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Teams and continuity of end-of-life care in hospitals: managing differences of opinion

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ABSTRACT

Background Recognised as an essential element in end-of-life care by the Australian Commission on Safety and Quality in Health Care, effective teamwork can enhance the quality and safety of end-of-life care for patients in hospitals. End-of-Life Essentials (EOLE) is a Commonwealth funded project that delivers peer-reviewed, evidence-based, online education and practice change resources for doctors, nurses and allied health professionals working in hospitals. 'Teams and Continuity for the Patient' features in the suite of EOLE modules and includes education around effective teamwork in end-of-life care. The aim of this study was to explore the views of module learners on managing differences of opinion among staff regarding patient care management.

Methods Participants were learners (health professionals) who registered to the EOLE website and engaged with the Teams module. Learner responses to a question posed at the end of the module 'How do you manage differences of opinion among staff regarding patient care management?' were extracted for a 12-month period. Qualitative data were analysed thematically in NVivo V.12, with pragmatism as an overarching theoretical framework. Data were coded using an inductive, open approach, and axial coding was used to organise the codes into themes and subthemes.

Findings A total of 293 learner statements were analysed, with subthemes organised into three overarching themes: *prioritising the patient, team collaboration* and *communication skills and emotional awareness*.

Conclusion In complex, fast-paced, hospital environments, the potential for conflict among teams is high. Quality care relies on team members who work in unison, who can also recognise conflict emerging and respond in respectful and appropriate ways. In this study, the management actions reported by health professionals as proving helpful when differences of opinion among team members arise, are valuable to organisations who are considering how to prepare for quality and safety accreditation.

Key messages

What is already known on this topic?

- Effective teamwork can enhance the quality and safety of end-of-life care for patients in hospitals.
- Healthcare professionals (HCPs) in acute settings often work within a culture which focuses on curative treatments, to the detriment of end-of-life care quality.
- Skills in overcoming conflict are central to well-functioning healthcare teams and delivery of safe, quality care.

What this study adds?

- This study adds qualitative survey response data from HCPs working in hospitals, on the ways in which they personally and professionally manage differences of opinion among staff when considering patient care.
- This study reports a range of themes and subthemes related to management actions that healthcare professionals found helpful in practice.

How this study might affect research, practice or policy?

- This study provides valuable information to both individual healthcare professionals and organisations on practical ways to equip hospital healthcare teams with the skills needed to appropriately respond to conflict and facilitate quality end-of-life care for patients.

INTRODUCTION

Across Australia, Canada, the UK and the USA, dying in hospital is common.[1–4] Hospitals are institutions that strive to cure, and in the context of such highly complex systems, providing both end-of-life and curative care can be a conundrum.[5] When a patient with complex morbidity deteriorates in hospital, differentiating between reversible causes and 'normal' dying can be highly challenging for clinicians.[6] Acute and critical care healthcare professionals (HCPs) work within a culture that can obstruct quality end-of-life care, in that it strives to prolong lives and treat or cure ill-health.[7] Highly adaptable and nimble teams enable multifaceted end-of-life and curative care to coexist and be delivered with quality within the same institution or system.[8 9]

Researchers have suggested that the way in which individual team members interact defines the function of the team, rather than the team's function being directed by policies and guidelines.[10] If individual team member interactions are so crucial, a

well-functioning team and skills in overcoming conflict becomes central.

The importance of teamwork is reflected in both the National Consensus Statement[11] and the National Safety and Quality Health Service Standards[12] developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC). The Commission leads and coordinates quality and safety initiatives nationally, emphasising the importance of teamwork and coordination of care in hospitals in contributing to high quality and safe end-of-life care.

End-of-Life Essentials (EOLE) is funded by the Australian Government Department of Health and provides evidence-based online education on end-of-life care, for doctors, nurses and allied health professionals who work in acute hospitals.[13] EOLE is based on the National Consensus Statement,[11] and translates the five processes of care elements from the statement: patient centred care; teamwork; goals of care; using triggers; responding to concerns, directly into a suite of education modules, each developed following consultation with industry and clinical partners.[14]

'Teams and Continuity for the Patient' (hereafter referred to as the Teams module) features in the suite of EOLE modules and includes education around essential elements of effective teamwork in end-of-life care.[15]

The aim of this study was to explore the views of learners from the Teams module on managing differences of opinion among staff regarding patient care management.

