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Interprofessional Empathy in an Acute Healthcare Setting

Keith Adamson
Wilfrid Laurier University

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INTERPROFESSIONAL EMPATHY IN AN ACUTE HEALTHCARE SETTING

by

Keith Adamson

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Abstract

interprofessional collaboration is emerging as a key factor in reshaping healthcare practices in Canada over the last eight years. Collaboration in healthcare necessarily implies health providers sharing responsibility and partnering with each other in order to provide comprehensive patient care. A review of the empirical literature on teamwork in healthcare settings suggests that relationships between service providers remain conflictual and variable in their commitment to interprofessional collaboration (Zwarnstein& Bryant 2000). Recently, social psychologists have given considerable attention to the possibility that empathy could be used to improve intergroup attitudes and relations (Batson & Ahmad, 2009). Although empathy may be referred to as a means to humanize healthcare practices, there have been no published studies from the healthcare literature on the nature of interprofessional empathy. Understanding frameworks different from your own and empathizing with other members of the team is fundamental to collaborative teamwork (Parker & Axtell, 2001). The aim of this study was to understand the nature of empathy between members of interprofessional teams within a hospital environment. The study followed the lived experience of 24 health professionals with their perspective of empathy on interprofessional teams. A two-step procedure to implement this study consisting of semi-structured interviews and depth interviews was used to understand the nature of interprofessional empathy. The analytical method of phenomenological data analysis as proposed by Moustakas (1994) was used to identify common themes and meanings across interviews. Findings from this study suggested that the following six themes were critical to developing high quality empathetic relationships on interprofessional

teams: (1) engaging in conscious interactions, (2) using dialogic communication, (3) understanding each other's roles, (4) appreciating personality differences, (5) perspective taking, and (6) nurturing the collective spirit. Knowledge around these themes will provide clinicians with the information necessary to develop a greater understanding of experiences that influence them in their day-to-day activities within their interprofessional teams. The research also found that (1) accessibility, (2) team-building, (3) overlapping scopes of practice, (4) teachable moments, (5) perception of workload, (6) empathetic leadership, (7) non-hierarchal work relationships, and (8) job security provided the necessary organizational supports to promote and sustain positive interprofessional relationships. The findings culminated in an idealized model of interprofessional empathy that was prescriptive in nature. The model delineated the foundational behaviors, actions and attitudes that may be necessary to support the development of healthy relationships among interprofessional team members.

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Introduction

The major aim of this dissertation is to describe and understand the phenomenon of *interprofessional empathy*. Before providing the reader with an operational definition of this concept, it is prudent to historically contextualize the birth of the term and provide context as to how the term was generated, some of the ideas from which it propagated, and the intention behind choosing the words that form the concept. There is a story connected to the emergence of the term that may enlighten readers about the choice of the term and what the term may ultimately mean. This will also give the reader a feel for the concerns that surfaced around the theme of empathy and how it coalesced with the impending need for collaboration between professionals in the healthcare world. A brief overview of the dissertation document is then provided.

The theme central to this dissertation—interprofessional empathy—has been germinating in me for a number of years. It first began to take root when I was manager of interprofessional practice at a downtown community teaching hospital in Toronto, Canada. At the time, the hospital had just received its patient satisfaction surveys with some very disappointing results. The most recent survey suggested that the hospital got average to high marks for attention to physical comfort but indicated that they could do better in providing adequate emotional support to patients. In reaction to the report the hospital was looking at ways to enhance its performance in providing emotional support. Attending to the dimension of emotional support would yield a major positive improvement in the overall patient satisfaction with the

hospital. In particular, it would be important to understand the nature of emotional support in the inpatient areas of the health centre, where the organization wanted to focus its efforts. More importantly, it would be crucial to understand emotional support from the patient's perspective. In other words, how do patients define emotional support? In the eyes of the patient, what are the behaviors of the healthcare provider that convey emotional support?

During that time, there was a bright young manager of quality and organizational performance who was given the task by the administration of studying the issue and making recommendations for the organization to make improvements in emotional support to patients. This manager knew that I was a social worker by training and thought that, as the manager of interprofessional practice, I could play a crucial role in changing clinician behavior so that patients perceived them as being more supportive. He recruited me onto the research team and we started our work.

The research lasted almost six months and yielded some very interesting results. One of the themes that emerged over and over again was the notion of empathy. In the emotional support study patients defined empathy as a mechanism through which caregivers conveyed to patients that they were understood and cared for. Words that participants used frequently to describe empathy included "caring", "gentle", "nice", "warmth", and "concern". The participants in the study referred to empathy as a vital component of the physical and psychological care they received from healthcare providers. Empathy for the participants centered on interactions that conveyed concern and understanding from the caregiver to the patient. Empathy was conveyed either through words or through actions, and sometimes through both.

Many of these themes were not new to me, but gave me reason to ponder the role of empathy within the present healthcare system. Through this emotional support study, I came to the conclusion that as healthcare providers we were focused on the technical aspects of care to the exclusion of the emotional aspects, and that there was an inordinate imbalance between what we thought was important for success with a patient and what the patient thought was important in order for them to move into a healing space. From that point I realized that empathy was not just a nicety in the clinical provision of services, but a necessary component in order for patients to feel cared for within the total provision of care.

I found myself thinking more and more about the wide spread issues around the provision of empathy in provider-patient relationships in general. Why was it that health care workers were having such difficulty providing empathy to their patients? My initial thought was to focus on nursing empathy, as they were and still are a major player in the provision of patient services within hospitals. However, as I continued to review the literature around nurse-patient relationships, it became apparent that many nurses believed that their challenge in displaying empathy towards patients was somehow linked to a lack of collegial support from other nurses. Nurses found themselves in adversarial relationships as opposed to supportive relationships with their fellow nursing colleagues.

My interest began to pique around the notion of collegial support. I briefly scanned the literature to explore how various disciplines were dealing with intra-professional relationships. As a professional social worker, I was particularly interested in understanding how social work dealt with the issue. Looking at the

social work literature I found that social workers believed that a major reason for burnout in the field of social work was due to a lack of collegial support. In the medical literature I found that physicians tended to be more competitive than collegial. I began to realize that in general, healthcare professionals had difficulty with intra-professional collegial relationships and that the nature of these relationships were having broad impacts on the quality of their work-life and the quality of care provided to patients.

I decided to share my concerns with a professor who was teaching a course I was taking on qualitative methodologies. She was a social worker by background and had done extensive research in interprofessional collaborative practice in palliative care. One day before class started I relayed to her my observations around the lack of collegial support within intraprofessional teams and that my interest was shifting from focusing solely on nursing to something with a wider scope, but that I was not clear on what I should focus. She suggested that if professionals were having difficulty providing support for each other intra-professionally, then this had to present serious implications for interprofessional collaboration. We discussed the fact that as healthcare systems in Canada began to push for interprofessional collaboration it would be critical to understand how members on interprofessional teams cared for, supported, and understood each other in the course of their teamwork. In other words, she suggested that I shift my focus from nursing empathy to interprofessional empathy on healthcare teams. It would be important to appreciate what interprofessional empathy looked like so that we could potentially leverage it against interprofessional collaborative relationships. The suggestion hit me like the proverbial

ton of bricks and I realized that I had found my cause, my raison d'être. I shared the idea with my thesis supervisor, who was excited that I had found a topic that I was excited about and helped me think through the initial study questions and research design.

My supervisor and I decided to use a phenomenological approach to understand the concept of interprofessional empathy. Phenomenological studies focus on describing what all participants have in common as they experience a particular phenomenon. The basic purpose of this phenomenological study was to understand how clinicians described empathy within their interprofessional team. My intent was to elicit these descriptions, in order to understand what clinicians had to say about the desirability, the value and the goodness of interprofessional empathy within the acute healthcare setting. Ultimately, my latent intention within the dissertation was to develop an idealized model that could be drawn upon to further support the development of empathy in healthcare clinical settings.

Partial support for this research was provided through an Ontario Graduate Scholarship which permitted the creation of paid research assistants and compensation of research participants. The research project giving rise to this dissertation was a team effort. The team was composed of an on-site research coordinator, two research assistants, and myself, as the principal investigator. Each member of the team had a specific role within the research project, which will be specified in the procedure section of the methods chapter of this document. As the dissertation focused on the idea of collaboration and relationships, I thought it would be imperative that we approach the research process in a manner which reflected a

spirit of collaboration and the infusion of multiple views and perspectives. As such, the following document demonstrates a team effort to understand the nature of interprofessional empathy in healthcare settings.

Chapter one provides an operational definition of interprofessional empathy and addresses the idea that the concept is a relatively new term. As no other research directly exists that studies interprofessional empathy, it was important to review the literature that addressed those constructs that were potentially related to the concept, mainly interprofessional collaboration, relationship-centered care, emotional intelligence, and empathy. It discusses the strengths and weaknesses of each of these concepts and how they could potentially play a role in the evolution of our understanding of interprofessional empathy. The chapter culminates in the central question of the dissertation: what is interprofessional empathy? It also provides the two sub-questions attached to the investigation of interprofessional empathy: how do professionals who are part of interprofessional teams describe empathy between team members? and what factors might enhance or diminish the ability of healthcare providers to be empathic with one another?

Chapter two examines the phenomenological approach employed and the methods used to carry out the research. It includes a review of the history of phenomenology and key concepts attached to the methodology, mainly epoche, phenomenological reduction, imaginative variation and synthesis of meanings. It then provides a rationale for choosing the Moustakas (1994) method of phenomenological analysis to help explore and understand the concept of interprofessional empathy.

Chapter three outlines how interprofessional empathy was described by healthcare workers who took part in this study and the environments in which they believe interprofessional empathy may flourish. The research revealed that interprofessional empathy is composed of six critical components and these components are supported by eight contextual elements. The chapter includes a phenomenological description of interprofessional empathy that synthesizes both the general description of how the phenomenon was experienced by participants and the contextual elements necessary for interprofessional empathy to thrive. A stage model is then proposed as a framework for future investigations into healthcare team relationships.

The final chapter summarizes what was discovered about the experience of interprofessional empathy and its relevance to me as a professional, to the healthcare field, to healthcare team work, and to healthcare organizations . It includes a critique of the research methods and procedures, including the limits and advantages of the research design, as well as the research team's intentions for future studies on interprofessional empathy. The findings of this research are discussed in light of the findings summarized in the literature review. The chapter closes with a discussion of the importance for organizations to nurture team relationships and the powerful impact that these relationships may have on patient satisfaction and outcomes.

Interprofessional Empathy

The History of Empathy in Healthcare

Empathy between healthcare professionals seems to be a taboo subject within healthcare environments, despite the fact that the concept is not at all alien to

healthcare. Over the past decade, there has been a plethora of studies on healthcare provider-patient relationships that overwhelmingly conclude that empathy is an essential ingredient within these interactions (Volker, 2007; Bylund & Makoul, 2002; Wilkin & Slevin, 2004). Based on this knowledge, these same studies implore and encourage healthcare workers to be empathic in their day-to-day interactions with their patients. Furthermore, during their professional instruction healthcare professionals are taught basic helping relationship skills and techniques on how to deal with patients. These teachings focus primarily on communication skills. A major oversight however, in both instructional and professional development programs is that healthcare workers are not taught to empathize with each other. It is a topic rarely addressed at conferences, or in academic and association journals. The lack of attention to the subject has led healthcare workers to be narrowly concerned about the relationships they have with their peers. To a greater degree, silence on the subject of empathy between providers has indirectly supported, in some instances, the continuance of non-collegial behaviors such as abuses of power, marginalization, hostility, and conflict. These behaviors may be fueled by a lack of professional and personal understanding between co-workers. It is noteworthy therefore, that while empathy is identified as a "helping" profession's most precious asset, its existence in the relationships between healthcare providers has been described as scarce to lukewarm (Shantz, 2007).

Understanding the nature of empathy between health providers may be critical for the implementation of new healthcare initiatives being supported by the federal and provincial governments over the last 10 years. In 2002, the Romanow

Commission report on healthcare reform in Canada challenged the healthcare system to move towards structures that encouraged "teamwork and interdisciplinary collaboration". This plea to collaborate grew out of the recognition that the complexity of health problems seen in patients required the cumulative knowledge of all health disciplines, as opposed to the exclusive knowledge of one discipline. The commission was reacting to patient accounts of their care from providers, as being competitive, fragmented and individualistic. Many patients wondered if their healthcare team members actually talked to one another. Patients compared their experience with healthcare teams, to being on an assembly line, where each professional came in, did an assessment, and then created their own treatment plan, as opposed to a collaborative plan that reflected the perspectives of various providers involved in the care of a particular patient, and included the patient perspective as well. The inexorable result of this lack of interprofessional collaboration was less than optimal patient care. As a result, collaboration has become a primary agenda within many healthcare settings.

The birth of a new era of collaboration between professionals entails various health professionals using their complementary skills to work together to provide care to patients based on mutual trust, and an understanding of each other's skills and knowledge. This may involve a mutually agreed upon division of roles and responsibilities which may vary according to the nature of the practice and skill sets of individuals. As such, collaboration in healthcare is built on a voluntary basis and implies cooperation, compromise, and conciliation (Martin-Rodriguez, Beaulieu,

D'Armour & Rerrada-Videla, 2005). It requires that the health professionals forego a competitive approach and adopt one based on sharing and partnership.

Transforming the present system from an intraprofessional focus to an interprofessional one comes with very impressive promises for both patients and providers. Improved teamwork and collaborative care have been shown to improve performance in many aspects of the healthcare system (Health Council of Canada, 2005). Recent reports on human health resources have suggested that teamwork might be an effective way of improving quality of care and patient safety as well as reducing staff shortages, stress and burnout among healthcare professionals (CIHI, 2001; Hayward, Forbes, Lau & Wilson, 2000). Other research has shown that teamwork can significantly increase job satisfaction of healthcare workers because of the potential for improved relationships between providers. The latter contributes to each member's well-being and professional growth (Borrill, West, Shapiro, & Rees, 2000). With such overwhelming evidence, it is hard to deny the benefits of collaboration.

The argument for interprofessional collaboration is so compelling that it should inspire healthcare workers to seek ways to improve their relationships. Today's healthcare workers need to realize that their working lives are set in collective environments with constant interactions with others (D'Amour, Ferrada-Videla, Rodriguez, & Bealieu, 2005; Safran, Miller, & Beckman, 2006), and that these interactions will have to reflect a new way of being with each other. As healthcare moves forward with integrating and improving teamwork, empathy may be

one mechanism used to facilitate and enhance understanding between the various social actors negotiating care within this particular context.

Empathic connection between colleagues has been described as a natural social need (Cacioppo, Fowler, & Christakis, 2009). Healthcare workers are people. The patients they look after are people. People—whether helper or those who are helped—have social needs. The need for connection, the need for socialization, and the need to belong are intricate to the development of human beings (Hawkley, Brown, & Cacioppo, 2005). Therefore, as human beings, healthcare workers have a need for connection. And though patients are considered to be the primary focus of healthcare interventions, relationships between healthcare providers should not be considered as secondary to provider-patient relationships in healthcare settings. These two relationships must go hand in hand. Good provider relationships should lead to better patient care outcomes. This is because good relationships mean that team members may be more prone to help each other, communicate with each other about patient care issues and challenges, support each other instrumentally and emotionally, and be willing to coordinate care in a manner that maximizes treatments for their patients.

Though the evidence for interprofessional collaboration has been convincing, achieving interprofessional collaborative relationships has proved to be a challenge in healthcare settings (Irvine, Kerridge, McPhee, & Freeman, 2002). The Canadian Health Services Research Foundation (2005) released a report stating that despite a number of interprofessional collaborative projects supporting cooperation, transformation to teamwork in healthcare has been slow. They added that

professionals continue to protect their turf or limit their scope of practice (i.e., their job-specific activities) to respond to their own needs and interests. Interprofessional relationships continue to be characterized by conflict and inconsistencies between the way that a particular profession views itself and how it is viewed by other occupations (Irvine, Kerridge, McPhee, & Freeman, 2002). Even more interesting is a review of the empirical literature on interprofessional teamwork in healthcare settings suggesting that the effects of programs created to assist health professionals in working together effectively have had mixed impact on professional practice and patient care (Reeves, Zwarenstein, Goldman, Freeth, Hammick, & Koppel, 2008). Even where professionals value their collaboration with each other, the relationship may still be characterized by conflict, independence and non-democratic interactions (Zwarnstein & Bryant, 2000). Though these authors' conclusions are not definitive about the impact of collaboration, based on the potential benefits of collaboration mentioned earlier, the healthcare system must continue to pursue strategies that support the development of collaborative practice. Patients' lives depend on good collaboration. Empathy may be one mechanism to build understanding between workers. Healthcare providers therefore need to reflect, describe, and understand their empathic stance towards one another and be aware of the conditions that nurture and support the development of strong empathic relationships between professional colleagues.

Interprofessional collaboration cannot be understood without taking into account the different perspectives among healthcare providers. Understanding points of views, perceptions, and ideas different from one's own and empathizing with

others appears to be fundamental to collaborative work (Parker & Axtell, 2001; Shih, Wang, Bucher & Stotzer, 2009). Empathy has been shown to be an important facilitator in the development of constructive interpersonal relationships (Lauder, Reynolds, Smith & Sharkey, 2002). While empathy has been described as a quality shown by individuals which enables them to accept others for who they are, to feel and perceive situations from another perspective, and to take a constructive attitude towards the advancement of the others' situation (Cooper, 2004), this may not be an accurate description of what is experienced by members of interprofessional teams in healthcare.

It has been suggested that empathy is not part of the clinical culture within healthcare environments (Reynolds & Scott, 2000). Others have described the relationship between providers as unsupportive (Reynolds, Scott & Austin, 2000). If this is true, then healthcare professionals need to examine their own understanding of the relationships they have with each other and how their empathic stance is fundamental to their collaborative endeavor. More importantly, how can caregivers understand their patients if they are challenged in understanding each other? This situation highlights a need for all healthcare professionals to adopt a non-defensive posture when relating to healthcare professionals from other discipline, to start to entertain various perspectives, and to identify with other professionals who may hold different views and values from their own.

A study by Shih, Wang, Bucher, and Stotzer (2009) found that perspective taking improves attitudes towards others. They found that being able to take perspective not only improved attitudes towards others but also reduced prejudice and

discriminatory behavior against others. If clinicians were able to bear witness to one another's experiences and ordeals then a new level of understanding, cooperation and caring may be forged. Charon (2001) has suggested that if clinicians bore witness to each other's experiences, this exchange could potentially forge new ground in the realm of cooperation between team members. As such, it seems imperative to focus our attention on those moments of empathic exchange between healthcare providers that may help us attain some clarity as to how to describe the essential components of the nature of empathy between providers. More importantly, it is essential to comprehend what that empathic exchange between healthcare providers actually looks like.

Empathizing with others may be fundamental to collaboration and interprofessional work. However, despite its relevance, there have been no published studies in healthcare on the nature of interprofessional empathy. Although empathy is amply referred to as a means of humanizing healthcare practices (Pembroke, 2007), the relationship between healthcare provider and patient has received most of the attention, with empathy between interprofessional team members receiving no attention at all. Because we have limited knowledge of the complexity of interprofessional relationships (D'Amour et al., 2005), and because there is a strong suggestion in organizational literature that empathy may be the key to a potentially more humane, less stressful and considerate environment, this aspect of interprofessional collaboration requires further investigation within the healthcare context.

Interprofessional Empathy

The concept of interprofessional empathy is the phenomenon of interest in this research. The word *interprofessional* means when two or more healthcare professionals from different disciplines come together to learn about, from, and with each other in order to work on a substantive matter or issue (World Health Organization, 2010). In general, *empathy* can be defined as the act of feeling oneself into the experience of another person in order to understand the other's experience fully (Pembroke, 2007). Interprofessional empathy in the context of this study is the ability and willingness of healthcare providers to listen to, understand, and care for each other. The ability to show empathy between providers may be a fundamental requirement to acting in a helpful way. More specifically, understanding the intrinsic and extrinsic characteristics and qualities of interprofessional empathy will shed light on how this concept actually manifests in day-to-day clinical work between providers.

Empathy has been touted as a key ingredient to improving intergroup attitudes and relations (Batson & Ahmad, 2009). As such, empathy may prove to be a key ingredient in supporting interprofessional collaborative relationships. In order for empathy to influence relationships within the healthcare environment, it is important to know what is meant by empathy between members from different professions. One challenge that healthcare workers may face within the context of their clinical settings is the opportunity to experience interprofessional empathy so that they are better prepared to integrate interprofessional empathy into their efforts towards collaborative practice. Before healthcare workers can provide these opportunities, however, they must understand their own experiences of giving and receiving

interprofessional empathy. The purpose of this phenomenological study will be to describe the nature of interprofessional empathy based on healthcare providers' lived experience with this phenomenon.

Significance of the Study

The study will enable healthcare providers to develop a greater understanding of experiences that influence them in their day-to-day activities within their interprofessional teams. Without an understanding of the lived experience of how healthcare providers experience empathy between each other, it is not possible to understand how empathy is or can be incorporated into interprofessional collaborative teamwork. More importantly, the word *team* within the context of this research refers to the number of persons associated in some joint action, regardless of whether the team membership was consistent or transient. I could have chosen a bounded team for this research, but the reality of healthcare teams is that they are far less bounded, and somewhat dispersed. This investigation into healthcare professional's experiences of empathy will therefore contribute to a better understanding of the phenomena of empathy within the context of interprofessional collaboration over the daily course of team interactions in healthcare work places.

Empirical studies suggest that empathy has a motivational influence on human interactions, which adds to the quality in every work place (Costa, Glinia, & Drakou, 2004). This means that people at work want to be supported in their efforts socially and emotionally. Furthermore, it has been suggested that mutual caring between members of a team is a vital piece of the group's effectiveness (Druskat & Wolff, 2001). In essence, people may therefore require empathy from others in their work

environment. Teamwork has become a sine qua non condition for effective practice in health-related organizations (D'Amour et al., 2005). As such, it would be expected that empathy should occur within these interprofessional teams. How this interaction looks and the conditions that generate it still appear unknown.

Empathy is becoming an important focus in organizational research. Costa, Glinia, and Drakou (2004) claim that empathic behavior should become the focus of future studies in the workplace, not only for the purpose of advanced service quality, but also for the team spirit and the working environment in general. More specifically, shared empathy among professionals within the healthcare environment may have significant benefits for empathy that patients experience over the course of their clinical treatment. If clinicians feel cared for and supported, we may see an enhancement in the quality of empathic responses towards patients. Understanding and identifying what empathy between healthcare professionals from diverse disciplines looks like therefore becomes essential, including an understanding of the factors that inhibit and facilitate the development of this phenomenon. Strategies can then be developed to support clinicians and organizations in creating environments conducive of interprofessional empathy, which may contribute to greater provider mental health, efficiency, and job satisfaction.

Review of Concepts Related to Interprofessional Empathy

Introduction

As no other research existed that directly studied interprofessional empathy in healthcare settings, it was helpful to address constructs that were potentially related to this concept and that had been investigated in the workplace. Four constructs that

were explored were interprofessional collaboration, relationship-centered care, emotional intelligence, and empathy. These constructs were sought out in order to help build and support the research for interprofessional empathy. Although all distinct phenomena with their own definitions, interprofessional collaboration, relationship-centered care, emotional intelligence, and empathy were intimately interrelated, and further exploration of these four elements in the literature provided me with substantial information to start my investigation. I will briefly provide a high level description of the relevance of these concepts to interprofessional empathy before going into more depth on each concept separately.

The literature on interprofessional collaboration focuses on the relationships and interactions that occur between co-workers (D'Amour et al. 2005). In other words, teamwork is a product of collaboration and collaboration is the process of interactions and relationships between health professionals working in a team environment. It is this process of collaboration that is most often discussed when talking about teamwork in healthcare (Meads, Ashcroft, Barr, & Scott, 2005). I was interested in looking at these relationships and trying to understand what makes them empathic.

One model that has been critical in understanding healthcare relationships is called Relationship-Centered Care (1994). In this model, relationships between patients and clinicians, among clinicians, and between clinicians and the community are emphasized. The model basically states that relationships provide the context for many functions and activities in healthcare and as such these activities and functions are mediated by the quality of relationships that link the patient, clinician, team,

organization and community. I would suggest that empathy plays a role in many aspects of this model, although often without its role being clearly specified. As such, this model provides a good foundation to understand meaningful relationships on teams within the healthcare environment.

Similarly, emotional intelligence might also be a key determinant in effective teamwork. Successful interactions entail the knowledge and application of good communication skills; they also encompass interpersonal skills that allow people to build good relationships with others (Grewal & Davidson, 2008). As such, emotional intelligence is a concept worth further exploration as it relates to interprofessional empathy, because it may be one of several important theories that can help move the understanding of healthcare relationships ahead by creating better working and caring environments.

Lastly, Salovey, and Mayer (1990) proposed that empathy may be the central characteristic of emotionally intelligent behavior. As such, it would be essential to explore the literature on empathy. Empathy has been identified as one of the 12 essential attributes necessary to meet the challenges of day-to-day team processes in the business world (Alligood, 2005). Empathy refers to the ability to fully comprehend other people from their own perspective. Within healthcare teams, learning to be empathic should facilitate the acquisition of the core competencies of trust and respect, knowledge of roles, appreciation of differences, and shared power and decision-making. These competencies are inextricably linked to interprofessional collaboration and practice.

