type of participants have been sought, and how they have been invited to take part. Then the data collection methods are explained in great detail, examining each step used to collect information on participant experiences with receiving care from an interprofessional team. The chapter ends with laying out the ethical considerations that needed to be addressed.

Recruitment

The plan was to recruit five participants with the desired goal that three participants would successfully complete the study. Participants had to be over the age of 18, speak, read and understand English, as well as be a patient at one of the two specified units of a large urban downtown hospital. The two units were both in-patient acute care units. The reason why these two units were selected is because they have been recommended as being highly interprofessional in their care delivery by the study coordinator at the healthcare organization site used for this study. Participants also needed to have had at least one other hospitalization outside of the two identified units. I wanted to make sure that they had other healthcare experiences to which they could compare their current one.

All participants were recruited from one of the two acute care units. That unit's patient population is comprised of adults who require primary, tertiary and quaternary levels of assessment, diagnosis and interventions, and is managed by nurse practitioners who work with one junior and one senior attending physician.

For this study, three participants were successfully recruited. This is an ideal number for a study that is narrative in nature because of the in-depth exploration of patients' stories of experience that is required (Creswell, 2007). The researcher is heavily involved in the data collection and analysis through full immersion in the stories participants bring forth, as the two together co-create developing knowledge; this would therefore be difficult to accomplish in detail with a large number of participants. Creswell (2007) states that an ideal sample size for Narrative Inquiry is two participants; it is acceptable to have a few more participants if the intention is to develop a collective story on the phenomenon. Since this study aims to identify possible links between interprofessional care and person-centered care through the combination of stories collected from patients, having three participants is both acceptable and appropriate.

The three participants were recruited in the following way:

1. Method of recruitment: Upon obtaining ethics approval, I was given permission to recruit participants from two units of an urban downtown healthcare institution that were known to practice interprofessional care. I began recruiting from one of the two acute care units first. If I was unable to recruit enough participants from this unit, I planned to recruit from the other acute care unit as well. I emailed the manager and the patient care coordinator introducing myself and my study. When I came onto the unit, the patient care coordinator gave me a list of patients who could be good candidates for the study. These patients, ten in total, were then provided with a study information letter (Appendix A), which included

a telephone number they could call if they were interested in participating or required any further information on the study.

2. Interested participants: Initially, all of the participants provided with the study information letter displayed interest in taking part in the study, but only three participants made contact with me to become involved. At our initial conversation, I explained the nature of their involvement in the study, the risks and benefits of participating and answered any questions they had about the research project. Additionally, I explained that all participants were eligible for an honorarium whether they completed the study or not. Since these individuals continued to display interest after our conversation, I scheduled our first meeting to review the consent form (Appendix B) and discuss in detail all the ethical considerations. This was the same meeting when the conversational narrative interview and the metaphor selection-drawing exercise took place. It was held in a private conference room on the unit where they were currently receiving care. Since I was able to obtain the required number of participants for this study from one unit, the other unit was never accessed.

Data Collection Methods

Before discussing the data collection methods employed in this study, it is vital to highlight that the usual steps of data collection in Narrative Inquiry occur in an iterative fashion. For the purpose of outlining the steps taken in this study, the data collection methods are described in a linear fashion.

The Narrative Reflective Process, as previously described (Schwind, 2008), allows participants to creatively explore their personal multidimensional stories of experience. This study utilized the creative self-expressive activities of storytelling, metaphor selection, and

drawing. The first two sessions described below were conducted during the one face-to-face meeting; there was only one face-to-face meeting with each of my participants during the study. The third session occurred at a different time period and was conducted over the phone, as a follow-up interview. More specifically, the data collection methods included:

Session one: The narrative interview was audio-taped and transcribed, lasting approximately sixty minutes in length per participant. The session occurred the same week for all the participants. For the session, I met with each of the participants in a private, quiet conference room on the unit where they were receiving interprofessional care. I scheduled the session either after breakfast or in the afternoon before or after dinner so that participants would not miss any of their daily procedures/appointments and for the session to receive minimal interruptions. I also made sure that the participants' nurses were aware where the patients were in case they needed to provide treatment to the participants while they were in the session.

Each participant was invited to share her/his experiences with regards to being a patient and receiving interprofessional care on her/his current unit. Also, s/he was asked about any previous hospitalizations where s/he did and/or did not receive interprofessional care.

The following questions were used to prompt the storytelling process (Please see Appendix C for the Sessions Guide):

1. How do you understand interprofessional care? How would you define interprofessional care in your own words?
2. Can you please describe your experiences/feelings with receiving care on this unit?
3. How did you experience/feel about your other hospitalizations where care was not delivered interprofessionally?
4. How do these compare to your current experience of receiving interprofessional care?

5. What kind of role do you see yourself playing in your hospitalization this time?
6. How is this different or the same from your previous hospitalizations?

It is vital to mention that as the interviews progressed with each of the three participants, more questions emerged and/or some of the above questions were modified, or omitted. As an example, one of the most common questions to be omitted from two of the three interviews was 'How is this different or the same from your previous hospitalizations?' This is because participants would have already answered this question within some of the earlier questions that had been asked. A common question that was added to all of the interviews was 'Does each team member identify her/himself and describe her/his roles to you?' The basis of the new question came from my own knowledge of interprofessional care, my practical and employment experiences with being a nurse working within an interprofessional team and previous interviews conducted with participants. This session was intended to be a fluid process.

Session two: The selection and the description of a symbolic image (metaphor) was the focus of this next session and required about thirty minutes of participants' time. This session occurred right after session one; all participants stated they were not fatigued and were comfortable with continuing.

Each participant was invited to select her/his own symbolic image that s/he felt best represented the care s/he was receiving from the interprofessional team during this present hospitalization. Then, s/he was given the option to either a) draw that symbolic image including a small description or b) talk about that symbolic image that s/he had selected. At the end, all participants ended up drawing their symbolic image and providing me with a small verbal description as to why they chose to draw the image they did.

Participants were instructed that this was a creative activity piece of the study, where they were given an opportunity to select their own symbolic image that best represented the interprofessional care they received. They were told that there was no right or wrong image to select and were given permission to select absolutely anything they believed would accurately represent their feelings and/or experiences about interprofessional care.

Session three: This session consisted of me contacting each of the participants by telephone (almost two months after the first two sessions of the data collection) and required approximately 10 minutes of their time. I ensured that I was alone, in a privacy-secured room while making the phone call so that no one would be able to hear my conversation with the participants.

This session represented the member checking aspect of ensuring credibility of the study findings. It was vital to ensure that an accurate representation of participants' experiences and feelings with receiving interprofessional care were captured through the stories constructed from the narrative dialogue that occurred in sessions one and two. During the telephone call, I read participants their stories that I had constructed, based on our conversations and asked them the following questions:

1. Is this new reconstructed story an accurate representation of your experience/feelings with being the recipient of interprofessional care?
    a. Can you elaborate?
2. Is there anything else you would like to add to your story in order for me to get a more accurate understanding of your experiences with and feelings about interprofessional care?

3. Is there anything that I should remove from your story in order for me to get a more accurate understanding of your experiences with and feelings about interprofessional care?
4. Is there anything that I should focus on in greater detail in order for me to get a more accurate understanding of your experiences with and feelings about interprofessional care?

At this point, participants were also asked as to how they would like to be described in the study and if they could provide any context with regard to their lives prior to their illness event. This was important, as it contextualizes who the participants were as individuals independent of their health condition. All of the participants agreed with the content of the stories that had been created from the conversational interview and did not ask for any changes. They did, however, add a few pieces of information to strengthen their stories, such as one participant further emphasized the importance of communication within interprofessional caring teams.

Throughout the entire process: Through each one of the sessions, as well as during participant recruitment, data collection and analysis stages, I have been constantly journaling my thoughts and feelings. It was the intention that through journaling I was able to sort through my experiences and emotions experienced throughout the study and consider these in the interpretation of results.

Data Analysis Methods

When discussing the data analysis methods used in this Narrative Inquiry study, it is first important to talk about how my field experience transitioned into field texts (Clandinin & Connelly, 2000). Once the narrative conversational interview and the metaphor-selection

drawing exercise sessions were conducted with the participants, I started to listen to the audio-recordings of these sessions and transcribing them word for word. I made sure to note for myself any changes in tone or emotions displayed, such as when participants were laughing or when a pause in conversation occurred. When I finished with the transcribing process, I took the documents and re-read them four times. I wanted to ensure that I used participants' own words to construct their stories of experience. I first erased all parts of the transcript that contained my words as a researcher: areas where I was asking questions or talking to the participant. I put these aside to review at a later time, as my words as a researcher might have contained information that could be used to provide context for discussion. From this I used participants' words to form a story. This process resulted in three participant stories describing their experiences of receiving care from an interprofessional team. I made sure to re-read the stories once they were complete and removed any participant identifying information, such as any mention of what health condition they had or the names of the units they were discussing. These stories then became the stories I shared with the participants during the telephone follow-up session.

Once the stories were read to the participants and agreed upon for accuracy by them, they became the field texts that I worked through during data analysis. As for the three dimensional Narrative Inquiry space, when analyzing participants' words, I considered theirs, as well as my own, past and how it has impacted our present situation and how it will impact our future choices. For sociality, I looked at the relationships participants had with their caregivers in the stories they told me, as well as with me as the researcher. For place, I took into consideration where participants' experiences unfolded and where the inquiry took place.

For this study, the collected data was analyzed through three levels of analysis in order to address "the three kinds of justification" required to support the findings: "the personal, the

practical, and the social" (Clandinin, Pushor, & Murray Orr, 2007, p. 24). The personal justification is the researcher situating herself in the study and is the first level of analysis (Clandinin et al., 2007). The way I did this is I first began with reading and re-reading each one of the participants' stories as well as examining their metaphor-selection drawings. Along with my field notes, I worked though each aspect of the story, paying significant attention to my own personal reactions to the participants' words. Within their stories I interjected my own reflective thoughts and observations. Here, my analysis was based on my immediate personal response to the stories I was reading.

For the second justification of 'the practical', the researcher now is looking at the data in terms of how it impacts her own and her colleagues' practice (Clandinin et al., 2007). Thus, for this next level of analysis, when I took a further step back and examined each one of the participant's stories, I was looking at the stories from a broader healthcare professional point of view. I was then reading not only the participants' stories, but also my own personal interjections within them; I was trying to think on a larger scale as to how I experience these words as a registered nurse. At this point, I introduced relevant literature to explore the concepts participants had raised in greater detail. I also used the *National Interprofessional Competency Framework* (Bainbridge et al., 2010) as well as the three dimensional Narrative Inquiry space of temporality, sociality and place (Connelly & Clandinin, 2006) to guide the process. In terms of the framework, when exploring participants' stories along with my own reflective thoughts, I considered what participants were looking for when receiving interprofessional care. I wanted to see how these aligned with the six competency domains presented in the framework for effective interprofessional collaboration. In this section I also introduced the narrative threads that I pulled from participants' stories. These emerged when I revisited my field notes and listened once again

to the audio-recordings of my sessions. I was looking for parts of participants' stories that they had placed more emphasis on, such as through a change in tone or pausing after an important point they raised.

Lastly, as I came closer to formulating my research text, I moved to 'the social' justification where it requires the researcher to now look at the data from a larger social context point of view and think about the "So what? and Who cares? questions" (Clandinin et al., 2007, p. 25). At this point in the process, I was taking a further step back and examining the stories as to how they fit within the greater healthcare context. The narrative threads that emerged 'across', no longer just within, participant stories were explored in greater detail, while looking for implications on a broader scale. This level of analysis is presented in the last chapter of this thesis and discussed in terms of the significance of the participants' shared stories with regards to interprofessional care. Additionally, I composed a letter from the patients' perspective based on my interpretation of the experiences participants have shared. I ensured to incorporate words from each one of the participants' stories and discuss areas for growth and what currently works well within interprofessional teams. This letter further exemplified the co-construction of knowledge between me and the study participants.

Personal Reflection

Throughout the entire research process, I have been reflecting on my own personal and professional experiences of healthcare: as a person, whose loved one was on the receiving end of interprofessional care, and as a registered nurse who delivers care within an interprofessional team. As narrative inquirers, we welcome our own feelings and experiences throughout the research we conduct, and especially so, alongside the chosen theoretical lens, into the analysis phase (Clandinin & Connelly, 2000; Holloway & Freshwater, 2007). As a researcher, however, I need to be mindful not to make assumptions about participants' feelings and experiences, but instead

to ensure that I am attentively present in the moment to fully hear their stories and to accurately represent their voices in this study. Thus, to ensure that assumptions are not made, and trustworthiness of this research is achieved, it is important to discuss rigour as its main goal is to ensure that participant experiences have been accurately and truthfully represented in the study (Streubert & Carpenter, 2011).

Rigour and Reflexivity

Four criteria of rigour addressed in the context of this study are credibility, transferability, dependability, and confirmability. Credibility refers to the extent the researcher has been able to establish confidence in the truth of the findings for the study participants (Lincoln & Guba, 1985). In this study, credibility is established by following up with the participants with a telephone call once the stories are created from the narrative interview to verify that their experiences have been accurately captured. At this time participants are also given the opportunity to change or add to any aspect of their stories. This is a form of member checking in that the collected data is "tested with members of those stakeholding groups from which the data were originally collected" (Lincoln & Guba, 1985, p. 314). Dependability refers to the triangulation of time and method of data collection (Lincoln & Guba, 1985). For this study, participants are approached at two different time periods spanning almost two months apart to tell their story, and two types of data collection methods of the narrative conversational interview and symbolic image selection exercise are used. Dependability also requires the researcher to be mindful of her own involvement in the construction of meaning, calling for the researcher to be reflexive in her work.

Reflexivity in this study occurs, as I listen and work through each of the participant's stories. I have been continuously writing journals of my thoughts, feelings and experiences, which could affect, and be affected by this research process. Confirmability is the degree to

which the findings come strictly from the participants and/or conditions of the research and not from alternative perspectives or biases (Krefting, 1991). In this study confirmability occurs through the keeping field notes, tracking every detail that occurs throughout the study development. These give an outside individual an ability to follow the study process and later aid in analyzing data and writing up results. Lastly, transferability is the degree that study findings can be applied to other settings, contexts, or individuals. Within this research, it is the intention that as the co-constructed narratives are disseminated, people reading or hearing these stories engage in their own narrative of experience with interprofessional care whether personal, as a patient, or professional, as a healthcare provider and so engage in their own reflective inquiry.

Ethical Considerations

Throughout the study participants were not involved in any deception or coercion. The re-constructed stories were shared and re-confirmed with the participants throughout the data collection and analysis process. Although there were no negative outcomes for participants in the study, participants were informed right at the beginning that if they experienced any emotions when discussing their experiences of being recipients of interprofessional care during their hospitalization, they would have the option of pausing the session temporarily or withdrawing permanently from the study without any penalty or consequences. They would still be given the honorarium as a thank you for their time. As well, if participants did become distressed in any way throughout the data collection process, I would ensure to ask their permission to refer them to the Unit Manager or Patient Relations to talk further about their experience. It was the intention that none of the study participants would be left in distress after participating in the study. In general, participants were informed that if they were not comfortable answering a question or wanted to withdraw from the study at any time for any reason they were free to do so

without any penalties. According to Bussel (2008), consent is a process and needs to be consistently re-evaluated with the participants, to see if they are still comfortable with taking part in the study.

Careful attention was placed not to breach confidentiality of the study participants. Both Research Ethics Boards (the university and the healthcare institution) would have been notified as well the Privacy Office contacted to obtain detailed instructions as to how this issue could be contained. Specifically for confidentiality, the audio-recordings of the interviews conducted with the participants were transcribed and saved as a password protected Word document on an encrypted USB key. The artwork and creative writing of participants were scanned, saved as password protected documents on an encrypted USB key and the originals returned to them. Both of the encrypted USB keys were saved in a locked filing cabinet and this cabinet was a different cabinet from the one where the signed consent forms and personal identifiers are saved. The participants were all asked to select pseudonyms for themselves, as suggested in Creswell (2007), so that they would not be referred to by their real names or discussed in any way that would revel their identity. Additionally, the consent form, the study information letter as well as the letter from the research ethics board of the healthcare institution, all have the name of the institution removed as well as any identifying information (name and contact information for the the principle investigator and the unit name).

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In this chapter, I outlined my recruitment and data collection and analysis strategies employed in the study. The next three chapters, 5, 6, and 7, present the unique experiences of each one of the participants (Fred, Sasha and Purple) receiving care from an interprofessional team beginning with Fred, the first participant. I have already embarked on my journey and am

about to meet my first travel companion. I do not know what to expect or how we will connect with one another. All I know is that I am more than prepared to accept the challenges this trip will bring forth.

CHAPTER 5: FRED'S JOURNEY

The Man on the Plane

Continuing with my metaphor of a journey, this chapter captures my encounter with my first travel companion; in my thesis, this is Fred. Walking onto the plane to begin my journey, all I can think of is the overwhelming number of people packed like sardines into a small confined space. Although we are all heading in the same direction, our final destinations are most likely very different. As I find my seat, I notice I am going to be sitting beside an elderly man and engaging in conversation with him for the next few hours; I look forward to learning more about him.

~

I begin this chapter, as well as the subsequent chapters by describing the progression of the two sessions I have with my participants: an in-person narrative interview followed by a telephone interview approximately two months later. This process allows you as the reader to visualize how Fred's personal narrative, discussed in this chapter, unfolded over the course of our meetings. I present Fred's story intertwined with my reflections, notes, thoughts, and comments and include Fred's metaphoric drawing of interprofessional care. This becomes the first step of my Narrative Inquiry analysis. Following, I conduct the second level of analysis, where I examine, from a broader healthcare professional perspective Fred's story and address my ponderings that were interjected within Fred's narrative. Here, I present, through the lens of the *National Interprofessional Competency Framework*, the narrative threads that emerged from Fred's story and metaphor selection drawing.

Building Blocks of the Story

Narrative Interview

Sunday, January 6th, 2013

Start: 1000 Finish: 1200

Place: Hospital unit private conference room

It is a cold, snowy Sunday morning in January. It is also the day of my Ukrainian Orthodox Christmas Eve. My mother has already called several times to ask when I will be coming over to spend some time with the family and help her prepare dinner. After explaining to her that I need to first work on my research, I pack all of my supplies (forms, coloured pencils, notebook and a tape recorder) and set out for the hospital. It is a short seven-minute walk from my downtown apartment, but on this day the walk seems much longer. I have so many thoughts running through my mind; I do not know what to expect. I have a prearranged meeting with a patient to interview for my study. However, I experience anxiety that the meeting might not progress as planned; being a patient, my participant could have been discharged home earlier than he thought before setting our meeting, or be undergoing an unscheduled procedure or simply be too tired or ill, or no longer willing to be part of this study.

When I arrive on the unit, I tiptoe quietly into Fred's room and pretend that I am knocking on his curtain; Fred is in a semi-private room. When he sees me, he immediately smiles and waves hello. I cannot help but smile back. Almost instantly, we are immersed in a conversation about current news, the results of the sports games from the previous evening (the Toronto Maple Leafs are playing hockey) and about our educational experiences. As this is happening, not once do I remember my earlier fears, wondering if he would still participate;

somehow I know he won't mind sharing stories of his experiences receiving interprofessional care.