METHODS

The EOLE modules

Freely available online, the EOLE education modules are designed to build capacity of HCPs working in acute hospitals, in delivering quality end-of-life care.[15] The modules each focus on a specific aspect or process of clinical care, consisting of learning content in the form of written information, infographics and videos demonstrating practical care scenarios.[14] Each module is accompanied by a downloadable implementation toolkit (resources and tailored checklists) for learners to take away and use in their clinical practice.[16] Writing and development of the education was guided by an expert national advisory group, and each module was peer reviewed by HCPs working in hospital settings across Australia. As with all aspects of the EOLE project, the modules are subject to routine evaluation and revision.

To date, more than 25 000 learners have registered to access the education, and can selectively engage with any or all modules in a self-paced manner.

The Teams module explores the benefits and essential elements of effective healthcare teams in acute hospitals, and takes 30–40 min for learners to complete. After completing the module learners should be able to:

- Reflect on who is in their team.
- Define why effective teamwork makes a difference.
- See the team from the patient's perspective.
- Identify the essential elements and tools of effective teamwork.
- List several steps they can put into their practice tomorrow to enhance their team and allow partnership with the patient and family.[15]

The Teams module is freely offered as continual professional development (CPD). HCPs are not required to complete the module, however the supplied certificate of completion may be used as evidence toward the standard of CPD required by professional registration.

Ethical considerations

Participation in the module evaluation is voluntary (opt-in). Learners can engage with the education without answering the evaluation questions.

Patient and public involvement

Patients and families were not directly involved in this study, however their views were included in the development of the consensus statement from which the EOLE education is derived.

Data collection and analysis

Participants in this study were self-selected learners (HCPs) who had engaged with the Teams module.

Qualitative data in the form of learner statements responding to a free-text question posed at the end of the module: 'How do you manage differences of opinion among staff regarding patient care management?' were extracted from the learning platform. Data were extracted for a 12-month period, 6 May 2019 to 6 May 2020. The data were cleaned, de-identified and imported into NVivo V.12 software package.

Data were analysed using NVivo V.12, with pragmatism used as the overarching theoretical framework to guide the qualitative analysis. A pragmatist approach focuses on obtaining a practical understanding of real-world issues and has been particularly useful in organisational settings.[17 18] Learner responses were analysed using thematic content analysis.[19 20] One author completed coding for all data and created a coding scheme.[19] An inductive, open approach to coding was used to privilege learner voices.[21] Learner statements were coded line-by-line, with similar words and segments of text grouped into codes, and new codes created as new concepts emerged.[19 21] Axial coding was then used to organise the codes into themes and subthemes.[21] To add rigour to the analysis, two authors reviewed and discussed the coding scheme at various points during the analysis and made minor modifications to the themes. The third author was also consulted towards the end of the analysis process.[19] In considering reflexivity, the authors were conscious of the need for the analysis to be driven by the learners' own words rather than the authors' individual preconceptions and experiences.[22]

RESULTS

In total, 590 learners completed the Teams module between 6 May 2019 and 6 May 2020 among which 73.1%

of learners (n=431) were nurses, 14.9% (n=88) were allied health professionals and 12.0% (n=71) were doctors and 70.2% (n=414) of learners were from acute hospitals, and 29.8% (n=176) were from other settings. From those who completed the module during the 12-month period, 293 learners responded to the free-text question, a response rate of 49.7%. The 293 learner statements (one statement per learner) were thematically analysed, with subthemes organised into three overarching themes: *prioritising the patient, team collaboration* and *communication skills and emotional awareness*. A description of each theme and subtheme, along with exemplar learner quotes, are presented below.

Prioritising the patient

The first overarching theme encompassed patient-centred care, including focusing on the wants/needs/wishes of the patient, identifying goals of care and patient advocacy.

Align with what the patient wants

This subtheme captured bringing discussion back to what the patient values and what they want, and letting the patient steer care.

> 'Align with patients values.'
>
> 'Be culturally aware ensuring that care is centred around patient.'
>
> 'Come back to the question: What would the patient want most?'

Identify goals of care

Captured here were statements around being clear in identifying patient goals of care, and relating care plans back to patient goals.

> 'Identify the goals of care of the patient and how to best meet them.'
>
> 'Following the goals of care is more important.'
>
> 'Coming up with goals of care according to pts advanced care plan.'

Advocate for the patient

This subtheme captured statements around being aware of when care diverges from patients' wishes and speaking up to be an advocate for the patient where needed.