Interprofessional Collaboration

Teamwork is not easy to accomplish within healthcare settings. In collaborative practice, individual team members assume profession-specific roles, but as a team, they identify and analyze problems, define goals and assume joint responsibility for actions and interventions to accomplish the goals (Counsell, Kennedy, Szwabo, Wadsworth, & Wohlgemuth, 1999). Goals that are developed must be compatible with the priorities of each team member. To interact meaningfully with each other and with the patient and/or family, team members must be familiar with the expertise and functions of the others' roles, and be in agreement on how goals will be met. Given the lack of common education and interprofessional experience, this poses a real challenge to practicing teams (Reese & Sontag, 2001).

Orchard, Curran, and Kabene (2005) suggested that although health professionals would likely report that they work in teams, in reality team members identified with their own professional group and this blocked their ability to consider the opinions and perspectives of others. They added that profession-specific world views merely prepared individuals to work within their profession, not to communicate with individuals from another profession. They concluded that autonomous and specialized professional training lead many professionals to believe that their discipline was sovereign. If disciplines believed in the sovereignty of their own perspective, this left little room for negotiation and partnership but most of all, understanding between professions. In a study by Zwarnstein, Reeves, Russell, Kenaszcuck, Conn, Miller, Lingard, and Thorpe (2007) on interprofessional communication a pre-intervention qualitative analysis revealed that a substantial

amount of interprofessional interaction lacked core elements of collaborative communication such as self-introduction, description of role, and solicitation of other professional perspectives. As such, despite an interest in wanting to use interprofessional approaches to promote collaboration in healthcare, studies are finding scant evidence in actual practice.

On any given team, each healthcare professional wants to be understood by the other members. To be understood in any circumstance is a basic human need (Meyers, 2003). This understanding forms the foundation upon which relationships are built. In the context of interprofessional collaboration the relationships that develop between the interprofessional team members are the foundation for collaborative practice. What attribute is it that gives the interprofessional team members the ability to understand each other and thereby promote the integration of various perspectives towards patient care? Some scholars have begun to make subtle references to empathy as a possible mechanism for facilitating interprofessional work.

Though there are many frameworks upon which we can implement interprofessional collaboration, one of the most popular in Canada is that of D'Amour and Oandasan (2005). This model has proposed interactional processes and organizational factors that support collaborative practice. Organizational factors refer to the development of leadership that understands interprofessional collaboration and the implementation of new mechanisms to restructure clinical care. Organizational factors can also speak to the mechanisms that leadership puts in place to support collaborative practice. The literature is scarce on organizational supports for collaborative practice, but what is known is that staffing patterns (Sinclair, Lingard &

Mohabeer, 2009; McCallin & McCallin, 2009), opportunities for members of the team to train together as a team (Baldwin, Royer, & Edinberg, 2007), non-hierarchal clinical relationships (Gaboury, Bujold, Boon, & Moher, 2009), and restructuring clinical care processes (Shantz & Napoli, 2003) may all play a role in developing stronger interprofessional collaborative relationships on teams. There is still a gap in understanding the necessary environmental supports for collaborative practice.

Interactional processes are concerned with two dimensions: shared team visions and sense of belonging. Shared patient oriented goals emerge when the team is focused on the patient, but at the same time one must recognize the diverse interests and the asymmetry of power of the various partners in care and the negotiations that result. The second interactional dimension—sense of belonging—refers to the bonds that develop between team members and their willingness to work together. This element contributes to a sense of mutual trust among members working in a team. In order to build trusting relationships, Oandasan and D'Amour (2005) stress that professionals must know each other personally and professionally. To know each other professionally means to be familiar with each other's mutual contribution to patient care through knowledge of each other's roles, responsibilities and theoretical frameworks. However, to know each other personally is not defined within the model. Though this "personal connection" is not explained, it can be reasoned that it refers to attitudes of transparency, commitment and sensitivity that team members may be expected to show towards one another. One may contend that the sense of belonging dimension in the model requires team members to adopt an empathic stance that supports a team atmosphere free of defensiveness that enables individuals to talk

about their needs and perceptions. However, though there may be a vague reference to the concept of empathy, this aspect of the model remains relatively unexplored.

Relationship-Centered Care

Relationship-Centered Care (RCC) (1994) was generated through the Pew-Fetzer task force on advancing psychosocial health education. Noticing discontent among patients and clinicians alike with the prevailing systems of healthcare, the task force sought to develop a values foundation for the work of healthcare professionals. As such, the relationship-centered model was built on four related principles: (1) relationships in healthcare ought to include dimensions of personhood as well as roles, (2) affect and emotion are important components of relationships, (3) all healthcare relationships occur in the context of reciprocal influence, and (4) RCC has a moral foundation. In suggesting that the focus of healthcare needs to be relationships, the model extends the latter principles to patient-clinician relationships, clinician-clinician relationships, and clinician-community relationships.

In an article by Beach, Inui, and the relationship-centered care research network (2005) these four dimensions have been explained further. In the clinical encounter RCC makes it explicit that clinicians are people caring for other people and as such this has to be taken into account in the patient-physician relationship. Others have suggested that the clinical encounter must also be supported by intentional behavior (Suchman, 2006). As such, RCC supports healthcare providers being unique individuals with their own set of experiences, values and perspectives. Providers are expected to be authentic in their interactions with the patient and each other. This

means that we respect the personhood of each clinician and patient, or any other individual with whom healthcare workers engage.

The second principle speaks to the idea that affect and emotions are important in developing, maintaining, and terminating relationships. Rather than adopting a neutral empathic stance, clinicians are encouraged to empathize with patients. The model is silent on affect and emotion on the clinician-clinician dimension, however, which needs further exploring. The importance of emotions is highlighted in studies by Miller, Reeves, Zwarnstein, Beales, Kenaszchuk, and Conn (2008) who explored how interprofessional teams managed their emotions and the emotions of others and found that there was more disengagement than emotional engagement. They stated that emotion work issues must be addressed before health care workers can engage with each other collaboratively.

The third principle simply states that there is a mutually beneficial relationship that occurs over the course of the clinical encounter. While the patient-clinician encounter has the goal of maintaining the patient's health, the clinician can also learn from the patient, and that should be acknowledged. And finally, RCC has a moral foundation, in the sense that genuine relationships are seen as morally desirable because it is through these relationships that clinicians are capable of generating the interest that one must possess in order to serve others. It speaks to a moral imperative to help another human being with genuineness and authenticity.

The RCC is a relationship model that needs to be fostered in healthcare. It speaks primarily to the patient-provider relationship, however, even though the model

itself includes multiple dimensions. As such, the clinician-clinician relationship dimension requires further exploration.

Emotional intelligence

Unlike interprofessional collaboration, empathy appears to be a clearly articulated central tenant in the emotional intelligence literature. Emotional intelligence (EI) has received much attention since its conceptualization by Daniel Goleman in 1995. The theory of EI was developed as the capacity for recognizing our own feelings and those of others, for motivating ourselves and for managing emotions well in us and in our relationships (Goleman, 1998). Emotional intelligence is using an awareness and understanding of emotion to improve thinking and action (Rapisarda, 2002). EI should be considered as an important concept for further exploration of interprofessional empathy, because empathy by itself is a skill and mind-set, often expressed and even measured in terms of emotional intelligence within the world of business (Cliff, 2008).

Goleman and his colleagues organized EI into two broad competency groups: personal and social competence. Personal competence included two sub-categories of skills necessary to manage oneself: self-awareness and self-management. Self-awareness was defined as knowing what we were feeling in the moment and using those preferences to guide our decision-making, as well as having a realistic assessment of our own abilities and a well-rounded sense of self confidence (Goleman, 1998). Others have reinforced the importance of self-awareness and have suggested that knowledge of self is key to understanding others (Alligood & May, 2000; Price & Archibold, 1997). Self-management was defined as handling our

emotions so that they facilitated rather than interfered with the task at hand, being conscientious and delaying gratification to pursue goals, and recovering well from emotional distress (Goleman, 1998). The second broad category of social competence included two other sub-categories of skills critical to the successful management of relationships: social skills and social awareness. Social skills was defined as handling emotions in relationships well, accurately reading social situations and networks, interacting smoothly, and using skills to persuade and lead, and to negotiate and settle disputes, for cooperation and teamwork (Goleman, 1998). Lastly, social awareness was defined as sensing what people were feeling, being able to take their perspective, and cultivating rapport and attunement with a broad diversity of people (Goleman, 1998). Empathy is a fundamental competence of social awareness. Goleman defined it as awareness of others' feelings, needs, and concerns (Goleman, 1998)

Rapisarda (2002) studied the impact of emotional intelligence on work team cohesiveness and performance. She examined the relationship between the average score of team members on thirteen emotional intelligence competencies, and ratings of team cohesiveness and high performance in 18 teams in an executive MBA program. She learned that EI competencies of influence and empathy were positively related to student and faculty ratings of team cohesiveness. In particular, empathy was positively related to student and faculty ratings of team performance. And though some scholars question how the subsumed competencies of EI are related to the overarching concept of EI (Zeidner, Mathews, & Roberts, 2004), it is clear that the competency of empathy plays a key role in the development of cohesiveness and high performance in teams. As a matter of fact, one of the most common criticisms of the

EI concept is that it subsumes a plethora of competencies such as empathy, conflict resolution, teamwork, communication skills, and leadership. Placing all such concepts under the overarching concept of emotional intelligence may confuse rather than clarify the role of empathy in the workplace. This suggests that empathy warrants special attention in its own right, particularly with respect to how it operates within organizational teams. Dealing with the distinct but possibly interrelated competency of empathy may be more tractable for research and practical purposes.

Goleman's categories of self-awareness and self-management referred to personal competencies, while social awareness and social skills were social competencies. Both competencies consisted of skills that were important for understanding ourselves and building relationships. Goleman's emotional competencies also concentrated on the values of caring, compassion, and collaboration at the interpersonal level. More importantly, the development of social and emotional competence and empathy awakened the sense of moral responsibility in individuals for the well-being of their peers (Gordon & Green, 2008). As such, these competencies may have the potential to contribute to social justice and accountability at the collective level. I would suggest that if Goldman highlighted personal and interpersonal intelligence, it is important to see the value of emotional intelligence in contributing to the development of a collective emotional intelligence, or the ability of members of a group to take responsibility for their actions or inactions towards each other. The development and understanding of the concept of interprofessional empathy may lend itself to the development of a collective emotional intelligence. As healthcare workers become aware of and integrate

interprofessional empathy into their practice, their awareness of and concern for one another may tip the ecology of the healthcare environment, to one that fully supports partnership, sharing, and collaboration and awakens the sense of moral responsibility in members of healthcare communities.

Empathy

Empathy appears to be very important to human relationships. Many scholars would argue that it is empathy that provides individuals with the capability to demonstrate understanding, caring and support for one another. It may also be considered an important ingredient in all human communication. However, despite years of interest and numerous studies on empathy, its meaning and nature remains unclear (Irving & Dickson, 2004; Decety & Jackson, 2006). The concept of empathy will be reviewed from a general perspective and will be discussed further within two contexts: workplace and healthcare settings.

Following an extensive review of the literature, Morse, et al. (1992) identified four components of empathy: moral, emotive, cognitive, and behavioral empathy. Moral empathy referred to an internal altruistic force that motivated the practice of empathy (Morse et al., 1992). More broadly, it referred to the unconditional acceptance of another human, just because the other person was a human being. Moral empathy encouraged a humanitarian approach to interacting with other individuals. Morse et al. (1992) referred to it as a predisposition that prepared individuals to receive others. Emotional empathy referred to the ability to subjectively experience and share in another's psychological state or intrinsic feelings (Morse et al., 1992). This kind of empathy was driven by a process called identification. Morse

et al. (1992) described identification as a process through which one individual's distress caused similar feelings in the empathizer. They stated that emotional responses could be vicariously generated. This emotional response gives way to a behavioral and cognitive response. Cognitive empathy referred to the intellectual ability to identify and understand another person's feelings and perspective from an objective stance (Morse et al. 1992). The cognitive component of empathy was primarily about being able to look at an issue or thing from another person's perspective. It was about being able to adopt another person's world view and examine the world as they would see it. Finally, behavioral empathy was a communicative response to convey understanding of another's perspective (Morse et. al., 1992). This form of empathy relied principally on conveying to the person in distress that the empathizer understands what the distressed person may be going through, and as a result, the empathizer demonstrated some sort of verbal or non-verbal gesture to confirm this understanding. The different components of empathy identified above, may all contribute to empathy but the extent to which they are all interrelated appears to be a source of disagreement among theorists (Reynolds and Scott, 1999).

In spite of frequent references to empathy as a human quality emphasizing the four previous components, alternative views were found in the literature. Kunyk and Olson (2001) attempted to review the literature on empathy using the methodology of concept analysis. They concluded that authors were approaching empathy from a variety of perspectives and suggested that there were five popular conceptualizations that merit our attention: empathy as a human trait, empathy as a professional state,

empathy as a communication process, empathy as caring, and empathy as a special relationship.

Conceptualizing empathy as a human trait suggests that empathy is an innate natural ability. Kunyk and Olson (2001) suggested that other terms used for this conceptualization of empathy were natural, instinctive, and emotional intelligence. This definition of empathy focused on the accurate perception of others' feelings and situations, and understanding what this means for the other person. Hodges and Klein (2001) have suggested that most people manage to pick up empathy skills without aid or special lessons, and though it may be acknowledged that most people may understand the benefits of empathy in their interpersonal interactions, empathy may differ from person to person. As such, empathy is a human trait that still must be nurtured. Alligood (2005) called this the "human developmental empathy trait". In other words, each individual had an innate ability to empathize, but this trait needed to be nurtured. Through nurturing and support a person could learn to use their individual strengths and empathic abilities.

Empathy as a professional state was envisioned as a learned communication skill comprised primarily of cognitive and behavioral components that was used to convey understanding of another person's reality to them. This conceptualization of empathy is quite popular in the healthcare system. Fields et al. (2004) studied empathy in nurses and physicians. Within this study they defined empathy as "a cognitive attribute that involved understanding of the inner experiences of the patient, combined with a capacity to communicate this understanding to the patient" (p. 84). The over-riding cognitive dimension of this definition puts aside any kind of

emotional connection to the patient. Haplern (2003) has suggested that many healthcare providers are taught to deal with their patients with a detached concern. He claimed that detached concern skills allowed healthcare workers to acknowledge emotions through the ability to label the emotional states of their patients, but these skills did not permit healthcare workers to accompany the patient in the patient's emotional state. He ended by suggesting that in today's medical education, empathy was taught to be an intellectual rather than emotional form of knowing. Consistent with this thinking, Maatta (2006) has addressed the issue of closeness and distance in the health provider-patient relationship. She suggested that in much of the healthcare literature the rule of keeping your distance appeared both implicitly and explicitly. She added that sometimes it was even thought that the ability to keep your distance was a prerequisite for being able to help in order to maintain one's objectivity. Bruhn (2001) stated that sometimes health professionals felt like they had to control their human side in order to maintain a professional distance. This conceptualization could lead to the dehumanization of the medical encounter. In this conceptualization, empathy included emotional distance from the client, an appropriate professional response that enhances objectivity.

The conceptualization of empathy as an exceptional form of communication breaks empathy into a process whereby the healthcare provider perceived the client's emotions and situation, then expressed understanding, and the client perceived the understanding of the care provider. The primary characteristic of this conceptualization was that the healthcare provider be able to communicate their empathic stance to the patient. This could be done in both verbal and non-verbal

ways; however, in order for the patient to know that the worker was empathic it must be expressed or made visible (Peterson, 2008). This implied that professionals must have the appropriate communication skills, to effectively express empathy to their clients. Others have found that positive communication patterns were important to good team relationships (Lemieux-Charles & McGuire, 2006). Given that communication skills work is focused on improving interaction with others, some authors believe that more research activities need to be focused on this very critical skill (Chant, Jenkinson, Randle, Russell, & Webb, 2002).

Empathy can be conceptualized as caring. In this conceptualization the client being understood was not considered an outcome of the empathic process. Rather the outcome of the empathic process was when the patient's suffering was physically and emotionally alleviated. Garden (2008) suggested that empathy was a collaboration between the patient and healthcare provider that involved an "action component". She added that providers must move beyond psychological engagement to material aid. Caring referred to what an individual actually did to and for another, based on the helper's perception of the other's experience. This idea was supported by Wilkin and Slevin (2004), who investigated the meaning of caring to nurses. The researchers found that caring was primarily described as a process involving feelings together with professional knowledge competence, skill, and action. In general, it would be important to note that caring therefore is not a passive endeavor, but is loaded with action.

Lastly, empathy as a special relationship required a reciprocal rapport to develop over time between the health provider and the client. This form of empathy

denoted more of a friendship than a professional relationship where distance was encouraged. Kirk (2007) suggested that empathic relationships needed to be characterized by reciprocal self-disclosure. She added that intimate interactions required complimentary behavior between parties. The over-riding notion from this perspective was that closeness could not be avoided, if humans were to be empathic. Furthermore, empathy has been described as "a shared moment of meaning" (Maatta, 2006, p.5), or a moment that is characterized by the merging of two worlds, where all parties involved put aside their separateness in order to experience an inter-human connection.

Despite the various conceptualizations and iterations of the components of empathy, one assertion has garnered unequivocal consensus: empathy is a powerful and important concept. There is also a large body of research and literature that demonstrates that empathy is the single most important ingredient in the helping relationship (Reynolds & Scott, 2001). Furthermore, the various conceptualization of empathy may prove interesting for interprofessional collaboration, because, if a particular profession is socialized to embrace one kind of empathy over another, then the possibility of not understanding the empathic concern of a colleague from a different profession may go unnoticed and unrequited. The very nature of how different professions understand and show empathy may be at the root cause of clinicians thinking that they work in an uncaring environment.

Empathy in the workplace.

There have been very few studies on empathy in the workplace. Those studies that have been done have focused primarily on empathy as a skill used by employees

to improve customer satisfaction, empathy as a skill that leads to leadership emergence, and empathy as a leadership skill that engenders increased performance and team outcomes. Most of these studies have been done within the competitive world of business. It would appear that though business is usually equated with the "bottom line" of dollars and cents, many business leaders have learned the value of paying attention to those skills that help them make more money, such as understanding their customers, which involves a certain degree of empathy.

In the business literature, empathy has been used as a mechanism to produce altruistic behavior in employees towards customers. Employees are taught about empathy and customer service and their performance is rated based on customer satisfaction. Hochschild (2003) introduced the concept of emotional labor to describe how workers in many service industries are expected to manage the experience of their customers by displaying emotions in a manner that elicit positive experiences for their customers. Employees within the service industries are being made aware of the potential impact of their dispositions on customers and as a result are being asked to recognize that their empathy is a powerful resource that can positively influence a service encounter.

Customer service has become so important that business organizations are trying to capture service quality through measuring customer satisfaction. For example, researchers Parasuraman, Zeithaml, and Leonard (1994) developed SERVQUAL, an instrument used within service organizations for clients to rate service quality. The survey includes five quality components: tangibles, responsiveness, reliability, assurance, and empathy. In their model, empathy refers to

a friendly and caring attitude demonstrated toward individuals, as well as individualized attention to customers. Moreover, it refers to the emotional understanding, emotional participation, and spirit of generosity by the service providers towards a client during a service incident (Barlow& Maul, 2000). Service quality in business revolves around these five dimensions (Pan & Kuo, 2010).

Empathy has also been studied in business from a leadership perspective. Kellet, Humphrey, and Sleeth (2006) did an empirical study of small workgroup peers. They investigated relationships among perceptions of emotional abilities and leadership emergence. While controlling for cognitive ability and complex task performance, they found that people who rated highly on empathy garnered attributions of leadership from their peers. Their study found that an individual's empathy related positively to ratings of task leadership and relations leadership. This study suggested that employees were particularly open to leaders that were perceived as empathetic. In an earlier study, Kellet, Humphrey, and Sleeth (2002) suggested that individuals recognized leadership qualities in people who displayed strong emotional abilities. Other authors concur and push the idea even further by stating that empathetic leadership is required to encourage quality relationships on work teams (Hammick, Freeth, Copperman, & Goodsman, 2009).

Skinner and Spurgeon (2005) studied the relationship between a healthcare manager's self-assessed empathy, their leadership behaviors as rated by subordinates, and subordinates' personal ratings on a range of work satisfaction and related outcomes: work satisfaction, willingness to put in extra effort, manager's effectiveness, and organizational commitment. Empathy in the study was conceived

of consisting of three distinct but related individual dispositions, namely empathic concern, perspective taking, and empathic matching. Perspective taking demonstrated an association with employee job satisfaction, manager effectiveness, and willingness of the employee to give a little extra effort. Empathic matching was correlated with organizational commitment and extra effort, while empathic concern was correlated with extra effort. This study shows a definite relationship between empathetic leadership and its impact on employee behavior and suggests that the workplace relies heavily on interpersonal relations between managers and their employees. It is therefore plausible to believe that employees would benefit from a similar empathic relationship with their peers. Unfortunately, Skinner and Spurgeon did not investigate the relationship between peers, nor did they study the context as far as the conditions/situations in which empathy might be most relevant. They also did not identify what exactly is involved or not involved in the behavior of managers that employees perceive to be empathic. In other words, the specific behaviors involved in empathy in the workplace remain unclear.

Empathy in healthcare settings.

Within the healthcare world, empathy has historically been seen as having more benefits for patients. In the healthcare environment, empathy has been studied primarily in terms of health provider-patient relations. There is a general understanding that patients benefit when all members of the healthcare team provide empathic care. A study by Mercer, Neumann, Wirtz, Fitzpatrick, and Vojt (2008) found that general practitioner empathy was associated with patient enablement at consultation, and that enablement predicts patient-rated changes one month later. The

aim of this study was to investigate the relationships between general practitioners' empathy, patient enablement, and patient-assessed outcomes in primary care consultations. Patient's perception of their general practitioner's empathy was measured using the Consultation and Relational Empathy Measure. Patient enablement was measured by the Patient Enablement Instrument which asked the patient to rate whether as a result of the consultation they felt more able to cope with life, able to understand their illness, able to cope with their illness, able to keep healthy, confident about their health, and able to help themselves. The results of the investigation suggested that patients' perceptions of the general practitioners' empathy had a positive relationship with patient enablement at consultation, which in turn was predictive of positive changes in main complaint and well-being one month after consultation.

Other studies corroborate the idea that empathy is highly underrated among professionals in healthcare environments. Various investigations have found the empathy levels of health professionals to be low to moderate (Reynolds & Scott, 2000; Watson, Garfinkel, Gallop, Stevens & Streiner, 2000). The cumulative evidence in the literature indicates that many recipients of professional help do not believe that professionals understand their feelings and perspective (Lauder, Reynolds, Smith & Sharkey, 2002). Similar to business organizations, service quality has been a preoccupation for healthcare, especially in respect to the provision of emotional support to patients. Empathy is considered to be one aspect of emotional support (Ravazi & Delvaux, 1997). Many national and provincial Ministries of health have been attempting to develop patient satisfaction surveys that include indicators of

responsiveness to patient's emotional needs. The Picker Institute developed and extensively tested a survey instrument that was routinely used as a quality measurement tool within many hospitals in Canada. The most recent research suggests that hospitals get average to high marks for attention to physical comfort but indicates that they could do better in providing adequate emotional support to patients (Benko, 2003).

Researchers have attempted to provide interesting justifications for this negative client experience. Some researchers suggest that the highly technological aspects of care appear to be more important to the worker than the "caring aspects" of care, especially because healthcare workers are focused on saving lives and this is seen as their primary goal (Wilkin & Slevin, 2004). Other researchers have alluded to the idea that healthcare work is emotionally, psychologically, and physically draining (Peter, Macfarlane and O'Brien-Pallas, 2004). If healthcare providers feel that nobody cares for them, this is likely to act as a barrier to empathy and, as a consequence, they are less likely to appreciate the meaning of the patient's experience (Reynolds, Scott, & Austin, 2000). It becomes important to recognize that one potential source of caring for healthcare providers in clinical environments comes from the interprofessional team. However, empathy between team members in the healthcare context has never been recognized as an important ingredient in teamwork and has received very little attention.

Though empathy has been studied focusing on individual professions in relation to patient care, there have been no published studies located that have focused on empathy in the interprofessional workforce. That said, there has been

much attention given to those elements in the healthcare environments that may impede clinicians for caring altogether about patients and each other. Some authors suggest that healthcare practitioners may not have enough time or resources to enable them to care (Deikelman, 2002; Smythe, 2002; Stein, 2002). These authors refer to the speed of healthcare today and the importance of working faster with fewer resources that creates an acceleration of the work that is purely task-driven. McCurdy (2002) suggests that healthcare organizations are focusing more and more on the cost-effectiveness of the services they provide, while Banja (2006) warns clinicians that in the midst of unreasonable performance pressures they must not succumb to the belief that non-empathetic behaviors are acceptable in any circumstance.

Is There a "Down Side" to Being Empathic?

It would be wise to look at both sides of the empathy issue. Though empathy has been touted as an important dimension in human interactions, it is important to examine whether it poses any disadvantages in these relationships. As demonstrated earlier, empathy may be conceptualized differently by various people and as such, not everyone might see empathy as an elixir to all relationships. It may be important, therefore, to ask questions like: Can a human being be too empathic? Are there disadvantages to empathy? Few authors have tackled these questions. Despite the obvious advantages of understanding, caring and supporting another human being, empathy apparently does come with social and psychological costs.

Hodges and Klein (2001) have cautioned that knowing what another person is thinking and feeling does not guarantee empathy in certain terms. They go on to say that empathy is considered to be a socially accepted positive behavior that is

supposed to promote the other person's best interest. However, they stated that understanding what someone else was thinking did not ensure the benevolence that characterized empathy. They suggested that understanding a person's perspective could lead to covert manipulation and deviousness. They followed this assertion with an example:

> The truly diabolical twists on empathy involve not only imagining what the average person would do in a particular situation in order to exploit it, but also using individuating information about another person to harm him or her, such as a bully at work who mentions the very topic he thinks his co-worker is personally most worried about in front of the boss. (p. 439)

Ultimately, understanding what another person thinks, believes, and needs could have very differing outcomes based on how the keeper of the information decides to use it.