After our lighthearted conversation of building rapport, I help Fred gather everything he needs (a glass of water, a blanket to cover himself, and his glasses) and escort him to the quiet conference room where the session is to take place. The conference room has no tables or chairs; I grab one for each of us from another room. Fred doesn't look very impressed with the meeting space either, but it is a private room where we can engage in our discussion without interruption or fears of confidentiality/privacy breaches. This is where we spend the next two hours.

After explaining the first step of our narrative interview, I begin by asking the first question. The conversation starts off slowly. I can tell that before we can begin to discuss personal details of Fred's experiences of the care he has been receiving from the interprofessional team, we need time to become comfortable with each other. For the first few questions, Fred takes time to think about them and carefully phrases his responses. Fred begins by talking about being a "frequent flyer on the cardiology unit" and how for him "nurse practitioners are the key" to his recovery, always being there for him and answering any of his questions. We talk about what interprofessional care means to him and how he would define it. For Fred, "it's all about teamwork and that qualifications of individuals within the team do not matter much; it's about finding the right person for the job". Fred provides a number of examples about role clarification within his experiences at a family practice clinic and the drug store.

We then delve into a discussion about the interactions Fred has had with professionals on the unit. Fred shares which healthcare providers he has met, how they first met and how much he likes the white board in his room. The white board states" Okay, today is…, my name is …, I'm your nurse …, the nurse practitioner who's on today is …, and the plan is..." Fred acknowledges

that this has helped him to be more involved with his care, which he thoroughly enjoys. He shares that he likes to inquire about his care and not just lay there, "having somebody come and stick needles in my arm".

As the conversation progresses, I ask Fred about how his current experiences of receiving care on this unit compared with his previous hospitalizations. Fred shares with me the major health episode he had the previous summer, where he saw "pretty much every doctor possible". For Fred though, this situation was unlike his present hospital stay because of its severity; it was a "much more complicated case". Fred goes on to state that at that moment in his life he did not feel right to contribute anything to his care and wanted to leave it to the experts, whereas now that the reason for him being in the hospital is not as severe, he enjoys expressing his opinions once in a while. Fred also talks about his experiences at the defibrillator clinic he visits and how these compare to his current hospitalization. We end this part of the meeting with Fred stating that for him "it is important that I be kept up to date with all the details and situations. I'm certainly not in the position to drive anything; I just want to be kept up to date."

Metaphor Drawing

At the same meeting, after we finish talking about Fred's experiences of receiving interprofessional care, I invite him to select a metaphor that best represents for him the meaning of interprofessional care he has been receiving. We spend some time talking about our respective artistic abilities and how Fred does not think he can draw his metaphor (or symbolic image as I explained it for him) of interprofessional care. I encourage him to give it a try, and within five minutes we not only have a picture, but a complete explanation of it.

As our meeting comes to a close, I cannot help, but feel sad. I enjoyed the two part session so much that I do not want it to end. I feel that Fred is also a little hesitant to say goodbye

as if there is still more to discuss and say, but at that moment we both do not have any more words to add. As we walk out of the room, his wife is standing there in the hallway waiting for him. She gives us both a warm smile. Fred told me earlier in our session that he had told his wife he was going to be participating in my study. She came to pick Fred up from the hospital as he is being discharged that same day. I instantly feel happy about the news and immediately look forward to our follow up phone conversation set for end of February.

Follow Up

Saturday, February 23rd, 2013

Start: 1800 Finish: 1815

Place: Telephone conversation

Almost two months have passed when Fred and I speak again. I call him on a Saturday afternoon to discuss our conversation in the hospital. As he is getting ready to sit down for a family dinner, he politely asks if he could call me back in an hour. Within exactly one hour my phone rings and I am happy to hear Fred's voice. I take time to read to him the story I composed of our January meeting. Before I start, I invite him to interrupt me at any point if something I am reading or saying is not accurate. He listens quietly and never interrupts. When I finish, Fred thanks me for the story and agrees with all of its parts. He goes on to add a few more important pieces of information about interprofessional teamwork he did not mention during our first meeting.

Fred stresses the importance of communication, ensuring that professionals work as a group effort, being flexible to the needs of the patient. He tells me that on the whole the team functions well on this unit, but he believes it's "the loss of communication within the team" that needs to be worked on. I then ask Fred to provide me with a few words as to how he would like

to be described within the study. Fred shares with me what he used to do for a living before he retired and what his hopes are for his future, independent of his present health condition. We close off the meeting by thanking each other. I express my gratitude to Fred for his valued time and contribution to the study. Fred thanks me for listening to him talk about his illness and his experiences of receiving care from an interprofessional team on this unit.

In the next section I present Fred's story based on our narrative interview. We co-constructed the narrative with our words intertwined: his direct words with my own reflective thoughts. To visually represent Fred's story, I chose bolded Bradley Hand Italics font, size 14. I think this font style is gentle, kind and wise like Fred himself; it represents perfection, each letter carefully drawn out, yet strong. My reflective researcher voice continues in Times New Roman, font 12 and is indented 0.7 cm.

Fred's Story

My name is Fred and I have been a frequent flyer on this cardiology unit. I have been really impressed with the way this unit works and the nurse practitioners are the key. I have probably met most of them here already. The nice thing about them is that they are around and I feel I can get an immediate and straight forward answer out of them, than waiting for the doctor to come around. If I ever needed anything they [nurse practitioners] ***were always there for me. They were the individuals who knew everything about my case.***

I agree with Fred's notion that nurse practitioners are vital. It reminds me of the nurse practitioners I have interacted with during my clinical practice as a student nurse. I noticed that they were always visible and present on the unit and available to answer any and all

patient questions. They took time to get to know the people they were taking care of. However, I wonder about registered nurses and why Fred is not seeing them in the same light.

From my experience, it is the nurses who spend the most time with the patients. Other healthcare team members enter in and out of the patient's situation, but nurses are the ones who are there all the time. Interesting that Fred does not mention much about them. Are nurses invisible? Physically present, but their work goes unnoticed by patients?

For me interprofessional care reminds me of teamwork; it's finding the right person for a particular aspect of the care. No one person can cover all aspects of the job. It makes a lot more sense to have people who are working together in some sort of a team with each other to overcome the limits and the capabilities of one person.

I am curious about who is doing this "finding". Who is finding the 'right' person for a particular aspect of the care? Is it the patient, the nurse assigned to his care or another appointed healthcare provider?

When it comes to interprofessional care, people's qualifications do not matter much for me; it's more of a combination of expertise. As an example, I visit a family practice clinic quite often for my pacemaker. Whenever I go to the drug store there, it makes more sense to me for the pharmacists to review all of my medications with me and know about potential drug interactions between them. It's really not worthwhile for the doctor herself to do it. The two professionals are

still working together, but it's more about bringing people in with the right expertise. Communication is crucial!

Again, who is responsible for bringing "people in with the right expertise"?

Everyone is working together around me. It's not like there is any formal structure of these teams.

I wonder what Fred means by this notion of there not being "no formal structure to the teams"? Does that mean that the composition of the teams changes regularly? Do professionals enter and exit the teams often? Is this difficult for the patient to get used to the new team members coming in and out of the team? Is it confusing and/or does it impact the patient's trust in the quality of care s/he is receiving?

Additionally, if a patient builds a close therapeutic relationship with one healthcare provider (a nurse or a physiotherapist, for example) and they leave the team, can another healthcare provider replace her/him and work equally effectively within the team and the patient.

If I need something to be done, I find somebody to do it rather than waiting around; the roles are not always defined. It's all about identifying a 'go to' person that I can ask questions about what my INR level was like today or when I am being discharged. Nurses change all the time and they might not always know your whole history, whereas somebody who has at least a bit of an overview, but is still around, I find is a huge impact on my care.

Thinking about Fred stating that "the roles are not always defined" I wonder how a patient would know what role each healthcare provider plays in his recovery. For example,

registered nurses' scope of practice in the province of Ontario is defined by the College of Nurses of Ontario (CNO) (2011) as "the promotion of health and the assessment of, the provision of, care for, and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function" (p. 3). The nurse practitioners' scope of practice includes the same definition, but because it is an expanded role, it also includes seven controlled acts. Some of these are casting fractures, communicating a diagnosis, and performing a procedure below the skin. To registered nurses, this definition is clear, but to those individuals outside the profession, the difference between the two roles may be nuanced and therefore not clearly defined. So I wonder, is it by each healthcare provider verbally telling Fred what services they can offer or by the patient taking the time to research this himself? Would patients benefit from being given a scope of practice manual of all the healthcare providers in the hospital, as an example?

I am, however, very impressed with the way team members talk to each other and find out about my care.

It seems like communication is an important part of care to Fred. Fred excludes himself from the definition of interprofessional care. I wonder if other patients also see themselves outside of the team and not part of the communication process that occurs between team members.

In terms of contact with professionals on the unit, I don't have very many issues, but I have been in contact with doctors such as surgeons and cardiologists, nurses, and nurse practitioners. I usually know who is who when they come in to see me and for the most part they introduce themselves. I like the

little whiteboard in my room that says, "Okay, today is, my name is.....I'm your nurse..... the nurse practitioner who's on today is this..... and the plan is....." Of course it's not always updated, but it's very helpful for me. It allows me to be more involved with my own care, which I like very much. That's a big deal for me where you know I'm not really interested in just lying there, having somebody come and stick needles in my arm every time. I like to inquire about my care, like about the medications I am on.

I wonder if level of education or professional title matters in the type of involvement a patient has with her/his care. Does it matter in Fred's case? It will certainly be interesting to explore the other two participants' stories to see if their level of education or age equate to greater involvement in their own care.

I am reasonably comfortable with saying, "Hello, I'm here." On the whole they do a great job and I know I am not at the Four Seasons so I'm not going to expect great food and stuff like that. In comparison, most of my other hospital experiences have been with getting the leads out of my defibrillator or something with my defibrillator itself. As well, I had a major episode over the summer where I think I met every doctor possible as I was met with a complicated case. I was not in fit shape at the time to know much about what was happening.

Although I have never been a patient in a hospital for an extended period of time, listening to Fred's words I wonder about the type of care I would like to receive. I think I would try to

be as involved in my care as Fred is in his. Being a healthcare provider, I believe I know what is best for me. Thus, I would like to know what my lab values are, what medications I am on, or what procedure I would be undergoing. Along with this, I also wonder about what type of care people, who are not healthcare providers themselves, would like to receive.

The care might be different even within a similar team when the condition of the person has changed. It was a more complicated business with me. At that stage I did not feel that I had anything to contribute whereas I think, within this unit I can mention an idea here and there. Within the family practice clinic, because my stay there is very predictable and laid out each time, the structure is very well defined and it's a team effort.

I am curious if the team composition is always the same on this unit, regardless of patient's diagnosis … one nurse, one nurse practitioner, one specialist doctor, one allied health member, one technician and one patient?

I go in, they look at the log on my defibrillator, they page the doctor and he or she will come in and say, "You know, this looks stable maybe we should look at this." You cannot compare the level of care I receive at the clinic with my current hospitalization because these two settings involve different aspects of my condition. I don't think one is better than the other. It's just that they're both doing the best they can, given the situation I present to them. Within any hospitalization, I would want to be made aware of what's going on and if there

were issues with my care I would want to know that. As an example, setting the leads into my defibrillator; I think it is important that I be kept up to date with all the details and situations. I'm certainly not in the position to drive anything; I just want to be sort of kept up to date.

It seems that the severity of Fred's condition matters in terms of the level of involvement he likes to have in his care or the level of information he would like to receive about his health state. I wonder how patients respond to interprofessional care depending on their health status. Are patients more involved within the team if their health condition requires less energy or when it is more serious?

Fred's Additions to the Story

Fred and I discuss these additions to the story at the follow-up telephone meeting where I read the story I composed for him and asked him if he agrees with its content.

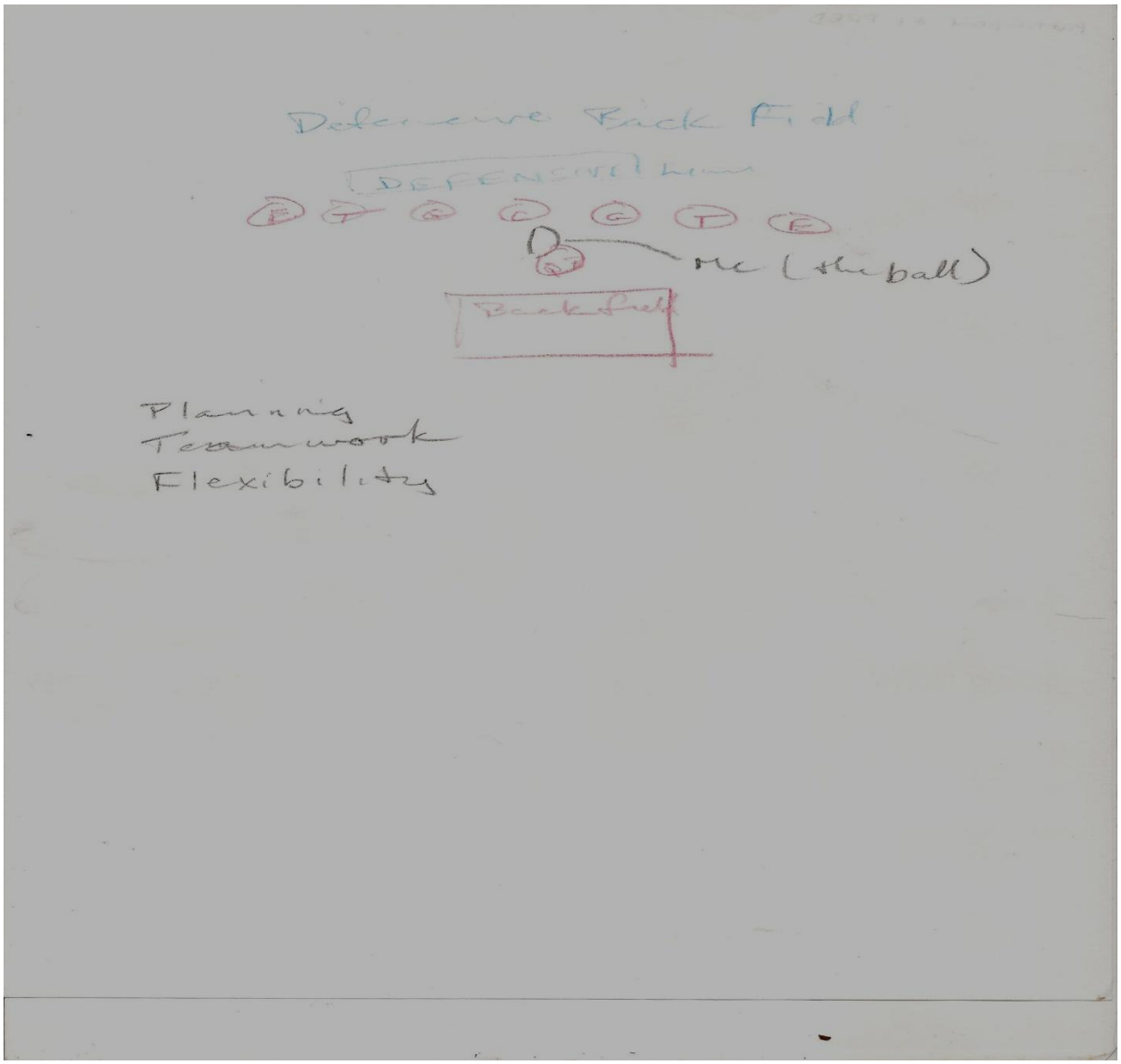
I am a retired professional with a relatively high level of education. I wanted to add that on the whole the system works very well, but it's the loss of communication within the team that you need to work through. Within the present unit there really are no problems with team functioning. When I was in the ICU (intensive care unit), communication was a problem, but I couldn't comment on it at that point because there were so many issues then for me to fall on. I felt I was at a loss there; it was a more complicated case there for me to

know what is going on. Overall, it should be a group effort and flexible enough to bring people with different expertise together for what I need.

Once again in Fred's words, I hear the importance of communication. I also wonder about who would be in charge of bringing "people with different expertise together". Does this happen naturally, that healthcare providers find each other around patient's care needs and form a team or is there a 'creator' of the team?

Fred's Metaphor of Interprofessional Care

I ask Fred to draw a metaphor to represent how he sees interprofessional care being delivered to him; how he defines interprofessional care.



As Fred was drawing his metaphor he was speaking out loud explaining the image. He said he sees interprofessional care like a football team with him representing the ball. Being a football,

I am involved in the game, but someone is making the important decisions on my behalf. I need to trust the person who is carrying the ball. If the guy has a firm hold on me I feel great; if the guy has no hold on me, a fumble.

Listening and watching Fred talk and draw, I wonder where healthcare providers obtain knowledge about each other's roles and how to 'work well together'?

When my meeting with Fred came to a close, I could not help, but begin to feel excitement about conversing with Sasha, the next person I meet on my journey that same day. As I walk down the long hospital corridor towards another patient room to meet her, I replay my meeting with Fred and wonder whether other patients hold similar experiences as him. Walking, I pass by a window and notice that the weather outside has changed significantly; the sky is getting darker as if it is going to snow. I know my mom is probably worried about my travels home for the festivities and surely there is already three missed calls from home, but I cannot leave the hospital just yet. I am too curious about my other participant's experiences with interprofessional care. I make a quick call to my mother to let her know I will be another few hours and tell her not to worry.

Narrative Inquiry Analysis of Fred's Story

Over three months have passed by since the follow-up conversation I had with Fred that February morning. I am now in the process of analyzing Fred's story that he has shared about the care he has received from an interprofessional team. Throughout this time, I have been reflecting on various aspects of his story and keeping a journal of my thoughts. Since my meeting with Fred I have also met and held sessions with the other two participants in my study, and I have reflected upon their stories of how they experienced receiving interprofessional care. These will be revealed in due course, as the chapters of this thesis progress.

In our conversation Fred focused on the following aspects of his experience receiving interprofessional care: interprofessional team members, communication, and the patient within the interprofessional team. This was evident by the change in the tone of voice that Fred exhibited when we discussed these topics I noticed when listening to the audio-recording of our sessions. Additionally, when Fred thought something was significant for me to note he would repeat it several times within a short period of time, such as when trying to stress the importance of communication.

Interprofessional Team Members

Our whole session started by talking about the care that a nurse practitioner has been providing for Fred on his current unit. Fred discussed how he thought a nurse practitioner is a vital member of the team, is present whenever he needs assistance, and knows everything about his health situation. According to Hayes (2007), patients when asked about nurse practitioners, often talk at length about their satisfaction with the plan of care they receive from these healthcare providers. Patients believe that nurse practitioners consider their opinions, have their best interests at heart, interact well together and contribute to enhanced satisfaction with care (Hayes, 2007).