> 'Clearly express your concerns if you do not believe a plan is appropriate for that pt—be an advocate'
>
> 'Speaking up is the right thing to do as the patient matters, and we advocate.'
>
> 'Try to always put the patient's needs at the centre of any discussions and advocate when needed.'

Team collaboration

The second overarching theme encompassed subthemes related to teamwork and respecting each member of the clinical team in discussing and planning patient care.

Inclusive discussions

This subtheme related to communication within teams and among staff, including descriptions of opportunities to brainstorm ideas, plan care options, collaborate and talk as a team. The opportunity for complex multidisciplinary teams to deliberate care plans and estimate prognosis, for example, were common.

> 'Bring everyone together for a group discussion to gather all opinions before openly discussing options.'
>
> 'Regular team meetings are held each week between allied health staff, Dr's, nurses and the Director of medicine. Each pt is discussed, with a plan and prognosis.'
>
> 'Sit everyone down together and find out what the problem is and ask each one how best to proceed with the situation and what their expectations are and how they think they can be solved.'

Liaise with the patient's family

This subtheme recognised the patient's family as part of the team, to be involved in discussion.

> 'Sit down and discusses the issue calmly and empathically in a private space. With the patient and family being central at all times.'
>
> 'Include family members to discuss care options.'
>
> 'Just remember that patient and families are part of the team as well as those caring. Speak to family.'

Acknowledge and respect individual staff concerns and opinions

Within this subtheme learners wrote about creating and maintaining a workplace environment in which all members of staff and the team feel safe to voice their opinions and be involved in the discussion. Letting everyone have their say, respecting different opinions and concerns, were also stated as ways of managing differences of opinion.

> 'Create a psychologically safe, respectful environment in which all views are heard.'
>
> 'Differences of opinion are not to be dismissed as this can lead to innovation or additional suitable care options.'
>
> 'Take the time to actively listen to the concerns or ideas other person identify, recognise emotional issues and explore and acknowledge concerns brainstorm solutions, without judgement, to enable efficient and effective care outcomes for the patient and their family.'

Negotiation

This subtheme related to negotiation or working together to come to an agreement, resolve the issue and find a solution/outcome, such as being able to compromise, and choosing to negotiate or work out a way forward.

> 'Differentiating the best possible solution from others. Negotiating a solution.'

'Communication and compromise is key in these situations.'

'Try to come to a conclusion that is effective for both the staff and the patient to be able to continue to give the utmost quality of care.'

Seek advice from senior staff or a third party

This subtheme covered escalating concerns and issues relating to conflict, including the option of asking a manager, senior staff member, mediator or other third party for their advice or assistance if needed.

'Ask senior staff for advice.'

'I listen to what my team members have to say and then put my point across. If I still think that it is not in the best interest of the patient I try and get a third party involved that is neutral.'

'I often find that junior medical staff are more difficult to converse with in regard to management. They are rotating staff, we don't know them, they don't know us and sometimes they are very junior. It is sometimes easier to bring these issues up with the permanent consultants.'

Communication skills and emotional awareness

The third overarching theme encompassed subthemes related to open communication, listening, using empathy and remaining calm in the face of conflict.

Open and honest communication

Collated here were statements around the importance of openly communicating with patients, families and staff in an honest manner.

'Have open discussion'

'Speaking openly to staff.'

'With open, honest and constructive communication.'

Active listening

This subtheme captured active listening (to the opinions and concerns of others).

'Active listening to everyone's point of view.'

'Listen to all sides.'

'Use active listening skill'

Anticipation of emotive potential

This subtheme captured, in the face of conflict or heated situations, the ability to be self-reflective, remain calm and aware of one's own emotions, take a non-judgemental approach, de-escalate the situation if needed and be prepared that emotions may escalate.

'If it begins getting heated intervene and deescalate the situation.'

'Be conscious of not reacting to team members comments personally and defensively.'

'Try and remain calm and don't let your emotions affect the conversation. When you notice a conflict situation, prepare yourself to not respond emotionally, find a non-judgemental way to respond and reframe from emotionally charged responses.'

Empathise

Captured here were learner statements related to maintaining empathy in considering and responding to others.

'Empathy for all opinions.'

'Respond empathetically.'

'Listen with empathy to the emotion being expressed.'

DISCUSSION

This study sought to explore the ways in which learners (HCPs) manage differences of opinion among staff regarding patient-care management. An array of overarching themes and subthemes were derived from learner responses, including prioritising the patient, team collaboration and communication skills and emotional awareness.