Hodges and Klein (2001) also provided another important social cost to empathy. It centered on the costs associated with the knowledge that accompanies empathy. There are some traits that we would rather not like to know about each other, or things that once we do know would make it personally and socially difficult to be motivated to help one another. As such, being able to see a facet of someone that most people would rather not see may handicap helping or collaborative efforts. For example, understanding the competitive nature of a colleague may squash an individual's desire to share a good idea, especially if they work in a cutthroat work environment.

The notion that greater empathic accuracy can enhance relationships may not prove to be true in all cases. Based on research by Simpson, Ickes, and Grich (1999), greater empathic understanding was associated with reduced feelings of closeness and with greater relationship instability. The researchers had dating couples infer their partners' thoughts and feelings from a videotaped interaction where each person in the couple rated slides of opposite sex individuals. They found that highly anxious, ambivalent individuals were more empathically accurate in a relationship-threatening situation; however, their self-reported thoughts indicated less confidence in their partners, and therefore they were less confident in their relationship. Among individuals who were not anxious about the relationship, the opposite pattern was found. As such, in some circumstances knowing or understanding more isn't always helpful, because it can increase an individual's feelings of threat and distress.

In a paper about clinical empathy in medicine, Pembroke (2007) argued that genuine empathy involved recognizing what the suffering of the patient felt like. However, he stated that emotional attunement was considered by some to be a liability in medical practice because emotional involvement interferes with the efficient execution of highly technical medical tasks. As a result, there is general agreement that empathy is important, but only on the condition that it does not interfere with the calmness and control of the physician. This is supported by Goleman (1998), who suggested that emotional intelligence skills were synergistic with cognitive ones. To perform well, individuals must have both. Goleman stated that "out of control emotions can make smart people stupid" (p. 22). This perspective

definitely leads one to believe that empathy must be a regulated and measured response.

A great number of publications and professional health journals warn clinicians against compassion fatigue, burnout, or caring too much. Huggard (2003) stated that central to these processes was the use of empathy by clinicians. He was not against the use of empathy in clinical encounters, as a matter of fact he advocated for it; however, he maintained that despite a health professional's best efforts to take care of patients, the use of empathy left the caregiver vulnerable to vicarious traumatization. He described the latter as the disturbing effects on clinicians that see or learn about the trauma experienced by their patients. He claimed that the dealing with empathy in healthcare rests more on organizational supports for workers, than worker individual coping mechanisms. He summarized this thought eloquently by writing:

> In caring for the carers, the challenge for health care organizations lies in developing respect and care for their employees in the same way they require employees to care for patients. In doing this, healthcare organizations will support and assist their employees in sustaining and further developing their humanism. (p.164)

Therefore, one cannot underestimate the importance of environmental supports that nurture and sustain empathy in healthcare environments.

The previous perspectives on empathy may provide some clarification as to the reasons that many healthcare environments may be described as scarce of empathy. A lack of "enough" empathy in these environments may be the result of a

defensive posture adopted by healthcare workers against the aforementioned issues. Many of the disadvantages to empathy may be seen ultimately as social, psychological and environmental barriers to empathic relationships. In particular, environmental barriers may shed some light as to how healthcare workers, who work in increasingly technologically sophisticated surroundings, must negotiate between the cognitive tasks of understanding and managing the technology in order to save lives and maintaining a desirable level of empathy in order to provide emotional support to their patients. As a matter of fact, in many circumstances medical technology acts as an interface between the provider and the patient (Pembroke, 2007). However, though we can speak to the argument that technical tools may get in the way of empathic relationships in provider-patient interactions, those technical tools should be less of a barrier for provider-provider relationships.

Research Questions

The present study is meant to explore the literature on interprofessional collaboration by building on past research on empathy and other related concepts, and extending them to a new context—interprofessional collaboration and practice. To the author's knowledge there is no other study that has been done in respect to interprofessional empathy within the hospital environment in Canada. For example, in doing a literature search in PubMed® and Medline® for information that spoke to team members being caring or empathetic towards one another, using various permutations in my search terms, I found very few studies that addressed this issue between providers, with the overwhelming majority of studies in healthcare addressing empathy in provider-patient relationships. Of those studies that addressed

empathy within healthcare teams, the focus was marginally geared around the relationships between providers and more about how to create a caring work environment. My study is important because it may fill a gap in the scarce research on interprofessional empathy between healthcare providers in the Canadian hospital literature.

Exploring empathy in this context is necessary, because empathy as a foundational concept in healthcare has been studied and applied primarily to the interpersonal process between healthcare provider and patient. And though this perspective holds much hope in fixing or improving provider-patient relations, we cannot assume that interprofessional empathy as a concept will look the same. For example, healthcare clinicians are trained to see their patients as helpless to a certain degree. There is an understanding that patients come to health providers because they know that they will be treated successfully. This puts the health provider in a powerful position. A health provider's demonstration of empathic behaviors like open questioning and exploring the psychological and social aspects of the patient's life experience may be generated through the need to rescue a patient in dire need. The provider may see the patient as vulnerable, and therefore remains in control and conducts the direction of the interaction. However, the demonstration of empathy between providers may be different. The power relationships are not the same when health providers are interacting with their peers. This shift in power dynamic might make empathy look very different from an interprofessional perspective.

The phenomenon investigated in this study is interprofessional empathy within collaborative teams in a healthcare setting. The following central question is

consistent with the exploratory intent of this study: What is the nature of interprofessional empathy?

An author typically presents a small number of subquestions that follow the central question (Stake 1995). As such the following questions will also be investigated as they pertain to interprofessional empathy:

1) How do professionals who are part of interprofessional teams describe empathy between team members?
2) What factors might enhance or diminish the ability of healthcare providers to be empathic with one another?

Methods

Methodological Considerations

Phenomenological research.

A qualitative, phenomenological approach was used to investigate the perception of interprofessional empathy between healthcare professionals. Qualitative studies are effective in providing an in-depth understanding of concepts and meaning (Britten, 1995). In order to discover how health professionals defined the meaning of interprofessional empathy and avoid the researchers' own bias, this methodology was most relevant and appropriate for this study.

Phenomenological research describes the meaning for several individuals of their lived experiences of a concept or a phenomenon (Creswell, 2007). The phenomenologist listens attentively to all individuals who share a common experience and systematically extracts those elements that all participants seem to have in common. The purpose of phenomenology is to reduce individual experiences with a

phenomenon to a description of the universal essence of the phenomenon. To this end, this study identified interprofessional empathy between healthcare workers as the focus of the investigation. Data were collected from healthcare workers' experiences with the phenomenon and a composite description of the essence of interprofessional empathy for all healthcare workers was developed. The experience of interprofessional empathy in this investigation is a lived experience and is therefore amenable to study through the use of a phenomenological method.

Philosophical perspectives in phenomenology.

Phenomenology as a philosophical tradition was first used toward the development of philosophy as a rigorous science by the German philosopher Edmond H. Husserl (1859-1938). Phenomenological psychology means the study of how people describe things and experience them through their senses (Patton, 2002). Husserl contended that people can only know what they experience by attending to the perceptions and the meanings awoken by their conscious awareness. As such, any object to which we direct our consciousness, anything upon which we focus our sense of smell, touch, taste, sight, and hearing are layered with personal meaning and perspective. Patton (2002) eloquently describes the link between experience, meaning, and conscious awareness. He states that initially all of our understanding comes from sensory experience of phenomena, but that experience must be described and interpreted. He continues to say that descriptions of experience and interpretations are so intertwined that they often become one. He concludes that the phenomenologist focuses on how individuals put together the phenomena they experience in such a way as to make sense of the world and, in doing so, develops a

world view. Essentially, phenomenology is about "what people experience" and how this experience helps them to shape their view of the world.

There are many different philosophical arguments for the use of phenomenology today. After looking across various perspectives, Creswell (2007) has suggested that phenomenology is essentially about the study of lived experiences of persons, that these experiences are conscious ones, and that the result of a phenomenological study is about developing a description of the essences of these experiences. However, at a broader level, three principle philosophical perspectives are emphasized in phenomenology:

A search for knowledge.

Research is about trying to answer questions about the world which need to be understood. It is a means through which humans can further understand the relationship between themselves and the things around them. The search for knowledge was the foundation for phenomenological inquiry. The empirical phenomenology approach involved a return to experience in order to obtain comprehensive descriptions that provided the basis for reflective analysis that portrayed the essences of experience (Moustakas, 1994). The return to experience was a departure from the accepted practice (during the end of the 19th century) where philosophy had become limited to exploring a world that could be observed or measured. Some thinkers of the time believed that a preconceived experimental design imposed so many conditions on subjects of an experiment that the results of the experiment could not speak to the full meaning of being human (Van Kaam, 1966). For Husserl, understanding the world started with being in tune with it. He

firmly believed that intuition was the gateway to knowing, and preceded empirical knowledge (Moustakas, 1994). Husserl did not believe that the methods used by other sciences were of any value to phenomenology because his approach to discovery was not influenced by induction or deduction but solely by intuition (Kockelmans, (1967).

Consciousness as an intentional experience.

The core doctrine in phenomenology is the teaching that every act of consciousness we perform, every experience that we have, is intentional. All of our awareness is directed toward objects (Sokolowski, 2000). Reality of an object then is inextricably related to one's consciousness of it (Moustakas, 1994). For example, in this study, I expected that individuals would rely on their internal and external experience of being conscious of the relationships they have with other healthcare professionals and that all of their awareness is directed towards describing interprofessional empathy, the object of this study. Intentionality supports the idea that consciousness is always directed toward an object.

Standpoint and its suspension.

Husserl called the freedom from suppositions the *epoche*, a Greek word meaning to stay away from or abstain (Moustakas, 1994). In the epoche, the researcher is supposed to set aside their prejudgments, biases, and preconceived ideas about the phenomena being studied. Essentially, the epoche process inclines one towards a greater and heightened receptiveness to information gathered through the interpretation of events, people, situations, and issues in the external world. Ultimately, in this process we are challenged to come to know things with an openness to receive information and a presence that lets us be, and lets situations and

things be, so that we can come to know them just as they appear to us (Moustakas, 1994). Previous ideas about our experience with a phenomenon should not taint our appreciation of anything new we wish to discover about it. However, there are some who question whether researchers can achieve this state of pure transcendence or receptivity without interpretation (McConnell-Henry et al., 2009). LeVassuer (2003) on the other hand, has suggested that the epoche may afford researchers an opportunity to question prior knowledge around a phenomenon, because the researcher assumes that he/she does not understand the phenomenon. He asserts that *bracketing*—a temporary suspension of prior knowledge—does not give way to a permanent denial of assumptions, but it should build curiosity.

Transcendental or hermeneutical phenomenology.

Husserl's phenomenology is also known as transcendental phenomenology. This eidetic phenomenology is focused on the descriptions of the experiences of participants. As such, participants are asked to describe a phenomenon, or a concern that affects them. In the process they reflect on the phenomenon as they have lived it. This is different from hermeneutical phenomenology, which relies heavily on the interpretations of the researcher.

There is an overarching guiding principle that research questions of any study must drive the choice of methodological approach. In considering which phenomenological approach to use in order to study interprofessional empathy, I considered three elements. First, in seeking to describe the nature of interprofessional empathy, I attended to the descriptions that individuals shared of their experience with that phenomenon. I am well aware that descriptions of experience and

interpretation of a particular experience are much intertwined. However, this study focused primarily on describing interprofessional empathy. Hermeneutic phenomenology is more concerned with interpretation, whereas transcendental phenomenology is focused primarily on description. The decisive factor in phenomenology is to create a faithful description of the object that is of central concern (Husserl, 1931). Second, related to the first element, I wanted to focus less on the interpretations of the researcher, and more on the description of the experiences of the research participants. As such, my interpretations as a researcher were not as critical to the understanding of interprofessional empathy as the perceptions of individuals who have experienced the phenomenon. Transcendental phenomenology is about capturing the experiences of others. Third, this study also sought to understand the conditions, situations, and contexts that support and nurture interprofessional empathy within healthcare teams. Though hermeneutical phenomenology asserts that context impacts heavily on existence and experience, transcendental phenomenology does not minimize the role of context either. Husserl (1931) introduced the concepts of *noema* and *noesis*. Noema refers to "that which is experienced"; the essential features of the experience consist of the neoma. On the other hand, noesis is about the act of consciousness. It refers to the way in which the what is experienced, or the act of experiencing the subject (Moustakas, 1994). In understanding how the phenomenon was experienced, the researcher must take into account the context and setting that simultaneously occurred as the phenomenon took place.

This study used the transcendental phenomenology method as developed by Clark Moustakas (1994). Moustakas summarized this form of phenomenology as a scientific study of the appearance of things, of phenomena just as we see them and as they appear to our consciousness. He adds that any phenomenon represents a suitable starting point for phenomenological reflection. He stresses that the very appearance of something makes it a phenomenon. He ends by stating that the challenge is to explicate the phenomenon in terms of its constituents and possible meanings, thus discerning the features and arriving at an understating of the essences of the experience.

There are four essential features to transcendental phenomenology that facilitate the acquisition of knowledge: epoche, transcendental phenomenological reduction, imaginative variation, and the synthesis of meanings.

Epoche.

As mentioned previously, epoche is a Greek word meaning to refrain from judgment. This is recommended as a first critical step for researchers in order to set aside their preconceived notions about things and look at the world where everything is perceived freshly. Husserl (1970) justifies this first step by saying:

> We must exclude all empirical interpretations and existential affirmations, we must take what is inwardly experienced or otherwise inwardly intuited as pure experiences. We thus achieve insights in pure phenomenology which here oriented to real constituents, whose descriptions are in every way ideal and free from presuppositions of real existence. (p.577).

As I personally reflect on the nature and meaning of epoche, I see it as a preparation for creating new knowledge, but also as an experience in itself, a process of setting aside prejudices and biases and allowing things to enter anew into consciousness. I embraced this idea when I began this project by describing my own views with interprofessional empathy and bracketing out my views before proceeding with understanding the experiences of others.

Transcendental phenomenological reduction.

In this step the researcher writes about what is experienced. Moustakas (1994) describes it as the task of describing the textural language of what one sees, not only in terms of the external object, but also the internal act of consciousness. He describes it as the relationship between the phenomenon and the self. He then suggests that the researcher focus on the qualities of the experience, filling in and articulating the meaning of the experience. Husserl (1931) states that:

> If we observe the rules which phenomenological reductions prescribe for us; if, as they require us to do, we strictly suspend all transcendences; if we take experience as pure, in accordance with their own natural essence, then after all we have set down there opens up before us a field of eidetic knowledge. (p. 187)

The final challenge of Phenomenological Reduction is the construction of a textural description of the experience. In the process of explicating the phenomenon, qualities are recognized and described; every perception is granted equal value, nonrepetitive constituents of the experience are linked thematically, and a full description is derived (Moustakas, 1994).

Imaginative variation.

In this step the researcher writes a description of how the phenomenon was experienced. This process recognizes the underlying themes or contexts that account for the emergence of the phenomenon. Moustakas (1994) states that the task of imaginative variation is to seek possible meanings through the utilization of imagination, employing polarities and reversals, varying the frames of reference, and approaching the phenomenon from divergent perspectives. Essentially the aim of this step is to arrive at what is known as a structural description of an experience, the underlying and precipitating factors that account for what is being experienced. In other words, it exposes the conditions that exist in the presence of the "what" of the experience. [1] Rapport and Wainwright (2006) would concur, and add that:

> Transcendental phenomenology movement is a dialectical process of analysis and synthesis and, as a result of the analysis-synthesis dialect; it results in the achievement of greater clarity of the world. Phenomenology is about coming to know the world through shifts of vision to arrive at clearer understandings of phenomena. (p. 232)

Synthesis of meanings and essences.

The final step in the phenomenological research process is the intuitive integration of the fundamental textural and structural descriptions into a unified statement of the essences of the experience of the phenomenon as a whole (Moustakas, 1994). Kockelmans (1967) has written, "Husserl uses the term essence to

[1] Structural descriptions within this research project on interprofessional empathy differ from Moustakas's in which he meant how the phenomenon was experienced by individuals in the study. For Moustakas a structural description answers how the experience of the phenomenon came to be what it is. In the present research structural is meant to include the environmental supports and contexts that nurture the development of empathy.

indicate that which in the intimate self-being of an individual thing or entity tells us 'what it is'" (p.80). Primarily, this step focused on the common experiences of the participants with respect to interprofessional empathy. Based on these experiences, we explored and determined the underlying structure of interprofessional empathy. It will be in this section that the reader will come away from the phenomenology with a conclusive understanding of the concept of interprofessional empathy, as seen in this particular research initiative.

The researcher's experience with the phenomenon.

To live out an ethic of interprofessional empathy means to be congruent with my personal values. Values determine how individuals face the world and relate with other people. For me, my life values are those that demonstrate what I care about. They guide my actions, choices, and decisions. As such, there are four core values that permeate my lifelong existence: caring, compassion, collaboration, and participation. Reflecting on the genesis of these four values in my life and how they have served me in my choices is critical to further understanding my interest in the subject of interprofessional empathy. My objective in this section is not to bore the reader with trivial aspects of my life, but to provide information about me as a "person" and a "healthcare professional". Sharing my story in a transparent manner is important, because as a qualitative researcher, I am the instrument through which the concept of interprofessional empathy will be filtered, interpreted, and described. My efforts to be self-analytical, politically aware, and reflexive will be the beginning of a personal journey and process that will hopefully bring authenticity and credibility to this investigation. I also want the reader to understand those personal and professional

experiences that have generated in me such an intense interest in interprofessional collaboration and more specifically, interprofessional empathy.

Going back to my childhood to examine the experiences that have contributed to the development of my present values challenged me to acknowledge those events that were joyful, and others that were painful. My parents divorced when I was 12 years old. My father's departure created significant economic, social, and psychological challenges that my mother, my two younger brothers, and I had to surmount. More importantly, these challenges evoked in me feelings of frustration, fear, anxiety, anguish, and despair. However, through all of this, I profoundly believe that the root of my caring came out of bearing witness to the suffering of my mother and brothers. As a matter of fact, my own experiences of personal suffering made me more sensitive to the suffering of those around me. This probably represents the birth of my wanting to understand the suffering of others and the genesis of what I call my compassion and my need to care for others. Empathy, from my perspective, was and still is about showing a genuine interest in other human beings and trying to understand each person's circumstance and as a result, treating them accordingly. Additionally, although Morse and al. (1992) describe four dimensions of empathy, I believe that the moral dimension is probably the most important component of empathy. I believe that I understand and endorse the moral components of empathy more than any other component. It is essential that a given individual encounters another as a person, which is a valuable adjunct to the whole process of coming to care what happens to each other and to respond with all one's talents and humanity.

When individuals see and treat each other as "human beings" they can now give and receive recognition, support, smiles, and laughter.

The concept of empathy became bothersome for me from the very inception of my career as a hospital social worker. During my years of formal training in social work and my subsequent employment in the hospital setting, the messages that I received about how to care for patients were somewhat contrary to what I had believed about the nature of caring. In the medical world, caring is called clinical empathy. It is the ability of the helper to understand the experience of the patient without actually participating in it. The aim is to relate to the patient with a "detached concern". It is held that opening oneself to emotion interferes with objectivity in providing effective and efficient services. However, I am of the opinion that genuine empathy and caring involves recognizing what the suffering of the patient feels like. Caring involves being moved emotionally by another person's experience, and not to detach yourself from it, but to live it with the person, to accompany them in their suffering. Isn't that what helping is all about? To break the feelings of loneliness that accompany despair? Many times I have cried with my patients and for my patients, but I have not shared these experiences with my colleagues. Reasons for not sharing include accusations that my emotional connection to my clients would have interfered with my clinical reasoning, and the tendency for colleagues to psychologize my behavior as being too "enmeshed" with patients.

I entered this research initiative with a bias that the work setting in healthcare is very complex because of the layers of contradictions within the system. For example, it has always been so amazing to me that healthcare workers are meant to be

empathic and supportive to patients, but that there is very little expectation for healthcare workers to be empathic with each other. Every day care providers must negotiate caring for sick patients in a manner that promotes the patient's psychological and physical well-being. This is not always an easy task for the healthcare worker because they must negotiate between the joys of contributing to a patient's healing process, the emotional and physical exhaustion that accompanies the activity of providing care, and the complex nature of relationships on their interprofessional team. Negotiating healthcare relationships in the midst of providing care to patients is a skill fraught with risks, especially when the team must integrate the perspectives and agendas of each professional involved in the patient's care in order to attain the best outcomes. For example, I have seen physicians, male and female, lash out at nurses, who in turn lash out at fellow nurses, who then target staff from social work and occupational therapy, without any of it coming to resolution. On a regular basis, they show up to work holding a grudge. This unresolved conflict affects the working environment with low morale and poor performance.

I remember a time when I was having a meeting with a physician and a patient, and during the meeting I referred to the physician by his first name. After the meeting, the first thought that was on that physician's mind was to scold me for calling him by his first name, and he asked me to address him as "Doctor" in front of his patients. Though his request may or may not have been legitimate, I could not help but feel "less than" an equal member of the team, and I felt oppressed. The conversation was left at that and there was no further discussion. Based on such professional experiences, I believe that there must be a conscious effort within the

healthcare system to choose interprofessional empathy not only as a mandate to give direction to interprofessional decisions and actions but also as a major inspiration to achieve excellence in everyday interprofessional practice. It is empathy, in my view, that should be recognized, internalized, and applied between healthcare providers in everyday practice.

However, I have also experienced brief moments of empathic exchange that came under the form of instrumental support. One of my first jobs in hospital social work was as a group therapist in a psychiatric day hospital. In this capacity I was dealing with patients who were suffering from mild depression and other mental health concerns. My job was to improve their psycho-social functioning through group modality by providing participants with coping strategies and techniques. I worked closely with an occupational therapist that was responsible for half of the groups. Together we were responsible for the whole day hospital group program. However, my role was not restricted to the day hospital program. I also had to perform family assessments with referred patients and cover the emergency department for mental health crisis emergencies. On several occasions, when I was exceptionally busy, the Occupational therapist was able to read my energy level. She was able to spot the exhaustion, and thus offered relief to me by running my groups for me. This show of empathy led to me being able to be more effective with the patients that I saw that day. There were days when I returned her kindness. These moments where we managed each other's workload were priceless. They demonstrated enormous caring and empathy. These moments made interprofessional practice worth all the effort.

Over the course of my professional career, I have held many roles in healthcare that focused completely or in part on interprofessional collaboration. Currently, I am Director of Health Disciplines at Women's College Hospital. One aspect of this role is to develop and create structures to facilitate interprofessional collaboration. Also, I was Manager of Interprofessional Practice for three years at St. Joseph Health Centre. I have been feverishly working towards making profound changes in the way that clinical care is structured so that it represents interprofessional collaboration, but I have been primarily focused on changing the nature of relationships between healthcare providers. In a conversation with my Chief Executive Officer, I told her that I was interested in interprofessional collaboration because I wanted people to be happy at work and I wanted patients to benefit from that joy. The various interprofessional practice projects were a means to doing this work. Ultimately, my philosophy is: how are we supposed to care for patients, if we can't care for each other as healthcare providers? The ability of human beings to extend themselves to each other appears to be a fundamental building block of communal love. Caring is generative. That is, if you have felt cared for, the probability that you will care for another is very likely. Not only will you want to care for that person, but you will know how to care for them, because you have had the experience of feeling what it is like to be cared for.

At this point it is difficult not to reflect on my education in community psychology and how it has influenced my stance on collaborative practice. As a matter of fact, there are tremendous similarities between community psychology and interprofessional collaboration. Community psychology's core values have been

classified into three groups: values of personal, relational, and collective well-being (Nelson & Prilleltensky, 2005). In particular, relational values of respect for diversity and the need for participation and collaboration, as well as the collective values of support for community structures, social justice, and accountability are important to underscore. These values are very consistent with those of interprofessional collaboration that speak to appreciating differences and resolving conflict, power sharing, shared decision-making, knowledge of roles, and trust and respect. It has been a serendipitous experience to learn about the founding principles and values of community psychology and be challenged to apply them every day in healthcare for the benefit of patients and staff.

Hence my experience with interprofessional empathy has been mixed, at times highlighting moments of a lack of empathic concern and at other times highlighting the power of empathy. I have also tried to live out an ethic of interprofessional empathy the way that I understand it: I have listened to my co- workers' professional and personal problems, I have tried to resolve disagreements with co-workers, and I have tried to be supportive of my colleagues. That said, on a regular, day-to-day basis, I have rarely seen interprofessional empathy in action. Or, maybe I have and did not take time to notice it. Just because I have not seen it every day does not mean that it does not exist in the clinical setting. In fact, with this research I have tried to look for it, find it, and describe it. I heard stories that shed light on the full richness and complexities of this phenomenon. My research participants' revelations included their best experiences of giving and receiving empathy, but also situations where they wanted to be emotionally engaged, but for one reason or another had to remain

emotionally detached. I wanted to harness the essence of their lived experiences to gain a deeper understanding and meaning of the nature of interprofessional empathy.

Biases and assumptions.