When thinking about this idea further I wonder about registered nurses. Why had Fred not mentioned much about them or discussed nurses in the same light as nurse practitioners? Were they not there for him whenever he needed assistance? Were they not, in his eyes, vital members of the healthcare team? Nurses, after all, are one of the few healthcare providers who spend the longest time with patients on inpatient units. The only time Fred mentioned registered nurses was when he was talking about identifying a go-to person: “nurses change all the time and they might not know your whole history whereas somebody [nurse practitioner, for him], who

has at least a bit of an overview, but is still around, I find, is a huge impact on my care." This is puzzling for me especially for a patient such as Fred, who himself has stated that he is a "frequent flyer on this cardiology unit", meaning he would have spent a significant amount of time with registered nurses, but does not discuss them in greater detail. I did not have an opportunity to go back to Fred and ask him more about registered nurse involvement in his care. Additionally, Fred does not talk about what relationship, if any, occurs between registered nurses and nurse practitioners within the interprofessional team. This is interesting, as nurses and nurse practitioners spend the most time with patients. Patients have a greater opportunity to notice the type of relationship occurring between these two healthcare providers than other members of the interprofessional teams, yet, Fred does not make reference to it.

Exploring the literature, currently there is limited research available on how patients view the work registered nurses do (Calman, 2006; McCabe, 2004). Despite that, in McCabe's study, patients talk about registered nurses as not providing enough information to them because they are way too concentrated on performing all of their tasks; the nurses come into the room to take a blood pressure reading, create small talk during that time, and leave as soon as the task is complete. Additionally, McCabe goes on to mention that nurses often make assumptions about patient needs as opposed to interacting with patients to find out what they need or what is important to them (McCabe, 2004). This information is interesting as I have always felt that, in my role of a registered nurse, I am there for my patients and spend a significant amount of time interacting with them while carrying out the physical care they require. However, the more I reflect on this, the more I can understand why some patients would feel this way. Oftentimes I do not have a lot of time to spend with each patient. Thus, I try to engage the patient in a conversation while I am performing a task, such as taking their vital signs (blood pressure, heart

and respiratory rate, and temperature). I always thought this was a good strategy, but now I am realizing that not all patients like this approach or count it as effective interaction. This knowledge of what patients are looking for from their healthcare providers can be quite valuable for all members of interprofessional teams, not just nurses.

Within Fred's case, one possibility could be that the registered nurses did physically spend more time around him, but this did not make a lasting impact on Fred like the nurse practitioners did. Thinking about this further, Fred's desire to have at least one caregiver who is always present makes my mind draw a connection to the concept of attentiveness in care. Attentiveness can be defined as the "quality of individuals to open themselves for the needs of others" (Klaver & Baart, 2011, p. 689). Thus, being attentive in the care we administer to our patients and their loved ones is vital for "good care" (defined as care that is more than useful, pleasant, or efficient) to occur and leads to relationship forming and building (Klaver & Baart, 2011, p. 687). In Fred's case, he has been able to form a relationship with the nurse practitioners taking care of him more than any other healthcare provider. This may be because they are always there for him and are his "go-to person"; the nurse practitioners have been able to "open themselves for the needs" of Fred (Klaver & Baart, 2011, p. 689). This statement does not mean that other healthcare providers do not have the capabilities to do so, but that from Fred's perspective, nurse practitioners were the ones who did just that. In line with talking about other healthcare providers, it is important to note that Fred only mentioned nurse practitioners, doctors, and nurses as members of his interprofessional team; no other healthcare providers were discussed. It is hard to tell why this is so. Might this be that by not talking about other healthcare providers, he was trying to communicate his dissatisfaction with the care they provide to him? Unfortunately, I did not have an opportunity to ask him. Fred did state that during this present

hospitalization he did not present with many issues and did not require care from a large number of different healthcare providers.

When a number of healthcare providers are brought to work together within a team, role clarification can be an issue. Fred had stated that he usually knows "who is who" but the "roles are not always defined". This is interesting because even working as a nurse, I am not fully clear as to the full scope of practice of all healthcare providers I interact with on a daily basis. To make things more complicated, I think of the introduction of Bill 179 in Ontario in 2009. Twenty-six health-related statutes were amended resulting in a number of significant changes to professional practice. Thus in certain areas of the province, for example, I might be working with pharmacists who can give flu shots or physiotherapists who can perform wound care while in other parts of the province they cannot. It is important for me to know my own scope of practice as a nurse and be familiar with what roles my colleagues within the interprofessional team play. To connect to the *National Interprofessional Competency Framework*, it mentions that a key component of interprofessional care teams is role clarification; healthcare providers need to be knowledgeable about their own role and the role of all team members in order to be able to provide the most effective care to patients and their families (Bainbridge et al., 2010). In reviewing the literature, I have noted that there is agreement between a number of authors that knowledge of self and others' roles should be a top priority within a team to ensure most successful interprofessional care delivery (Dempsey & Larson, 2004; Insalaco, Ozkurt, & Santiago, 2006; MacDonald et al, 2010). Additionally, the patients' role should also be discussed and mutually agreed upon by the patient and the interprofessional team members from the beginning to avoid any confusion.

Communication

What has become apparent in the limited literature available on patient perceptions of the work nurses do is the repetition of the concept of communication and how vital it is to patients to be able to communicate effectively with their healthcare providers. Fred has talked at length about his communication exchanges with his nurse practitioner, mentioning that he can get "an immediate and straight forward answer" when inquiring about his care or lab values.

Another important item that Fred and I discussed during his sessions was his belief that for interprofessional teams to be effective, communication is crucial. He stated that he is "very impressed with the way team members talk with each other. Additionally, during our follow-up conversation Fred added that on the whole the "system" works "very well…it's the loss of communication within the teams that" needs to be worked on. As we saw in Chapter 3, within the *National Interprofessional Competency Framework* (2010), communication is identified as one of the six essential competency domains required for effective collaborative practice. In fact, in this framework, communication and patient/client/family/community centered care are "elements that influence the other four competency domains" of role clarification, team functioning, dealing with interprofessional conflict, and collaborative leadership (Bainbridge et al., 2010, p. 8). I agree that it is vital that healthcare providers from different disciplines are able to communicate with one another in a respectful, collaborative and responsive manner to provide the most interprofessional and effective care to their patients (Bainbridge et al., 2010). Fred himself has mentioned that "it's more about bringing people in with the right expertise" that are able to communicate among each other. For my own practice as a nurse, this information has brought an increased awareness about the importance of continuing to be an effective communicator with members of the interprofessional team I work with, as well as with my

patients. This includes listening actively, being open and respectful within my communication exchanges.

Patient within Interprofessional Team

Speaking specifically about interprofessional teams, after reading and re-reading Fred's story numerous times, a number of questions came up for me in relation to role clarification, team structure, team functioning, and leadership. I had asked Fred to define interprofessional care and he stated that it reminds him of

> teamwork; it's finding the right person for a particular aspect of the care. No one person can cover all aspects of the job. It makes a lot more sense to have people who are working together in some sort of a team with each other to overcome the limits and the capabilities of one person.

Interestingly, Fred had not included himself as part of the definition of interprofessional care or as a member of an interprofessional team. In fact he even stated that "everyone is working together around me". This is also evident in the metaphorical image Fred drew, where he is the ball that is being thrown around in a football game; for him the game is centered on everyone working with each other around the ball, Fred. Within Fred's description of his drawing he further shared that he is "involved in the game, but someone is making the important decisions" on his behalf. It is quite significant to see how Fred's metaphor further illuminates the meaning of his experiences that he has shared verbally during the narrative interview. To substantiate, later on in our session, Fred also mentioned a number of ways that he likes to be involved in, and inquire about, his care: "I'm not really interested in just lying here, having somebody come and stick needles in my arm every time". This is evident through his desire to be kept informed about his care outcomes, like his blood levels (INR), and the decisions being made about his condition, such as when he will be discharged.

Additionally, Fred also talked about the white board in his room and how he likes that it is updated most of the time, as it allows him to be informed about who is looking after him on each shift and what the plan of care is for him that day. In a way Fred is an active participant within his interprofessional team, perhaps without fully realizing it himself. Shaw (2008) writes that when patients have been asked about their level of involvement within interprofessional teams, their answers were mixed: some patients felt as valid contributors in their healthcare, whereas others felt that they were playing the role of the patient and accepting decisions, with the possibility of negotiations, from the healthcare professionals (Shaw, 2008). Fred is similar to the patients described in Shaw (2008): he does not see himself as part of the interprofessional team yet his level of involvement shows that he is a valuable contributor in the decisions the team makes regarding his care.

To further elaborate on team structure, Fred did acknowledge that "no one can cover all aspects of the job [...] people's qualifications do not matter much for me […] it's more of a combination of expertise." The membership of interprofessional teams is decided by the leader of the team who knows best the details of the patient's case (Shaw, 2008). Reflecting on this further, I imagine it is probable that the leader of the team then is the one who finds the appropriate healthcare providers, Fred talks about, to make up these teams. The membership of interprofessional care teams can change depending on the patient's condition and needs (Shaw, 2008). I assume that this might be hard for some patients, especially when they get used to one healthcare provider. Once that healthcare provider leaves the team, another professional might not be able to build as an effective therapeutic relationship with the patient as the previous one, resulting in a disconnection with the new healthcare provider. This is independent of when healthcare providers exit the teams for a brief period of time and the patient is aware of it, such

as when they take time off, are ill, or have to attend to another aspect of their job. Although Fred does not really mention his feelings about the change in composition of his interprofessional team, he does talk about the importance of having that one go-to person who is consistently present for his care.

In regards to the role a patient can play within her/his hospitalization, Fred had mentioned that he does not like to be passive within his care. He stated that he is "reasonably comfortable with saying, "Hello, I'm here." With Fred being a retired university professor, I had wondered if level of education or professional title matters in the type of involvement a patient has within her/his care. Fred likes to inquire about his care to know what medications he is taking or what procedure he needs to receive. What is significant to note is that no literature could be found in relation to whether education level, socioeconomic status, and/or age play(s) a factor in the level of involvement patients display within their own care. However, the study by Martin, DiMatteo, and Lepper (2001), where they developed and validated a Facilitation of Patient Involvement in Care Scale, found that, from the healthcare providers' perspective, they do not promote greater patient involvement in care based on the patient's education level, age or gender. This is interesting as I understand that the more individuals are health literate the more they are likely to engage and become involved in their own care. Should this be considered by healthcare providers when inviting patients to become more involved in their care (Couter, 2012)? This is especially so since the concept of health literacy goes hand in hand with the level of education and the ability to read, write and understand health information (Couter, 2012; Institute of Medicine of the National Academies, 2004). For Fred, later on in his story, he shares that it is the "severity", frequency, and type of condition that impacts his level of involvement or the information he would like to receive about his healthcare. Fred discussed the hospitalization

he had the previous summer. During that hospitalization, Fred experienced a complicated situation with his health that required intensive care. He was not fully present himself, to be able to "drive anything". Similar to how patients respond to a change in the structure of interprofessional teams, what I can take away from this for my own practice, is that the level of involvement a patient displays in her/his care is really individual to that patient and her/his state of illness, among other things.

~

After talking to Fred and analyzing the experiences he has shared, Chapter 6 provides a detailed account of my sessions with Sasha and discusses how our meetings unfolded, what we discussed, and how her story progressed. I too, present my analysis of Sasha's experience at the end as I have done for Fred.

CHAPTER 6: SASHA'S JOURNEY

The Young Woman on the Train

Running to catch the train, I cannot stop thinking about the conversation I have just had with Fred, the man on the plane, and how this complete stranger had trusted me so much to share significant aspects of his interprofessional hospital experience. I am looking forward to the next travel companions I will meet on my journey and wonder if I will be able to find others who are as willing to discuss their own personal stories of receiving interprofessional care.

As I just make it onto the train and realize that there are no empty seats left, my eyes immediately catch glimpse of a girl who waves at me and offers her seat. For some reason, I know right there, that this would be yet another new travel companion with whom I would engage in a deep conversation. This becomes my second participant, Sasha.

~

In this chapter, I talk about my narrative interview and metaphor drawing sessions that I conduct with Sasha. I present the story that I create using Sasha's own words and include my researcher voice that has been intertwined within it. I then display Sasha's drawing of receiving interprofessional care and include the analysis of Sasha's story at the end.

Building Blocks of the Story

Narrative Interview

Sunday, January 6th, 2013
Start: 1300 Finish: 1500
Place: Hospital unit private conference room

Like with Fred, Sasha and I have one in-person meeting during the data collection process. With her I use the same conference room I used with Fred. It feels a little uncomfortable initially because my mind is still fresh with the conversation I had an hour earlier within these

same four walls. I make sure that there is a sufficient time gap between my sessions with Fred and Sasha so that there is no chance that the two participants would see each other interacting with me.

I begin by explaining the narrative interview and ask the first question I have on my list. My experience with Sasha is different. We do not need to spend time developing a relationship in order for her to start to open up to me about the care she has been receiving from the interprofessional team on this unit. For some reason she trusts me right from the start; perhaps this is because Sasha and I are closer in age than Fred and I.

Sasha begins by telling me that she has now been receiving care for three months on this unit and each week she sees a different doctor. It is frustrating for her to always have to explain her case to everyone, but she is happy that there is a nurse practitioner on the team who does not change; she has had the same nurse practitioner since she came on the unit. The nurse practitioner is like the "go-to person" for her. She communicates to the team any concerns Sasha may have. Sasha also feels that she does not receive enough attention from registered nurses on the unit. She feels that she is not a high priority case for them, because she has been on the unit for an extensive period of time, as compared to some of the other patients.

Our discussion progresses on the topic of interprofessional care and what this term means for Sasha. She defines it as "the relationship between a nurse, patient, doctor, surgeon, specialist, as an example. Interprofessional care is anyone that's dealing with my case". We also discuss the components that are vital for interprofessional care to be successful and Sasha mentions "communication, explaining things precisely and communicating the information properly to whoever is going to see you next or is involved with your case" is important. Sasha provides a number of examples within her own care and how interprofessional care is not fully provided for

her. As an example, she talks about feeling like she is an object ("a lab rat") and not a part of the team, and that it sometimes takes a while for her wishes about her care to be heard, and how the severity of her condition often impacts her level of involvement in her own care and within the team.

As the conversation progresses, I continue to ask Sasha questions about team functioning. She shares that she feels like she constantly has to manage her care herself, being aware of what procedures she is going to get or what medications she is on. The most frustrating situation for Sasha is "the constant switch in professionals who are involved" in her care.

We then delve into a discussion about comparison of hospitalizations. I ask Sasha if she could discuss a previous hospitalization that she has had where interprofessional care was not provided for her and how it compares to her present experiences on this unit. Sasha shares her previous experiences in the ICU where she received one to one care that she really enjoyed. For her though, team based care was more evident on her current unit with the interaction between physiotherapists and nurses, for example. Sasha does talk about the doctor-nurse relationship and how she notices a disconnection there. Overall though, she does state that she feels "the care is more positive than negative". For the most part she is kept in the know about her care, which she is happy about: what procedures she needs to get, what the plan for discharge is, or what medications need to be tapered.

Metaphor Drawing

At the same meeting, after we finish talking about her experiences with receiving care from an interprofessional team on her current unit, I invite Sasha to select a metaphor (symbolic image) that best represents the interprofessional care she has been receiving. Sasha seems excited about this part of the data collection process, although she does take some time to think of a

metaphoric image she wants to draw. As she states, she is a "perfectionist" and wants to make sure what she draws is the most ideal representation of the care she has been receiving. She does try re-drawing her image several times to ensure it is very neat, but ends up being happy with the first image she drew. Sasha too provides a detailed description of her drawing and why she chose the metaphor that she did.

Follow-up

Sunday, February 24th, 2013
Start: 2000 Finish: 2020
Place: Telephone conversation

On Sunday I call Sasha at home, but she is not in. I leave a message with her mother for her to give me a call back and she does later on in the evening. I again explain the reason for my call and inform her that I have written a story, using her own words from our first meeting, of her experiences with receiving care from an interprofessional team. I proceed with reading the story to Sasha in its entirety and instruct Sasha that she can interrupt at any time. Just like with Fred, I want to give Sasha the opportunity to add any pieces of information to the story that I might have missed or correct any inaccuracies. As I finish reading the story, without any objections from Sasha, she informs me that I have captured her experiences perfectly and she is happy with how her story has been depicted. When I ask her if there is anything else she would like to add or if she has any final comments on the topic, Sasha declines. I then ask her to provide a few words I can use to describe her in my study. Sasha shares that she enjoys a very active lifestyle. She sees herself as a young and creative individual. Sasha is university educated and is currently working in her field of study. We close off the follow-up conversation with Sasha thanking me for accurately capturing her experiences, and I expressing my gratitude for Sasha's willingness to share her story.

To visually represent Sasha's story, I chose the Cooper Black, size 14 font. I think this font type is strong, bold and courageous just like Sasha; it represents Sasha being able to overcome an extremely serious health condition and continue on, on her life path, living as normal a life as possible. I once again continue in Times New Roman, font 12 and indented 0.7 cm, to represent my reflective researcher voice intertwined within Sasha's story.

Sasha's Story

I have been receiving care on this unit for over three months now. My feelings and experiences vary and are different in all cases when it comes to my care. Each week I see a different doctor. Sometimes I feel frustrated having to explain my case to whoever is new. I feel like they don't want to get to know me and I constantly have to explain myself.

As Sasha speaks, I sense her frustration of repeatedly meeting new healthcare providers. It must be so tiring for patients to have to do this, especially when they are so ill.

Overall most of my feelings are positive with care on this unit. There is my nurse practitioner who knows everything about me. I thank God that there is that one person who is with you for the whole time and knows your history. She often is the main one who will communicate things back to the team on my behalf if I do not do it myself. The nurse practitioner is like the go to person

if I have any concerns; she will get the right doctor to come see me or the right medications and so on.

I wonder if other patients experience the same connection to the nurse practitioners as Sasha and Fred do. Does this connection stay the same or change if the setting is altered? Are patients as close to nurse practitioners in the community as they are in acute care settings?

The nurses are amazing. I do sometimes feel though, as if I am not a high priority patient because I have been here for so long. I feel like I am always on their schedule. Someone comes and tells me that a doctor will come see me at eleven and he doesn't come until two, but at two I have guests visiting me, so it's frustrating sometimes. I'm trying to manage my time here as well.

I am curious, do team members notice the effect their delay has on the patient's health outcomes. I wonder what team members can do to ensure it is not so "frustrating" for the patient to constantly feel as if s/he is on "their [the doctors/ healthcare providers] schedule".

The way I understand interprofessional care is the relationship between a nurse, patient, doctor, surgeon and specialist. Interprofessional care is anyone that's dealing with my case.

When defining interprofessional care, Sasha has mentioned a variety of different healthcare providers, but excluded herself from the list. I wonder if other patients feel the same, that they are not part of the interprofessional team.

From a family member perspective, I recall when my loved one was hospitalized. I often felt part of the interprofessional team. The entire team never failed to ask my family our opinion or include us in any decision making. I wonder if my hospitalized family member would have described interprofessional care by including herself in the definition.

Components of interprofessional care include communication, explaining things precisely and communicating the information properly to whomever is going to see you next or is involved with your case.