Overall, the findings suggest a range of strategies related to the management of differences of opinion among staff. These strategies were generally operational at the individual clinician level, rather than the system or service level. This is in keeping with the conceptualisation of the Teams module which was designed for individual HCPs. Evidence supports teamwork in healthcare as vital to the quality and safety of healthcare delivery.[23] However, lack of empirical research into the complex relationship between teamwork and patient safety means that the nuance of mediating effects is unknown.[24] Different sizes, types and configurations of teams exist in acute hospitals, and the need for practical knowledge on how to strengthen teams will lead to improved interventions and greater care quality and safety.[23] The scope of findings in this study underscores the importance of managing conflict as it has potential to impact greatly on the quality and safety of patient end-of-life care management.

Team collaboration

In this study, learners discussed aspects of team collaboration, including the importance of inclusive discussions, acknowledging and respecting individual concerns and opinions, negotiation, seeking advice from senior staff or a third party and liaising with the patient's family. Having inclusive discussions about goals of care is crucial in hospital settings, particularly when patients are approaching end of life, or when a patient's condition begins to deteriorate.[11] Results from the current study show that having inclusive discussions around estimating prognosis and fine-tuning care plans can facilitate team decision-making. Creating opportunities for inclusive discussions allows for an appreciation of patients' and families' perspectives around dignity and symptom management.[25]

Feeling safe to speak up in a team is a foundational element of collaboration, highlighted here. Psychological safety is a belief that no one will be punished or

humiliated for speaking up with ideas, questions, concerns or mistakes.[26] In healthcare, doctors, nurses and other HCPs face significant challenges in the delivery of high-quality care. Characteristics of healthcare organisations which contribute to these challenges include the 'high stakes' nature of the work involving the health, life and death of patients, the existence of 'nested' groups of clinical units and professional hierarchies within and among different disciplines.[26] Existing professional and workplace norms and culture often create barriers to workers speaking up, asking for help or reporting errors.[23 26] Good leadership is a critical factor in determining an individual's sense of psychological safety. Prior research has found that psychological safety is increased when leaders and managers work to reduce status gaps between themselves and other workers, as well as respecting and supporting them.[26]

Unsurprisingly, negotiation emerged as a subtheme in this study. Negotiation is critical to well-functioning teams working within hospitals. One of the foundations of negotiation is to understand team members' roles and goals.[27] This is especially relevant in situations where end-of-life care is the focus. When the goal of care is shifting, or oscillating, from curative intent to one that focuses on or prioritises end-of-life care, it is crucial to have a common and shared understanding of prognosis, treatment plans and the end-of-life needs of the patient, and to support the family.[11 28] End-of-life decision-making about withdrawing and withholding treatments leveraged off the combined expertise and well-functioning collaborative relationships between nurses and physicians, can predict better outcomes for patients.[29] Also, agreed prognostication among nurses and physicians can predict more accurately compared with the prognostication of a solo practitioner.[30] Importantly, mutual respect within a well-functioning team may offset moral distress and assist in building team resilience.[30]

Effective teamwork and resolution of conflict requires professional team members to engage with patients, carers and families, who should be recognised as team members and invited to collaborate and negotiate shared care.[11 31] This subtheme of liaising with the patient's family also emerged. Formal family meetings are key to sharing information with families about the patient's condition and prognosis, and enable family members to advocate for the patient and be part of the decision-making process.[32] Conflict is often seen as unwelcome, however well managed, respectful responses to conflict have the potential to strengthen team respect and decision-making.[31] Clear discussions that include senior staff, patients and families do not always occur in a timely way, and junior staff, who are tasked with these complex discussions, may be poorly equipped in their knowledge of who should be included in such important discussions.[33] However, incorporating senior staff or a mediator in decision-making and communication allows an avenue through which to escalate concerns and overt or manage conflict, our results suggest.