Before beginning phenomenological research, the first step for the investigator is to identify biases and assumptions that influence the investigator. By identifying understandings, beliefs, assumptions, presuppositions and theories, the investigator acknowledges them so that the investigator may deliberately place them aside during the course of the investigation. In phenomenology, this step is called the epoche process or bracketing. In the epoche, we set aside our prejudgments, biases and preconceived ideas about things. We hold back and exclude all commitments with reference to previous knowledge and experience (Schmitt, 1968). Some authors have gone as far to say that, theoretically, it is not recommended that transcendental phenomenological researchers actually do literature reviews before starting a study, as they claim that the adoption of any theoretical model innately develops a set of beliefs that can interfere with this phenomenological research process (McConnell, Chapman, & Francis, 2009).

Nonetheless, I have had an opportunity to reflect on the content of what I have written about my experience with the phenomenon of interprofessional empathy. This written exercise provided me with the possibility of reflecting on my personal meaning of empathy, my professional meaning of it, and how it has influenced the interactions that I have had with my colleagues. Interestingly enough, through the process of writing my stance, I learned about the assumptions that may or may not taint how I interpret the plethora of data that I received over the course of my

investigation into interprofessional empathy in healthcare settings. Ultimately, through this process I have learned that the following are my assumptions:

1. Interprofessional empathy is strictly a moral process.
2. Empathy between healthcare team members is essential in promoting interprofessional collaboration
3. Medical professions have embraced the concept of "detached concern", which would make a healthcare professional's expression of empathy towards others difficult to detect. Also, some healthcare settings may not be receptive to open displays of empathy; as a consequence clinicians may be providing empathy to each other in covert ways that may be difficult to detect.
4. Interprofessional empathy is a lived experience which is best described by the person who is living it.
5. Feeling empathy and living out an ethic of interprofessional empathy should be more than a simple choice that clinicians have. It should be a professional obligation and standard.
6. Healthcare environments are complex settings where the nature of relationships between the different actors in the setting must be negotiated.

Research Design

This study sought to describe the meaning for several individuals of their experience with interprofessional empathy. A phenomenological approach was used to investigate this concept. The study used a one-group design ($k = 1$), with participants ($N = 24$) representing a diverse professional composition. A stratified purposeful (convenience) sampling strategy was used in this research. Though

stratified purposeful sampling is often used to capture major variations among different groups, it was used in this research project to capture and identify a common core among these different professions. This meant that the selection process included individuals who could purposefully inform an understanding of interprofessional empathy.

Research Context

One of the first tasks in this research project was to choose a field setting where the research could take place. St. Joseph's Health Centre is a Catholic acute care community teaching hospital sponsored by the Catholic Health Association of Ontario and associated with the University of Toronto. Employing over 2,200 staff with 373 doctors, the hospital serves Toronto's West End community of 500,000 residents while also serving a broader community across the city, province, and country (St. Joseph Health Centre, 2010).

The hospital embraces an interdisciplinary approach to patient care—physical, emotional, and spiritual—through five clinical program areas (Women's, Children's and Family Health; Surgery and Oncology Services; Emergency, Ambulatory and Access Service; Medicine and Seniors Health; and Mental Health and Addictions Services), and four clinical service units (Diagnostic Imaging, Pharmacy, Laboratory, and Cardio-Respiratory) (St. Joseph Health Centre, July 2010). The Health Centre has a vibrant interprofessional practice infrastructure which consists of Professional Practice Leaders, who are the discipline-specific heads responsible for practice issues within their specific professions; discipline-specific practice councils that served the purpose of bringing all the members of a single profession together to set practice

standards and role clarity for the given profession hospital wide; and an interprofessional advisory committee, which is a forum that brings together all the heads of each discipline in order to discuss, debate, and share information that has interprofessional practice implications.

During the last three years St. Joseph's Health Centre had been active in interprofessional collaborative projects and has made interprofessional collaboration part of their strategic plan. The organization has gone through an exhaustive formal exercise to train nearly 500 staff members on interprofessional collaboration. The Health Centre was the recipient of more than three interprofessional collaborative grants to promote interprofessional collaborative practice which generated two St. Joseph Health Centre work books: one on the core competencies for interprofessional practice and the other on remodeling clinical practice for interprofessional collaborative care. These workbooks were being disseminated to support the implementation of interprofessional collaborative practice in other hospitals across the province during the execution of this interprofessional empathy research project.

The main reason we chose the St. Joseph Health Centre as a research site was because it demonstrated salient features relevant to the research study on interprofessional empathy. Pope and Mays (2006) stated that the choice of setting should typically be purposive. We wanted to select a setting that was likely to demonstrate salient features and events or categories of behavior relevant to the research questions. For example, one critical feature relevant for the study on interprofessional empathy was that the study site contained interprofessional clinical teams. The Health Centre has a vibrant interprofessional community as well as strong

interprofessional teams within many of its service units. Another critical feature was that clinical staff had to have some knowledge about interprofessional collaboration above and beyond their own personal understandings of the concept. St. Joseph Health Centre had previously trained up to 500 staff members in the five core competencies of collaborative practice: knowledge of roles, appreciating differences, shared power, shared decision-making, and trust and respect. As such, the organization supports a strong interprofessional work ethic and the development of interprofessional working relationships based on important elements of collaboration like trust, shared decision-making, and partnerships.

Sample Size and Study Population

Patton (2002) suggested that there are no rules for sample size in qualitative research. He did say however that less depth from a large number of people (as opposed to more depth from a small number of people) could be especially helpful in exploring a phenomenon. I would suggest that in this study, the research team attempted to achieve depth and breadth by being systematic in our approach to the research, and by being as comprehensive as possible in attempting to retrieve in-depth information from our research participants. For the purposes of this study it was anticipated that to obtain an in-depth understanding of interprofessional empathy, we needed to interview 24 participants.

Consequently, 24 participants were selected to take part in this study. The sample consisted of 10 men and 14 women between the ages of 18 and 65 years old. There were three participants from each of the following professions: nursing, occupational therapy, physiotherapy, unit clerkship, medicine, social work,

respiratory technology, and pharmacy. Thirteen individual professionals identified themselves as working on more than one interprofessional team within the hospital, and 11 individual professionals identified themselves as belonging to one core team. More importantly, the word "team" within the context of this research referred to the number of persons associated in some joint action, regardless of whether the team membership was consistent or transient. We could have chosen a bounded team, but the reality of healthcare team work suggests that healthcare teams are far less bounded and somewhat dispersed. Participants came from diverse clinical areas of the Health Centre, mainly oncology, emergency, general medicine, intensive care, psychiatry, pediatrics, palliative care, gerontology, and surgery.

Data Collection Instruments

Semi-structured interview.

A semi-structured interview method was adopted to collect data. The semi-structured interview consisted of eight open-ended, broad questions that facilitated the emergence of rich descriptions of the phenomenon of interprofessional empathy (see Appendix A for interview questions). Semi-structured interviews served as a method for gathering data in a short time frame in order to gain a broad spectrum of views on interprofessional empathy.

The semi structured interview guide went through several iterations. The original questions were developed from information based on the literature review of healthcare worker collegial relationships and other literature on empathy. The original interview questionnaire was vetted by my dissertation committee and modified for the purposes of the research. Furthermore, the research coordinator and I had a meeting

after the second and fourth interviews to analyze the data, in order to test if the interview questions were really helping us understand the essence of interprofessional empathy. The interview questionnaire was also revised based on the perception that the research interviewer had of participants' reactions and responses to each question.

There were other techniques used to further test the questionnaire's consistency. At the end of each of the first four participant interviews the research interviewer asked the participants about their appreciation of the interview questions. Those questions that were not easily comprehensible, or that participants themselves found did not link back to interprofessional empathy were modified or excluded from the questionnaire.

The research team wanted to ask questions that participants understood and were comfortable answering, and that permitted participants to speak confidently about their experiences with respect to interprofessional empathy between healthcare professionals. Patton (1987) said that good questions in qualitative interviews should be open-ended, neutral, sensitive, and clear to the interviewee. He listed six types of questions that could be asked: those based on behavior or experience, on opinion or value, on feeling, on knowledge, on sensory experience, and those asking about demographic or background details. Based on this, the interview consisted of open-ended questions directed at obtaining information on empathy between team members. Healthcare providers were encouraged to share their thoughts, feelings, and insights of what interprofessional empathy meant to them. With the help of participants, the research team was able to develop eight questions that were open-

ended, neutral, sensitive, and clear to the interviewee. The questions were asked in the following order:

1. What does empathy mean to you personally?
2. Can you describe your experience of empathy on your interprofessional team?
3. When working with the interprofessional team, how would you describe the ways in which you show empathy to each other?
4. What factors might make it challenging for interprofessional team members to show empathy to each other?
5. Imagine that there was more empathy on interprofessional teams. What would be different or better?
6. Imagine that there was more empathy on interprofessional teams. What would an organization have to do to support the development of empathy on teams?
7. How can empathy between providers support patient care? Please provide an example.
8. I appreciate that you have shared your experiences and reflections of interprofessional empathy. My last question is to ask you to define interprofessional empathy.

Depth interview.

A depth interview method was adopted as a means of collecting further data on interprofessional empathy. A depth interview is a non-structured interview that covers only one or two issues. This kind of interview served to explore interprofessional empathy through in-depth probing and questioning. Based on a free-flowing emergent conversation with interviewees, the interviewer asked one question

and the rest of the interview consisted mostly of clarification and probing for details (see Appendix B). Critical to the success of this kind of interview was that the questions posed by the interviewer facilitated full disclosure of the participant's experience.

The depth interview guide went through several iterations. The original questions were developed from information based on the initial themes generated as a result of the semi-structured interview analysis. The original depth interview guide was vetted by the research coordinator, one of the research assistants and myself. The interview guide was modified for the purposes of gathering specifics on each of the dimensions related to the phenomenon of interprofessional empathy.

There were other techniques used to further test the questionnaire's consistency. At the end of each of the first two participant depth interviews the research interviewer asked each participant about their appreciation of the interview questions. Those questions that were not easily comprehensible, or that participants found did not encourage the sharing of further details around each theme of interprofessional empathy were excluded from the questionnaire. The depth interview questionnaire was also reviewed based on the perception that the research interviewer had of participants' reactions and responses to each question.

Procedure

Entry into the field.

Gaining access to the site involved several steps. Central elements of access involved negotiating entry into the study site with gatekeepers. Gatekeepers are those members of organizations who control access to potential research participants within

organizations where research is intended to take place. These people can help or hinder research depending upon their personal thoughts on the validity of the research and its value, as well as their approach to the welfare of the people under their charge (Reeves, 2010). The gatekeepers with whom we had to negotiate in order to move the interprofessional empathy research forward within the St. Joseph's Health Centre consisted of the vice president of clinical services and chief of interprofessional practice, the Health Centre's Research Ethics Board, the interprofessional advisory committee, and the clinical managerial group.

It is important at this point to declare that we were not going into the research site with the regular challenges of an unknown researcher. Another reason for choosing this site was because I was known to members of the organization and therefore it was accessible to this individual. I had a previous relationship with the organization, as I had worked there as their manager of interprofessional practice for three years prior to departing in 2009. I did not have the challenge of having to build credibility with the gatekeepers, and I also understood how to get privileged access to the important gatekeepers. For example, the vice president clinical services and chief of interprofessional practice was whom I reported to when I was manager of interprofessional practice. This vice president was responsible for all operational activities and professional activities within the Health Centre. Any research affecting or involving clinical staff would have to be sanctioned and signed off on or approved by this individual. I met with the vice president on two occasions. The first meeting was simply to ask him to consider having me do the research study at the hospital. The second time we met was to explain to him the nature and scope of the research.

After these two meetings, he sanctioned the research and gave me approval to proceed to the next step.

Regardless of my privileged position as a researcher with previous working history at the research site, permission to do the research still needed to be sought from the organization's Research Ethics Board. The St. Joseph's Research Ethics Board reviews research studies for their potential harmful impact on and risk to participants. The process involved submitting a proposal to the board that detailed the nature, scope and procedures of the interprofessional empathy research project. They reviewed the interprofessional empathy research ethics board application, with special attention given to the consent form for content, and found that both of these elements met the board's specific criteria. Upon initial review, the project was given conditional acceptance. The board had imposed three conditions on the study. The first condition was that I had to guarantee that the one hour research interview with clinicians would not take place during scheduled work hours. The second condition was that I had to find an on-site research coordinator to monitor and manage the study at St. Joseph Health Centre. This person would have to be an employee of the Health Centre. And finally the third condition was that I had to include a statement in the recruitment letter to participants that the St. Joseph's Health Centre Research Ethics Board had approved the interprofessional empathy study. There were several other minor issues to address but these three were the major concerns emphasized by the board. Within a week I replied to the board with a clear plan for meeting their requirements and was granted full approval shortly thereafter.

Once the study received ethics approval from the Health Centre, I arranged to meet with the interprofessional advisory committee. I sent the chair of the committee an email explaining my research and the journey that I had undergone so far in my attempt to gain access to the research site. He invited me to a meeting of the committee. At this meeting I again explained the nature, scope and procedures involved in the research. More specifically, I focused on how the professional practice leaders—professional leaders of the various disciplines at the Health Centre—were to play a role in the recruitment of participants in the research. I also focused on how the Director of Medical Affairs—the professional representative for all physicians at the Health Centre—could send the recruitment letter to physicians that she thought might be interested in the study. It was agreed that I would create a standardized recruitment email and send it to the appropriate professional leaders and the Director of Medical Affairs. They in return would send it out to their respective clinicians. I had my contact information on the recruitment letter and any clinicians wanting to participate in the research were able to contact me directly. In this way, there was no coercion towards the clinicians to participate in the research from me, the principal researcher.

I also contacted several of the clinical managers via email to introduce myself (though I already knew many of the managers) and introduced them to the research project, explaining the scope and purpose of the research project. This group was important to contact because the professional unit clerks reported to the clinical managers. In the email I asked the managers to send out the participant recruitment letter to their respective unit clerks.

Development of the research team.

This research was sponsored by a grant from the Ministry of University and Colleges and this funding facilitated the assembly of an experienced research team. The team was composed of myself as the principal investigator, an on-site research coordinator (as prescribed by the research ethics board), and two research assistants.

The principal investigator was responsible for conceptualizing the study, managing the research budget, and allocating work for the research team. The primary investigator also took part in the data collection process and led the data analysis process in accordance with the appropriate phenomenological methodology. The principal investigator collated, organized, and reconciled the data into a final report. The principal investigator is a professional social worker, was trained as a qualitative researcher, and has experience with leading qualitative research studies.

The research coordinator was responsible for monitoring the research timeline and managing the project. As such, she coordinated the scheduling of all participant interviews, and managed the research timelines. She also participated in the data collection and analysis process. Having this role situated at St. Joseph Health Centre facilitated communication with participants and sampling with replacement, in the eventuality that a potential participant withdrew from the study for any reason. The research coordinator held a Bachelor of Science in business and science and was a trained researcher with a certification in clinical trials. She was also trained in qualitative research methods at St. Joseph Health Centre. Her official job at the Health Centre was that of research coordinator in the research department of the organization.

The research assistants were primarily responsible for transcribing participants' interviews. There were two research assistants that provided transcription support for this study. The research assistants had strong qualitative research experience and at the time were both students in the masters program in community psychology at Wilfrid Laurier University. Though both research assistants were involved in transcribing transcripts, only one of them was involved in data analysis.

Ethics.

The research team all had previous training and experience regarding the conduct of qualitative interviews. The research coordinator, both research assistants and I completed the Tri-council certificate in ethics. This study was approved by the St. Joseph Health Centre Research ethics board and the Wilfrid Laurier University Research Ethics Board.

Each participant was given $40.00 for their participation in the interviews. Patton (2002) discussed the issue of whether or how to compensate interviewees. He raised the argument that payment could potentially affect people's responses, increase acquiescence, or alternatively, enhance the incentive to respond thoughtfully. I had numerous conversations about the payment to participants with my thesis supervisor. It was decided that if the professional healthcare research participant was to be interviewed on their own time (not during their scheduled work hours) then it was only reasonable and appropriate to pay the respective respondent for their time and effort. This financial compensation would highlight the importance of the interviewee's contribution. As such, potential participants were made aware of the

payment in the recruitment letters that were sent out within the organization. Within the first paragraph of the letter the issue of compensation was addressed. Payment was made to the participant at the end of each interview.

It has been argued that the assurance of confidentiality and anonymity is a major safeguard against the invasion of privacy through research (Denzin& Lincoln, 1994). Every effort was made to assure confidentiality and to keep the study participants unknown for the purposes of this study. The three following methods were used to guarantee confidentiality: participant names were not used in any reports, a study code was used to identify participant transcripts, and all materials were kept behind locked doors as well as held electronically in a secure, password access only database at Wilfrid Laurier University. As mentioned before, we also sought to choose a research interview location that was separate and removed from the clinical service areas, as to provide research participants with an extra layer of anonymity and confidentiality.

Participant recruitment process.

I created a research recruitment letter inviting staff to be part of the interprofessional empathy study and sent it the appropriate discipline professional advisors, unit/service managers, and the director of medical affairs. Professional leaders, managers, and the director of medical affairs sent the study participant recruitment email to approximately 425 staff at the Health Centre. The emails to all of the potential study participants went out one week after my initial contact with the interprofessional advisory members and the clinical managers. Within two weeks I had received 45 responses for individuals who wanted to participate in the study. In

the sampling strategy for this research study participants self-selected by volunteering to be a part of the study, and then the research coordinator and I selected specific individuals for the study, paying attention to gender, professional affiliation, and the clinical service area from which the potential participants came. This strategy was chosen because we did not want an over-representation of one gender and we wanted to make sure that the phenomenon of interprofessional empathy was anchored in the commonalities between the multiple perspectives generated by professionals working in the various service areas within the Health Centre.

Once participants were selected for the research study, the research coordinator contacted them either by phone or email in order to explain to the prospective participants the purpose and nature of the research and to confirm a date for an interview. Potential participants were sent a consent form at that time. Participants were also given an opportunity to ask questions about the study and the consent process prior to the interview. Once the prospective participant was willing to be part of the study by the end of the first contact with the research coordinator, they were sent the interview questions in advance via email. The rationale for this action was that the questions on interprofessional empathy required substantial reflection and recall of past events. The ability for the professional to recall significant moments including the circumstances and context around those moments were heightened when provided with time to think about those instances that affected their interprofessional relationships. All consent forms were signed prior to each interview and each participant was given a copy of the consent form.

Data Collection

Data collection involved a series of activities in which the researcher engaged as a means of obtaining information about the phenomenon being studied. Creswell (2007) stated that for a phenomenological study, the process of collecting information involves primarily doing an interview. The important focus of the interview was to describe the meaning of the phenomenon for a number of individuals. He concluded that often multiple interviews are conducted with each of the research participants. In this research on interprofessional empathy we used a two step data collection method: a semi-structured interview followed by a depth interview.

Semi-structured interviews (step 1).

Semi-structured interviews were conducted with 24 individuals representing eight different professional groups as key informants. The interview was designed to last approximately 40–60 minutes. An interview guide was developed for the purposes of this study (see Appendix A). The guide was reviewed with the interviewee prior to the actual interview. The questions were developed from information based on the literature review of healthcare worker collegial relationships and other literature on empathy. Probes and prompts not included in the interview guide were used to encourage participants to elaborate on their responses and provide further discussion. The interviewer asked the questions and used the interview guide in the same manner with each interviewee. However, the interviewer was free to alter the order of the questions and probe the participant for more information. During the course of the qualitative study, the interviewer could have introduced further questions based on how the interviewee responded to a given question. At the

conclusion of each interview, the participants were given an opportunity to express any additional concerns they had. The entire interview was digitally recorded and transcribed, verbatim, shortly thereafter. The interview took place in a room that was secured for the purposes of the research by the research coordinator. The interview room was not located close to any of the service unit areas, which was one way we assured participant confidentiality and anonymity.

Depth interview (step 2).

This interview took place after the semi-structured interview. I re-interviewed one third of the research participants (eight individuals, one from each professional group involved in the research) in order to get their extended views on unanswered questions that may have been generated from the researchers' initial analysis of the data in step 1, as well as to verify the themes that emerged from step 1 and obtain any further reflection the participants may have had on the nature of interprofessional empathy. The interview was designed to last approximately 40–60 minutes. An interview guide (see Appendix B) was developed for the purposes of this step in the research. The entire interview was digitally recorded and transcribed, verbatim, shortly thereafter.

Data Analysis

I will start with a very general overview of the analytical process. An in-depth, phenomenological analysis was carried out on each participant's semi-structured interview. Common themes and meanings were identified across interviews. This study used the analytical method of phenomenological data analysis suggested by Moustakas (1994). Building on the data from the first and second

research questions, the research coordinator, one of the research assistants and I went through the data (interview transcripts) and highlighted the significant statements, sentences and excerpts that provided an understanding of how the participants experienced the phenomenon. Moustakas (1994) calls this step *horizonilization.* These significant statements and themes were then used to write a description of what the participants experienced (textural description). They were also used to write a description of the context or setting that influenced how participants experienced the phenomenon, called the structural description. Finally, I wrote a composite description of the phenomenon incorporating both the textural and structural descriptions. These passages described the essence of interprofessional empathy and represented the culminating aspect of this phenomenological research.

More specifically, the following steps were used to carry out the data analysis on the semi-structured interviews:

1. Consistent with Moustakas's phenomenological approach, the verbatim transcript for each participant was completed using the following steps:
    a. Consider each statement with respect to significance for description of the experience.
    b. Record all relevant statements.
    c. Relate and cluster the invariant meaning units into themes.
    d. Synthesize the invariant meaning units or themes into a description of the textures of the experience.
    e. Reflect on the textural description. Construct a description of the structures of the experience.

f. Construct a composite textural description and structural description of the meaning and essences of the experience for each participant.

2. From the participants' textural description, create a group textural description.
3. From the participants' structural description, create a group structural description.
4. Create a composite group textural and structural description representing the universal description of the experience for the group as a whole.

Transcripts for this study were analyzed using the procedures described in step 1, a through f.

The first task of analysis was to reduce the data and make sense of the data collected. The research coordinator, as well as one of the research assistants, and I proceeded to methodically analyze the data according to the Moustakas method. Each researcher was given eight transcripts to analyze according to the process identified in the procedures a through f, above. A lead individual within the research team was identified for each transcript. The job of the lead on each transcript was to write up a summary (see Appendix E) in accordance with the Moustakas method. Every researcher was tasked with reading all of the transcripts, and independently searched for recurring themes or items of interest with respect to the phenomenon being studied. We then had meetings to discuss the consistency between themes that each researcher selected for each participant. At these meetings, each researcher had the opportunity to discuss the rationale for their choice of a given theme. The main goal of this activity was to come up with and agree on a consistent number of common themes between all researchers for each participant transcript. The lead for each

transcript would then finalize the themes associated with each participant summary, based on the research team's deliberation.

The research team then had several other meetings to look at the agreed-upon broad themes. We went over the transcripts again in order to look at the characteristics of each theme and its relationship to other identified themes. We then created sub-themes for some of the identified broader themes. Based on this preliminary information, the team created a code book. The code book was then used to help populate fields within the qualitative software named NVivo(8). The NVivo software was used to help the research team to further organize the qualitative data. All 24 transcripts were therefore coded again in accordance with the code book using the NVivo software. Each researcher was given eight transcripts to code in NVivo. All three researchers used the NVivo software to code and further analyze the data across participants. Seeing that each transcript already went through a very rigorous coding process, this second coding exercise was about placing the data into qualitative software in order to further facilitate analysis. A process of constant comparison method was used to check and compare each coded data item against the rest of the data. This process helped connect themes that we initially did not see as connected between participants. The process helped refine existing categories and the code book was finalized.

After the code book was finalized, the research coordinator, one research assistant and I focused our attention on the depth interview transcripts. The research coordinator, one research assistant and I read all eight of the depth interviews. Significant statements were highlighted and discussed within the research team.

There were no new themes that emerged from the depth interviews, and much of the information provided by participants was confirmatory of the textural and structural themes that were the result of the semi-structured interview analytical process. The depth analysis however, did add significant texture and detail to the already existing themes, and significant statements were simply placed within their appropriate thematic categories. Once the categories were refined and solidified, I preceded with steps two, three and four of the Moustakas method.

One of the goals of this phenomenological research was to gain insight into the phenomenon being studied until a point of saturation was reached. Saturation occurred when no new themes were emerging with subsequent interviews. This was important because attaining saturation enhanced the credibility of the results. For the purposes of this study saturation was reached after 15 interviews.

Rigor

In using the transcendental phenomenological methodology to conduct this research, we took into account the importance of rigor. Husserl (1931) viewed phenomenology as a rigorous science. Explaining this point, Kockelmans (1967) declared:

> We wish to emphasize that by means of his phenomenology, Husserl wanted to arrive at philosophy as a rigorous science...through a rigorously critical and systematic investigation, Husserl's phenomenological philosophy wanted to attain absolutely valid knowledge of things (p. 26)

Husserlian phenomenologists see value in structured approaches by employing clearly defined methods in order to ensure validity (McConnell-Henry, Chapman, &

Francis, 2009). The above-quoted statement supports the idea that a methodical approach needed to be used in this research in order to produce objective data. Consistent with the ideological premise of transcendental phenomenology, every step was taken to approach the research topic of interprofessional empathy in an organized, systematic, and thorough way.

To assess the trustworthiness of qualitative data, Lincoln and Guba (1985) suggested four criteria to judge the value and plausibility of the interpretations: credibility, transferability, dependability, and confirmability.