I am curious if the components of interprofessional care that Sasha has outlined apply both to healthcare providers and the patient; for example, explaining things precisely and communicating information clearly. If they do, do patients feel the added burden of this extra responsibility?

For me, I often have a team that comes to see me, but it is pretty much residents with specialist doctors. The nurse practitioner doesn't always come with them. The main doctor running the team will introduce himself before he talks about my case, but he doesn't always introduce the five or so students with him. Because I have been here for so long I already know most of the faces anyways.

Thinking about Sasha, does she feel vulnerable when she is encircled by a group of doctors to whom she is not introduced to? I wonder how this makes other patients feel talking about their health with people who they do not know or have been introduced to properly. Do

patients feel comfortable sharing aspects of their health situation with a large number of people listening?

In terms of my care, I feel like I sometimes have to tell the care providers several times what I need for them to understand, although for the most part I feel heard. As an example, if something is ordered by them, like an x-ray, then it will get done faster than something that is bothering me that I will have to constantly remind them about. On days when I am feeling exhausted, tired or fed up of this place, I stop caring and just want them to do what they have to do. On good days, I want to cooperate and figure out what's the next step into getting better. For me, the severity of my condition or my feelings drives my level of involvement with my care.

I find it interesting that Sasha has specifically mentioned that her level of involvement in her care is dependent on her feelings or the severity of her health condition on any given day. I make a connection with Fred's comment about his hospitalization in the ICU and how he felt he was "at a loss there". Fred shared that the more complications he experiences with his health state the less he is able to be involved in his care. Overall, I am curious about what impacts patients' level of involvement in their own care or participation within interprofessional teams.

When it comes to the major things they do consider my feelings and consult me, especially the nurse practitioner. She will often relay things back to the team because I'm younger than most patients here and have gone through a lot. I am just trying to do what I have to do to get myself out of here.

Within the team, I feel like an object and not like I am involved. I feel like I should be at the center of the team and control it, but I'm not. The reason for this is because my condition is so rare. I'm almost like a test subject. There is no information yet available about it and a lot of people are interested in my case. I'm the lab rat; I'm that once-in-a-blue-moon-healthy-person-gets-sick-now – is-recovering-quickly case. They call it my case.

> I wonder if other patients, receiving care from an interprofessional team feel the same as Sasha, like a "test subject" or a "lab rat". I am curious about what is it in the interprofessional team members' care, words, attitudes, or behaviors that gives Sasha, and perhaps other patients, the feeling of being " a lab rat". What can interprofessional care providers do to improve or create a better relationship with the patient?

You have to manage yourself here and it's kind of weird because if you're old it may be harder for you. When I first came up here I was heavily medicated and you don't want to be monitoring yourself, what pills you take, what needs to be done at that stage.

You expect the nurse or the doctor to know, but the longer I've stayed here the more I've realized you have to be alert with what medications you take or what needs to be done because at the end of the day we're all people and people make mistakes.

Listening to Sasha speak I think about my own practice as a nurse. We are often assigned to different patients from shift to shift. It is hard for us to maintain some type of continuity of care with our patients especially when I might only see them once during their hospitalization. I often ask my patients about the care they have received during the previous shift, in addition to reviewing their chart and receiving report from a nurse from the previous shift. I feel patients know most about their care. I have never really considered this from Sasha's perspective that patients might not always want to be "monitoring" themselves.

Things happen and it's good to keep track of things. No one tells you though that you should be writing down what happens every day, just in case. As an example, I have the same nurse for 2 to 3 days, and when they switch, the new nurse will come and ask me questions of all types. This worries me sometimes because I don't always have the answer and wonder shouldn't this stuff already be in my chart for them to review?

I wonder if we as healthcare providers should give patients instructions when they are hospitalized to keep track of the care they are receiving. Are patients currently asked, even expected, to keep on top of their own care?

It's hard with the constant switch in professionals who are involved in my care. Especially when it comes to doctors, I like and get along with some of them, and others I feel the cold shoulder from, as if I'm just an everyday case for them. I wish some of them would stay and be involved in my care on a more permanent basis.

A hospitalization that I could compare my current experience with would be another hospital that I had to visit when I was feeling sick and no one could diagnose me. The people weren't as good as they are here. They weren't really respectful, as in the doctor would come in and not shake your hand or introduce themselves. I wasn't treated right.

> I wonder whether patients experience a different level of care from an interprofessional team depending on the type of healthcare institution they visit. How is the care different in a rural hospital from an urban hospital? What about a clinic as compared to the hospital and the type of care they receive from an interprofessional team?

Another example is that I have previously been at the ICU. I was on life support then. In the ICU I felt uncomfortable because my body was still swollen and recovering. The nurses there were amazing; having one nurse taking care of you, so that I didn't have to wait for care, was great. Once you get up here though, I

have to wait for nurses to come when I call for them. It's an adjustment I had to get used to.

In the ICU I couldn't walk so I had to get someone to take me to the bathroom and when I got up here, I was still weak; someone still had to take me to the bathroom. I found, I would almost have to predetermine when I needed to go to the bathroom which isn't the case. When you need to go to the bathroom you go to the bathroom. So I had to be like, "Okay maybe 20 minutes from now I might have to go to the bathroom so I can call the nurse now, so they can be here to take me then."

What Sasha is saying sheds light on our healthcare system in terms of the staffing ratios, time allotted for contact with each patient, and the pressures put upon healthcare providers to discharge patients as soon as physiologically possible. Hearing Sasha speak I wonder about other healthcare providers, not just nurses. Are healthcare providers such as patient care assistants, personal support workers or patient care coordinators also so constrained in the time they have available to dedicate to each patient?

In terms of the doctors in the ICU, I don't remember interacting with them much.

On this unit now, despite some of the small issues I have with my care, I do feel the care is more positive than negative. The nurses do look after you and want the best for you. I always remember

the physiotherapists and nurses working together as a good team. The doctors are most distant from the nurses, not always relaying the information. The disconnect is evident sometimes.

It is interesting to see how Sasha sees the relationships between healthcare providers. I wonder why there is such a "disconnect" between the doctors and the nurses? Is it due to the traditional hierarchy between the two professions? I wonder how that could be remedied.

In terms of the plan of care, I know for the most part what the plan is and what is going to happen. It's about what procedures need to be done, my plan for discharge, or what medications need to be tapered down. They kind of relay it to me week by week through the nurse practitioner. Sometimes aspects of the plan get postponed. For example, they wanted to put a device into me in December and it's been a month now that I am still without it. It's frustrating not knowing because it is a significant procedure that does scare me or make me anxious not knowing when it will happen. The wait just heightens my anxiety, especially since my gut opinion originally told me this is not something I need. I am fairly young and I feel fine. I was very healthy and active before. Now, I feel like I should get this procedure done because they scared me by saying that I could have the same accident as I had that brought me in this hospital in the first place.

I wonder how and when are patients included in decision making about their care. In Sasha's case it seems as if she experienced "anxiety" about the proposed procedure, was not well informed about it, and had to rely on her own gut feeling to make a decision. How can healthcare providers more supportively communicate difficult decisions to their patients?

It was like a collaboration of doctors that talked to me that helped me understand the process from different points of view. Now, I am glad I'm getting it. I feel like I'm making the right decision. At the end of the day I was given the option to decide for myself and I could even say no to it on the operating table; it's my body and I sign off on whatever needs to be done, but I do feel like the doctors push their opinions on me.

I wonder why the doctors impose their opinions on patients. Do they think they know best because of their medical training what the patient needs? Do they even consider patients' wishes? Is it possible that because of the power differential that exists between the patient and the doctor, that the patient feels intimidated and makes a choice that is not what s/he originally wanted?

Sasha's Additions to the Story

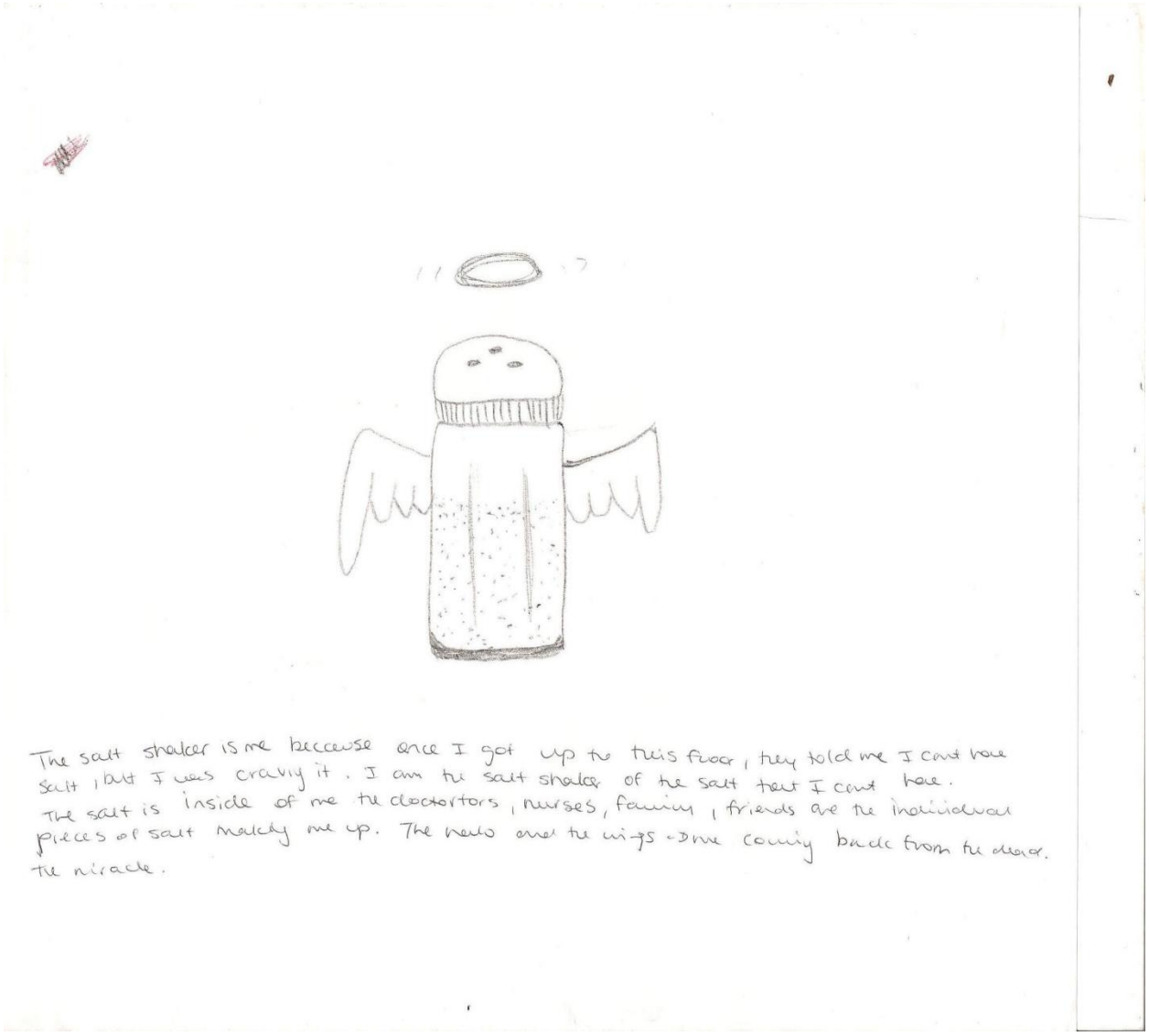
These story additions happened during the telephone follow up session where I read Sasha's story to her and asked her if she agreed with the content. Sasha declined to add anything else to her story as she was happy with the content. When I asked Sasha how she would like to be described in the thesis she replied with:

I am a young, working, very active person and I enjoy being very creative. I am university educated and currently work within my field of study. I just want to add that I have always been a healthy, completely healthy individual. That's why it was surprising when I got this condition. I am now recovering back to my completely healthy state.

During the conversation I wonder and ask Sasha if she sees herself as a perfectionist because during the metaphor drawing exercise she attempted to draw her image several times, each time trying to be neater. Sasha agrees with me.

Sasha's Metaphor of Interprofessional Care

I ask Sasha to draw a metaphor to represent how she sees interprofessional care being delivered to her; how she defines interprofessional care



As Sasha is attempting to draw her metaphor of interprofessional care, she is speaking out loud about the image she has selected.

The salt shaker is me because once I got up to this floor, they told me I can't have salt, but I was craving it. I am the salt shaker of

the salt that I can't have. The salt is inside of me. Doctors, nurses, family, and friends are the individual pieces of salt that make me up. The halo and the wings are me coming back from the dead: the miracle.

Sasha also discusses at length that all the individual salt granules are interacting well with each other within her to make her feel better. Listening to Sasha talk while observing her illustration, I wonder where family fits within interprofessional care. Person-centered care is part of interprofessional care, but is family-centered care a vital component of interprofessional care as well?

As I exit Sasha's room and leave the hospital, in my mind I replay my meeting with Sasha and reflect on how she and Fred experience the care they receive on the same unit. Meeting with Sasha is a little different for me than meeting with Fred. During our conversation my mind could not help but wonder back to my meeting with Fred and draw connections between similarities and differences between their stories. One such similarity that was evident right away is that both Sasha and Fred are satisfied with the care they are receiving from the nurse practitioners on their unit, mentioning that doctors are not always present to answer their questions. A noticeable difference is that Sasha has had an intensive care unit (ICU) experience to compare her current hospitalization to, while Fred has compared his hospital stay to a previous clinic visit. Specifically in relation to interprofessional care, I am surprised to learn that both patients do not see themselves as members of the team, although they do feel that sometimes their opinions are considered.

As I am leaving the hospital, I notice that by now the weather has cooled down significantly with the fading afternoon light. I turn my attention to going home to be with my

family for the Holiday celebration. I am meeting with my next participant in two days and I need to contain my anticipation about this future encounter. I am curious to find out what further similarities and differences will present themselves between Fred, Sasha and my third participant, Purple.

Narrative Inquiry Analysis of Sasha's Story

Similar to Fred, the last time I have spoken with Sasha was when I called her for the follow-up conversation three months ago and we discussed her story of experience that I had composed using her transcribed words. Throughout this lapse in time, I have engaged extensively in reflection on her experiences.

Listening to the audiotape of Sasha's story it quickly became evident what she was passionate about. Whenever she discussed something important to her, she spoke at a significantly faster pace and at greater lengths than during the other parts of our conversation. For Sasha, the same narrative threads arose as they did in Fred's story. I, however, address them in the order that they came up in Sasha's story. Thus, Sasha talked at length about her experiences with interprofessional team members, her position within the interprofessional team, and the importance of communication.

Interprofessional Team Members

Sasha started her storytelling by talking about doctors and nurse practitioners. She drew a parallel between the two professions stating that she is "frustrated having to explain" her case "to whoever is new" feeling like they do not want to get to know her or that she is "just an everyday case for them". She shared that she wished "some of them [doctors] would stay and be involved" in her care on a "more permanent basis". As for nurse practitioners Sasha described them as knowing "everything" about her and being her "go to person" if she had any concerns. Sasha

added that she thanked God "that there is that one person who is with you for the whole time and knows your history." Mainly, Sasha wanted a caregiver who would be consistently involved in her care and not change all the time, so she would not have to constantly explain herself. In a study conducted by Laurant et al. (2008), the authors found that patient satisfaction with care received from a doctor or a nurse practitioner is highly dependent on the individual characteristics of the patient. However, they identified that patients were more satisfied with nurse practitioners than with doctors for the support and the time they made available to provide care to them and their families (Laurent et al., 2008). Patients looked towards doctors more than nurse practitioners for medical information (Laurent et al., 2008). In line with the *National Interprofessional Competency Framework*, one of the three concepts underpinning the six competency domains is complexity of the situation. This is dependent on the characteristics or the health condition the patient presents with to the interprofessional team (Bainbridge et al., 2010). Thus, if the condition is easily manageable, the patient might be seen mainly by one care provider and for a shorter period of time. If the condition requires intensive care, then a team of healthcare providers and an extensive amount of face-to-face as well as follow-up time would occur. Thus, in Sasha's case, during her present hospitalization, her condition had been showing signs of improvement and she no longer required extensive team follow-up. This could be the reason why she was consistently seen by only one member of her interprofessional team, the nurse practitioner.

In relation to the practice setting, a study by Lenz, O'Neil Mundinger, Kane, Hopkins, and Lin (2004) found that patients were satisfied with nurse practitioners and doctors on the same level when it came to receiving care in the community. Possibly, this is because patients are consistently in contact with the same healthcare provider for all of their health care needs,

such as when patients visit their family physician. At the start of the care delivery, at their first few points of contact with the healthcare provider, patients identified being more satisfied with nurse practitioners because their length of consultation was longer than the time physicians spend with each of their patients (Lenz et al., 2004).

With regard to other members of her interprofessional team, Sasha did talk about registered nurses and how she thought they were "amazing". On the unit where she was previously hospitalized she liked "having one nurse taking care" of her so that she didn't have to "wait for care". However, on her present unit, Sasha's experiences were different in that she had to wait and sometimes called for nurses several times to receive care. As Sasha stated, "It's an adjustment I had to get used to." Sasha's words highlight the discussion on staffing ratios and time allotted for contact with each patient within our healthcare system. McGillis Hall and Doran (2004) conducted a study, comparing units that have an all nurse ratio (registered nurses and registered practical nurses) to the interprofessional units that have a professional (registered nurses and registered practical nurses) and unregulated staff (patient care assistants) caring model. Results show that units with a professional - unregulated staff mix ratio lend themselves well to "individualized approaches to patient care, or to good communication and coordination of care on the units" (McGillis Hall & Doran, 2004, p.29).

Sasha only talked about nurses being too busy to assist her within an appropriate time frame. Thus, although I have not had an opportunity to ask her, I do wonder whether unregulated care providers were present and able to attend to Sasha's needs, as with the example she used (having to wait for someone to assist her to the bathroom). Within my own practice, the two units that I work on both have patient care assistants available to us; they provide an overwhelming amount of support to all members of the interprofessional healthcare team as well

as to the patients. As an example, they assist physiotherapists with getting patients up from the bed into the chair, lend a hand to nurses when a patient needs to be repositioned or changed, and oftentimes relay information about a patient's concern to the charge nurse or the patient care coordinator. Working with unregulated care providers is an ideal example of collaborative leadership, one of the competencies in the *National Interprofessional Competency Framework*, which talks about healthcare providers working with each other (the registered nurses and the unregulated care providers) and with the patient to implement care (Bainbridge et al., 2010).