Communication skills and emotional awareness

Prior research has found that most clinicians are not adequately equipped with the type of evidence-based communication skills needed to provide high quality end-of-life care.[34] Provision of end-of-life care often calls on HCPs to engage and communicate with patients living with and expressing vulnerable feelings and emotions. Some commentators have stated that, understandably, professionals may react with their own emotions, which can lead to a cascade of unhelpful consequences, such as grief, loss, fear or a sense of professional failure.[35] In particular, transitions of care in acute settings are where communication breakdowns often occur, causing patient harm through provision of inappropriate therapies or medication errors, or missed opportunities.[23] Communication skills and emotional awareness was a key theme in this study, where learners linked the skill of managing team conflict with honest and open engagement. Being open and honest relies on team members feeling emotionally safe to do so. Being able to recognise and examine one's own emotional triggers, and understanding the emotive potential in delivering care, was also identified in this study, and others researching communication.[34]

Despite there being only one specific use of the term within the Teams module, a significant proportion of learner statements mentioned 'active listening'. Active listening is a core skill for HCPs that builds trust, commitment and support.[36 37] Active listening is more than hearing, it is a communication skill that can be cultivated and honed,[37] and has been described as an attitude which is free of judgement.[36–39] Providing feedback to the speaker is key, helping to build mutual understanding and respect.[36 39] Non-verbal communication through posture, eye contact and attentive silences, all assist in showing interest and demonstrating understanding.[37] In the current study, actively listening to and understanding others team members' point of view, was a key factor in managing conflict.

Active listening is closely associated with empathy,[40] and the importance of empathy in managing team conflict is evidenced in this study. Hunt and colleagues reviewed the literature in this field and suggest that there are different types of empathy.[41] Emotional empathy is the sharing of emotions that can lead to emotional exhaustion, distress or burnout. Whereas cognitive empathy is the capacity to understand another person's state of mind while at the same time being able to regulate one's own emotions.[41] Protective factors in preventing burnout in HCPs include increased experience and age, support from their organisation and further education.[41]

The delivery of end-of-life care is often surrounded by heightened emotions and complexity among staff and families.[5 32] A subtheme in our study was anticipation of emotive potential, which holds statements from learners who mentioned being mindful of not personally or emotionally reacting to situations or other professionals, practicing self-reflective skills and preparing for escalation of emotions. For some HCPs, managing family

distress and grief alongside their own emotions, can be difficult. It is important that HCPs have opportunities for debriefing and counselling, where needed.[32 42 43]

Prioritising the patient

Improvements in HCPs' active listening leads to improvements in empathy and, in turn, patient-centred care.[40] Patient-centred care helps the patient to feel respected and heard and is linked to better patient outcomes.[40] Many learners in this study emphasised the importance of prioritising the needs and wants of the patient and putting the patient at the centre of decisions around goals of care. Shared decision-making is an essential component of patient-centred care and should be prioritised for patients in hospital.[6] Tools such as the ISBAR (Introduction, Situation, Background Assessment, Recommendation) and REMAP tool (Reframe, Expect Emotion, Map the Future, Align with the patients values, Plan medical treatments that match patient values) provide a framework for staff to raise concerns, speak up for patient needs and values and navigate goals of care discussions, keeping the patient at the centre.[44 45]

IMPLICATIONS

Oscillating between providing life prolonging care and quality end-of-life care in hospitals, requires healthcare teams to be highly nimble to continually assess patients and treatment intent, plan appropriate goals of care and navigate provision of care in fast-paced complex environments. The potential for conflict is high. Unresolved conflict and quality care are not compatible. This study describes a variety of ways that healthcare teams manage conflict. Psychological safety, team collaboration, communication skills and emotional awareness and prioritising the patient, are integral to good practice. A team which provides quality care and service in unison is key, and moving from discord to harmony can require attention to a wide range of factors, as our results show.

FUTURE

The importance of well-functioning teams in contributing to high quality and safe end-of-life care in hospitals, is emphasised in the ACSQHC National Consensus Statement[11] and the National Safety and Quality Health Service Standards.[12] Hospitals are complex institutions, and matching quality and safety drivers that modify and affect change in these systems, is required. This study explored the management of differences of opinion among staff regarding patient care. More work is required however, to understand the nuance and makeup of well-functioning teams who deliver end-of-life care in hospitals. There is also a need to investigate the views of patients, families and carers, regarding their expectations of the teams that deliver their care, and the inclusivity of care provided.

LIMITATIONS

Of the 590 learners who completed the module during the 12-month period, a total of 293 learners responded to the free-text question that feeds into this study. The difference between the completion and response rates is due to the voluntary nature of the evaluation questions. Learners are invited to complete the questions embedded within each module, however answers are not forced. Learners can choose to engage with the education without answering the evaluation questions. The data analysed is self-reported, and it is unknown which management strategies, if any, have been implemented, or if these strategies were adopted or quoted from the recently completed education module. Organisational policies and cultures, along with government policies and resources, also impact the systems and capacity of teams to work together. This study focused on the individual clinician level and as such did not incorporate the macro picture of healthcare systems.