Credibility concerns whether the research findings accurately reflect the reality of the phenomenon under study. In other words, credibility refers to the truth value of the findings of a certain investigation. Consequently, due to my own professional socialization and my immersion in philosophies, values, and basic theoretical perspectives inherent to community psychology and social work, I was very mindful of my interpretations of the data generated from health professions that adhered to different conceptual models than my own. I was also mindful to incorporate a wide range of various perspectives about interprofessional empathy, so that my personal and professional viewpoint was not presented as the sole truth. Mays and Pope (2006) use the term *fair dealing* to describe the process of attempting to be non-partisan. I used the peer review or debriefing technique as an external check of my research process. Lincoln and Guba (1985) defined the role of the debriefer as an individual who keeps the researcher honest; asks hard questions about methods, meanings, and interpretations; and provides the researcher with the opportunity for catharsis by sympathetically listening to the researcher's feelings. In order to get

objective feedback, the debriefer did not have a clinical background in the professions that were the object of this study, but had a fairly good understanding of collaborative work. My thesis supervisor acted as a debriefer for this interprofessional empathy project. We had regular debriefing sessions approximately twice a month during the six-month data collection and analysis process.

As a debriefer, my supervisor was instrumental in the research team being true to the research data. For example, when the research team was exploring the benefits of healthcare team members sharing stories with each other, I was reminded by my supervisor to be mindful of data that showed instances where individuals were hesitant or uncomfortable sharing their stories with their colleagues and the reasons for which they could not initiate such a practice. In effect, in my sometimes over-zealous nature to show the value of empathy on healthcare teams, I tended to not pay enough attention to the negative cases. My supervisor also played a role in asking hard questions about meanings and interpretations. She reviewed four participants' transcripts and discussed their respective summaries with me. We discussed themes as well as sub-themes, and how the various components potentially linked back to a developing model of interprofessional empathy. These discussions led me as principal investigator—and ultimately the research team as well—to explore the interprofessional empathy data in a more fulsome manner.

According to Mays and Pope (2006), respondent validation, or member checking, includes a range of techniques in which the investigator's account is compared with the accounts of those who had been investigated to establish the level of correspondence between the two sets. Lincoln and Guba (1985) regarded

respondent validation as the strongest available check on the credibility of a research project. The final themes from the study on interprofessional empathy were presented to eight of the 24 interview participants, who had agreed to be contacted for this purpose. This process enabled them to indicate if they perceived the data that emerged as a true reflection of their interprofessional experiences. It was important that the participants agree that the statements within the final document were consistent with their experiences. All eight participants agreed that the statements within this document were consistent with their experiences of interprofessional empathy within their healthcare setting.

Transferability refers to the extent to which research findings could be applied to similar settings or contexts. In the present study, transferability was achieved through the use of thick description in the research process and the research context, in order to provide sufficient information for readers to judge the extent of transferability. Thick description allowed independent readers to determine whether the results were transferable to different settings.

Dependability speaks to the internal reliability of the processes by which the results of the research were identified (Lincoln & Guba, 1985). In order to satisfy this requirement, the research study used intercoder agreement based on the use of multiple coders to analyze transcript data. The research coordinator, one of the research assistants and I, independently analyzed all 24 participant semi-structured interview transcripts. We then met in order to seek intercoder agreement on identified codes and themes.

Confirmability is the ability to demonstrate that the study's rationale and methodology were able to account for its results. This was achieved through the use of an audit trail. An audit trail is a systematic method of recording from where exactly each quotation was obtained, which includes the raw data, data reduction and analysis products, and researcher process notes.

Findings

Phenomenological investigations provide a researcher with opportunities to explore the lived experience of a particular phenomenon. The purpose of this chapter is to present the findings of a phenomenological investigation into the lived experience of interprofessional empathy within the context of healthcare teams. This chapter is divided into two sections. In the first section, or the textural description, findings represent what interprofessional empathy looks like in everyday practice based on the perception of a diverse group of healthcare professionals working on interprofessional teams (e.g., nurse, physician, pharmacist). In the second section, or the structural description, findings associated with the context or the situations that typically influence how participants experienced interprofessional empathy are provided. It is important to note that both the textural and structural descriptions also emerged out of clinician descriptions of interprofessional empathy as a desired phenomenon. The chapter ends with a composite description (the integration of both the textural and structural descriptions) that presents the essence of interprofessional empathy.

In order to provide evidence for the themes generated in this interprofessional empathy research study, participant quotes, known as significant statements in

phenomenological terminology, will be used to represent participant voices within both sections. The reader will find two types of quotes. Indented quotes from 5–8 lines long signify a different perspective. Indented quotes are generally brief but where necessary, they are lengthy because they are illustrative of a point. Embedded quotes are briefly quoted phrases or words within my thematic narrative. These briefly quoted phrases or words between quotations within a paragraph are intended to demonstrate to the reader that the information is in the participant's words.

This part of the findings section answers the first research question: How do professionals who are part of interprofessional teams describe empathy between team members? This question addresses the textural description of interprofessional empathy. As an overview of the textural description of interprofessional empathy, 380 significant statements (quotes that provide an understanding of the phenomenon) were extracted from 32 verbatim transcripts. Arranging the significant statements into meaning units (themes) resulted in six themes: (1) engaging in conscious interactions, (2) using dialogic communication, (3) understanding the role of others, (4) appreciating personality differences, (5) perspective taking, and (6) nurturing the collective spirit. A summary of findings is presented in Table 1, which contains a list of meaning units and sub-meaning units that were clustered under each theme followed by a detailed presentation of findings by theme.

Table 1

Meaning Units and All Related Sub-themes Components of Interprofessional Empathy

1. Engaging in Conscious Interactions	1a. Humanization of the work	-Considering the person before the profession -Acknowledging team members -Understanding the need for empathy between healthcare providers
	1b. Personalization of the work	
2. Using Dialogic Communication	2a. Monologic communication 2b. Dialogic communication	-Mutual openness -Non-judgmental attitude -Active listening -Checking assumptions
3. Understanding the Role of Others	3a. Knowledge of the scope of practice of another discipline 3b. Knowledge of the "job" associated with a task	
4. Appreciating Personality Differences	4a. Appreciating individual personality differences 4b. Ability to negotiate professional stereotypes	
5. Perspective Taking	(no sub-themes)	
6. Nurturing the Collective Spirit	6a. Sharing the load 6b. Inclusive behaviors 6c. Consideration of a higher purpose 6d. Ability to express vulnerability 6e. Adopting a supportive presence 6f. Shared emotional connection	

1. Engaging in Conscious Interactions

Engaging in conscious interactions refers to work relationships that were characterized by authenticity, warmth, and an inherent respect for each team member as a human being. This theme reflects participants' desire to see co-workers not as just objects that exist in order to facilitate the accomplishment of specific work tasks and goals, but as individuals who bring with them personal stories and experiences that shape how each person does their work and interprets their experiences on their interprofessional team. An occupational therapist described interprofessional empathy as follows:

> To engage another human being on a human level so that you dispense with all the political trappings that comes with your identity through your profession, and that helps to generate or foster a sense of community and camaraderie between the two individuals who are working together.

"To engage another human being on a human level" implies that interactions are thoughtful, purposeful, and intentional. This requires recognizing that every encounter with another healthcare professional, whether it be brief or lengthy, has the potential to impact both parties in a negative or positive way. Ultimately, the broad theme of engaging in conscious interactions speaks to the overarching need for members on interprofessional teams to recognize the universality of human needs and to recognize the natural push or altruistic drive that team members have to assist each other in meeting their psychological, social, and emotional needs. Through engaging

others with the intent of meeting their needs, participants alluded to the importance of showing one's colleagues that "I really do care about you as a person". A unit clerk reinforced the importance of being thoughtful and purposeful in her interactions with her team members:

> I just think you have to be conscious...I think it's something that you kind of experience and learn as you grow and you kind of try to be conscious when you're interacting and it just may become part of your nature, more or less, that's what I'm trying to get at.

Other words used by participants to characterize conscious interactions were "being present", and "one on one" conversations. This implies that participants want to foster interpersonal connections that help them understand each other and at the same time fulfill a need for personal connection to their co-workers. Many participants commented that this kind of connection still needed to be fostered in healthcare environments. Participants identified conscious interactions as being expressed in two ways: humanization of the work and personalization of the work.

1a. Humanization of the work.

Humanization of the work referred to a general philosophy that participants articulated as they conveyed the need for interprofessional healthcare team members to be altruistically accountable to care for each other. In other words, interacting with each other with the sole purpose of executing tasks and work functions would not engender empathy, especially if team members undervalued the duty to consider the needs of others on the team. Considering the needs of others meant that team members respected the individuality of each team member and the unique

requirements that made the working relationship meaningful for each person. This theme supports the philosophy that the nature of relationships within the work context could foster the portrayal of each health care provider as a whole individual that ought to be respected for the unique human qualities they bring to the team. Participants defined human qualities as "feelings, values, spirituality, and all the things that we bring to ourselves". Furthermore, humanization of the work spoke to core beliefs that affirmed co-workers' moral obligation to care for each other as human beings. These core beliefs included: considering the person before the profession, acknowledging team members, and understanding the need for empathy between healthcare providers.

Considering the person behind the profession.

Participants stated that they were interested in knowing the "person behind the profession". There was a deeply entrenched belief among participants that team members should see each other as human beings that have faults and bring their own individuality, idiosyncrasies, and individual perspectives to the work. Participants suggested that it was important for them to know who their colleagues were before understanding what their colleagues did as a professional. Understanding who their colleagues were appeared to be a strategy employed to create a level of authenticity within work relationships. For example, one respiratory therapist felt that the foundation of a successful interaction between professionals was to have an established rapport between two individuals. She defined rapport as understanding that the other person was a person first, with feelings and emotions that existed as a result of their unique personal situation. She stated:

> You identify with your colleague as a person first, and everybody's different, but I always say that your job doesn't define you, your job can be a big part of who you are but it's not everything about who you are.

Clinicians also reported not wanting to stifle or withhold parts of their personality or unique human qualities from their work relationships. They want the opportunity to bring their "true selves" to their interactions. One social worker emphasized the importance of being able to show her personality in interactions with her team. She spoke of the notion of having to put on a persona, or act as if she were somebody else when in situations with colleagues with whom she was not familiar. As a result, she did not bring her "true" self to these interactions. This lack of authenticity downgraded the meaning and value of these of interactions for her:

> How personal is the professional? I think very. It's with this particular team, I've learned exponentially more that to be able to get your work done there has to be something else there. You can't just, you know, there has to be more to be, to feel that sense of support and connectedness as a team, I feel that there has to be more. To be able to feel at ease with my communication with a team member, and not have to think alright, I have to ask a question, I have to step outside of my silo, okay, let's get formal now.

An occupational therapist who had just accepted a managerial position also reminisced about how important it was for him as a practicing clinician to feel that his team members accepted him for who he was as an individual:

> In a professional stream, I can say whatever I want, because I am in a very comfortable place with those people and they know me, they know my personality, they accept me words and all, and, and it's fabulous, I loved working there for 10 years and the only reason I left was because I was no longer challenged by the work , but yeah, and that's something I actually miss, is being able to totally be myself, you know, it's true though.

Participants mentioned that there had to be more than just the professional connection between co-workers in healthcare. Clinicians had to meet as people first and professionals second. Two clinicians offered a rationale for the importance of seeing the personhood before the job. One clinician stated that ultimately each person wanted to know that they were cared about as a person by others. She believed that "this is important to a lot of people but people will not come out and say it". The second clinician emphasized that "once you get to know a person then you can empathize with them". Ultimately when colleagues were receptive to the individuality of others, it conveyed the perception of an acceptance that engendered mutual interest and a willingness to engage with the other person.

Acknowledging team members.

Participants stated that it was important to acknowledge people on their teams. In its simplest form, acknowledging someone within healthcare settings could be demonstrated by using their name or by saying hello. Within the team these simple salutations served a function in that they permitted team members to see that they were counted and recognized as individuals. A respiratory therapist stated:

> I am a people person and I love to work with people and so, it means a lot to people when you remember their name, cause it kind of shows that person that you're human too and before you have this work ahead of you.

A physician spoke to the importance of knowing the names of other members of the team. This physician worked on a specific team that offered palliative care services hospital wide. He described the challenge faced by individuals who consulted with other practitioners around the hospital, who were not necessarily assigned to one core team:

> I sometimes wonder if because I don't know the nurses very well, you know if I have to go find out something about a patient from the nurse and I read the name [of the nurse assigned to the patient] on the board, and I go looking for Cheryl [the patient's nurse] I have no idea who Cheryl is and I'm sort of asking who's Cheryl? Who's Cheryl? and when I finally meet Cheryl, it's probably not the best way to meet Cheryl, right?

This physician was implying that his first encounter with this nurse would probably result in him giving the nurse an order to carry out on the patient. This was a highly technical and depersonalized interaction. The physician gave a recommendation that it would be preferable if there were a mechanism that would provide an introduction to each team member. He suggested that a picture of the team members on the unit would make it easier to navigate through the various individuals. He ended by stating:

> If I knew all the nurses it would be easier to be empathetic and for them to be empathetic towards me if they knew me, the same way that it's easier for our smaller group, the nurse, the social worker, and the palliative care coordinator to be empathetic to each other.

Though this participant recognized the importance of knowing the nurses name, he hinted that some doctors were less likely to be preoccupied with mutual introductions if they were rushed, which potentially could leave a "bad first impression" with other team members.

When there was no recognition of the presence of another human being, there were profound consequences for the team and the unrecognized individual. One respiratory therapist spoke about a nurse who worked in her department and was systematically ignored by the rest of the interprofessional team. She thought that this was a self-defeating strategy for the team, as the work in her particular area was physically demanding and required people to help each other. Any opportunity to forgo using all of the resources within the department increased the risk of team members "blowing their backs". The same participant also recognized the negative impact that this lack of acknowledgement had on the nurse in question, in particular on the nurse's self-esteem:

> I just noticed that she was kind of like upset or like, kind of burying her head into her book and kind of isolating herself a little bit, right and I just kind of came out and I said, is everything ok? Like are you alright, or, and she kind of looked at me like surprised that I even asked her and she's like well nobody likes me here.

This participant thought that the team's attempt to isolate this nurse by not acknowledging her was "inhumane" and despite the reasons that others may have had for treating this particular nurse in this way, the participant felt that there had to be a common decency and manner to treat people. She implied that each person had a fundamental need to know that they would not be ignored and isolated in the workplace.

Understanding the need for empathy between healthcare providers.

Understanding the need for empathy between healthcare providers refers to appreciating who should be the recipient of empathy within the healthcare environment. Participants were clear that they understood the overarching value of respect for others and acting with care towards another human being. Participants endorsed the universal healthcare ethic that promoted connections that were sincere, caring, and authentic. However, though healthcare workers believed in this ethic, there appeared to be a discrepancy between intellectually understanding that ethic and translating it into consistent and intentional action, in particular within peer relationships. Participants articulated that a large component of all team members' roles was to provide empathy to the patients they served. As such, it was challenging for many participants to view empathy within the context of providing empathy to their team members. This challenge was also demonstrated during the research interview process. Interviewees tended to address empathy from the patient's perspective and interviewers repeatedly redirected the interviewees to discuss empathy between team members. One respiratory therapist alluded to this divergence when she stated inquisitively:

> We're in a profession where we should be empathetic people. That we should look at each other and have empathy towards each other and look to each other for (support)...I think that people are better at relaying empathy to their patients than they are to each other.

It was clear that in the use of the word "should" that the participant was alluding to the ideal that healthcare workers ought to be supporting each other emotionally, psychologically, and socially.

Another nurse participant spoke clearly about the prioritization of the individuals to whom he showed empathy. He stated that, for him, patient empathy would always trump the empathy he showed for his colleagues:

> When we have the patient there, my priority will be there, and sometimes the empathy to the interprofessional practice will be [affected] because we prioritize the patient.

He admitted that this may not necessarily be the best perspective however; within the life and death context of the work that he does, he could not afford to empathize with clinicians. Furthermore, this participant claimed that he had been trained to adopt the patient's perspective on everything and that his colleagues had been trained to do the same thing. "We have been trained to succeed and to get to a point, our point is to make the patients well, so we have the same commitments." One physician stated that he was also not taught to empathize with his colleagues.

> We're not taught to be empathetic with our colleagues, we're taught to be empathetic with our patients, but I can't think of any curriculum really that talked about being empathetic towards our colleagues,

> other than, you know, being respectful, you know, like in medicine, certainly we had lectures like on being respectful and understanding the roles of physiotherapists and nurses and stuff, and, actually being empathetic or you know caring for or finding ways to make meaningful connections with team, as a way of making a team? Uh, no.

This statement shows that the lack of training around collegial empathy in healthcare education and socialization has made patients the sole beneficiaries of empathy within healthcare. How healthcare providers treat each other may not necessarily be at the forefront of the professional's mind. There is a singular and exclusive focus on patient needs at the exclusion of the teams needs and such exclusion can give rise to behavior that may appear to be non-collegial.

An intensive care nurse provided her reflections on empathy between healthcare professionals, stating, "I do think that one thing that is really lacking in the health profession in general is empathy for each other". She described the lack of empathy displayed by nurses not only towards members of the interprofessional team, but also to newcomers to the nursing profession:

> I thought about looking into it myself, like you know, trying to see what we could do to help each other, instead we just seem to, as they say, nurses eat their young...we seem to take great pleasure almost in not helping our own.

This participant made a comparison between interprofessional empathy and "nurses eating their young", a metaphor used in the nursing community to describe the

mistreatment of new nurses by other, more experienced nurses (Stanley, Martin, Michel, Welton & Nemeth, 2007). Antagonism, verbal and psychological abuse between nurses has persisted for decades (Sheridan-Leos, 2008). The expression, "nurses eat their young", is far removed from the idea of caring and nurturing intraprofessional and interprofessional relationships. But the comparison may highlight some of the same hostilities that take place between interprofessional team members, as evidenced by the former example where a registered nurse was not acknowledged by her team.

Participants suggested that the scope of empathy in healthcare must begin to include empathy for staff members within the healthcare setting. Participants were aware that there was a need to provide empathy to their colleagues, but there was a duty to provide it to their patients. While the duty to empathize with patients was important there was an equal recognition but lesser imperative to care for each other in the workplace.

1b. Personalization of the work.

Personalization of the work referred to methods used by co-workers to get to know each other. Participants found conversations that were not always about task-oriented work activities helpful in developing their working relationships. One pharmacist described the nature of the non-work-related verbal exchanges between staff as "side conversations". The participant described the side conversations as sharing stories about family, about vacations, about personal problems at work or outside of work, and about individual and personal successes and challenges. These side conversations gave each team member an opportunity to share their story.

Storytelling was a method used by team members to get to know and understand each other. Participants believed that in order to be a good team member one had to be interested in knowing these stories.

According to one unit clerk "everybody has a story." Individual team members provided a "snapshot" of who they were to their team members every day through telling stories about themselves. One participant described story telling as a way of team members providing their "back story" to each other. A back story referred to an individual's personal history. Sharing this history with co-workers helped members understand the person and helped them understand what made that person "tick". Through story telling one could potentially learn how a team member felt about certain things, how they reacted to certain situations, what stressed them out, and how they dealt with their feelings. It provided a multidimensional view of team members that could leverage team dynamics and understanding. A social worker described that much was revealed through colleagues telling each other their stories. He stated:

> When you talk about stuff that's happening outside of their work life it sort of gives you the back story of what makes that person tick.

Participants generally saw getting to know the personal stories of their colleagues as a highly empathetic activity. An occupational therapist said:

> I think you develop personal working relationships with people, and you learn about them, you learn about their lives and find out what you have in common, so that makes you closer to them and you're (I think) willing then to help out...I believe that a lot of the world

> works on relationships and that if teams are going to work effectively, that those interpersonal relationships are critical to a well functioning team.

Participants saw storytelling as a way of finding common ground amongst each other, and helped accentuate the similarities between team members. Finding commonality appeared to mitigate power differences imposed by the traditional hierarchy in healthcare between some team members. A physiotherapist expanded on this idea:

> Well, I guess that it makes you feel, there's a level of comfort that creates between the two of you, or, you know, if it's all of you, like if it's a bigger team, but it puts you sort of on the same level, it humanizes your working relationship and puts you on the same level, even though you could be a doctor and I could be a physiotherapist or a nurse, if we're all having trouble with our kids, then it humanizes it so that everybody's on the same level, so they would have their areas of expertise, I would have my area of expertise, but really we're all the same, we're all on the same level.

Participants saw the telling of personal stories as having another critical team function. Participants claimed that having personal insight into the world of individuals with whom they worked helped mitigate particular work circumstances that one could otherwise have difficulty negotiating. For example, one occupational therapist stated that when one of her colleagues' father was hospitalized she re-arranged the workload so that her colleague could take the day off of work in order to look after her family issues. She claimed that this knowledge of others' stories bred

trust and respect within the work environment. It also humanized the relationship, because one accepted the person as a whole and not as segmented or cut off from the rest of their lives. This participant thought that being able to integrate work demands and life demands through negotiating her needs with her co-workers led her to be more willing to forgo at times her own needs in order to accommodate the needs of the team. Ultimately, understanding the personal stories of co-workers permitted the team to re-adjust work processes and workload, based on individual team member's psychological, social, emotional, and situational needs.

Not everyone, however, was comfortable with telling their personal stories. One physician spoke about his reluctance to share his story with his team:

> Over the six months, we've had a lot of sort of side stories where we just talk about things that have nothing to do with medicine, and a lot of other doctors are often telling me about their kids or their husbands, wives, sort of things like that, so it does seem to be part of our group sort of culture to give out information that is personal and I think it makes a big difference, I think the first month that I started here, I wasn't doing that, I wasn't comfortable divulging information, I was a bit more timid and but as you see other people giving you information like that, you become more comfortable I think and are more willing.

The physician pointed out that not everyone was comfortable with disclosing personal information. One occupational therapist also stated that not everyone would be comfortable in sharing their personal stories:

> I think there's a group of people who would be really uncomfortable with it (sharing personal stories) and would see it as woefully inappropriate in this context, in this setting in the workplace.

Nonetheless, over two thirds of the participants took the position that sharing personal stories was an important behavior in building relationships between team members. One physiotherapist said that clinicians who did not want to share their stories, who wanted to remain purely "business-like" in their dealings with others, limited the ability of the team to be effective, because they created potential barriers to relationship building. When faced with the possibility of team members not wanting to share their stories with the team, this physiotherapist faced the issue with ambivalence:

> I don't think we'd disrespect them, but it takes a lot harder, I think its personally harder for us to...it's not a case of us respecting them, I can respect the work that they do, I don't necessarily have to respect how they react to the rest of the team. So I can respect their work and the quality of their work, but um, you know, then you wonder (laughs).

Participants suggested that they could have professional respect without necessarily respecting the person for who they were.

2. Using Dialogic Communication

Participants stated that communication was an essential part of creating empathy on interprofessional teams. Participants described communication as one of

the foundational requirements necessary in order for a team to function in a cohesive, coherent, and efficient manner:

> I think in terms of a team, it's vital. I mean, without communication it's, there's like a total break-down in terms of effectiveness and efficiency within a, within a work environment.

Communication can be defined as "the process by which information is exchanged and understood by two or more people, usually with the intent to motivate or influence behavior" (Draft, 1997). And though various mechanisms for communication were described as essential for team functioning, participants focused primarily on verbal communication between clinicians and its impact on their working relationships. One social worker stated:

> I guess communication, then, is not basic and rudimentary. It's not just talking, it's not just saying words. There's more to communication than just stringing words together in a sentence.

This comment implied that communication was more complex than just giving a message. Participants acknowledged that healthcare communication was an important working tool.

Participants spoke about communication with their interprofessional colleagues in two ways. The first way was described as communications that were primarily technical in nature. These communications concerned aspects of patient care and team coordination, where the goal was to achieve objective understanding. This technical form of communication was characterized by information going from one healthcare worker to another, where the other worker received the information

with very little opportunity for discussion. The second form of communication was characterized by healthcare workers having deliberate conversations and dialogue about patient care and team process. Within this form of communication, colleagues exercised a genuine effort to understand the point of view of others, and arrived at a consensus about patient care or team process. These two forms of communication had a striking difference in their communicative intent and their impact on the relationships of the individuals who were communicating and on the development of empathy.

As a way of approaching the data under the theme of communication, the research team decided to use deductive codes for these two forms of communication, based on Buber's (1958) theory of communication. We divided communication into two basic modes that the research team named *monologic* and *dialogic*, respectively. The monologic mode was based on the classical one-way communication model associated with the transmission of a message to the recipient and the dialogic mode was based on an interactive communication model that encouraged participatory approaches.

2a. Monologic communication.

Monologic communication was based on a one-way flow of information for the purposes of informing someone about something or getting someone to carry out the wishes of the communicator. The main purpose of monologic communications appeared to be about informing and convincing. Furthermore, monologic communication seemed to be about the objectification of the other in a conversation

without attending to feelings and not necessarily being open to hearing the other's view.

Communication that aimed to inform was typically used when building awareness or providing knowledge in order to achieve a particular outcome. Within the healthcare context participants implied that verbal communication between one healthcare professional and another sounded like individuals talking *to* each other, as opposed to individuals talking *with* each other. Despite this impression, participants still described the usefulness of employing the monologic form of communication while performing medical procedures, medical interventions, or giving medical orders to be carried out. A physician described the linear transmission of information required to perform certain medical procedures. He stated:

> So if you're working with another health care provider and you have a discussion at the bedside where you're asking, you're trying to have a common goal, for example, something as simple as doing a procedure, right? Uh, having proper communication so that the common goal would be to get the procedure done in an efficient manner, and uh the proper manner with no uh I guess negative effects on the patient, uh, is if you communicate properly to each other and if you are, following each other's instructions.