This highlights another point Sasha raised: her feeling that she was not a "high priority patient" because she had been a patient on her unit for an extended period of time. I know in my own nursing practice, I always strive to deliver the best, timely care possible to my patients. Despite this, I never really thought about this from the patient's perspective in terms of them waiting for my care. When I am late with my care delivery, because another patient required more assistance than I had originally anticipated, I apologize to my next patient for waiting. Now I wonder if an apology is enough, considering how Sasha is feeling about "always being on their [healthcare providers'] schedule". I try to be there as much as I can for my patients and attend to as many of their needs as I am able to within my shift. Additionally, what I find important is continuity of care and being consistently present during the patients' hospitalization on my unit, which does not currently occur. We as nurses rotate every few shifts. I enter the patient's life for eight to twelve hours and exit, leaving her/him to start a new relationship with another nurse coming on to take over the care giving. I now can understand why some of my patients are frustrated when I ask them to answer my questions about their condition. Just like Sasha, they might be tired of repeating the same information time and time again. It has also occurred to me that my patients, as well as Sasha, might not only be waiting around to receive care from me, but

also wait to receive care from all the other members of the interprofessional team. Sasha provided an example of the doctors who said they would come in to see her at eleven, but did not come until two, when she had family visiting.

In terms of any other team members, Sasha did not talk in greater detail about anyone else. She did mention the relationship she noticed between "physiotherapists and nurses working together as a good team". She added that "doctors are the most distant from [registered nurses] not always relaying the information." Interesting that Sasha was able to observe this from a patient perspective. A study conducted by Muller-Juge et al. (2013) where residents' and nurses' expectations and perceptions of their own and each other's roles were compared, showed that there were significant differences between the expectations and perceptions among the two professions, especially in relation to teamwork. Nurses sought residents to be more involved in teamwork, display greater recognition for their work including listening to and considering their options more, as well as provide more information about patient problems and treatment. Residents, on the other hand, felt that they had been already doing all of that, causing a disconnection between their intentions and nurses' expectations (Muller-Juge et al., 2013). The authors went on to provide an example of a study by Thomas, Sexton, and Helmreich (2003) where nurses and physicians were asked to rate collaboration and communication amongst each other. Only 33 % of nurses rated these two concepts as occurring high or very high while 73% physicians had done so (Thomas et al., 2003). This difference between doctors and nurses and how they perceive teamwork is significant for future creations and functioning of interprofessional care teams.

Despite Sasha's observation that doctors and nurses are the most distant from one another, while drawing her metaphor of interprofessional care, Sasha discussed that all the

individual salt granules inside of her ("doctors, nurses, family and friends") are interacting with each other to make her feel better. As discussed in Schwind (2009), metaphors can bring forth a deeper understanding of a topic under study that words alone are not always able to do. Thus, Sasha's description of her metaphorical image is not fully congruent with what she had shared during the narrative conversation; Sasha sees doctors and nurses interacting within her metaphor, but verbally discussed that a disconnection exists between them. Perhaps this is because she is more privy to noticing the relationship between the nurse practitioner and the doctor due to the amount of time they spend working together in front of Sasha. In comparison, the doctors and the registered nurses could also be working together, but not when Sasha could directly witness their interactions, such as in the nurse's station.

Patient within Interprofessional Team

Next, it is important to discuss interprofessional care more closely and examine how Sasha had defined it. For Sasha, interprofessional care is "the relationship between a nurse, patient, doctor, surgeon, and specialist. Interprofessional care is anyone that's dealing with" her case. Interestingly, Sasha, same as Fred, had not included herself as part of the definition of interprofessional care. When thinking about my personal family experience, I felt as if I was a member of the healthcare team when my relative was hospitalized. I wondered however, if the family member felt like she was part of the team. Interestingly she did not. I find this puzzling as I felt like the team that took care of her was very open with us and communicated the plan of care appropriately. However, she did not feel included in any healthcare decisions and conversations about her care. In order for true interprofessional collaboration to occur, it being the main goal of the *National Interprofessional Competency Framework*, a partnership needs to develop between healthcare providers and the patient (Bainbridge et al., 2010). Within this

partnership a collaborative, participatory, and coordinated approach to decision making about health and social issues is used (Bainbridge et al., 2010). Thus, even though we as a family were included as part of the decision making process, because my loved one was not, she felt like she was not involved within the team and the collaboration occurred on her behalf, not with her.

In her story, Sasha went on to state that within the team, she felt like an "object". She knew that she should be "at the center of the team and control it," but she was not. Sasha related this to the rarity of her condition and people being interested in it, continuing to say that she was a "lab rat […] that once-in-a-blue-moon-healthy-person-gets-sick-now-is-recovering-quickly case". Interestingly, this also applies to the main goal of the *National Interprofessional Competency Framework* of interprofessional collaboration where the patient should be at the center of the care delivery. Within the framework the patient should be at the center of all care provided regardless of the condition they have. Sasha in a way is at the center of the care delivery, but for a different reason than she would like to be; it is due to the rarity of her condition.

When Sasha talked about her feelings of losing control within her care, I think further about what being in control means for a patient. Sahlsten, Larsson, Sjostrom, and Plos (2008) conducted an analysis of patient participation in the context of nursing practice and revealed that for patients to feel as equal contributors within their own healthcare, a number of things need to occur: "an established relationship, a surrendering of some power or control by the nurse, shared information and knowledge, and active mutual engagement in intellectual and/or physical activities" (p. 6). Thus, when these things occur, and not only between patients and nurses, but patients and other members of the healthcare team, patients are able to regain some sense of power and control within their lives in the hospital (Sahlsten et al., 2008). This is because a

healthcare provider, who is in a position of power, is giving up some of her/his control to the patient.

I wonder if I in some way disempower my patients when I work as a registered nurse. With the time constraints I am under during my shift, I often want to do tasks for my patients to speed up the care delivery process. I have been taught however, that we should be encouraging our patients to do as many activities of daily living as independently as possible. An ideal example of this would be feeding a patient who requires supervision during meals as opposed to being present at the bedside and letting the patient take the time s/he needs to feed her/himself. I try my best to promote independence and leave power as well as control in the hands of my patients when it comes to driving their own care, but sometimes I find it is not entirely possible. For Sasha, feeling like she had at least some control within her hospitalization might have enhanced the experiences she had with receiving care; she might not have referred to herself as a "lab rat".

Sasha shared that she sometimes felt like she had to repeat herself several times to the healthcare providers in order for them to be aware of what she wanted done as part of her plan of care. She went on to state that if it was something the team wanted, "it will get done faster than something" that was bothering her. This involvement in her care is dependent on Sasha's emotional state: on days when she was "exhausted, tired or fed up of this place" she stopped caring and wanted them "to do what they have to do". On her good days, she wanted to "cooperate" and figure out what the next steps would be for her to get better. Sasha herself stated that for her it is also the severity of her condition, along with mood, that drives her involvement within her own care. This is similar to how Fred talked about his level of involvement within his own care stating the more complicated of a case it is for him in terms of his health, the less he

was able to be part of the care decisions being made. There is agreement in the literature that patient level of involvement in own care can be effected by the patient's physical illness or acute pain, as well as any psychological vulnerabilities at the time of participation (Brody, Miller, Lerman, Smith, & Caputo, 1989; Howe, 2006; Vincent & Coulter, 2002).

Interestingly, Sasha had also raised an important idea when it comes to patient involvement in own care, which is management of self. As she stated, "You have to manage yourself here… monitoring yourself…you should be writing down what happens every day." With this I think about my own practice as a registered nurse and how much I rely, even after receiving report from the previous shift and having read the patients' chart, on the patient for information about her/his condition. I have never considered this from patients' perspective, such as Sasha's, that they might not always want to be feeling like they have to monitor themselves. This goes not only for registered nurses, but all members of the interprofessional team who come to conduct their assessment or to converse with the patient. The more I think about this the more I wonder if patients feel like they should be keeping on top of their own care. Especially with the significant number of different healthcare providers or members of the interprofessional team that look after them, patients might be doing so out of fear that something might be missed. A literature search on this topic revealed no studies on patients' level of involvement with own care within interprofessional teams suggesting a gap that needs to be addressed in order for patient care to be more effective.

When discussing the interprofessional team that is looking after Sasha, she stated that the team is made up of "residents with specialist doctors; the nurse practitioner doesn't always come with them." Additionally, Sasha stated that the healthcare providers she experienced during her previous hospitalization where interprofessional care was not delivered were not "as good as" the

professionals making up her current team. “They weren’t really respectful, as in the doctor would come in and not shake your hand or introduce themselves. I wasn’t treated right.”

However, within her current hospitalization, Sasha stated that the main doctor running the team “will introduce himself before he talks” about her case, although he does not “always introduce the five or so students with him.” This is interesting that Sasha has labeled her current healthcare providers as good when they also do not always introduce all the members of the team to her similar to her previous hospitalization. Regardless, thinking about this further, it must have been difficult for Sasha to have to share aspects of her health condition with a large number of people listening, the majority of whom she had not been introduced to properly. Role clarification is a vital component of effective collaborative practice (Bainbridge et al., 2010). Although the *National Interprofessional Competency Framework* does not include the patient under the role clarification competency domain, it is important for the patient to also be aware of the composition of interprofessional teams and be introduced to all of its members before s/he is asked to share private information. Through this I reflect on my own practice, when I ask personal questions of my patients just after I have met them. It is awkward even for me to do so, as I feel like I have not yet established a trusting therapeutic relationship; yet at times I need to ask very private questions of the patient so that I can carry on with my care. A large part of this has to do with the amount of time I have to spend with each patient within an eight to twelve hour shift. I cannot even imagine how Sasha must have felt having to discuss her condition time and again in front of a large number of people who she was not introduced to.

Communication

This leads into a discussion of the necessary components of interprofessional care. Sasha stated that “components of interprofessional care include communication, explaining things

precisely and communicating information properly to whomever is going to see you next or is involved in your case." The components that Sasha had identified as important to her also align well with the *National Interprofessional Competency Framework* in which communication is identified as being one of the six competency domains vital for effective collaborative practice to occur (Bainbridge et al., 2010). In relation to this, I wonder if the components of interprofessional care that Sasha had outlined as applying to members of the healthcare team also apply to the patient as team member. Within the *National Interprofessional Competency Framework* the importance of interprofessional communication is explained through discussing that "communication skills are essential for all learners/practitioners and involve the ability to communicate effectively with others, especially those from other professions, as well as patients/clients/ families, in a collaborative, responsive and responsible manner" (Canadian Interprofessional Health Collaborative, 2010, p. 16). Interestingly, when it comes to communication, Sasha often talked about the nurse practitioner as being the "main one who will communicate things back to the team" on her behalf if she was not able to do it herself. This is similar to Fred, who also talked about the nurse practitioner being his go-to person when he needed something done. This may suggest for these patients that they are involved in the communication process of the team, but this happens through one of the team members communicating on the patient's behalf.

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With having shared Sasha's experiences of receiving interprofessional care, chapter 7 provides a detailed discussion of my encounter with Purple. I revisit our sessions and how they unfolded, followed by the analysis of Purple's experience.

CHAPTER 7: PURPLE'S JOURNEY

The Woman on the Bus

I am getting close to my final destination; all I need to do is hop on the bus. Already, I have met two wonderful travel companions that have shared aspects of their storied lives. I am excited about the anticipation of who I will meet next. As soon as I get to the bus stop, I notice that there is another woman already waiting there, even though the bus would not come for another few hours. I do not know why, but I trust her right away and leave my bags under her care while I go to buy something to eat. When I get back, we engage in a deep conversation that carries onto the bus ride up until it is my time to get off.

This encounter is unlike the two I have just had with Fred and Sasha. I now have two previous experiences to compare our conversation to. I am completely shocked at how quickly my mind draws connections between all the conversations I have had during the trip. The similarities and differences are becoming clearer.

~

This chapter demonstrates how my meeting unfolds with my third participant, Purple. I share Purple's story in its entirety and include my own reflective thoughts within her words. I then present the piece of artwork that Purple draws when she is asked to think of a metaphor to represent the care she has been receiving on this unit from an interprofessional care team. I finish off this chapter with providing a detailed analysis of Purple's story.

Building Blocks of the Story

Narrative Interview

Tuesday, January 8th, 2013
Start: 1000 Finish: 1200
Place: Hospital unit private conference room

I notice that I have developed the same structure with all of my participants through meeting with them in person for the data collection process. This has worked well for all of them. With Purple and I, we hold our session in a different conference room than the sessions I held with Fred and Sasha. This is a little challenging to get used to at first as I have become accustomed to the previous conference room. I am however optimistic that with the change of location my mind will be able to reflect and ponder in new ways about the information Purple shares.

Our session commences when I explain to Purple how the data collection process will unfold. She seems eager and excited to begin. Initially, similar to Fred, Purple takes a little longer to open up and respond to my prompts. I think that this is not because we need to take time to trust each other, but because she is trying to be careful with how she phrases her responses not to give away too much revealing information and so protect her identity. I explain to her that even if she named a healthcare provider or discussed aspects of her condition, I would make sure to keep these things confidential and not include them when writing her story. Purple begins to open up more.

Purple starts by telling me that she has "been a patient since birth". Throughout her various hospitalizations she has met a large number of healthcare providers from a number of health professions. For her, interprofessional care is "care provided by many different individuals". What sets Purple apart right away from the other two participants is that Purple also sees herself as part of the interprofessional team; she states that she is "consulted and asked questions". She likes to be involved in her care.

Our conversation progresses on to a discussion about her current hospitalization and how she feels about receiving care from an interprofessional team. Purple is satisfied with the care she

is getting now, especially because she knows most of the doctors that come in to see her. She mentions about fellows that join doctors on their rounds and how she likes the fact that they rotate each week. We continue our discussion about healthcare providers, by focusing on nursing practitioners. Purple shares that she sees the nurse practitioner on a consistent basis and she can often talk to the nurse practitioner about any issue she may have.

I begin to ask Purple more questions about team functioning and she elaborates on the relationship she notices that exists between the nurse practitioner and the doctors. She states that they "work very well together". The communication between them is evident; "once in a while the doctor will come in and say that the nurse practitioner told him this and that". Purple even mentions that some of the doctors and the nurse practitioner will "let you email them if you have an issue."

We continue our discussion by talking about registered nurses. Nurses "are sort of on their own team, separate from the doctors and the nurse practitioner". Purple states that she notices the relationship and the way communication occurs between doctors/nurse practitioners and nurses is different from the communication between doctors and nurse practitioners. Purple thinks nurses are friendly and caring on this unit, because they often smile at her when she is walking down the hall. In comparison to her previous hospitalization, the minute she entered the unit she felt that the "whole vibe of the unit that was not pleasant at all". Purple provides an example of how she knew something was wrong with her health and she had asked the nurse to page the doctor. They had paged the wrong one and Purple did not receive the care that she needed until the next morning, when time was very vital for her. Purple continues to mention that she is most comfortable with receiving care on this current unit, having a very specific condition, because "they might have more experience with people like me".

We then delve into talking about some of the other healthcare providers that Purple has had contact with during her hospitalization. She shares that she has been seen by a dietician and a physiotherapist, but these healthcare providers are not part of the "team that is involved in my immediate care". In general, all healthcare providers who come in to see her, whether she knows them or not, introduce themselves to her and tell her what their title is.

I progress with asking her how she receives information about her plan of care. Overall Purple feels as if her opinions are valued and taken into consideration, although she does provide an example where she was told about getting a procedure done and had to be on "their" [the healthcare providers'] schedule. Despite this, Purple does share that she feels that she is part of the team, and that she is comfortable with voicing her problems to the healthcare providers. Purple further stresses that it is important for an individual to "know as much as you can about your condition and try to express your feelings."

Lastly, we talk about an experience Purple had when she had to visit an emergency room for her condition and was made to wait for over two hours without receiving care. Her condition necessitates immediate care, thus Purple always tries to come to this hospital. Healthcare providers here ensure she is in a hospital room within the first ten minutes because they know her case very well and the type of attention it requires.

Metaphor Drawing

As our narrative interview comes to an end, I slowly transition Purple into the next part of our session, the metaphor selection/drawing exercise. Similar to Fred, Purple is a little hesitant at first, stating she is not sure what metaphor to select or confident in her drawing abilities. It does not take her long, however, to come up with a symbol and draw an image. It is not

surprising that Purple chooses a purple crayon to draw her picture. As she finishes the exercise she ensures to provide an explanation of why she selected her image.

Follow Up Meeting

Saturday, February 23rd, 2013
Start: 1830 Finish: 1845
Place: Telephone conversation

I call Purple for our follow-up conversation right after I find out that Sasha is not home. Thus, our discussion occurs immediately after I speak to Fred and before I converse with Sasha. I start the call by informing Purple that her story, composed from our narrative interview, is ready and I would like to read it to her to ensure I accurately captured her experience. I let her know that she has permission to stop me at any time if there is something she would like to add to a particular section or to correct an error in the wording. Purple never does interrupt. She ends up agreeing with all aspects of the story. I progress by asking Purple how she would like to be described in the study. She tells me that she is in her mid-thirties and has studied at the post-secondary level. She wants to be described as friendly, positive, funny and outgoing individual. She is currently out of the hospital and working. We finish our conversation with saying goodbye and displaying our gratitude to each other for this experience.

To visually represent Purple's story, I chose the Forte, size 14 font. I think this font type is warm, inviting, and deep just like Purple. Its bold black colour depicts Purple's strength of character to be able to overcome years of health issues. I once again continue in Times New Roman, font 12 and indented 0.7 cm, to represent my reflective researcher voice intertwined within Purple's story.

Purple's Story

I have been a patient since birth. Through my experiences I've always had a big team of people looking after me. It always consisted of a nurse practitioner, nurses, sometimes surgeons, depending on what I needed to get done, and other doctors and cardiologists. I met a lot of different types of doctors, I guess you can say. Interprofessional care is care provided by many different individuals and I also see myself part of the definition because I am consulted and asked questions. I am definitely involved.

It is interesting that Purple has included herself as part of the definition of interprofessional care. Fred and Sasha, on the other hand have not.

Receiving care during this current hospitalization has made me very happy. I have known this team of doctors for a long time so I am very comfortable with them. They also have fellows that come in every few weeks and rotate so I do get to meet the new fellows. They're from different countries sometimes, so it's really interesting; it's really nice to see that. There is also the nurse practitioner that I see consistently on a daily basis. If I have an issue or a problem I can often talk to the nurse practitioner about it and she will relate it back to the team.

Listening to Purple speak further sheds light on the importance nurse practitioners play in the recovery or enhancement of patients' health state on this unit. Her comments bring to mind Fred and Sasha, who also talked about them. I wonder if nurse practitioners are always seen in a positive way by patients and how the care they provide impacts the recovery process of the patient's illness event.

What's interesting is that the nurse practitioner and some of the doctors will even let you email them if you have an issue and the whole team will be in the know about it. Even if you are not in their immediate care everyone knows a bit about your case.

Thinking what Purple said about emailing healthcare providers I am curious about what other modes of communication are being used today to bring patients and healthcare providers closer together; to ensure patient's problems are voiced directly to the appropriate healthcare provider and not passed on by a third party such as a nurse.

The way the team works is also evident. The nurse practitioner and the doctors work very well together. Once in a while the doctor will come in and say that the nurse practitioner told him this and that. It's evident that they communicate well with each other. The nurses are sort of on their own team, separate from the doctors and the nurse practitioner. The doctor or the nurse practitioner does communicate to them, but on a different level than the doctor and the nurse practitioner talk to each other.

I wonder why the relationship between the doctors/nurse practitioners and nurses is not as close as the relationship the doctors and the nurse practitioners share between each other. Is this because the nurse practitioner and the doctor have a similar level of knowledge/care delivery responsibilities and can relate to each other better than to nurses? Is this due to a hierarchical structure between professions?