CONCLUSION

In the complex, fast-paced hospital environment, the potential for conflict among hospital teams is high. Autonomous professional practice can often clash with cohesive teamwork in this setting, impacting on the provision and delivery of quality end-of-life care for patients. Quality care relies on team members who work in unison, who can recognise conflict emerging and respond in a respectful and appropriate way. This study reports a wide range of management actions that HCPs say are helpful when differences of opinion among team members arise. These actions may be valuable to organisations considering how to address quality and safety in end-of-life care. Well-functioning teams who are equipped with strategies to identify and work through differences of opinion, strengthened by education and team building exercises, can evolve into stronger teams that are respectful and work towards upholding psychological safety.

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REFERENCES

1 Productivity Commission. *Introducing competition and informed user choice into human services: reforms to human services: report No. 85*. Canberra, ACT: Commonwealth of Australia, 2015.
2 Statistics Canada. Table 13-10-1715-10 deaths, by place of death (Hospital or non-hospital), 2021. Available: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310071501 [Accessed 2 Nov 2021].
3 Public Health England. Palliative and end of life care profiles, 2021. Available: https://fingertips.phe.org.uk/profile/end-of-life/data#page/4/gid/1938132883/pat/6/par/E92000001/ati/15/are/E92000001 [Accessed 2 Nov 2021].
4 Warraich H. *Modern death: how medicine changed the end of life*. New York: St Martin's Press/MacMillan, 2017.
5 Bloomer M. The challenges of end of life care in acute hospitals. *Collegian* 2015;22:241–2.
6 Bloomer M. Palliative care provision in acute and critical care settings: what are the challenges? *Palliat Med* 2019;33:1239–40.
7 Lund S, Richardson A, May C. Barriers to advance care planning at the end of life: an explanatory systematic review of implementation studies. *PLoS One* 2015;10:e0116629.
8 Ho A, Jameson K, Pavlish C. An exploratory study of interprofessional collaboration in end-of-life decision-making beyond palliative care settings. *J Interprof Care* 2016;30:795–803.
9 Noble C, Grealish L, Teodorczuk A, *et al*. How can end of life care excellence be normalized in hospitals? Lessons from a qualitative framework study. *BMC Palliat Care* 2018;17:100.
10 Pype P, Mertens F, Helewaut F, *et al*. Healthcare teams as complex adaptive systems: understanding team behaviour through team members' perception of interpersonal interaction. *BMC Health Serv Res* 2018;18:570.
11 Australian Commission on Safety and Quality in Health Care. *National consensus statement: essential elements for safe and high-quality end-of-life care*. Sydney: ACSQHC, 2015.
12 Australian Commission on Safety and Quality in Health Care. *National safety and quality health service standards*. 2 edn. Sydney: ACSQHC, 2017.
13 End-of-Life Essentials. End-of-Life essentials: education for acute hospitals, 2021. Available: https://www.endoflifeessentials.com.au/ [Accessed 1 March 2022].
14 Rawlings D, Devery K, Poole N. Improving quality in hospital end-of-life care: honest communication, compassion and empathy. *BMJ Open Qual* 2019;8:e000669.
15 End-of-Life Essentials. Education modules, 2021. Available: https://www.endoflifeessentials.com.au/tabid/5195/Default.aspx [Accessed 1 March 2022].
16 Hutchinson C, Tieman J, Devery K. Evaluation of a toolkit resource package to support positive workplace behaviours in relation to quality end-of-life care in Australian hospitals. *BMJ Open Qual* 2018;7:e000286.
17 Patton M. *Qualititive Research & Evaluation Methods: Integrating theory and practice*. 4th edition. SAGE Publications, 2015.
18 Kelly LM, Cordeiro M. Three principles of pragmatism for research on organizational processes. *Method Innov* 2020;13:205979912093724.
19 Green J, Thorogood N. *Qualitative methods for health research*. 4th edition. London, UK: SAGE Publications, 2018.
20 Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. *Nurs Health Sci* 2013;15:398–405.