Participants also stated that monologic communication was necessary in other circumstances. Professionals spoke about the benefit of monologic communication in emergency situations. One nurse stated that:

> I was covering an assignment for a nurse while she went on her break. I covered for 45 minutes. During the covering they brought in someone that was very sick and we were about to start Cardiopulmonary resuscitation and resuscitate the patient, while I was resuscitating the patient, the nurse that belonged to that area was coming back from her break and then rather than come and say what can I do to finish this, she was trying to take over to let me go, and I turned to her and said "what are you doing? This is not a moment to take over, let's focus on saving the patient's life."

Monologic communication provided direction and timely feedback that could make a difference in the execution of team tasks.

Another physician explained how healthcare professionals communicated during patient rounds and shift-handovers. Patient rounds are a communication forum where interprofessional team members discuss the progress of patients and create treatment care plans. Shift-handovers are planned forums of communication where the interprofessional team exchanges information about a patient's daily progress. In this physician's reflection about communication at these forums, he inferred that the hegemony of information transmission or technical communication between healthcare professionals, objectifies team relationships:

> I think it adds a lot to be able to, you know, take ten minutes here and there to talk about something that isn't necessarily work related, it humanized your relationship a little bit, like we're not Blackberries that just send data back and forth so to develop a collegial

> relationship and having a sense of enjoying working with people involves more that doing just, you know, patient number one this, this, this, patient number two that, that, that, patient number three and so on.

This comment was part of a broader observation by this physician where he pointed out that physicians, in general, had to shift the nature of how they conducted their rounds to accommodate other forms of communication, in order to develop team relationships.

Monologic communication occurred in the discourse of all participants. One physician warned against the consistent use of monologic communication:

> The physician or other team member has to be willing to be listened to, receive support, you know, interact with other people in that sort of way, like, if you're Captain and all you do is give orders, then it's very unlikely that people are going to be willing to provide anything more than carrying out your orders, and do so literally.

This physician commented that physicians as a group are in a unique position to influence team communication. He implied that physicians were seen as the coordinators of the patient's care. The status of physicians as leaders of patient treatment puts them in a unique situation to influence communication patterns on teams.

Generally, participants inferred that there was a prevalent pattern of monologic communication within healthcare interactions. One social worker pointed out that at times "people just talk about communication as the message that's

delivered". This perception led some clinicians in healthcare to believe that they were engaging in fulsome conversations about care and other issues, when they were not. For example, one participant provided a scenario of a physician that listened to a nurse speak about a patient's condition and her feelings about the patient's condition; the participant thought this was a dialogic conversation. After listening to the nurse's concerns the physician provided the nurse with instructions for the patient. Though the physician listened to the nurse's description of the patient's condition, the participant did not realize that both parties—the nurse and the physician—transmitted the information to each other without the acknowledgement of feelings and without coming to a consensus on what to do. The physician ended by determining the order for the nurse to carry out on the patient. The communication was primarily relaying information back and forth. The primary intent was for the sender to persuade or inform the receiver about the importance of the information. It was a purely technical conversation.

2b. Dialogic communication.

Using dialogic communication referred to the notion that dialogue was more than talking, or a simple back-and-forth method of interaction. Dialogic communication included team members' sharing information and perspectives, acknowledging each other's feelings, inquiries about patient care, team functioning, and any other conversations tied to the business of the team. When participants were asked about the forms of communication that would provide the most empathy on teams they described a two-way interactive process. In defining communication that would be supportive to team members, one occupational therapist stated, "I would say

it is this idea of it being mutual, it's not just one way". A unit clerk reinforced this idea by being more explicit and stating that communication was a "two-way thing".

Dialogic communication is a mutual process. In dialogic communication there is an attendance to feelings and a genuine interest in the other person's perspective. Two attitudes and two behaviors that were critical to participants within the context of interprofessional communication that engendered empathy were mutual openness, a non-judgmental attitude, active listening, and checking assumptions between team members.

Mutual openness.

In explaining her perspective on team communication and her intentions within her interactions with her colleagues, a social worker stated that she wanted to understand their experience:

> Listening to their experience, changes my view. It's learning for me as well. The intellectual and the emotional components opens up my learning, it opens me into their world, into their experience a little bit more.

This social worker addressed the open attitude that she adopted when participating in dialogue. Her statement implied that she possessed qualities of open-heartedness, honesty, a lack of pretense, and a sense of responsibility for the information she received.

Non-judgmental attitude.

Participants articulated that they did not want to be judged by their teammates. A respiratory therapist attempted to articulate that in healthcare environments, some

clinicians held back from being transparent in their communications because of the fear of being judged by the rest of the team. He claimed that many people withheld their feelings about particular situations and those feelings tended to fester:

> Well there's always that fear of being judged, right?. There's always that fear of somebody you know, maybe you don't know as well thinking you know, wow, I didn't know they felt that way, that's a bit weird you know and fear of not being understood, not being heard so they become a bit more introspective as opposed to like expressive about their feelings.

He asserted that being empathetic in communications required individuals to see the other's point of view even if it was opposed to their own. He claimed that teams needed to learn to affirm and confirm opposing viewpoints without being overly critical and dismissive.

Other clinicians talked about the benefits of being on a team where members were free to be transparent and inquisitive in their communication:

> I think people, you know, if people are really connected and visible together then a lot of times frustrations can be brought out in the open and dealt with sooner, they don't fester so much, so that you have a chance to say hmm, I'm really being bugged by this, like, quite often, our nurse will say, this is really bothering me, or I can say this, this bit here is really bothering me.

Active listening.

Dialogic communication appears to function as a means of engaging individuals in sharing ideas about an issue that leads to generating ideas collaboratively, in order to solve a problem. Active listening appears to be an important part of that process. In other words, dialogic communication is not used to inform, rather it is used to share perspectives and create understanding. This idea was reinforced by a unit clerk who shared her views about active listening:

> Communication is speaking, basically, and being able to express, what you would like the person to do, or what, but it's not just speaking or somebody telling you something, it's you actually listening to it, hearing it, understanding what they're asking of you. Because sometimes you can say a lot of things, but you don't really understand what the person wants from you, so I think it's a two-way thing, it's also saying it, expressing it, and understanding it, what they want.

Other clinicians used techniques such as probing questions when demonstrating their use of active listening. They used this technique when trying to elicit further information behind a team member's attempt to convey a message. Some clinicians stated that with the rampant speed of activity in healthcare it was not easy to practice active listening with their peers. Participants also suggested that organizations needed to provide time for team members to listen to each other in their clinical interactions. The importance that clinicians put on listening skills highlighted its value to

empathetic relationships within teams. Listening seemed to create an empathetic space where dialogue could occur.

Checking assumptions.

Checking in with peers and challenging the assumptions that team members had about one another or had about an issue was a useful strategy that permitted team members to verify their adopted beliefs. One physician claimed that it was a customary practice for him to ask his interprofessional team members if treatment care plans that he had put forward made sense and if they did not make sense he wanted the team to deliberate the issue:

> I think one of the ways [to communicate] is to, not be, not hold too strong to what you're saying, so saying something in a sort of semi open ended, like this is what I think I would do, or this is what I would do, but what do you think? Or does that make sense? Is that what you were thinking? Sort of checking in and sort of not, not assuming too much I think is one of the ways that I notice when we're communicating we do a lot of that, we try not to assume and we try to check in, like is that, is that what you were thinking?

Checking assumptions ensured mutual understanding and through the exploration of a particular situation or issue, each member of the team had an opportunity to confirm points of view and to participate in problem solving. The secondary benefit to this process was that each person, having had a voice in the problem solving deliberations, left empowered from the interaction. Participants were clear that checking assumptions was a preventative strategy for conflict mitigation.

Participants stated that dialogic communication was an idealized form of communication. They described this communication as the "ultimate form of communication" that they would like to see happening all the time. However, they imposed some conditions on its use. They stated that dialogic communication required a group of people who really understood each other, who were cognizant of their own feelings and the feelings of others, and who were not afraid to be vulnerable. Participants stated that this form of communication required trust between individuals, knowledge and experience of each other and a tolerance for a certain degree of intimacy. They implied that dialogic communication was an endeavor that would evolve with time, and could not be expected in teams that were newly formed or relatively young in their development. A pharmacist stated:

> I think the more you communicate with another individual, the more that you can understand their point of view and the more you understand their point of view, the more you can I guess understand, that place their feelings come from...from their side I think it allows them to open up more, because there's someone who's listening.

A physician supported this view, explaining that two-way communication implied a lot of trust, a lot of knowledge and experience with the other person, a great degree of comfort, and tolerance of a certain degree of intimacy in discussion personal things, noting that evolves over months and years, not over minutes or days. He continued to say that this kind of communication would be difficult in teams where there was high turnover.

Participants iterated however, that dialogic communication was still achievable and of tremendous value to the clinical endeavor. A physician gave an exemplary scenario of dialogic communication that could be used on a daily basis. He used the example of a nurse who came to him with an undifferentiated concern about a patient:

> So, if a nurse, for example, comes to me and is worried about Mrs. X, who's oxygen saturation is 78%, I don't say, uh, well, I'll see her later today sometime, like the nurse is worried enough about that patient that she's come to me first thing to say I'm worried about this person. Do you dismiss it? Do you take it seriously? Do you ask for more information? So part of working well together as a team is being able to recognize when your coworkers are struggling with something and being able to respond to help them, because when the nurse comes to you and says Mrs. X doesn't look well, she's done this before and she knows that most of the time she's going to get eyes rolled to the back of the head [by the physician]. Well, I'm taking for granted that it's valid, the question is how much of a priority is it? Right, so can I do my seven discharges and see the patient in an hour and a half or do I need to go right now? If I chose to see the patient in an hour and a half, that nurse is going to be anxious about that patient for the next hour and a half, and if the patient happens to deteriorate in the next hour and a half, she's going to be overtly angry with me because maybe if I'd gone, when she

> said so in the first place, that person might not have deteriorated. Part of the interaction becomes while you're walking to the room with the nurse, you said Mrs. X isn't feeling well, what do you think is going on? Like what do you think, you know, is it the tuna surprise that she had Friday evening for supper that makes half the people throw up, or you know, she was in heart failure last week, do you think that she's going into heart failure again? Because people have ideas. They may not necessarily have the skills to make a diagnosis or confirm their suspicion, but they have ideas. So, by encouraging participation in that process, they do better the next time. So if I can take some of the burden away from that nurse, she's going to do a lot better with the rest of her cases and what my hope is, is that having dealt with this one successfully and maybe a few more, then next time she'll do the vital signs first and she'll kind of check the oxygen saturation first, so when she comes to me saying, you know, two weeks later saying Mrs. X doesn't feel well, oh, and by the way, here are her vital signs, and I noticed that her legs are more swollen since yesterday, do you think she could be in heart failure? That makes it an awful lot easier for me to deal with the problem, and it also improves her professional satisfaction, because not only has she identified a problem, but she's started to solve it.

This scenario demonstrated that dialogic communication allowed open and honest communication and required active listening, nonjudgmental attitudes, and disregard

for previous assumptions. Dialogic communication also provided the foundation for conflict resolution and mentorship.

Dialogic communication also strengthened work relationships. Participants indicated that they had stronger professional and personal relationships with those with whom they could engage in dialogic communication. A pharmacist stated:

> When you feel that someone understands you, you open up a lot more, and so the lines of communication, open up more, and so, you just want to share more, so it's, it can be, it can be personal it can be work related, so I think in an ideal world if empathy was there, there would be more communication.

3. Understanding the Role of Others

Understanding the roles of others refers to a clinician's ability to appreciate "what" other team members do on their interprofessional team. Participants spoke about knowledge of roles as being the key to understanding the everyday reality of team members from different disciplines. Having a broad conceptual understanding of "how" other members occupy their day (execution of their respective daily routines) provided interprofessional colleagues with cognitive insight into the professional activities of another. One physiotherapist defined interprofessional empathy as follows:

> The ability of a team to understand and appreciate each other's strengths and limitations as well as being able to understand their roles, their contributions, how they would impact your contributions to the team and vice versa.

He referred to the notion that interprofessional teams required a reciprocal reliance on colleagues for knowledge and effort. He also implied that an understanding of interprofessional roles included familiarity with role limitations, and valuing the contributions of other team members. Without this understanding team members' ability to provide informational, tangible, and emotional support, as well as respite to each other, would be limited. There are two levels of understanding essential for interprofessional empathy: Knowledge of the scope of practice of another discipline and knowledge of the "task" associated with a professional role.

3a. Knowledge of the scope of practice of another discipline.

Knowledge of the scope of practice of another discipline means that members of interprofessional teams understand the scope of practice of other members on their teams. Scope of practice refers to the knowledge and skills required to practice a particular profession. Each member of the interprofessional team should have a broad, general knowledge of what each team member's scope is in order to understand how they contribute to the overall activity of the team. According to an occupational therapist, when this knowledge was lacking, it created tension between team members:

> One's experience of a lack of empathy from other professionals is sometimes informed by the fact that they don't understand the roles...how you do what you do, and so, most of it comes from, I guess it's mostly interaction is with doctors, because they're the ones who are, forced to actually speak to you in order to give you instructions as to how to carry out whatever it is they want you to

> carry out with their patients, so then, having less than a full understanding of what you're doing and then saying here's what I want you to do, and then you requiring some clarification, and then, they're on their own path, they're trying very quickly to get through their own clinic, so they're going to go from patient, to patient, to patient, to patient and they don't have the time to sit there...so that sometimes creates some discord.

This example showed that the clinician did not feel respected within this interaction because his role was arbitrarily defined by the physician, as opposed to the physician engaging in dialogue with the clinician about the clinician's potential contribution to the patient's treatment plan. Also, the physician's request may have been outside the boundaries of the services that the clinician could provide. The clinician was not provided with an opportunity to educate the physician about the scope of his services. Understanding the role and working context of other practitioners was critical in helping professionals identify how they were connected to each other professionally. In order to understand the heart of this connection, each team member must be willing to be confident in what they knew and what they did not know, and be willing to engage in conversations with others about the nature and scope of their respective practices.

3b. Knowledge of the task associated with a professional role.

Knowledge of the task associated with a professional role refers to members of interprofessional teams not just understanding the scope of practice of other team members, but having a deeper understanding of what it actually took to perform their

respective roles. Access to this knowledge provided clinicians with an opportunity to understand the complexities behind a particular task of a peer. Many participants described this theme by talking about activities that their colleagues did not know they performed in the context of a particular activity associated with a professional role. These new insights into the role of their colleagues could be referred to "blind spots" that one had about another profession. A social worker, whose role included the function of discharge planning, explained that at times other professionals believed that discharging patients from the hospital was primarily about filling out an application form:

> Where I've been discussing on the other end with um, a coordinator for a rehab program, and they have more questions of the application, being able to sit with my colleague right there and say "well, I have the physiotherapist here or I have the occupational therapist here, do you mind holding while I can discuss this with them?" and that way not only can they, not only can I keep in communication with them and keep in communication with the other, but the other professionals see on the other side the advocacy that I may have to do, or the additional information, or the other parts of, rather than just filling out the paperwork and handing it off and hear back whenever if they get accepted, if they don't, but they see what else is involved in my role in the application process.

Participants suggested that understanding scope of practice was one piece of the collaborative puzzle, but understanding what a particular job entailed was another.

Participants highlighted that knowledge of roles provided the team with the ability to be inclusive in the manner in which they accessed clinicians for patient care. However, sometimes once they were accessed there were some unrealistic demands placed on them that led them to feel unappreciated and misunderstood. These demands had to do with the tasks attached to the role. One respiratory therapist explained:

> The doctor will come in and say "I want to do this procedure like five minutes from now". What you don't understand is that it takes me 20 minutes to set up and then it takes me like an hour to clean up, so yes you [referring to the doctor] may come in and say "don't worry, it'll take two minutes", but for you it takes two minutes for me it takes two hours, so like at least thank me when you're leaving, don't just okay, well great, okay, bye, you know what I mean? And so then when you look at it from that perspective, if that happens you feel under-appreciated and you totally feel like that person doesn't understand where you are coming from...I think that generally other professions appreciate when they know that you know how long it takes them to do something.

A pharmacist concurred with the former statement. She described a procedure that was regularly asked for by physicians where pharmacists were expected to compound a thrombolytic agent that was to be inserted into a patient's chest tube to facilitate the dispersion of clots in the body:

> It's according to their time. They are like I need it now, which I mean it's fine to need it now, but you know, now can mean half an hour because the pharmacy technicians have to make it, put it in a syringe and then another pharmacist has to check it downstairs and then it has to get delivered, right? And they are like I want it now...like I try to get it done as soon as possible, but I don't think half an hour is an unreasonable time frame, but it's like, I want it now.

The lack of understanding of tasks associated with a role sets the foundation for potential conflict between clinicians. Mitigation behaviors within these circumstances were suggested by participants, such as team members educating each other about the necessity for advanced notice in order to prepare for a particular procedure, for staff members who requested a particular procedure to acknowledge team member's efforts, or by taking the opportunity to "shadow" each other on occasion, in order to "walk in the shoes of" another professional colleague to experience the world from their perspective.

Interprofessional team members have to educate each other in order to understand the demands of the tasks that fall within their respective roles. Team members needed an understanding of more than just a person's "role". With superficial knowledge of each other's roles, there existed the latent possibility of having misconceptions or making assumptions about another discipline's professional responsibilities or working contexts that were inaccurate and invalid. Once interprofessional team members sort out "what" they do with each other, it would be imperative that they start to have conversations about "how" each of them does what

they do. If team members had insight into the "how" of their teammate's professional action, then they would be better able to empathize with the specific challenges within the tasks that they were expected to do.

4. Appreciating Personality Differences

Appreciating personality differences referred to the valuing of the diverse attitudes, styles, and personal traits that impacted interprofessional relationships on a team. Participants described the need to understand the various styles of each team member in order to successfully negotiate patient care, conflict, and interpersonal relationships. There were two forms: those personalities that were associated with the individual and those that were associated with a given profession. The latter is commonly known as a stereotype.

4a. Appreciating individual personality differences.

Appreciating individual personality differences refers to a clinician's ability to negotiate the personality of other individual members of the team. Participants were aware that each individual had a collection of unique qualities that they possessed which they demonstrated frequently in their everyday business of living and working.

Participants stated that part of being empathetic with team members involved appreciating that not everyone had the same degree of empathy. A physician stated:

> I think, well, I think that empathic abilities, to a certain degree, um, is personality based, to a certain degree, there's some individual um differences in how empathic you are, right? Because it's, like, true empathy is based on, I think, to a certain degree, social intelligence, right? So there's a little bit of that involved, but I think that you can

> coach to a certain degree and teach people to be more aware of the need for empathy and perhaps that might help them with understanding empathy.

Another clinician stated that "no two people were identical, so we work with people in very different spectrums of emotional receptiveness and some are very close, some people are very open".

A commonality between these statements was the notion that empathy was not equal in all members of the interprofessional team. Some people were more empathetic than others and, essentially, individuals differed in their empathetic ability. Furthermore, some participants stated that true empathy was based on a degree of social intelligence and awareness. Though only one participant mentioned the word "emotional intelligence", there was a strong reference to a difference in individual team members' ability to tune into the emotions of other members by understanding and anticipating what colleagues needed. Participants claimed that it would be up to organizations to teach people to be more aware of the need for empathy, perhaps even helping them understand empathy and its benefit to the team and ultimately patient care.

The greatest challenge to participants in appreciating personality differences was to appreciate those personalities that were opposite to their own by nature. Many of the participants spoke about team members whose working styles were diametrically opposite their own preferred styles. One nurse stated that as an extravert, he tended to show his feelings, while on the other hand introverts did not:

> So if you are an extravert, I think extra—no, I might generalize, but I'm an extravert, and I think that because I can reach out to people I might be able to empathize, but some people who are introvert, they stay within and I, if you only stay within, how can you empathize with me if you don't come out and see, you know what I'm trying, do you get what I'm trying to say? That people who are say, like introverts, they don't express their feelings, they don't try to reach out to feelings, so how could you empathize to somebody else if you only are staying within?

This statement pointed out the fundamental opposition between two attitudes. And though this represents one type of polarity within personality styles, a social worker mentioned another type of polarity. Within her team some of her interprofessional peers were described as very "concrete" in their thinking, while she saw herself as more flexible:

> Because you'll always sit in meetings and look at that person like 'the strangest things always come out of your mouth all the time, all the time" and there's that block, that barrier to trying to understand a little bit more, to try to engage a little bit more, to try to have that empathy. I mean, I've experienced, other people have experienced it, where there's that block of you're so concrete, like, why do you have to be so concrete

Participants said that individual team members who did not want to work through personality differences were imposing a barrier on themselves. They claimed that

every individual had the choice of simply stating, "that person is difficult" and as a consequence abandoning any attempt to understand other team members. A social worker suggested that one option for team members in dealing with people they saw as "difficult personalities" was to understand the "sense of logic that guided their team member's actions". In other words, participants suggested having conversations within the team that facilitated understanding each person's perspective that included the sharing of the logic behind a given position. Participants suggested that in this way, the team could learn and work towards the constructive use of human differences. The ability to recognize the divergence, accept the divergence, and learn about the preferred style/trait in the other person, was an important skill to use to negotiate relationships within the team. A physiotherapist stated:

> I know person A on the staff likes to take a more aggressive approach, they're a go-getter, person B is a little bit more, you know, they tend to go a bit more on the conservative side, so depending on which person is involved in that patient's care, I find that I'm finding it easier to tailor my approach and how I'm going to give those services, give that care, to the best of my ability as well as you know to the standards as they're expected of me, but also taking into consideration how other people within the team, approach the situation.

There were some personalities that participants found to be subversive and counter-productive to the team:

> I think some of it can be as simple as you may not necessarily like your, the team member you're working with, I mean, if you actively dislike them because they didn't happen to use deodorant that day...or because they are complaining all the time and they rub you the wrong way by doing that, it's very difficult to look past that.

Another occupational therapist stated that it was important for everyone to share the team work ethic:

> That everyone is giving all of their effort, they're not um, they're not being lazy, um, they're not, um, you know, running off and doing other things when they have to do patient care, um, so that they're, they're there for the team.

Essentially, there were some instances where personality differences were too large or too rife with conflict to negotiate successfully within a team.

4b. Negotiating professional stereotypes.

Negotiating professional stereotypes referred to a professional's ability to negotiate the particular shared traits, styles, and attitudes of another profession, and how a profession managed stereotypes about itself. Participants stated that making assumptions about a group without getting to know the group could lead to personal barriers in a relationship.

Participants shared that there were stereotypes about most of the professional health disciplines. They also stated that professional socialization dictated how certain professions acted. A respiratory therapist articulated this thought best when he said that:

> Different professions deal with difficult, uh challenging situations differently, right, so the way that we're taught in school, um, is very different depending on what profession you're in, be it nursing, physiotherapy, respiratory therapy, social work, how you relate to the patients, and how you handle death dying or how you communicate to the patient is not always the same.

This implied that each professional group developed its own style of communication, language, and ways of being, which in turn could lead to characteristic or typical behavior for that profession. Individuals outside the profession could see this as an occupational culture and make stereotypical judgments.

When participants spoke about stereotypes, however, they often spoke about the stereotype that other professions held about them. For example, the social worker knew that other disciplines saw social workers as "touchy feely". This was corroborated by the references other disciplines made about "emotional work" and referred to this kind of labor as "social worky". In general, participants worked implicitly to counter these stereotypes, through highlighting their skill and knowledge contribution on their teams.

There was only one professional group, however, where negative stereotypes did have an impact on interprofessional relationships. Most of the stereotypes within the context of this study were projected towards medical doctors. The stereotypes were recognized by other professions and the medical doctors themselves. Words used to describe physicians were "arrogant", "top of the food chain", and "autocratic". Physicians also recognized the existence of these stereotypes. One

physician continued the list of negative stereotypes that he had heard about his own profession:

> Doctors are rude, uncooperative, they don't listen, they are dismissive, they are hierarchical, they tend to give orders and not necessarily listen to feedback from other team members.

Physicians did not deny that there was some truth to these stereotypes, but they did provide a rationale for why some physicians would act in this way. They stated that physicians are usually perceived as the unofficial leaders of their teams, (even when a manager, the official leader, is present). Physicians felt reluctant to trust others completely and unwilling to share authority because they feel responsible for all aspects of the patient's care. They also conceded however, that though much of the patient care depended on the physician's input, the way the physician interacted with staff members set the tone for interprofessional relationships that engendered empathy:

> Some doctors, unfortunately are quite notorious for not being helpful when they're on call at night and you know, staff call with various problems, and it's usually doctor/nurse, and so they get to the point where they just don't call, or they you know call and hear maybe not what they wanted and they just get frustrated and then what might naturally follow would be a disparaging remark to the patient and family, well, I called doctor X and here's what he said and I'm sorry that that's all that I can do sort of saying, well you know, he's very uncooperative.

Physician stereotypes were usually generated based on one-on-one transient encounters with healthcare workers. Without the ability to "get to know" the physician some individuals made assumptions about the physician's personality, their behavior, and their values. After having frequent negative physician encounters, individually based stereotypes anchored themselves as professional ones. When participants in this study had an established relationship with the physician on their team, they spoke about the profession in positive terms, whereas when there was no relationship there seemed to be more negative stereotyping.

Furthermore, having a positive relationship with one physician did not always generalize into a positive perception of all physicians. A social worker stated that a positive interaction with a profession toward which he had a negative stereotype made him temporarily suspend his stereotype against this particular group, as opposed to getting rid of the stereotype all together. This participant provided an example of his negative stereotype of security guards to illustrate this point:

> Like I guess security guards for example, like if I have one really positive experience with a security guard, the next time I deal with a security guard, I might expect the same approach, but I have that in the back of my head and I could say well, let's see how this person is gonna be, and I'll suspend my stereotype for a moment.