However, the nurses are excellent, although every few days they rotate. There are a couple of them that I have had on and off for the duration of my stay. They're always friendly and caring. When I walk down the hall, they smile at me; I really like it.

Reflecting on the qualities Purple shares about nurses on her current unit I wonder about the qualities patients seek from their nurses. What characteristics of nurses are important for patients? I wonder how my patients see me when I care for them. Do they see me as a knowledgeable and caring nurse or just as a 'nice nurse'?

During my previous hospitalization on a different unit it was not like that. The nurses weren't as friendly, even the PCAs weren't that friendly. It was the whole vibe of the unit that was not pleasant at all. I felt that as soon as I entered the ward and that was the time I was recovering from surgery that I had after how many years.

I wonder if patients view nurses differently depending on the type of unit they are on. For example, are nurses from an intensive care unit or post-anesthetic care unit viewed the same

as nurses on a general internal medicine floor? Thinking further about this question, this notion also applies to other healthcare providers and members of an interprofessional team. Are healthcare providers viewed differently by patients depending on the type of unit they are on? This same question came up for me when I was talking with Sasha and Fred.

It was a little stressful for me, but this is maybe because I was not used to that floor. I kept on asking to be moved. I think it could also be because I am a special patient and they do not have much knowledge of people like me. Once I had an issue and I asked them to page the doctor. They did not want to call him right away and said they would monitor me, but I knew what I was talking about. I knew that they needed to page him right away because of the issue I was having not take time to monitor me. When they finally did page the doctor they called the doctor responsible for the unit not for my specific condition. He was not familiar with my case and said that what I was experiencing was fine and if it went worse than to re-page him. I was a bit confused by this, but what was I supposed to do. In the morning when my regular doctor came in to see me, he was acting as if nothing happened the night before. That is when I found out he did not even know what happened. For me, it was a stressful situation all together because how come they did

not know which doctor they needed to page? Wasn't this in my chart? I am used to coming to this current unit where I know all of these girls and guys who take care of me and make me feel comfortable. They know me here and it could be because they might have more experience with people like me. I really like the team on this floor.

How can we improve communication between healthcare providers whether or not they are part of interprofessional teams to ensure situations, potentially life threatening as in Purple's case, occur less frequently or not at all?

I have had the dietician and physiotherapist visit me as well on this current unit. They work separately from the team that is involved with my immediate care.

I wonder why dieticians and physiotherapists work separate from the interprofessional team or enter the team for a brief period of time. Is there some underlying reason for this? Are certain health professionals more prominent within interprofessional teams because of the length of time they spend within the teams?

Regardless of who comes in to see me, if I have never met them before they will introduce themselves to me and say where they are from, like what team or department. In terms of my plan of care, mostly they come in and tell me what they are thinking of doing. The weekend before they told me I was getting

something in on one day, but it happened a few days later. I am okay with that though; I understand.

Similar to Sasha having to wait for a procedure or a doctor to come in to see her, I wonder what we can do, as healthcare providers, to deliver timely service to our patients. Is this even possible within our present healthcare system and the constraints we are currently faced with?

They do ask me every day how I am feeling or if I have any concerns and come to discuss the lab results with me. This makes me feel like I am not just an object and as if my opinions are valued.

This is interesting as Purple's words are in stark contrast with Sasha's experiences of feeling as if she is an object or a "lab-rat" within the team.

I feel like as if I am a different profession and I am comfortable voicing my issues within the team. As my nurse practitioner had put it, I am my own advocate. It's good to discuss my own things that are specific to my case. When I get a particular procedure done it has to be modified a bit for me, when normally it would not be. Not everybody knows that. I have been educated on this so I am free to tell them that they need to do this. You should know as much as you can about your condition and try to express your feelings or voice your concerns.

I wonder if Purple's experiences are different from that of Sasha's and Fred's because of the type of person that she is or because of her condition. Do length of hospital stay, age, education level, type of illness, and individual characteristics (introvert/extrovert) affect the level of involvement patients have within their care? Do they increase or decrease the level of participation patients display within interprofessional teams?

Some of the care I am receiving now is because I suggested it to the team. They do respect what I suggest and tell them. Once I suggested stopping the medicine for a few days and things like that. Sometimes it's a possibility and sometimes it's not. They tell me whether it is possible or not, but at least they listen.

I wonder if patients experience greater satisfaction with the care they are receiving from an interprofessional team when team members are more flexible in allowing patients to have a say in the care they would like to receive. Does it matter?

I also have my own opinions as to where I seek care. I try to come to this unit every time I get sick. One time when I had to call an ambulance, it took me to the nearest hospital beside my house. It was frustrating for me because that hospital did not know what to do with me, as I am a special patient. I sat in the EMERG for two hours. With my case I cannot be without care for that long. When I come here with a similar issue I am in a room within 10 minutes

not waiting for that long. We tried to tell them, but they were not listening to us. I was getting more and more anxious and frustrated especially when I knew time was of the essence for me to get care. We ended up leaving and coming here. It's hard to say why this was so. Maybe they have their own special procedures or rules, but I was trying to get through to them that this was serious. I try my best, every time I have a problem to come to this hospital. I am not sure if I am doing myself any harm by taking the extra time to come all the way here, but at least they know me well. It's very stressful for me, especially when other hospitals don't know what to do with me.

Although I cannot fully identify with Purple as I have never had to be hospitalized for an extended period of time with a serious illness, I do wonder, however, how we can improve our healthcare system to better accommodate patients such as Purple. How do we improve communication between hospitals and healthcare teams?

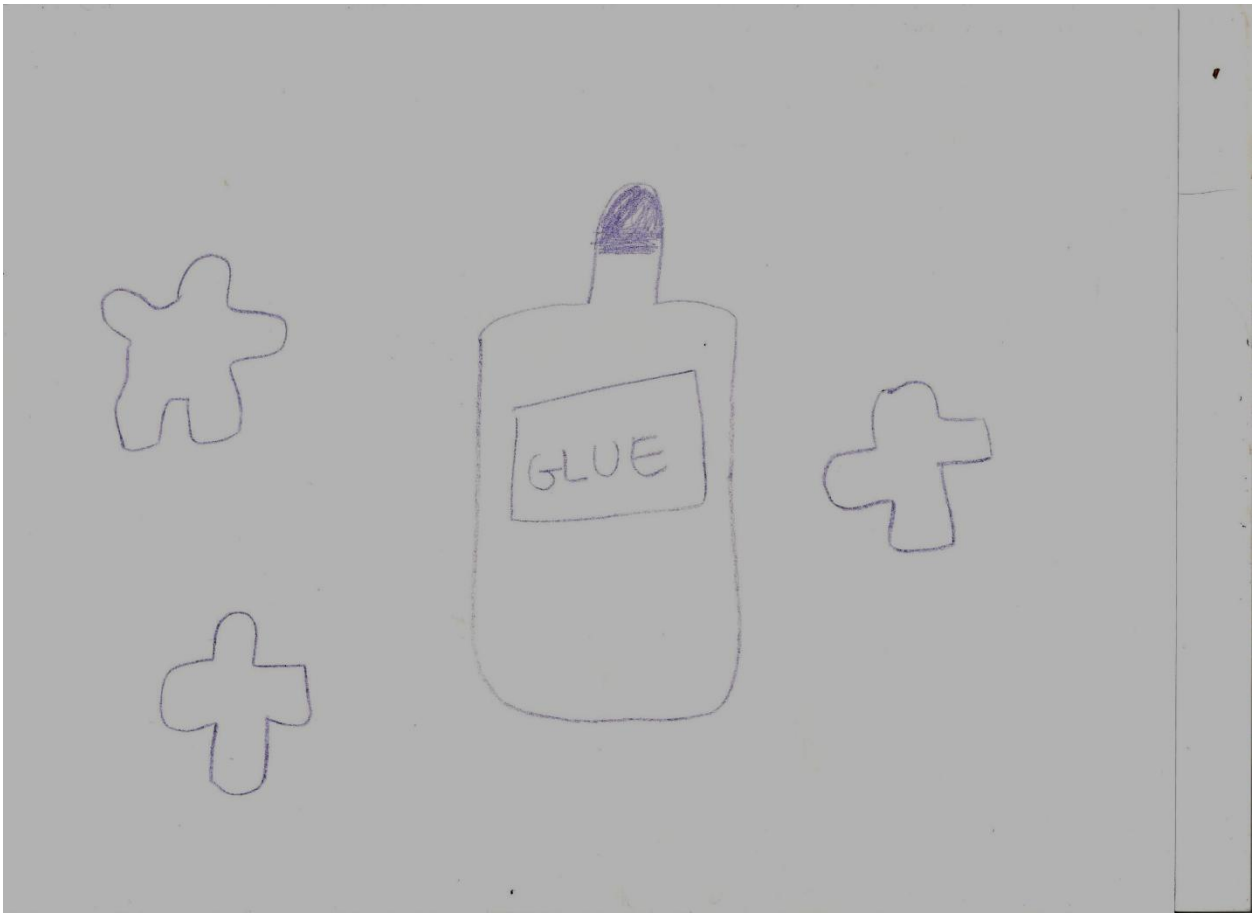
Purple's Additions to the Story

I call Purple for our follow-up conversation right after I find out that Sasha is not home. Thus, our discussion occurs immediately after I speak to Fred and before I converse with Sasha. I start the call by informing Purple that her story, composed from our narrative interview, is ready and I would like to read it to her to ensure I accurately captured her experience. I let her know that she has permission to stop me at any time if there is something she would like to add to a

particular section or to correct an error in the wording. Purple never does interrupt. She ends up agreeing with all aspects of the story. I progress by asking Purple how she would like to be described in the study. She tells me that she is in her mid thirties and has studied at the post-secondary level. She wants to be described as friendly, positive, funny and outgoing individual. She is currently out of the hospital and working. We finish our conversation with saying goodbye and displaying our gratitude to each other for this experience.

Purple's Metaphor of Interprofessional Care

After our narrative interview, I invite Purple to select a metaphor that best represents the interprofessional care she has been receiving on this unit. I give her an option to write a small description of the metaphor or draw it. After an initial hesitation, Purple chooses to draw her metaphor. She also provides a few descriptive words of her image.



Once Purple has finished her drawing, she tells me that she chose to draw glue and puzzle pieces because:

When you work together or stick together like glue, you can get things accomplished. The bond between the team needs to be so strong like glue, working really well together. I am [the puzzle pieces] what they are gluing back together.

As my session with Purple is coming to a close and I am exiting her room, I am having a hard time believing that I have finished travelling on my last mode of transportation. So much preparation and time has gone into ensuring I would get to my final destination successfully, that now, it's hard to think that the travel part of it is all over. On a positive note, my journey is not yet done. I cannot stop replaying the conversations I have had with all of my travel companions, with all the lovely people I met along the way. They have been kind enough to open up about very deep aspects of their lives and trust that I would keep their experiences safe. My mind is drawing similarities between Fred, Sasha and Purple, but the differences are also vividly apparent. I cannot wait to get to my hotel room and write down the narrative threads that I have noticed exist within the stories I heard; I do not want to forget these conversations. First though I want to explore the details of Purple's story in more depth.

Narrative Inquiry Analysis of Purple's Story

At this point in the process, I have already met with each of my three participants to hear their stories of experience with receiving care from the interprofessional team. I have also conducted a Narrative Inquiry analysis of Fred's and Sasha's stories, noting the narrative threads that came up. I am now interested in seeing what narrative threads emerge in Purple's story and how they intersect with those of Fred's and Sasha's stories, respectively.

Within Purple's story of experience, she spoke in the same tone of voice and speed throughout the entire conversational narrative interview. Thus, initially it was hard to pinpoint what aspects of her care were central for her. However, one thing Purple did different, and I noticed this after our session, is she paused after making a statement she considered as important to her. The same as for Fred and Sasha, Purple too discussed the patient's role within the team, interprofessional team members, and the importance of communication. These are also presented in the order as they arose for Purple.

Patient within Interprofessional Team

Purple began her storytelling process by sharing that she had always had "a big team of people" looking after her. This team "consisted of a nurse practitioner, nurses, sometimes surgeons….other doctors, and cardiologists." Thus for Purple, interprofessional care is "care provided by many different individuals". She also stated that she saw herself as part of the interprofessional care team because she was "consulted and asked questions"; she was definitely involved. Additionally, later on in her story, Purple added that she felt as if she was included within the team and that she was comfortable in voicing any issues she had within the team. Purple's feeling of inclusion as a team member is in line with the definition of interprofessional collaboration as described in the *National Interprofessional Competency Framework.* The patient is in a partnership with the members of the interprofessional and they all work together to enhance health outcomes through mutual decision-making (Bainbridge et al., 2010). To elaborate, examining the drawing Purple had done of what interprofessional care meant to her further substantiated what she was saying during our narrative conversational interview. She was the puzzle that they were all concentrated on, to put back together; Purple was at the center of her care delivery.

Interestingly, Fred stated that he was involved within his own care, but he did not include himself in his definition of interprofessional care. Sasha, on the other, not only excluded herself from the definition, but also talked about her feelings of being a "lab rat" or an "object" within the team. I am wondering whether these three participants received care from the same interprofessional team. In other words, did all three participants have the same nurse practitioner, doctor, registered nurse looking after them? The reason for this curiosity is because they were all patients on the same unit during the exact same time period, but all had different illness trajectories and ages. Thus, it would be interesting to see if patients' feelings of inclusion or exclusion within interprofessional teams are dependent on their characteristics, context (procedures, diagnoses, familiarity with the healthcare system), or on members of the interprofessional team, as discussed in Shaw (2008).

In relation to the care Purple had been receiving during her current hospitalization, she stated that it had made her "very happy". She went on to mention that she had "known this team of doctors for a long time" being "very comfortable with them". "They also have fellows that come in every few weeks and rotate [...] they're from different countries sometimes […] it's really nice to see that." Purple's words and aspects of the story are in opposition with Sasha's experiences with new doctors coming in to see her. Sasha stated that she wished there would be some consistency in her caregivers so that she would not have to explain her case anew each time. What I have realized with this is that it is really dependent on the patient how s/he responds to the changing composition of an interprofessional team. Essentially, what is important within any interprofessional team, regardless of its structure, is collaborative leadership as discussed in the *National Interprofessional Competency Framework* where all team members are able to work

together with each other and the patient to achieve the most optimal health outcomes for the patient in question (Bainbridge et al., 2010).

In terms of Purple's plan of care, she had stated that healthcare providers usually let her know what they are thinking of doing. Purple went on to provide an example of a delay that had occurred in her care, but stated that she was okay with it and understood the reason provided. Although Fred had not mentioned much about delays in receiving care, Sasha in her story talked about the frustration and anxiety she experienced having to wait for the doctor to come see her or for a scheduled procedure to be done. I wonder what we can do, as healthcare providers, to ensure our services are delivered in a timely manner to our patients. Is this even possible within our present healthcare system? Purple does state that one thing members of her interprofessional team do is ask her on a daily basis how she is feeling or if she has any concerns. This makes her feel like her opinions are valued and that she is "not just an object", once again in stark contrast to Sasha's experience.

Purple continued her discussion on her level of involvement within her care by stating that some of the care she had been receiving on the unit was because she had "suggested it to the team" and that the team listened to her. She went on to provide an example of a hospitalization where Purple experienced stress when the wrong doctor was paged regarding a medical complication she was having. She could not understand why such a miscommunication occurred, as she had told the nurses which doctor to contact. This leads into the competency domain of patient/client/family/community-centered care within the *National Interprofessional Competency Framework* in which healthcare providers seek out and incorporate the input of patients/clients/families in delivering their care (Bainbridge et al., 2010). On that particular unit person-centered care was not practiced; the healthcare team members did not acknowledge what

Purple was telling them regarding her care. Purple further reiterated that she "really like[s] the team on this floor" (the floor where she was receiving interprofessional care when I interviewed her). Listening to Purple share the experience that she had with being a patient on a unit that did not deliver interprofessional care I wonder about how we can, as healthcare providers, more effectively support and acknowledge patients' concerns. As per the *National Interprofessional Competency Framework,* in order to achieve the most optimal interprofessional collaboration and ensure that it is centered on the person in our care, we need to be able to fulfill all six competency domains of role clarification, team functioning, dealing with interprofessional conflict, collaborative leadership, interprofessional communication, and patient/client/family/community centered care (Bainbridge et al., 2010). As well, we should take into consideration the larger three concepts underpinning the competency domains of complexity of the encounter or situation our patient presents her/himself with, the place or context of practice, and the overarching philosophy of quality improvement (Bainbridge et al., 2010).

Communication

Purple had talked at length about her feeling of being involved within her care and her opinions being considered by the team. A model created by Salt, Rowles, and Reed (2012) presented patients' perception of quality patient-provider communication. Participants identified that both healthcare providers and patients enter into "an encounter with individual perceptions" (Salt et al., 2012, p. 170). For effective communication to occur between both parties patients would like to be given the opportunity to describe their symptoms entirely and healthcare providers to listen, believe in, and understand the information shared (Salt et al., 2012). Researchers found that both patients and healthcare providers should offer opinions as well as ask and answer each other's questions (Salt et al., 2012). Patients felt that one of the main tasks

of healthcare providers during communication is for them to disseminate information in relation to the patient's condition and make their recommendations for the next plan of care (Salt et al., 2012). Reviewing the results of this study, I am now more aware of what patients are seeking from healthcare providers when communicating with one another. For my own practice as a registered nurse and member of an interprofessional team, I will make sure to continue to fulfill my role within the communication process: disseminating information about and making appropriate recommendations for the care of my patients, as well as answering any questions my patients have in a timely manner.

In terms of the types of communication Purple had encountered during her hospitalization, she shared that her "nurse practitioner and some of the doctors will even let you email them if you have an issue and the whole team will be in the know about it". Thinking what Purple said about emailing her interprofessional team members, I wonder if patients would prefer other modes of communication to supplement, not eliminate, the standard face-to-face communication style. A study by Fisher and Clayton (2012) was conducted to explore patient preferences for the use of social media in their care. Patients identified that they wanted their healthcare providers to use social media for things such as "appointment setting and reminders, reporting diagnostic test results, prescription notifications, providing health information, and as a forum for asking general questions" (Fisher & Clayton, 2012, p. 100). Fisher and Clayton stated that appropriate use of social media may actually increase patient engagement in their own care. Perhaps this would have increased Fred's and Sasha's involvement within their own care and they would have been more inclined to communicate things themselves about their care as opposed to going through the nurse practitioner.