21 Saldana J. *The coding manual for qualitative researchers*. London, UK: Sage Publications, 2016.
22 Ramani S, Könings KD, Mann K, *et al*. A guide to reflexivity for qualitative researchers in education. *Acad Med* 2018;93:1257.
23 Rosen MA, DiazGranados D, Dietz AS, *et al*. Teamwork in healthcare: key discoveries enabling safer, high-quality care. *Am Psychol* 2018;73:433–50.
24 O'Donovan R, Ward M, De Brún A, *et al*. Safety culture in health care teams: a narrative review of the literature. *J Nurs Manag* 2019;27:871–83.
25 Robertson SB, Hjörleifsdóttir E, Sigurðardóttir Þórhalla. Family caregivers' experiences of end-of-life care in the acute hospital setting. A qualitative study. *Scand J Caring Sci* 2021. doi:10.1111/scs.13025. [Epub ahead of print: 12 Aug 2021].
26 Edmondson AC, Higgins M, Singer S. Understanding psychological safety in health care and education organizations: a comparative perspective. special issue on the role of psychological safety in human development. *Res Hum Dev* 2016;13:65–83.
27 Walter JK, Arnold RM, Curley MAQ, *et al*. Teamwork when conducting family meetings: concepts, terminology, and the importance of team-team practices. *J Pain Symptom Manage* 2019;58:336–43.
28 Australian Commission on Safety and Quality in Health Care. *Safety and quality of end-of-life care in acute hospitals: a background paper*. Sydney: ACSQHC, 2013.
29 Baggs JG, Schmitt MH, Mushlin AI, *et al*. Association between nurse-physician collaboration and patient outcomes in three intensive care units. *Crit Care Med* 1999;27:1991–8.
30 Aslakson RA, Cox CE, Baggs JG, *et al*. Palliative and end-of-life care: prioritizing compassion within the ICU and beyond. *Crit Care Med* 2021;49:1626–37.
31 Back AL, Arnold RM. Dealing with conflict in caring for the seriously ill: "it was just out of the question". *JAMA* 2005;293:1374–81.
32 Bloomer MJ, Ranse K, Butler A, *et al*. A national position statement on adult end-of-life care in critical care. *Aust Crit Care* 2021;9. doi:10.1016/j.aucc.2021.06.006. [Epub ahead of print: 09 Aug 2021].
33 Perera N, Gold M, O'Driscoll L, *et al*. Goals of care discussions over the course of a patient's end of life admission: a retrospective study. *Am J Hosp Palliat Care* 2021:10499091211035322.
34 Back AL, Fromme EK, Meier DE. Training clinicians with communication skills needed to match medical treatments to patient values. *J Am Geriatr Soc* 2019;67:S435–41.
35 Meier DE, Back AL, Morrison RS. The inner life of physicians and care of the seriously ill. *JAMA* 2001;286:3007–14.
36 Doas M. Are we losing the art of actively listening to our patients? Connecting the art of active listening with emotionally competent behaviors. *Open J Nurs* 2015;05:566–70.
37 Jahromi VK, Tabatabaee SS, Abdar ZE, *et al*. Active listening: the key of successful communication in hospital managers. *Electron Physician* 2016;8:2123–8.
38 Robertson K. Active listening: more than just paying attention. *Aust Fam Physician* 2005;34:1053–5.
39 Jonsdottir IJ, Fridriksdottir K. Active listening: is it the forgotten dimension in managerial communication? *Int J List* 2020;34:178–88.
40 Haley B, Heo S, Wright P, *et al*. Relationships among active listening, self-awareness, empathy, and patient-centered care in associate and baccalaureate degree nursing students. *NursingPlus Open* 2017;3:11–16.
41 Hunt PA, Denieffe S, Gooney M. Burnout and its relationship to empathy in nursing: a review of the literature. *J Res Nurs* 2017;22:7–22.
42 Bodie GD. The active-empathic listening scale (AELS): conceptualization and evidence of validity within the interpersonal domain. *Commun Q* 2011;59:277–95.
43 Mercer SW, Maxwell M, Heaney D, *et al*. The consultation and relational empathy (care) measure: development and preliminary validation and reliability of an empathy-based consultation process measure. *Fam Pract* 2004;21:699–705.
44 Institute for Healthcare Improvement. SBAR tool: situation-background-assessment-recommendation, 2021. Available: http://www.ihi.org/resources/Pages/Tools/sbartoolkit.aspx [Accessed 3 Nov 2021].
45 Childers JW, Back AL, Tulsky JA, *et al*. REMAP: a framework for goals of care conversations. *J Oncol Pract* 2017;13:e844–50.