In general, stereotypes had to be recognized and dealt with. The ability of professional groups to be aware of stereotypes directed toward their respective profession and work towards managing those stereotypes was an important step to improving interprofessional relationships. Without each profession working

adamantly to change the stereotypes within its own profession, behaviors portrayed by some of its own members would continue to reinforce old stereotypes nurturing prejudices and influencing how professions interacted with each other. Though participants did not articulate it in this way, they inferred that each professional member on a team had to look at how they saw themselves and how they wanted themselves to be seen within their teams. They had to recognize this convergence, work towards mitigating the convergence, and dispel stereotypes about their respective professions. On the other hand, each health discipline member equally had to take a serious introspective look at the prejudices that they had about other disciplines, in order to challenge the assumptions and stereotypes they had about other professional identities.

5. Perspective-Taking

Perspective taking refers to the ability of clinicians to take another perspective, or to forgo momentarily their own view of a situation in order to temporarily adopt another team member's point of view. The primary statement most participants used to describe perspective taking was to "walk in someone else's shoes".

Participants suggested that the first element of perspective taking consisted of understanding the content of how a situation looked from another profession's point of view:

> Empathy to me means, uh, having the ability to comprehend and, um, and put yourself in someone else's shoes regarding, um, regarding their state of mind, regarding their state of emotion, given a particular

> situation. It's being able to relate to them directly and come to a very close understanding as to what's going on, how they're reacting to a situation and most often, empathy to me means you would probably respond in the same manner if that situation was faced or addressed to you directly.

Participants suggested that the second element of perspective taking was an understanding of the emotional content of a situation from the other profession's perspective:

> I think of it as putting yourself in the other person's shoes, trying to imagine what they're thinking, feeling, experiencing, in any given moment, or through any given experience, um, trying to meet them where they're at emotionally, and be aware of how they're feeling.

Participants stated that this emotional understanding did not entail becoming "emotionally entangled" with the target of their perspective taking, but having an intellectual understanding of how that person was feeling.

One social worker stated that although perspective taking sounded easy, it posed a major "ego challenge":

> I would think that it would be very important for the person doing the emoting or to feel understood would be to have you understand their perspective and you reflect back what your understanding is of that perspective, and I guess that I'm thinking that I need to be aware of how I'm reacting to this stuff, but I need to know what's mine? Like what are my feelings about this and I also need to be able to step out

> of that and [think] that I might feel differently about this, or I would not feel that way if I was in their situation, but I can see why they would feel that way.

Participants suggested that perspective taking required moving beyond one's own point of view in order to consider a point of view with which one may not necessarily agree. This implied that it was easy for someone to take a perspective on a situation with which they agreed however, it was incumbent on each healthcare professional to challenge themselves to entertain view points with which they would tend to disagree. This was an essential skill because the essence of perspective taking was demonstrating understanding. Participants stated that the primary function of perspective taking was to "build a bridge between me and them". In conflict, when one conveyed an understanding of another's point of view or feelings, this understanding began to loosen the jam of opposing positions.

When participants spoke about understanding another person's point of view, they addressed this skill as a foundational aptitude for interprofessional empathy. Because of its foundational nature, perspective taking would appear to be implicit throughout communication, understanding the role of others, and appreciating personality differences.

6. Nurturing the Collective Spirit

Nurturing the collective spirit refers to any individual team member's behavior that contributes to the overall well-being of the interprofessional team. It requires that individuals momentarily abandon their own personal and professional agendas (goals and needs) in order to accommodate the "agenda" of others on the

team. Participants conveyed that the ability of an individual team member to forgo their own professional agenda in order to accommodate the needs of the collective team was a key strategy for developing strong psychological, emotional, and social ties within the team. Participants used phrases such as "self-sacrificing", "extending a hand", and "giving and taking" to describe the nature of how they managed their individual professional needs versus the needs of the collective team.

Participants stated that teams that functioned well or teams that were together for a long time developed "family-like" relationships:

> The experience of a lot of people is that the team you work in particularly if you know, there isn't a lot of friction becomes like a second family. And you actually wind up spending, often, more time with your interdisciplinary family, the people that you work with, than you do with your own family because, well, I mean some people work very long hours and, you know, who spends eight hours a day with your spouse?

The former comment implied that team members would have a desire to nurture their healthcare family in the same way they support their real families. In essence, as each team member's domestic family requires an investment of economic, social, psychological, and emotional resources to sustain itself, so too does the interprofessional family. As such, each person within the "family" has an explicit duty to support and uphold the foundational integrity of the group.

Participants also stated that once members understood the needs of other individuals in the team, it was imperative that the understanding be followed by action:

> You can have empathy for someone, but if you don't turn it into action, it can't build, it can't build the team, it can't build the relationships, and it can't improve the care, so I think you always have to, you can have the feelings, you can have the identification, you can have the understanding, but you have to take the next step to put it into action.

Therefore, the ability of team members to understand each other was critical, but not sufficient for empathy to take place.

The following six behaviors were a clear demonstration of each team member's social responsibility to their interprofessional team.

6a. Sharing the load.

Sharing the load is the concept that clinicians on a team collectively negotiate workload demands. In simple terms, sharing the load was when one individual from a profession attempted to help with the workload of a team member from another profession. Participants thought that this tangible support was essential in order to negotiate increases in workload within the system. They stated that though there is a push towards team work in healthcare, the implicit rule that every individual must carry their load was still pervasive within healthcare cultures. A nurse noted:

> There has been many times in which every individual is doing their own thing and it seems so exhausting and we have only seen 20

> patients but it's because we are doing our own thing without seeing that maybe working as a team will make this easier, faster and better.

A pharmacist added "when you're asked to do more and more there is no time to reflect and have one-on-one conversation". She claimed that one becomes totally focused on one's own tasks. She explained that as you focus on your specific tasks you distance yourself slowly from other individuals on the team to the point where there is a sense of isolation that begins to overwhelm the individual. She claimed that eventually people become jaded and start to look out for themselves, in order to keep up with the demand. She ended by saying that when everyone on the team engaged in such behavior, it created a vicious cycle.

When members of interprofessional teams were instrumentally supportive to each other, the support was initiated based on the helper's perception of alleviating the emotional and physical impact of workload on a colleague. The impetus for this action was sometimes generated through a team member asking for help with their work, but appeared to be more often initiated by the altruistic motivation of the helper, or through a helper's perception that their teammate was overwhelmed by their workload:

> If you see that somebody's a little bit down, just being able to help them out, like even through the work day, extending a hand, like if somebody's, you know, overwhelmed with something, you can offer help to say "can I help you with something?" Or take over a task.

Participants insisted that sharing tasks could potentially improve efficiency. Though interprofessional team members were assigned tasks that were specific to their scope

of practice, there was ample overlap between professions to permit interprofessional team members to provide respite and tangible support to each other.

> The quote I can't stand, "that's not my job" I hate that, that drives me absolutely insane. If you aren't showing the respect for your colleague to boost a patient up to the bed or to help turn them over, um, to you know, deliver them a piece of paper that they may need, like, what, what are we in this for?

Participants recognized that there were patient care tasks that did not fall within a specific profession's "protected" scopes of practice, and could therefore be shared with others. When the workload was shared, participants felt more positive about their colleagues, which motivated team members to want to help each other even more.

6b. Inclusion behaviors.

Inclusion behaviors refers to the ability of clinicians on a team to include all members of the team in the team's core business activities. This meant, for example, that when creating patient treatment plans there was intentional consideration as to who needed to be at the table for comprehensive and fulsome deliberations to take place.

When inclusion was not considered by interprofessional team members or clinicians felt like their "voice" was not heard, feelings of under-appreciation and exclusion resulted. One occupational therapist provided an example where a physician, after asking for a home safety assessment to be done with a patient, did not wait for the occupational therapy assessment report before discharging the patient

home. Furthermore, this occupational therapist commented that he felt like patient care decisions were made by certain physicians without his input:

> We need to know so we can send this person home. Get the occupational therapist to do a cognitive assessment on them [the patient]...and then they ask, can the patient go home or not? And nine times out of 10 they've already made the decision whether they're ready for it or not, so there's a lack of...respect.

Participants also stated that inclusion was evidenced in daily clinical practice when health professionals attempted to create a common language that everyone understood between team members. They stated that each profession had its own language and professional terms. Sharing a common language—forms of written or spoken communication—indicated boundaries of membership within a team. One physician spoke about his attempt to communicate with his nurse colleagues:

> Trying to answer the question in a way she needs to hear it, but then just day to day so that that's sort of me trying to be as empathetic as I could be, trying to see the, the situation from her eyes, but even day to day, just writing notes and putting yourself in the eyes of the person that's gonna read it next, whether it's one of those people or even if it's someone you don't even know, one of the nurses, but writing the note in a way that would be understood by hopefully anyone who reads it and not just like your resident, who you know, so that, that's a sort of day to day, I find, it helps to try to be empathetic in writing notes, that's a sort of a communication issue.

A team member's willingness to learn and contribute to creating a common language around the work of the interprofessional team facilitated communication and understanding.

Inclusion.

Inclusion behaviors also create a sense of belonging. One social worker commented on how being inclusive of all members of her team during patient care rounds had a positive effect on team cohesion. She stated:

> There's an inclusiveness that happens and it's not something you can put into words, it's a, when you walk into the room you can feel it, you know, if a team is a cozy team that's working together as opposed to one that's full of rifts, you can feel it, you know, it's a tangible feeling when you're walking into that setting, it's like coming home...you know that, okay, when I sit down here, we're going to get something accomplished.

6c. Consideration of a higher purpose.

Consideration of a higher purpose means that team members recognize that there are team goals and there are professional goals that are potentially always in conflict. This theme referred to the clinician's ability to embrace the broader team goals, and to put those goals before their own professional ones, when necessary. For example, an occupational therapist explained that at times on her team when there was a major educational seminar on a popular topic, that all team members wanted to attend, it was obvious that not everyone could go. The ability of team members to negotiate who went to the seminar was a demonstration of how this theme played

itself out on interprofessional teams. The team had to choose one individual, usually the most appropriate person from the team to attend. She stated that in these circumstances it was important to "say what's the best thing for the team; to not always put yourself first, but to say, what's the best thing for the team?"

At times, professional goals appeared to trump team goals. This was usually manifested in what participants called "goal blocking" your peers. Goal blocking essentially refers to competition between providers for priority to carry out patient treatment activities consistent with the treatment plan. It would appear that in treatment planning sequential prioritization of what needs to be done first with the patient may not always be discussed between team members which leads to conflict around who should see the patient first. A respiratory therapist explained:

> As professionals who have different goals and focuses within patient care, we all see just what we have to do so when it comes to a point where there's a limitation or there's another part of the team that needs to have something done maybe first. I think that you, you have to be patient and you have to really kind of try to understand where that other team member is coming from...but so, like, do I stand in the way of that, do I block that goal in terms of that patient? I think that, when you look at the patient as a whole and you look at all the goals that need to be completed for the patient you have to look at yourselves in terms of we're, we're a team that has goals to accomplish, not I have a) she has b) and he has c) right, it's, it's we

> all have this to do and we can all make it work, then, then that's to the benefit of the patient which is why we're here.

Participants spoke about the importance of not "goal blocking" other professionals on the team. A fairly common form of goal blocking within interprofessional teams was related to another direct patient care activity known as "charting". Participants stated that having access to patient charts, in order to log intervention activities with patients by various professionals was probably the most common form of goal blocking within healthcare today. A physician stated:

> Everyone is competing for the chart, I want the chart, the nurse wants the chart, the therapist wants the chart, somebody's gotta stand back and say okay, you do your part first and you do your part second and I'll go third...but sometimes you wind up grinding your teeth...it means everybody has to take a deep breath and step back and say, can I really control my anxiety and my desire to get my work done by 4:30...sometimes it could be very conflictual.

Generally, considering the team's higher purpose required that interprofessional team members put aside their professional egos in order to consider what may be in the best interest of the patient or what may be in the best interest of the team.

6d. Ability to express vulnerability.

Ability to express vulnerability refers to the capacity of each team member to permit other team members to show a vulnerable side of themselves without fear of criticism from the team. Participants in this study identified gaps in practice

knowledge and exposing their feelings and emotions as possible areas where team members were vulnerable to scrutiny and reproach. As a result, healthcare workers were afraid of being labeled deficient within their teams, as opposed to finding refuge and support in the collective capacities of the team to help fill in the gaps in knowledge and provide the emotional support that is sometimes necessary when working with difficult healthcare situations and outcomes.

There was a pervasive impression among the participants that traditionally, as healthcare workers, a portion of each member's value to the team was attached to having a specialized body of knowledge that was specific to that profession. That specific knowledge gave each member power and privilege on the team. Each professional held out their knowledge as a constant and continual proof of their worth to the team. However, since the advent of interprofessionalism, healthcare workers have had to broaden their understanding of their work into practice areas that are traditionally not held within a specific profession, and as a result team members must rely on the knowledge of others to successfully negotiate patient care. This has meant that team members must relinquish the illusion of the all-knowing clinician to embrace the journey of the all-learning clinician. This was a source of implicit psychological stress for team members because they stated that asking questions on an "expert" team could be perceived as "a sign of weakness" or "a sign of stupidity" by members of the team. One physician commented about clinicians having to feign always knowing:

> It's rare that someone would acknowledge that, I guess the pressure is to not be thought of as not intelligent or not be thought of as less

> intelligent than someone else, I do, I remember when I was doing a rotation in [place] a doctor telling me how he was a bit frustrated by some doctors who always felt the need to give an answer to patients, even if they didn't know, um, and so patients would come to him with a question and he didn't know the answer, except that he was a specialist and was pretty confident that no one else knew the answer.

Nonetheless, in order to create opportunities to provide informational support to each other, one occupational therapist insisted:

> At times you may [have] to be vulnerable, you have to be able to say to someone, I don't understand this. Like I can go to the surgeons and say I don't understand what this surgery was, or I don't understand, you know, what type of infection this is, or, you know, what does that mean? And, uh, and they'll explain it to me. Because even though I've been, you know, a clinician for, well, well over 25 years, there's still things that I don't know.

Participants who felt very connected to their teams spoke about being encouraged by interprofessional teammates to ask questions and clarification about work activities, procedures, and processes. The explicit articulation of the team norm of "making it okay to ask each other questions" seemed to set the ground for teams to address gaps in practice knowledge. It also created an impetus for mutual aid to take place between clinicians.

The ability to express emotions on teams was a much more contentious issue for participants. Participants stated that "emotional work", which was defined as the

hearing and sharing of feelings between co-workers, was generally a challenge in healthcare settings.

Participants stated that there seemed to be little importance attached to emotional work within healthcare teams. As a matter of fact, emotional work between healthcare providers was regularly alluded to as "fluff":

> Healthcare workers generally, the people that I've worked with and not only our teams but a lot of other people are wired to be analytical thinkers, problem solvers and yes, a lot of them have that personal connection, love dealing with people, but if any aspect of your job is technical at all, you have that wiring in you to just, just want to problem solve, just want to get in there and fix everything, so I think that when they hear, okay, we're gonna talk about our feelings now, it's like okay...what? Like people aren't ready to do that, they don't want to do that, you know? It's just, they don't...you know what I mean.

Similarly, a physician also commented on the lack of respect for emotional work among his peers:

> I don't agree with many people in my class who felt that teaching about this sort of stuff [empathy] is futile, like I really do think that these skills can be learned.

One occupational therapist suggested that emotional work between providers was not popular in healthcare because most healthcare workers "relied on clinical distance". They were taught to have a "detached concern". This orientation to empathy

promoted emotional detachment and warned the clinician against personal engagement. As such, it would be natural to conceive that "feelings" have no place within professional work, and that anyone who displayed too much feeling would be either seen as out of control or unprofessional.

Participants also stated that due to a demanding work environment with heavy workloads, there was little time to speak about their feelings concerning certain work related issues. So with little time for formal or informal opportunities to talk about their feelings related to clinical/work situations, some participants suggested that they just went through the motions. Eventually, some individuals felt so disconnected from their feelings that they compared themselves to being mechanical robots:

> We don't have time to kind of say ok, just slow down and look at what just happened a death or you know, whatever, um, then people are not so in-tuned to each others feelings you know, we kind of just say ok, well we can't deal with this now, we have to keep going you know, so...they're, they're just kind of being robots, you know, they're not uh, not listening and they're not, they're, working, I think if we had a little bit more time.

A nurse provided another example:

> It was Christmas day, I had a gentleman, he was 47 years old, his son was 21, the son's mom had died in a car accident three years before and this was his dad, he was dying and screaming please do not let him go, I need him, I have nothing else, and also it was Christmas, he told me that I cannot be alone on Christmas. I started crying with the

> patient, uh, I mean I had to tell him that there was nothing else that I could do, that it was over, that he have nobody else, and it was really hard because I only could spend so much time with him. The minute that I finished with him, I was in resuscitation room, they brought in another dying patient, sorry, there is a new family, with a new pain, with a new dealing and I have to go for it. So where is the empathy from the health centre for situational crisis like this one? Oh yeah, go and take five minutes outside. Sorry, emotional impacts don't take five minutes to recover, some things stay in your core for ages, you know. I don't have grieving moments [at work], I don't have this emotional, recovery situation, my only recovery is to interact with my teammate and see how we both feel about that and be there for each other, that's my only recovery moment, so there is no policy empathizing with situations like that in the healthcare centre.

Though there were local strategies between team members in supporting each other emotionally by giving each other "breaks" or speaking one-on-one with each other, there often were few formal mechanisms that responded to the emotional needs of the staff. One respiratory therapist spoke about the benefits of formal debriefings on his team, where staff had an opportunity to talk about their emotional reactions to difficult cases. He underscored the importance of team members being able to find a "safe place to talk" about their feelings and rely on the other team members for emotional support. He stated that part of the benefit of having debriefings was that team members had an opportunity to openly communicate with each other, and it

gave team members an opportunity and permission to express themselves, which helped individuals develop an appreciation for the struggles of others on the team. He stated that more frequent opportunities to meet as a team and debrief work situations would be of significant benefit to the psychological and emotional health of the team members.

Lastly, emotional work within teams was challenging because it could be psychologically threatening:

> What makes it hard for them [team members] to show other staff empathy, is that there is a fear that if I show you empathy...what is going to be the demand on me if I show you empathy? If you're feeling really sad and I acknowledge the sadness or the feeling, and if I'm a manager do I have to say oh take the day off? Like even though there may not be a demand there but, it's like, how is that going to affect your behavior towards them I guess, because you can show empathy but then it feels like that takes you to a vulnerable space when you're showing empathy, and how's that, how's that going to play out?

This statement inferred that being empathetic required a certain amount of personal and professional vulnerability. Not engaging in emotional work with teammates could be seen as a self-protective mechanism where the risk of "getting hurt" by a colleague or "being judged" by a colleague was reduced.

Overall, participants contended that healthcare workers were potentially more effective at their work when they engaged in emotional work with each other, but that there still were structural and psychological barriers that prevented this practice.

6e. Adopting a supportive presence.

Adopting a supportive presence includes gestures or words used by individual team members to show solidarity with their fellow teammates. Participants referred to this theme as "knowing that the team members were there for them" or "knowing that the other team members had their back", or even "knowing that their team was thinking of them". This type of support was mostly psychological in nature, but was sometimes expressed through symbolic gestures, such as " a pat on the back" or "sending a card". Participants reported that having that sense of solidarity generated an emotional connection between members of teams, because individuals felt "lifted up", encouraged, and strengthened in their ability to do the work. For example, one respiratory therapist spoke about a situation that she experienced where the participant and a nurse were doing a procedure that required her to place a tube in a patient's chest. As she was placing the tube in the chest, blood spat out of the tube and landed on the participants face. This was the first time that this had ever happened to her and she was visibly startled by the occurrence. She claimed that the nurse, who was assisting her in the procedure, saw that the respiratory therapist was startled, calmly asked for assistance from other nurses to take over the procedure, took the respiratory therapist to a corner, and told her to sit on a chair. The nurse then went to get a rag cloth, soaked it with water, approached the respiratory therapist, and gently washed her face, without a word being spoken.

Participants stated that there was an implicit expectation that team members were going to look after each other. They would support each other by relying on each other for various situational and emotional needs. Participants described the ability of the team to continually adjust its resources to meet workload and output demands based on the needs of the individuals in the group. When team members readjusted work processes to cater to the personal needs of a teammate, I referred to this process as *dynamic reciprocity*. When individuals felt like they had the support of their teammates, it was clear that each team member expected to be supported and was also expected to support others. This process was not based on an "I owe you" system. Participants stated that without supporting each other the work would not get done. The ultimate goal of readjusting work processes was to make sure that the greater good of the patient was served.

6f. Shared emotional connection.

Shared emotional connection means having a shared history and shared participation for members within a given group. When interprofessional team members partook in a celebration, or navigated through "a crisis" or "a difficult situation" together, these communal experiences increased the emotional bonds between them:

> I think anytime you face a challenge and you overcome that challenge, you get the shared story and that creates, any time you have a shared anecdote, that creates a team building situation, so people have something in common that they can either laugh about or complain about, mostly complain, but sometimes you complain

because it's funny and that's, I think that's a great team building exercise.

During difficult situations, participants came together to help each other out. Participants reported that teams worked best when they were faced with a particular crisis, but that celebrating successful outcomes of these situations was important for reinforcing interprofessional team behaviors that were helpful to the team. Nurturing the collective spirit centered on action-oriented behaviors that supported the integrity and sustenance of the team.

A (Textural) Description of Interprofessional Empathy

This study identified six dimensions that were important for healthcare professionals in their perception of interprofessional empathy on interprofessional healthcare teams. Engaging in conscious interactions, using dialogic communication, understanding the role of others, appreciating personality differences, perspective taking, and nurturing the collective spirit all contributed to increasing healthcare professionals' sense of receiving empathy from and providing empathy to each other. Based on the key components raised within each theme, a general textural description of interprofessional empathy from participants of this study emerged from the descriptors health providers used to define interprofessional empathy (figure 1).

When healthcare workers talked about interprofessional empathy they used words like "conscious", "being present", and "one-on-one" interactions. Participants spoke about approaching each other in a manner that engendered respect and about knowing the "person behind the profession". There was a strong undertone of approaching and meeting other professionals as "human beings" first, then as people

in a role. Essentially, every interaction with another member of the team would be based on a conscious awareness of the potential impact of the contact.

Clinicians described interprofessional empathy by the manner in which health professionals talked to each other. It was important for clinicians to talk with their peers in a manner where communication was more than just "a message that was delivered". Communication was seen as empathic when colleagues sought, honored, acknowledged, and deliberated upon input from other team members. Communication was a principal mechanism through which the team shared job knowledge, learned about each other's personalities, and exchanged perspectives with other members. The ability to negotiate the former three elements was seen as empathic behavior because recognizing that "no two people were identical" was to accept the different gifts that various individuals bring to the team. Recognizing these differences also meant that conflict was expected and discussed as well.

Ultimately, healthcare workers described interprofessional empathy as an altruistic endeavor. They used words like "self sacrifice" and "extending a hand" to show that healthcare team members had a social responsibility to their teammates. That essentially, team members were there to "offer help" to each other, and be there for each other when clinical or personal situations became emotionally, physically, and psychologically taxing, in order to offer instrumental, emotional and informational support.

Figure 1. A Textural Description of Interprofessional Empathy

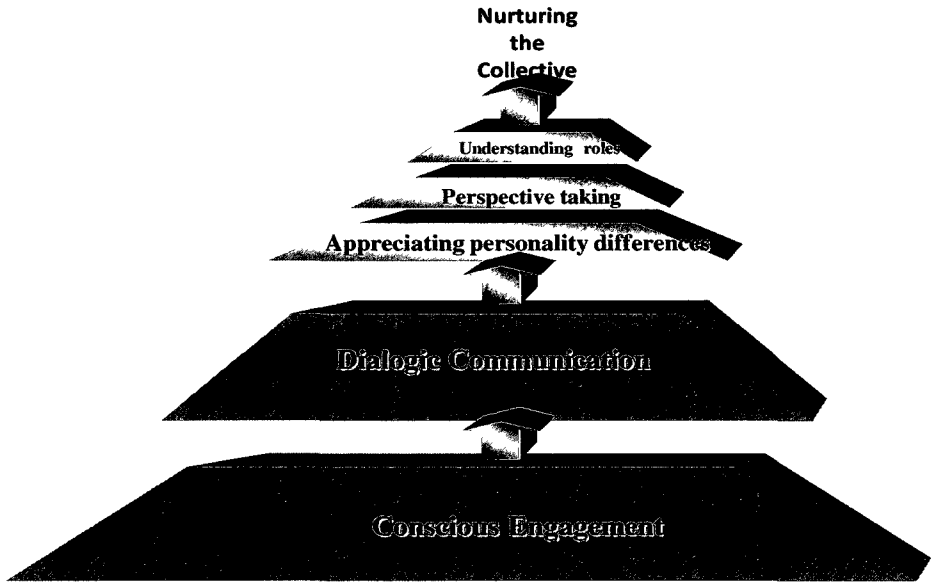

Figure 1. **The six identified dimensions that are described as being part of interprofessional empathy.**

Contextual Factors in Interprofessional Empathy

Talking about empathy on interprofessional teams must take into account the role of context. Simply imploring clinicians to be more empathetic with each other was to reduce the origin of the empathy issue in healthcare to the individual psychological processes of interprofessional team members. This would merely diminish the lack of empathy between members of healthcare teams to individual deficiencies. In fact, this may not often be the case. Though clinicians on interprofessional teams claimed that empathy was an important personal endeavor, and somewhat recognized its part in their work with each other, they were also clear about some of the contexts which facilitated "empathy" between team members. As such, through their textural descriptions of interprofessional empathy, many of them

made reference to qualities of the healthcare environments that blocked the growth of empathy on teams and those qualities of environments that promoted and nurtured empathy between individuals.