Interprofessional Team Members

Purple shared her experiences with nurse practitioners as having a significant impact in her care, just like Sasha and Fred had as well. Purple stated that if she had a problem she could often "talk to the nurse practitioner about it and she will relate it back to the team" on her behalf. This echoes Sasha's words quite precisely when she shared that the nurse practitioner is often "the main one who will communicate things back to the team" on her behalf if she was not able to do so herself. Taking this similarity into consideration further brought to the importance the role nurse practitioners play in the care patients receive from an interprofessional team. With this, it is interesting that all three of the participants valued the care nurse practitioners had provided them with, especially since they were patients on a nurse practitioner led unit. Their experiences made me wonder how prevalent this might be among all patients. A study reviewed within Fred's analysis section by Hayes (2007) additionally showed that overall patients trusted nurse practitioners and were appreciative of them always taking the time to listen to their concerns as well as help them find valuable resources to enhance their health outcomes (Hayes, 2007). From the patients that have been visited by a nurse practitioner within some of my undergraduate practicum settings, I have heard nothing but positive experiences. As well, patients displayed great adherence to the plan of care nurse practitioners had outlined for them. It is evident that the nurse practitioners have had a lasting impact on my study participants, as all three of them outlined the significance nurse practitioners have had in their hospital stay and recovery.

In relation to registered nurses, while Sasha referred to them as "amazing", but later elaborated that it was difficult for her to receive timely care from them, Purple labeled nurses as being "excellent…always friendly and caring". Thinking about the descriptive words Sasha and

Purple used to talk about their nurses, I reviewed a study by Davis (2005), which explored what patients are looking for from their nurses. Results show that patients wanted an attentive, available, calm, comforting, courteous, empathetic, gentle, kind, reassuring, and sincere nurse. They also expected nurses to be competent, knowledgeable, and critical thinkers (Davis, 2005). Interestingly, these qualities that patients seek of their nurses do not change significantly depending on the practice setting. A study by Wysong and Driver (2009) identified that patients in the progressive care unit ranked interpersonal skills (caring, compassionate, friendly, kind and good listeners) as being the highest measure of nursing ability, followed by critical thinking skills (analysis, inference, interpretation, knowledge, open-mindedness, and reasoning) and last being technical skills (hands on skills such as obtaining blood samples and inserting IVs).

In terms of other healthcare providers that Purple had been in contact with during her present hospitalization she shared that she had also had the "dietician and physiotherapist visit" her, but that "they work separately from the team that is involved" within her immediate care. I wonder why this was so. From Purple's perspective, it seems as if interprofessional teams mainly consist of nurse practitioners, doctors from a number of specialties, and sometimes registered nurses; allied health members are often a team of their own, as has been identified by my study participants. To substantiate, Sasha also mentioned that she often observed the nurses and the physiotherapists having a close working relationship that was separate from the relationships occurring within her interprofessional team. Is this because certain health professionals are more prominent within interprofessional teams due to the length of time they spend within the teams? For example, the dietician might need to see the patient one-two times during their hospitalization whereas the nurse practitioner sees the patient almost every day. No literature could be found to explain why this is so.

~

Having explored Purple's story in greater detail, in the next and last chapter of this thesis, as per Narrative Inquiry process, I step back further from the immediacy of the experience to consider the social significance of the told stories. Possible implications as well as a look back-looking forward for the thesis are provided.

CHAPTER 8: SOCIAL SIGNIFICANCE OF THE THREE PATIENTS' STORIES AND IMPLICATIONS FOR HEALTHCARE

The End to the Journey?

I finally have reached my destination, but I do not feel like my journey has ended. This adventure started with one purpose: to give voice to patients' stories of how they experience receiving interprofessional care and thereby to contribute to the ongoing research into interprofessional person-centered care. I am now staying at the seaside hotel where I have time to reflect on my travel and the stories I heard from my three travel companions that I met along the way. What have I learned from these conversations? What have I been prompted to reflect upon and delve into deeper? What significance do their stories have for our healthcare, and specifically for interprofessional care? These are the questions that are running through my mind as I think back on my experiences.

It has now been over six months since I met with my participants face-to-face and four months since we spoke on the telephone during the follow-up conversation. I have been working through their individual stories, and as per Narrative Inquiry methodology, reflecting upon and analyzing them throughout this time. Having explored each of my participants' stories individually within their respective chapters, I can now, more clearly, visualize the narrative threads that emerge between all the stories. The threads that weave through each one of the stories can be depicted as flowing inward and outward to "tap into personal and social dimensions and forward and backward to explore the meaning of experiences from the past to the present and into a projected future" (Taylor, 2007, p. 284). Thus, in the first part of this chapter I present the letter I wrote to members of interprofessional teams representing patients' voice. Specifically, the letter demonstrates the co-construction of knowledge between me and

the three study participants as it includes participants' words and my own interpretation of what they had said. The second part of the chapter, using the three dimensional Narrative Inquiry space and the *National Interprofessional Competency Framework*, I propose the significance of the three narrative threads (communication, interprofessional team members, and the patient within the interprofessional team) to current and future interprofessional teams and the greater healthcare system. I complete this chapter by looking back at the entire thesis.

Letter to the Interprofessional Healthcare Teams

Following is the letter to healthcare providers who are members of current and future interprofessional teams. I have written this letter as a synthesis of the stories my participants have shared and my interpretation of what they would like to see happen from their interprofessional teams.

Dear healthcare providers of interprofessional care teams,

We first would like to thank you for the care you have been providing us while we were ill. If it wasn't for your collaborative care delivery, we would not be where we are today: recovering at home in our community, no longer staying in the hospital. With each story we shared about our experiences, we want to put forward a few important points for consideration, which we hope will help future patients and interprofessional collaborations.

Time and time again, we have identified that communication is very important for us, and we mean not only communication between members of the interprofessional team, but also the communication between us, the patients, and the interprofessional care team members. It is vital for us to be involved within the decision making process in relation to our care; we

want to know what our lab values are or what medications we are taking; and we find it significantly less stressful when we are told about timelines of procedures we are to receive or any delays that will occur in our care delivery. When we have questions to ask or suggestions to make in relation to our care, we would like for them to be addressed, even if all the answers are not available or what we are asking for is not possible or a good idea. In our role of patient, we have already lost some control and the power is somewhat out of our hands, especially in relation to all the medical knowledge, terminology, and procedures we experience.

The communication among healthcare providers within the team is currently only evident between doctors and nurse practitioners. Our experiences could be enhanced knowing that all interprofessional team members are updated about our condition on a consistent basis, especially at a time when only one team member, on behalf of the team, comes to see us. We do not like repeating ourselves, particularly when the same questions are asked of us by different healthcare providers. Taking this into consideration and reviewing our charts or conversing with the other team members who have already visited us earlier in the day might be a solution to reducing the same questions being asked. It is hard for us to further comment on the communication that occurs between other members of the team, as we have only been privy to seeing nurse, nurse practitioner, doctor, and physiotherapist communication exchanges during our hospital stay. One major thing we want to reiterate is that from our perspective, communication is vital to interprofessional care. For us it is important that healthcare providers know that we want to be part of the communication process.

This leads us to discussing the interprofessional team more closely. Most of us currently do not see ourselves as members of our interprofessional team. Although, we do mention being involved within our care, we do not include ourselves in our definition of interprofessional care. We understand that we should be at the center of the team, but we are not. In line with person-centered care, listening to our questions, ideas and suggestions brings us closer to feeling included within the team. Communicate with, consult, question, and include us in all important conversations, decisions and discussions about our own care plan. Although we might speak a different language (English not medical), not fully understanding the medical terms involved in our care, we are curious about our health state and recovery process. We are willing to learn, listen, share, collaborate and discuss.

We understand, however, that there are a number of factors that can impact our level of involvement, so re-evaluating this on a regular basis might be an effective strategy. Sometimes our emotional state, feelings and/or illness severity impact how much and at what level we would like to be involved and that at times we just want to be taken care of. Please consider this and not think that we no longer wish to actively participate in our own care.

Currently we are not fully aware of the composition of our entire healthcare team; we do not know who all the team members are, as we do not have consistent contact with them. Perhaps if we were introduced to all the members of our healthcare team at the beginning of our stay and each of their roles within our plan of care is explained to us, we would be more aware as to why consistency in care delivery does not always happen.

Next, it is difficult for some of us to deal with a change in membership of our team. We do understand that new professionals have to be brought into the team to deal with certain aspects of our care that they specialize in or to replace a sick/on vacation team member, but it's hard for us when doctors, such as medical students and residents, change all the time. Some of us enjoy seeing new faces, but for the rest of us having to constantly build a relationship with the new professionals and learn to trust them with the personal information we share and the care we receive from them, takes a lot of our energy.

Thus far, we have mainly addressed what healthcare providers can do to improve our experiences within interprofessional teams. We do recognize that we as patients also play an active role in the care we receive. We know that we should be more open about what we would like to see within our care. Just as we have mentioned that the way healthcare providers communicate with us is important, it is as equally important the way we communicate with them. We are aware that if we do not speak up about what is bothering us, improvements in our care cannot happen. Since our main job within our hospitalization is to work towards improving our health, we cannot always perform within the team as we would like to. As our metaphor drawings depict, we as patients acknowledge that the patient should be at the center of the care delivery, whether the patient is a football being thrown around in a game, a jigsaw puzzle being put together, or the salt shaker being full of salt granules. These pictures show that when collaborations happen, positive results have a greater chance to occur, such as no fumbles, a completed puzzle, and a satisfying recovery.

We also want to note some things currently in place that work well for us. We really appreciate having the one consistent caregiver, in our case it being the nurse practitioner, who stays with us throughout our hospitalization; is our go-to person, communicates things to the team on our behalf, advocates for us and is there to answer any and all questions we have. We understand that the whole team cannot always be present whenever we have a problem or an issue to discuss or deal with. Thus, we hope this practice of identifying one member of the team who can be present within our care or entire stay on the unit continues. The white board in our rooms, when it gets updated, is a useful tool for us to know the names of our caregivers and what care to expect that day. Lastly, we would like the current communication patterns between doctors and nurse practitioners to continue. We hope that our stories will be able to enhance the care we and other patients will receive from interprofessional care teams in the future.

Sincerely,

Patients in your care

Social Significance of Participants' Stories

Having provided the letter written to healthcare providers who are or will be members of interprofessional teams, we now move to the last level of analysis, asking the question: What significance do the three narrative threads have for our healthcare system and, specifically, for interprofessional care we deliver to our patients?

The original purpose of the study was to give voice to patients' stories of how they experience receiving interprofessional care. The social significance of this study is that we have now started to hear the patient's voice on this issue. By giving patients the opportunity to share their experiences in the form of stories and metaphor-selection drawings, they became introduced into research on interprofessional care. Through this process they became an active part of the person-centered interprofessional care team.

The three narrative threads that became apparent in the stories are further discussed within this third level of analysis; they are not isolated from one another, but are interwoven. These threads not only overlap, but also cannot exist without one another. For example, the patient needs to not only be an active participant, but also needs to be at the center of the interprofessional care team; this could be achieved through effective communication between the team members, while including the patient.

Narrative Thread #1: Communication

Throughout each of my three participants' stories it was really apparent that communication was one of the most significant aspects of their care. In fact, when participants were asked to define interprofessional care, communication was always part of the definition in some form. Fred had stated that "when it comes to interprofessional care, people's qualifications do not matter […] it's more about bringing people in with the right expertise. Communication is

crucial!" Additionally, Sasha, when discussing components of interprofessional care also talked about "communication, explaining things precisely and communicating the information properly" as being important to her. Why is communication so important to patients? And, what can effective communication provide for both patients and members of interprofessional teams? Communication was discussed in two ways by the study participants: communication that takes place between healthcare providers within the interprofessional team, and that between interprofessional care team and patients.

To first address the communication occurring between team members, when healthcare providers communicate effectively with each other, duplication and repetition in care could potentially be decreased. This could then result in a lessened chance of adverse health outcomes and errors in care delivery (Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2007). To substantiate this, JCAHO in the United States has outlined that 65% of sentinel events reported were a result of poor communication between healthcare providers. Additionally, effective communication could improve the relationships among healthcare providers. A study by Sargeant, Loney, and Murphy (2008) found that through improving communication among team members, increased understanding, collaboration and cooperation occurred within the team. Within the N*ational Interprofessional Competency Framework,* one of the key competency domains is interprofessional communication, which is described as healthcare providers from different disciplines communicating with each other in "a collaborative, responsive, and responsible manner" (Bainbridge et al., 2010, p. 9). Interprofessional communication, along with patient/client/family/community centered care, could support the remaining competency domains of the framework for effective interprofessional collaboration: role clarification, collaborative leadership, team functioning and

dealing with interprofessional conflict. To further draw a connection, Suter et al. (2009) conducted interviews with healthcare providers and administrators from seven healthcare sites across Alberta, Canada. Communication, along with role clarification, was consistently raised as being significant for effective collaborative practice and for achievement of other competencies.

The second type of communication, which occurs between patients and the interprofessional care team members, can be a starting point in working towards achieving the goal of effective person-centered care communication. Including patients in communication exchanges within the team, keeping in mind their suggestions/comments/questions, and asking for their input enhances the relationship formed between patients, families, and healthcare providers (Hoffer Gittell, Godfrey, & Thistlethwaite, 2013). With respect to the current study, effective communication seems to lower patients' level of stress and anxiety, as evidenced in each participant's story. Fred, Sasha, and Purple all experienced delays in their care and were left waiting anxiously, not knowing when to expect the procedures to happen. As Sasha had articulated, if only she was notified about the delay, she would not have experienced the unnecessary worrying. Also, members of interprofessional teams should not only focus on communicating with patients, but their families, as well. Gittell et al. (2013), describe the core values of interprofessional collaboration, highlighting the importance of including the family in communication exchanges that occur between interprofessional team members and patients. This aspect of communication could contribute to ensuring that the family is fully informed about the care their loved one is receiving.

Narrative Thread #2: Interprofessional Team Members

Regarding the composition of interprofessional teams, participants rarely talked about all the members of their interprofessional team, and they were not aware of their entire team

composition. Fred, Sasha, and Purple discussed at length nurse practitioners, doctors, and registered nurses, but only briefly mentioned physiotherapists and dieticians. Additionally, Sasha was not sure if the physiotherapist and the dietician were members of her immediate interprofessional team, while Purple thought they were not members. Fred simply stated that during his present hospitalization there weren't that many issues, meaning he did not require a significant number of different caregivers, not elaborating on whom exactly was part of his interprofessional team. What does this mean for patient care delivery? Role clarification is one of the six competency domains discussed within the *National Interprofessional Competency Framework* required for effective interprofessional collaboration between patients and care providers (Bainbridge et al., 2010). Members of interprofessional teams need to "understand their own role and the roles of those in other professions" (Bainbridge et al., 2010, p. 9) in order to eliminate patient confusion. Although an awareness of interprofessional team member roles is important for all units, it is especially important on specialized units, like the one these study participants were on, which run differently from the traditional physician led unit. This unit is managed and overseen by nurse practitioners who work with one junior and one senior staff physician, which may inadvertently alter the pattern of team communication.

Overall, it is important to introduce the entire interprofessional team to the patient. This would allow patients to have a better idea what roles each member of the interprofessional team can play within their hospitalization. As with effective communication, "role understanding leads to better patient outcomes as … duplication of care [is] avoided and team functioning increases" (Suter et al., 2009, p. 49). One way this could be understood is that the patient is not asked to answer the same questions or take part in the same procedures, when another healthcare provider has already asked them to do. For example, today most of the healthcare providers who visit a

particular patient assess her/his vital signs during their consultation, even though the previous healthcare provider has already done so and recorded the findings in the patient's chart.

Narrative Thread #3: Patient within Interprofessional Team

Within this study, Fred and Sasha did not see themselves as part of the interprofessional team. They felt like they were not consulted or involved in the decision making around their care. They had to repeat themselves several times to get the team's attention to address an aspect of care that was important to them. As Sasha had put it "within the team I feel like an object and not like another profession. I feel like I should be at the center of the team and control it, but I'm not." Interestingly, Purple viewed her hospitalization differently from Fred and Sasha, stating she saw herself as part of her interprofessional team and felt like her opinions were valued and considered.

As previously discussed, patients' level of involvement in care and the way they perceive their hospitalization can be dependent on the relationship they have established with their caregivers, their own personal characteristics, and the context surrounding their illness (Petrie & Weinman, 2010). Context, acuity of the illness, length of hospitalization, and previous experiences within the healthcare system all impacted participants' experiences of receiving care from an interprofessional team. Purple, being a patient since birth, spoke of her current hospitalization in a calm, peaceful voice. She was familiar with how the interprofessional team taking care of her worked, as well as what to expect from a previous admission to this unit. It is quite possible that the way the team interacted with Purple differed from the way that same team would have interacted with Fred and Sasha, because of the preexisting relationship they had formed. In contrast, Sasha was a healthy young adult who enjoyed being active. Her illness came on suddenly and was life-threatening from the beginning. She was brought into an unfamiliar

environment. Her story was filled with her feelings of stress, anger, frustration, and of "being a lab rat" and an "object". Although with this it is clearly evident that no one patient is the same or will experience their interprofessional care in the same way, this information further sheds light on the importance of considering the holistic nature of patients in our care. This knowledge and awareness could contribute to how patients are viewed and understood within interprofessional teams and potentially improve the relationships formed. Healthcare providers could ask patients from their first meeting, how the patient would like to be involved with her/his care and within the interprofessional team. The team could re-evaluate the desired level of involvement consistently, but most importantly at times when a change in care or health state occurs.

Additionally, it is important to discuss the concept of power within this narrative thread. Healthcare providers, by their advanced level of medical knowledge, skill and language, hold more power over patients, whether intentional or not. Sahlsten et al. (2008) suggest that for patients to feel as equal contributors within the healthcare provider relationship, the healthcare provider needs to be "surrendering some power or control" to the patient (p. 9). From an interprofessional care lens, patients should be at the center of their care delivery and included within interprofessional teams. Within the *National Interprofessional Competency Framework*, one of the six competency domains is patient/client/family/community centered care. It calls upon healthcare providers to value and incorporate input from patients and their families, as partners, when it comes to developing and/or implementing healthcare services (Bainbridge et al., 2010). Patients may feel like they are able to regain some control within their hospitalization experience when they are provided with opportunities to have input about their care delivery and involved in the decision making process surrounding their care.

The three narrative threads that have emerged from participants' stories of experience could inform our understanding of the healthcare system and how it serves the patients and their families. In this way interprofessional care could become more effective and rewarding for both the healthcare provider and the patient.

Possible Implications for Healthcare

As with any Narrative Inquiry study this is not the end, but just the beginning. My exploration into participants' experiences of receiving interprofessional care has not been done to produce finite answers, but to reveal patient's voices of experience receiving interprofessional care and to open up the possibilities for further inquiry within the field. This section provides future possibilities for education, practice, policy and research. The implications should be read as suggestions that could be used within education, practice, policy and research after further investigation. It is not the expectation that definitive changes would be made in these areas as a result of hearing three participants stories; it is, however, expected that these patients' voices do stimulate thoughts about how education, practice, policy and research could be enhanced to become more interprofessional and person-centered.

Education

Based on this study's findings and the literature reviewed, an important recommendation for education is for current and future educators of healthcare students to consider these patient stories of experience, as well as others, and use them within their teachings. This could provide an important contribution of patient's voice to the interprofessional care relationships. In other words, this could raise healthcare providers' level of awareness about how patients currently view interprofessional teams and how they could enhance the quality of therapeutic relationships. Thus, it is not too late to start to think of how patients could be included more

effectively within our healthcare delivery. In the literature a number of current examples can be found of undergraduate interprofessional opportunities available to students (Doucet et al., 2013; Fortugno, Chandra, Espin, & Gucciardi, 2013; Mellor, Cottrell, & Moran, 2013; Neville, Petro, Mitchell, & Brady, 2013). However, although this is a growing trend, currently patient stories of experience are not yet widely used for teaching students about interprofessional care, teams, or competencies. Towle and Godolphin (2013) propose a model on how faculty could arrange for patients with chronic conditions to be brought together with students, for patient centered learning to take place. The authors do state that this model has yet to be implemented.

Additionally, in relation to courses on concepts of interprofessional care, a number of suggestions are available. Attendance in these courses could be made open and accessible to a number of different health profession students in order to provide them with an opportunity to learn about each other's roles and scopes of practice. In fact according to the *National Interprofessional Competency Framework,* interprofessional education necessitates learning to occur together, from and about one another where healthcare providers or students are brought together (Baindridge et al., 2010). Ideally, a course could have more than one educator/teacher/instructor/ professor from different professional backgrounds. If this is not possible speakers/representatives could be invited from different professions for presentations or interactive sessions. This strategy would engage students experientially in interprofessional principles and content, which would serve them well in practice. As well, consideration should be given to the timing of the delivery of these courses: should healthcare providers be introduced for the first time to interprofessional education courses within their graduate education, having already worked in the field, or should this be done during their undergraduate education? Should they learn about interprofessional care within their practice setting? Many healthcare providers

enter the practice setting after their undergraduate studies. Thus, education of students about interprofessional competencies could start early on within their educational paths so that when they enter the practice setting, at least they would have had exposure to the meaning of working interprofessionally. For example, Doucet, Buchanan, Cole, and McCoy (2013) describe a team-taught course on interprofessional communication delivered to upper level undergraduate students. Within this course fundamental communication skills were taught along with interprofessional competencies, which were woven into weekly discussions and assignments (Doucet et al., 2013). Students developed an understanding of what interprofessional communication is and what competencies they need to fulfill when working within interprofessional teams. Healthcare providers, who have not had an opportunity to take part in interprofessional education courses within their undergraduate or graduate studies and are already practicing, could participate in experiential educational workshops on interprofessional communication held within their respective work environments. All these educational approaches could be strengthened by using patient stories, such as those from this study.

Practice

Interprofessional care can be introduced within all contexts and practice settings. However, care delivered to patients and their families within one setting is potentially different from the way care is delivered in another setting. This is evidenced by the stories Fred, Sasha, and Purple have shared about their experiences with being patients on different units throughout their illness. Care could be designed according to several factors including the type of unit, the complexity of the situation or severity of patient's health, and the number of healthcare providers available to form interprofessional teams (Brody et al., 1989; Howe, 2006; Vincent & Coulter, 2002). Thus, interprofessional care could be modified, adapted, or adjusted to particular units, as

long as healthcare providers meet as many competency domains of interprofessional team working, such as some of the six competency domains outlined within the *National Interprofessional Competency Framework,* for effective interprofessional collaboration to take place.

A starting point for supporting current or future formation of interprofessional teams could be the letter written to healthcare providers found at the beginning of this chapter, as well as the patient stories of receiving interprofessional care. These two items could provide a number of valuable learning points, areas for growth and consideration, as well as insights members of interprofessional teams could use to enhance the care they deliver to their patients. However, the suggestions provided in the letter, as well as within patients' stories, need to be carefully considered and reviewed prior to any implementation; namely, patients want to be included in the decision making around their care, seek timely care and consistency in their care delivery, but most importantly patients want to be seen and heard.

Policy

Recommendations for policy changes are not often made as a result of three patient stories. However, based on the context of what participants have shared about their experiences of receiving interprofessional care, the policy makers are given opportunity to hear the patient's voice: what interprofessional care looks like from the patient's perspective. Based on these patient stories of experience with interprofessional care, a dialogue could be started about initiating an organizational policy to inform new healthcare providers, during orientation, to learn about interprofessional collaboration through examining or reviewing the six competency domains of the *National Interprofessional Competency Framework,* as an example. Then, on a yearly basis these professionals could partake in at least one interprofessional session, course,

conference, workshop or another form of education delivery in order to maintain at least some if not all of their *National Interprofessional Competency Framework* competencies or other interprofessional framework competencies. This approach could support the collaboration of interprofessional teams, as well as interprofessional person-centered care. Additionally, a conversation about policies on education of delivering interprofessional person-centered care could be started, if it hasn't already, within academic institutions. Bainbridge et al. (2010) talk about policymakers from countries such as Canada, the United States, the United Kingdom and New Zealand to be "increasingly recommending changes in health professional curricula in order to ensure student acquisition of competencies that facilitate collaborative practice" (p. 6).

Research

The recommendation for research is to conduct further Narrative Inquiry studies exploring patients' experiences with interprofessional person-centered care in a variety of practice settings. Currently, Narrative Inquiry research approach is new to healthcare. Thus, using this methodology more frequently would provide increasing opportunities to study the quality of patient experiences in interprofessional care situations. Another recommendation would be to increase the overall number of studies, using various methodologies, on interprofessional care from patients' perspective. Creating studies that involve a greater number of participants from a number of different practice settings or sites could further the work of this thesis. Additionally, future studies on interprofessional care could also include examining family members' stories of experience with interprofessional care. This work could enhance the way interprofessional care is delivered within a variety of healthcare settings, as well as strengthen teamwork and caregiver-care receiver relationships.

Strengths and Limitations

Strength of Narrative Inquiry, if effectively carried out, is its ability to invite the reader to enter her/his own inquiry. In this thesis, the reader might be in the role of a patient, caregiver, teacher, or another researcher. By drawing connections with the thesis text, future actions become informed by the stories on these pages, thus making the findings transferable to other situations. The conclusions that the reader might draw from my work could be different from my own, and that is certainly not only acceptable, but expected. What a Narrative Inquiry study allows is for the stories of experience that my participants had shared, to be continually open for interpretation and re-interpretation, and revisited time and time again. Additionally, this type of study provides a more holistic perspective of the phenomenon of interest, in this case interprofessional person-centered care from the patients' perspective.

Within a Narrative Inquiry study it is normal to have a small number of participants, thus this study having three participants is not a limitation. However, what a Narrative Inquiry study does need is time. In this study, due to my program time parameters, I only met with the participants once to conduct the narrative conversational interview and metaphor selection-drawing exercise, as well as held one telephone follow-up session, which occurred prior to the commencement of data analysis. I did not have another opportunity to go back to the participants to invite them to expand on some of their thoughts, or to ask them questions that arose for me when I was critically reflecting on their stories. Within Narrative Inquiry it is strongly encouraged that a continuous dialogue is maintained with the study participants (Clandinin & Connelly, 2000), as it enhances the credibility of the study: the researcher can establish confidence in the truth of the findings for the study participants (Lincoln & Guba, 1985).

Looking Back-Looking Forward

As I reflect on the path my thesis has taken me on, I cannot help but think back to my metaphor of a journey. Arriving at what I thought would be my final destination and spending time in the hotel room critically reflecting on my experiences, I realize that it is only the beginning of new possible journeys and explorations. Where do I go from here? What places do I visit and what will I learn from my future travel companions? As with any narrative study the inquiry continues to expand from here …

Appendix A: Study Information Letter

PATIENTS' EXPERIENCES OF INTERPROFESSIONAL CARE: A NARRATIVE STUDY

My name is Kateryna Aksenchuk and I am a Master of Nursing student at Ryerson University. I am conducting a study as part of my degree requirements entitled *Patients' Experiences of Interprofessional Care: A Narrative Study. D*ata collected through this study will not be shared directly with the (name of the hospital) or health professionals involved directly in your care at the hospital.

Purpose: To give you an opportunity to share your experiences and feelings of being a patient on this unit and comment on any previous hospitalizations you have had.

Participation Criteria: If you are over the age of 18, speak, read and understand English, a patient at (name of the hospital) units (name of the units) and have had at least one other hospitalization outside of these two units, I invite you to participate.

Involvement in Study: Sharing of your stories and selection of a symbolic image to represent your experiences will occur in two one-hour sessions.
Together we will talk about your experiences of being a patient. Our conversation will be audio taped so that I can keep track of it. Then, you will be invited to select your own symbolic image for interprofessional care that you can either draw or talk about. Your drawings, if you choose to draw your symbolic image, will be photocopied and the originals returned to you. Upon that, at a later time, there will be a one telephone session of about 15 minutes where we will discuss my understanding of the stories you have shared.

Benefits: You may or may not receive any direct benefit from being in this study. Information learned though the study may or may not help you and/or future patients who will be receiving interprofessional care.

Participation is completely voluntary. Whether you choose to participate or not, your professional or personal relations with Ryerson University or medical care from the (name of the hospital) will not be affected. If you decide to participate, but later change your mind, you are free to withdraw and stop your participation at any time without penalty or loss of benefits to which you are entitled.

You Will Be Compensated For Your Time

If you are interested in participating or have questions about the study, please contact me, Kateryna Aksenchuk, by telephone (number provided)

Appendix B: Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title Patients' Experiences of Interprofessional Care: A Narrative Study

(Name of the Hospital) Principal Investigator
(Name of the Investigator); RN, MScN
Tel: (phone number)

Co- Investigators
Kateryna Aksenchuk, RN, MN(c)
Masters of Nursing Student
Tel: (phone number)

Dr. Jasna K. Schwind, RN, PhD
Thesis Supervisor
Tel: (phone number)

Introduction
You are being asked to take part in a research study. This study is conducted by a Ryerson University graduate student as part of the Master of Nursing degree requirements. Please read this explanation about the study and its risks and benefits before you decide if you would like to take part. You should take as much time as you need to make your decision. You should ask the study co-investigator (Kateryna) or her supervisor (Dr. J. Schwind) to explain anything that you do not understand and make sure that all of your questions have been answered before signing the consent form. Before you make your decision, feel free to talk about this study with anyone you wish. Participation in this study is voluntary.

Background and Purpose
Research shows that close interprofessional collaboration between healthcare providers and patients impacts patient health outcomes. The purpose of this study is to learn about your experiences and feelings of being the recipient of interprofessional care on this unit and any previous hospitalizations you have had that were not necessarily interprofessionally focused. For your reference, interprofessional care is care that is delivered by two or more *different* healthcare providers who continuously interact and work together with each other and the patient for more effective health outcomes. Within interprofessional care, the patient is at the center of the healthcare delivery, and collaborates with all the healthcare providers. An example of interprofessional care is when a nurse, a social worker, and a respiratory therapist work with the patient to collaboratively plan and deliver care.
This study seeks a total of 5 patients from (name of the hospital)

Study Design
There are three sessions in this study. You will be asked to take part in two individual sessions to talk about your experiences and feelings of receiving interprofessional care and previous hospitalizations where interprofessional care was not necessarily delivered to you. The sessions will consist of a semi-structured interview (where the co-investigator will have a few questions to guide the conversation about your experiences) and selection of your own symbolic image (an

item or an object that you think is ideal) to represent your experience. As well, you will also be involved in the third session which consists of the story reconstruction process (the stories collected during the first two sessions will be analyzed and reflected upon by the co-investigator, Kateryna). The co-investigator (Kateryna) will be in contact with you by telephone at a later point in the study to discuss whether the new stories are an accurate representation of your experience.

Study Visits and Procedures

Session one: Storytelling/interview: This will be audio-taped and transcribed and is expected to require about 60 minutes of your time.
You will be invited to share your experiences being a patient and receiving interprofessional care on your current unit. Also, you will be asked about any previous hospitalizations where you did not necessarily receive interprofessional care.
The following are possible questions to prompt the storytelling process:

7. How do you understand interprofessional care? How would you define interprofessional care in your own words?
8. Can you please describe your experiences/feelings with receiving care on this unit?
9. How did you experience/feel about your other hospitalizations where care was not delivered interprofessionally?
10. How do these compare to your current experience of receiving interprofessional care?
11. What kind of role do you see yourself playing in your hospitalization this time?
12. How is this different or the same from your previous hospitalizations?

Session two: The selection and description of a symbolic image is the focus of this next session and will require about 60 minutes of your time.
You will be invited to select your own symbolic image that you feel best represents the care you are receiving from the interprofessional team during this present hospitalization. Then, you will be given the option to either a) draw that symbolic image including a small description or b) talk about that symbolic image that you have selected.
This is the creative activity piece of the study, where you are given an opportunity to select your own symbolic image that best represents for you the interprofessional care you received. There is no right or wrong image to select; you can select absolutely anything you believe will accurately represent your feelings and/or experiences about interprofessional care.

Session three: The study co-investigator (Kateryna) will contact you by telephone, which will require about 15 minutes of your time, to ensure that an accurate representation of your experiences and feelings with care has been created. This telephone call will take place approximately 4-6 weeks after session two.

Risks Related to Being in the Study
There are no medical risks if you take part in this study. However, being in this study and sharing stories of being a patient might make you feel uncomfortable. Should this occur, you may refuse to answer any question or stop the interview all altogether, without penalty. If you become distressed during the course of the study, the researcher will then ask your permission to refer

you to talk more about your experience with the Nursing Unit Manager or (name of the hospital) Patient Relations. As well, the researcher is a registered nurse who has the professional skills to provide supportive-therapeutic care.

Benefits to Being in the Study
You may or may not receive any direct benefit from being in this study. Information learned from this study may or may not help you and/or future patients who will be receiving interprofessional care.

Voluntary Participation
Your participation in this study is voluntary. You may decide not to be in this study, or to be in the study now and then change your mind later. Your decision to take part or not to take part in the study will have no effect upon your employment/academic standing with Ryerson University and/or your care at the (name of the hospital). Your healthcare providers at the (name of the hospital) will not have any knowledge of what is discussed and shared between you and me, the co-investigator (Kateryna) in the study. Also, you may refuse to answer any question you do not want to answer, or not answer an interview question by saying "pass".

Confidentiality
Personal Health Information
If you agree to join this study, the study team will collect only the personal health information they need for the study. Personal health information is any information that could be used to identify you and includes your:

- Name
- Contact telephone number
- Year of birth or age

The information that is collected for the study (the personal health information, the audio-recordings of the interviews, and the drawings) will be kept in a locked area by the study team in a secure research environment at Ryerson University for 10 years, after which it will be destroyed. The information will be held in strict confidence and only the study team or the people or groups listed below will be allowed to look at the study data.

The following people may look at the study records to check that the information collected for the study is correct and to make sure the study followed proper laws and guidelines:

- Representatives of the (name of the hospital) and Ryerson Research Ethics Board.

If you do not agree to join this study, all of the above personal health information, name, contact telephone number and year of birth or age will be shredded (securely disposed off) and not kept.

Study Information that Does Not Identify You
Some study information will be sent outside of the hospital to Ryerson University. Any information about you that is sent out of the hospital will have a code and will not show your name or address, or any information that directly identifies you.
You will not be named in any reports, publications, or presentations that may come from this study. If you decide to leave the study after consenting to participate, the information about you

that was collected before you left the study will still be used. No new information will be collected without your permission.

In Case You Are Harmed in the Study
If you become emotionally uncomfortable or distressed as a result of taking part in this study, you will receive care. The reasonable costs of such care will be covered for any emotional harm or distress that is directly a result of being in this study. In no way does signing this consent form waive your legal rights nor does it relieve the investigators, sponsors or involved institutions from their legal and professional responsibilities. You do not give up any of your legal rights by signing this consent form.

Expenses Associated with Participating in the Study
You will not have to pay for any activities in this study. You will be provided with a $10.00 coffee gift card as a thank you for your time at the end of the two one-hour sessions and before the 15 minute telephone follow-up. Should you choose to leave the study and withdraw your participation at any time, you will still be given the coffee gift card.

Conflict of Interest
The Study Principal Investigator and the Co-Investigators have an interest in completing this study. Their interests should not influence your decision to participate in this study. You should not feel pressured to join this study

Questions about the Study
If you have any questions, concerns or would like to speak to the study team for any reason, please call Kateryna Aksenchuk at (phone number) or (name of the Principle Investigator) at (phone number).

If you have any questions about your rights as a research participant or concerns about this study, call the Chair of the (name of the hospital) Research Ethics Board (REB), the Research Ethics office number at (phone number), or the Chair of the Ryerson University REB at (phone number).The REB is a group of people who oversee the ethical conduct of research studies. These people are not part of the study team. Everything that you discuss will be kept confidential.

Consent
This study has been explained to me and any questions I had have been answered.
I know that I may leave the study at any time. I agree to take part in this study.

_____	_____	_____
Print Study Participant's Name	Signature	Date

I agree to be audio-taped during the sharing of my stories about my hospital experiences.

_____	_____	_____
Print Study Participant's Name	Signature	Date

I agree to have my artwork, if I choose to draw my symbolic image, photocopied for data analysis.

Print Study Participant's Name	Signature	Date

I agree to have my photocopied artwork displayed publicly.

Print Study Participant's Name	Signature	Date

(You will be given a signed copy of this consent form)

My signature means that I have explained the study to the participant named above. I have answered all questions.

Print Name of Person Obtaining Consent	Signature	Date

☐ The consent form was read to the participant. The person signing below attests that the study as set out in this form was accurately explained to, and has had any questions answered.

Print Name of Witness	Signature	Date

Relationship to Participant

Appendix C: Sessions Guide

PATIENTS' EXPERIENCES OF INTERPROFESSIONAL CARE: A NARRATIVE STUDY

Interview and Follow-up Session Guide

There will be two one-hour meetings and one 15 minute follow-up telephone session.

The two one-hour meetings will consist of two steps:

1. Storytelling/interview: This will be audio-taped and transcribed

You will be invited to share your experiences being a patient and receiving care on your current unit. Also, you will be asked about any previous hospitalizations where you did not receive care from an interprofessional team

The following are possible questions to prompt the storytelling process:

1. Can you please describe your experience and/or feelings with receiving care from an interprofessional team?
2. How do you experience the care you are receiving from the interprofessional team?
3. How does this type of care (interprofessional care) make you feel?
4. How did you experience/ feel about your other hospitalizations where care was not delivered within an interprofessional team?
5. How do these compare to your current experience of receiving interprofessional care?
6. What kind of role do you see yourself playing in your hospitalization this time?
7. How is this different or the same from your previous hospitalizations?

2. Symbolic image selection and description: Artwork photocopied and originals returned to you

You will be invited to choose your own symbolic image that you feel best represents the care you are receiving from the interprofessional team during this present hospitalization. You will either draw it including a small description or talk about it.

The one telephone sessions will consist of a short 15 minute discussion. The following are possible questions that could be used to prompt the telephone session:

5. Is this new reconstructed story an accurate representation of your experience/feelings with being the recipient of interprofessional care?
   b. Can you elaborate?
6. Is there anything else you would like to add to your story in order for me to get a more accurate understanding of your experiences with and feelings about interprofessional care?
7. Is there anything that I should remove from your story in order for me to get a more accurate understanding of your experiences with and feelings about interprofessional care?

8. Is there anything that I should focus on in greater detail in order for me to get a more accurate understanding of your experiences with and feelings about interprofessional care?

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