This section of the findings addresses the second research question: What factors might enhance or diminish the ability of healthcare providers to be empathic with one another? This question addresses the structural components of interprofessional empathy. As an overview of the structural description of interprofessional empathy, 198 significant statements (quotes that provide an understanding of the phenomenon) were extracted from 32 verbatim transcripts. Arranging the significant statements into meaning units (themes) resulted in nine themes that influenced clinician behavior and affected how they treated each other in an empathetic way. The meaning units were: accessibility, team-building, overlapping scopes of practice, perception of workload, teachable moments, empathetic leadership, non-hierarchal work relationships, and job security. A summary of findings is presented in Table 2. Table 2 contains a list of meaning units and sub-meaning units that were clustered under each theme. This is followed by a detailed presentation of findings by theme.

Table 2

Meaning Units and Related Structural Components of Interprofessional Empathy

1. Accessibility	1a. Proximity 1b. Frequency of Contact 1c. Consistent Staffing 1d. Team venues for communication
2. Team Building	
3. Overlapping Scopes of Practice	
4. Perception of Workload	
5. Teachable Moments	
6. Empathetic Leadership	
7. Non-hierarchal Relationships	
8. Job Security	

1. Accessibility.

Accessibility refers to the ability of members of interprofessional teams to access each other for emotional, informational or tangible support. Accessibility speaks to situations or opportunities that permit the members of the team to connect with each other, and provided a space for each person to interact with other members of their interprofessional team. Participants identified four elements about accessibility that lent itself to the development of empathy:

1a. Proximity.

Proximity referred to working in a shared space or working in a space where it was easy for professionals to see and talk with each other. Participants spoke about having greater affinity with those clinicians with whom they shared spaces, because it was easier to connect:

> A limiting factor is space. It's funny, there's almost too much space between rooms, so there's this disconnect there, so in the unit that I used to work in, in ICU, the rooms were very, very close to one another, right, so there was that, opportunity to kind of have a social aspect or social discussion while you were still performing the patient care, the rooms now become, are so silo-ed and so distant. Space becomes a challenge towards interprofessional empathy because your limited with, you're not just going to go down the hallway to speak to that person, because they're actually like, miles away almost, like obviously figuratively speaking but like, literally they're quite a long ways away so that's played an impact on the ability or the opportunities for interprofessional empathy to be occurring.

Participants also suggested that shared spaces between clinicians lent itself to individual clinician's having opportunities to "witness" the work of their colleagues which led to a greater understanding of roles between clinicians.

1b. Frequency of contact.

Frequency of contact refers to the number of interactions that team members had with each other within a given time. Participants made a link between the number of interactions between team members and the development of empathy on teams:

> I think that it's those sorts of teams where you have less interaction, less opportunity for interaction where I find it takes time to develop that sort of empathy.

Participants stated that the more contact they had with a team member from another discipline, the more this contact increased their chances of knowing that person professionally and personally:

> Because the RT has worked with Dr. S. he knows that he will want him to do this and that, so I think the more you interact with people from a different practice, you will get to know them and then you will, oh, she likes things to be done this way, so I'm going to do it this way because that will make my work easier and better and we will function as a team better.

Frequent interaction also provided opportunity for emotional bonding:

> You develop an emotional bond with people simply because you work with them, you problem solve with them, you deal with them on a day to day basis, you work together with them, sometimes for years.

Frequent interactions facilitated emotional bonding, through team members experiencing mutually positive interactions with each other.

1c. Consistent staffing.

Consistent staffing refers to the stability of membership on the team. Many participants spoke to the need to maintain consistent membership on interprofessional teams. Team stability was important because when teams collaborated and developed treatment plans for patients they created what was known as *continuity of thought* within the psyche of the team. Continuity of thought supports each member's understanding of the flow of work that was intended for a particular patient and contributes to the development of team cohesion.

Continuity of thought was challenging to maintain within a team when inconsistent members rotated through the team. This may be especially so for teams whose practitioners did not work together consistently, but collaborated on a case-by-case basis, or when practitioners came and went based on the needs of a medical service. One physician spoke about the advantage of being part of a team that had fairly stable membership:

> Another thing that's kind of unique about the team on 8G is that there's very little turn over in terms of the staff, much less than on other units, that's a factor, I mean, on the general medical units, which are on 9M and 9 east and 10M, the doctor, for example, changes every two weeks and every weekend. So how do you get some continuity of thought and care, when there's that much change in the medical feedback and the medical assessments?

Team members transitioning in and out of the team had an impact on team functioning. This physician's comments supported the notion that interprofessional

team members negotiated care, and through this negotiation members usually developed a common understanding to their approach to a particular patient. The integration of new members who were not privy to the team's "shared ways of working" caused considerable disruption in the smooth flow of work. He used the example of physicians who changed every weekend on the medical units and what happened when the weekend physician on call came in to take care of a patient and prescribed a completely different set of medications for that patient. This in turn reversed the negotiated collaborative treatment plan that was established between the regular physician and the other team members during the week. Essentially, after each change in membership teams had to re-establish shared purposes and goals.

Stability of team membership may also make it easier for the development of empathy:

> So I'm kind of bouncing from service to service, so it's a little bit difficult to actually form, you know, really close bonds as opposed to people who work within the same service.

Participants implied that they were more willing to invest in relationship building if they knew that relationships would not be short lived. When team members were assured of 'permanency" within their work relationships, they appeared more prone to make an effort to engage in intentional relationship building with their colleagues.

1d. Team venues for communication.

Team venues for communication include formal and informal forums where interprofessional team members can engage in meaningful conversations about the

work they do together, about the effects that the work has on them personally, and about how their team works:

> I think it's, this piece of having time to communicate, I think that's a big piece, ensuring that there is time, either during the day, or at least once a week where there is that time set aside for communication, um, as well as, you know, that kind of weekly meeting is important, for the bigger things, and then, having that avenue of communication that can happen every day is also important, just in terms of that sense of connectedness, and there is certain, kind of smaller pieces of information that need to be shared, you know, can't always wait until the meeting at the end of the week.

Participants stated that regular team meetings were an important mechanism in keeping staff psychologically and emotionally connected to each other. Having regular meetings provided space to negotiate patient care; time for learning with, from, and about one another; and an opportunity to debrief difficult work related situations. One social worker provided a scenario where a colleague had passed away, and the emotional impact that it had on the team:

> We have rounds every morning, interdisciplinary rounds and at the end of the rounds one of the nurses clearly just became very emotional, you could see the emotion in her eyes and, basically she said you know, what can we do about this because it feels like nobody's even talked about [our colleague's death] and the manager pretty quickly, I think eventually sort of became a bit defensive

> saying well you know I can't talk about the causes and I can't, I can't disclose and I couldn't disclose this and I couldn't disclose that, and the, but then the staff said but no, we just, we don't want to know that, we just want to talk about it, like have a shared experience to be able to talk about this.

Participants spoke about the importance of creating space for emotional work to happen within teams and between team members. Whether this work was done during a meeting or whether there was time created in special purpose meetings, participants were clear that creating venues for communication was an important endeavor for nurturing empathy.

2. Team building.

Team building refers to the formal activity of bringing members of teams together to help them learn to work as a team. This means providing each member with the skills necessary to negotiate the many professional and interpersonal challenges that the team faces over the course of its development. This theme speaks to "how" team members were prepared and sustained in their ability to work on interprofessional teams. Team building may not be the only mechanism to address role clarity and personality issues, but it is a critical first step in preparing clinicians to appreciate the concepts of role clarity and the gifts of diverse personality on a team. One occupational therapist spoke about how team-building opportunities within her mental health service supported the development of high quality relationships within her team:

> I was fortunate enough that when I was hired, I was hired on during the development of the program and half of the team was hired on during that phase, so at that point there were two OTs, a social worker, and a nurse and during part of that program development we did a lot of team building as well, which I think really set the foundation, for the culture of the program, and through that team building we did a lot of exploration around, you know, what are the different professions, what do we have to offer, learning a little bit about each other and that sort of thing. I recognize that is not kind of a typical experience, I think when someone's coming into a job, but for me that was what happened, so and I think it very much played a role in terms of the good relationship we have within our team.

The former comment also addressed the issue that team building was not a typical experience within healthcare settings. Few participants reported having regular team building sessions:

> Well, like what training do people get? How do you learn to work on a team? You get thrown into one. It's like swimming with no swimming lessons, here, you're in the deep end, good luck. No, seriously. What training, what information is provided, what skill sets are provided, what advice is provided, what resources are provided for you to deal with problems that you might be having?

Participants described the present system of forming healthcare teams as "parachutism", where individuals were literally dropped into a team with little or no

training and no knowledge about the individuals with whom they were expected to work. They were expected to negotiate and feel their way through those work relationships without any organizational support. Participants noticed that there was no expectation of team building when new individuals were introduced into a team for either long-term or short-term positions on healthcare teams. Participants were somewhat dismayed that healthcare organizations would not provide team building to its healthcare workers, especially in light of the collective benefits it would have on how team members collaborated with each other. They felt that training for quality relationships needed to be part of the healthcare organization's mandate. Participants suggested that healthcare organizations should not take for granted that healthcare workers possessed skills that would lead them to work effectively and collaboratively with each other. One physician described his experience:

> So a doctor's parachuted into a team, hi I'm your doctor for the next two weeks, let's go! That's it. Does he get any preparation? Well maybe the doctor who was on the previous week left some notes about okay, patient number one has this and this, patient number two is going to go home on Wednesday and this is what you need to do, but in terms of issues around dealing with the staff, and interactions with people, there is not training, there's nothing, so how are people supposed to learn?

There was strong support for formal team building activities within the healthcare environment. However, participants still held the perception that within healthcare, team-building was not done frequently enough and not acknowledged as a valuable

tool. "This idea of team building, although it's kind of cheesy, I think it is effective". Team building would provide more opportunities for staff to understand each other, and ultimately create space for empathy to develop.

3. Overlapping scopes of practice.

Overlapping scopes of practice refers to more than one profession being able to do a specific task within a team. This means that no one profession actually owns a skill or activity in and of itself. One activity does not define a profession, but it is the entire scope of activities within a defined limit that make any particular profession unique. Participants identified that those individuals who worked in a model of care where there was significant overlap in scope between professions created what was termed *team optimization*. Participants described team optimization as the process of looking at the skills needed to meet patient demands and assigning individuals shared tasks based on those activities in order for team members to increase efficiency of patient care. One social worker explained that permitting professional team members to generalize their roles meant that the team optimized its functioning:

> The program is set up so that we're all generalists first and then our profession comes next, like our discipline comes next, so we're supposed to be really primarily focused on the elderly, so that's our knowledge. Any of us can go out and do the assessment, so we automatically haven't got boundaries that might happen if you were on a team with somebody who was strictly doing their own discipline.

An occupational therapist provided an example of a clinic where overlapping scopes of practice contributed to stronger working relationships between team members. This occupational therapist spoke at length about the overlap in scopes of practice between physiotherapists and occupational therapists in the hospital's hand clinic. She spoke about the initial resistance and fear held by physiotherapists and occupational therapists when the hospital wanted to integrate both their roles so that the two professions could work interchangeably with patients. The new model of care required both professions to share practices that were thought to be exclusive to each profession respectively. However, she did say that with time and reciprocal teaching, an understanding and mutual respect for the strengths of each profession developed amongst the team, and the level of understanding of their respective roles was much deeper than that between physiotherapists and occupational therapists in other areas of the hospital where there was less overlap in scopes of practice.

It is important to note that shared practices did not only include controlled acts as defined by legal statutes, but those practices that could be shared by all and that were not protected by legislation:

> It's almost as though everybody in that department feels they're responsible for, it's not my job and your job, it's our job. And I don't think you get that everywhere in the hospital, but, even something as simple as picking up a telephone, if you're sitting near it, answer it, you know, it doesn't have to be a nurse, it doesn't have to be a clerk. Whoever hears it ringing, there's someone on the end that needs some help.

Essentially, participants stated that when scopes overlapped, it permitted the coming together or intersection of different worlds, which created an opportunity for conscious interactions, and deep learning about the role and job of another profession. It permitted clinicians the chance to have an insider's perspective into the work of their colleagues, without the need to imagine the activity. Team members had to actually teach each other the activity.

Barrier-less work environments appear to be a fertile ground to support good interprofessional relationships because they provide clinicians with an opportunity to share in common patient care experiences and structured care processes. Clinicians from different professions then share in a common experience and negotiate common challenges:

> I think in the moments of the overlap, that's when I think there is a sense of empathy because there is that intellectual understanding, in the moments of overlap, as well as the emotional understanding, in the moments of overlap. And, there is a greater propensity towards being empathic to your colleague in that moment.

Those practitioners who were not able to let go of their protectionist posture in regards to their role had greater difficulty working in environments where there was much overlap in scopes between professionals, and as a consequence had greater discomfort because they were not willing to share their knowledge with others. In these situations, overlapping scopes of practice could lead to turf wars. "The ones who I think are identified as empathetically interprofessional are the ones who are not militant about their roles". Participants stated that professional protectionism

prevented the sharing of knowledge between professions. Without the willingness to share knowledge and skills wholeheartedly, areas of overlap in practice created tension and anxiety amongst the team.

4. Perception of workload.

Perception of workload refers to how clinicians see the amount of work that they have to accomplish within a given time and how they negotiate the time and effort in relation to a specific demand. Participants spoke about the need to create less speed and more meaning within healthcare environments. They reported that the busy nature of the healthcare environment disabled team members' ability to provide empathy to one another:

> I think time constraint is a big one. When we're all under a lot of pressure and we're seeing, you know, a certain number of clients...there isn't that opportunity to touch base, and to um, to seek out empathy or be able to provide someone else with empathy.

Participants suggested that when healthcare workers felt overwhelmed with the amount of work they had to do, they focused more on the task and less on the process of getting the task done. Some clinicians would not reach out for or provide to their peers instrumental, tangible, or emotional support. In commenting on some of the barriers to empathy in healthcare environments a pharmacist stated:

> One is just time constraints...work load issues, if everyone has to see a certain number of patients, do a certain number of things then we're all just focused on the tasks and not really, you know, maybe

> interested in helping each other or bonding with each other necessarily.

This statement implies that healthcare workers are making the choice not to be empathetic because they are too busy. However, participants suggested that there has been an acceleration of work within service units; the speed at which workers are expected to complete activities has increased, which leaves little time to collaboratively talk about process, and it is within the context of talking about process that empathy develops within teams:

> I think right now the lack of empathy is sustained by our need to get people through the system as fast as possible, and if you're busy, talking over things to the degree [that I am describing] you sacrifice a little bit of efficiency.

Other clinicians suggested that the perception of being busy held psychological impacts for team members as well. Busyness in healthcare activated what some clinicians described as an internal survival system that participants termed as "tunnel vision"—not being able to see anything else around them but their specific tasks. Tunnel vision was experienced most often on teams where each worker was expected to "carry" his or her load:

> We're burnt out already, so you're so, it's, it's you're being selfish when, when you're out of time when you're stressed right... You're so self absorbed you don't, you don't want to reflect on anybody else's being burnt out.

Participants suggested that healthcare organizations are running on a fairly tight time line. They have the sense that time is always of the essence. Organizations are relying on clinicians to provide timely care. Organizational timelines are so finite and connected to their financial bottom line, that efficiency has become the primary focus of the healthcare organization today. This theme spoke to the drive for efficiency in healthcare systems and the sacrifice that was made in the name of efficiency, including the interprofessional kind of human qualities that would make working with other people worthwhile.

One clinician stated that hospitals are slowly moving towards a corporate model for healthcare. This participant added, "corporations are not empathetic organizations", suggesting that corporate values that focus exclusively on financial drivers are not naturally compatible with the development of caring and empathy in the healthcare environment. Though other participants never made this direct link between corporate values and healthcare, they all alluded to the idea that the operations of the hospital centered on efficiency, which eroded caring and empathy both for patients and team members. Essentially, participants argued that the drive for efficiency has threatened the development of empathy within healthcare settings by integrating commercial ideologies into healthcare operations.

5. Teachable moments.

Teachable moments are those instances where healthcare professionals have an opportunity to share knowledge with and teach each other. This sharing of knowledge provides an opportunity for interprofessional bonding:

Those who are concerned with teaching and making sure that

> everybody gets the full breadth of what's going on are to be more engaging and as a result, at least appear more empathetic, because they are reaching out to you because they see you're struggling with something or they see that you don't understand what's going on.

Teaching between professionals allows for "learning moments". Participants stated that it was important for the professional who was teaching to ensure that the professional who was learning felt secure, safe, and at ease within the context of that interaction. The learner was assumed to be vulnerable because of a gap in knowledge, and the teacher was assumed to be powerful, because they were seen as knowledge holders. This is where the worker-worker relationship mimicked the teacher-student relationship, and required a degree of empathic exchange. Within this learning moment a considerable amount of attention was provided to the student, as well as the teacher being in tune with the student's needs, resulting in high levels of engagement, sharing and dialogue. Participants conveyed that it was always reassuring to call on other team members when they needed to know something or learn something new without feeling that they had to figure things out on their own or sacrifice their professional credibility:

> And so if you can get, in a teaching environment, in an empathetic environment, you could be free to ask questions without feeling like you were going to get your come-up ins or without feeling like um, that you are somewhat sacrificing your profession.

Many participants stated that teachable moments were an opportunity to cultivate learning about one another in a positive intentional interaction. This

interaction took place without having to fault the professional learner for not knowing what one would presumably expect them to know on their team. Participants were adamant that in healthcare settings, one either knew or did not know, and if one did not know, then there was a fear that individuals would be perceived as weak or incompetent. Participants strongly criticized the culture of "having to know everything". Much of this culture was inculcated during professional education in many of the healthcare disciplines. One physician stated:

> The training certainly when I went through was that you basically have to be omniscient and perfect, and that's the expectation. You have to be right all the time, you are not allowed to make mistakes because there might be a bad outcome as a result, and it's an absolute expectation that you will do everything perfectly, on your own, and you're allowed to ask for consultation from a sub-specialist in a particular area, if the patient has, you know, a problem in that area, but essentially you are responsible, 100% for that particular patient that you are caring for in terms of their outcome. There's no one, there's no suggestion of if you're having problems here's who you should call or here's who you can call, and in the situations where there might be some, you know, teaching or feedback, often it's critical...you get berated a lot.

Participants claimed that health care professionals in general were professionally socialized to berate each other if an action was seen as a failure or a wrong answer was given to an inquiry. An occupational therapist stated:

> I think it is cultured from the way professionals are trained, you know, because if you ask too many questions, it's seen as a sign of weakness, you don't know what you're doing, what kind of professional are you, asking these kinds of ridiculous questions, so there you have it, it's the circle, it's the circle of lack of empathy completed.

Participants spoke about the strong influence of the manner in which individuals were indoctrinated into the medical professions. Many individuals seemed to experience being "jumped on" by their peers when they made errors. Participants stated that even though this was not the way clinicians desired to respond to each other, maintaining professional credibility depended on how much more one appeared to know than others. One participant referred to this as "intellectual Ramboism", stating:

> The way people are taught is in a fairly aggressive style where they're forced into a situation where they have to make a decision and make a mistake and everybody pounces on you, um, and that establishes sort of what I like to call, uh knee-jerk intellectual Rambo-ism where anybody who's wrong, you just jump on that mistake and hammer it home for them.

Participants questioned the effect that this experience had on an individual's ability to interact with others, and take responsibility to communicate about mistakes. When team members were afraid to be wrong about anything, how were they supposed to

interact with team members who they may not have agreed with in terms of a particular situation?

6. Empathetic leadership.

Empathetic leadership refers to the qualities of a leader that nurture supportive behavior between members of the interprofessional team. Said one respondent:

> And that I think is the management responsibility. How you lead your people into from me to we, from I to us, and I don't think it's employees' responsibility, I think it's the management responsibility, you have to create the environment for people to be successful.

Leadership for interprofessional empathy requires managers and other team leaders to focus on the growth of individuals and the strengthening of relationships.

Participants also indicated they wanted managers and leaders who were empathetic in their own right. These leaders were in a position to role model empathy to their teams. Participants spoke of leaders who were able to actively listen to their interprofessional teams, who were authentic in their communication, and who did not say one thing and then do another:

> And I think that that piece also of feeling like you can go to your manager and talk about a particular problem and feel like they're going to stop what they're doing and listen and actually provide some supportive feedback as well as help you problem solve, and may even follow up um in terms of how things went.

Leaders are also important in supporting the development of interprofessional empathy because they control the nature and flow of the work of the people they lead

or manage. As such, they can facilitate opportunities for the team to have formal communications, but can also set expectations on the team that all team members must "work together":

> The leader of an organization can have a tremendous amount of influence on how these people interact, like they establish the standards...they do help shape the way people interact right, leaders often affect the whole organization.

Participants reported a marked difference in the nature of interprofessional relationships on a team if the leader was interested in the team's functioning, as demonstrated by their supportive presence:

> I think they themselves have to be empathetic, so feeling like that person is interested in the team's functioning, and is also available to coming to the team meetings, because that also sends a message, too, you know when the manager never comes to the meeting, you know, how important is the team, and you know, whereas you know, if the manager is coming and listening and participating, and you know, being kind of on equal footing.

Participants also stated that managers who were autocratic did not necessarily inspire interprofessional empathy between team members. They wanted managers who were able to respond to a team's needs and foster the use of shared power.

7. Non-hierarchal work relationships.

Non-hierarchal work relationships refers to the power dynamic between healthcare workers from various professions. Participants mentioned that the challenge for healthcare workers was to look for ways to share power with each other, and build positive relationships that support the team's patient care mandate:

> I guess one of the most important features of an interprofessional team is that the members treat each other as colleagues, right? And that there is not so much of a power differential in terms of either, uh, I mean there is differentials in knowledge-based, but there's not a differential in terms of influence. Okay?

Participants conveyed that they envisioned professional relations where power differentials were minimized, where empathy outweighed personal interests, and where mutual aid and support were more important than status systems and systems of authority:

> Another factor would be, the different, professions and the hierarchy levels, so you have less allocation than me, therefore I am more important than you, you say no, no everybody is a person, everybody has the same right and to, receive the same respect.

One physiotherapist addressed the impact of having a hierarchal interprofessional team dynamic:

> Not that they're unempathetic or being giant A-holes or anything, it's just...it's a hierarchy there, so you really don't feel, you don't feel

> that social connection almost that you get with all of us on the other level.

There was the predominant thought from participants that equality was a precondition to good social relations between healthcare workers.

8. Job security.

Job security is the probability that an individual will keep his or her job. Job security can affect the viability of a particular discipline on the team, especially if human health resource cut backs were forced by fiscal constraints. Participants spoke about the effect of budget cuts on professional competition:

> I think all the professions are jockeying for a spot so that they're not going to be cut, you know, where as I think, um, so I think that there's some jockeying and so that boils down to budget and that need to not be cut and things like that.

There is a constant and continuing trend in healthcare to be more lean and efficient. This has caused clinicians who were concerned about sharing their knowledge and expertise with each other to view interprofessional collaboration as a covert strategy for replacing some providers over others:

> So I think that's part of it, you know, I think if you want to enter into that idea of maximizing scope of practice, there has to be a give and take, because you feel threatened if I'm not gaining new skills and expanding my own scope when I see someone else's scope expanding, I'm doing the training, that sets me into a mode of like,

I'm threatened that I'm going to get laid off and that, because that,

I've just trained this person to do all my work.

Without some stability and job security within the healthcare environment, clinicians find it difficult to completely and whole heartedly buy into the notion of interprofessionalism because they never feel like their position is "safe". This affects individual team member's ability to be empathetic. One participant noted, "the more cuts there are, the less empathetic I think we're all becoming". Organizational financial cut backs and "belt tightening" engendered competition amongst team members, which is the antithesis of empathy.

Structural Description of Interprofessional Empathy

The structural description referred to the context in which interprofessional empathy did occur (Figure 2). Some participants stated that it was important to have access to each other in order to have opportunities to be empathetic. Shared work spaces increased contact between clinicians, which allowed for frequent contact and more occasions to communicate in order to learn, with, from, and about one another. They stated that having consistent team membership made it easier to know people and develop relationships. As such, some individuals were more prone to want to invest in intentional relationship building with colleagues only if there was a predictable permanency to the affiliation. However, regardless of the consistency of membership on a team, participants talked about the importance of having formal and informal venues where healthcare workers could engage in meaningful conversations about the work they did together, the effects of the work, and how their teams worked. More importantly, participants stated that formal activities that brought the

team together to learn to work as a team provided space for empathy to develop. Formal team building allowed team members to learn about role clarity, team coordination, appreciating the multiplicity of personalities on the team, and conflict management. All of this organizational activity would be supported by leadership that was interested in seeing the team work as a collective, and by leadership that actively listened and responded to the psychological and emotional needs of the healthcare organization's workers. Essentially, leaders would be role models for empathic behavior.

Non-hierarchal work relationships within interprofessional teams were seen as a contributing factor to the development of interprofessional empathy. Participants were clear that when power was abused or misused between professionals it did not engender cooperation, collaboration, or good social relations. When power differences were minimized on clinical teams, clinicians engaged in teaching each other about their respective roles, and felt comfortable sharing common patient care tasks. The more scopes of practices overlapped, the more clinicians gained perspective and understanding about the work of their peers, which created common ground for conversations about care and other relevant conversations to happen.

Time was an important factor in how interprofessional empathy was experienced. Participants stated that in today's healthcare institutions, demanding workloads affected the nature of relationships between team members. With little time to focus on how the work gets done, there was an expectation within organizations to look at how much work got done. Healthcare providers stated that they focused on tasks when workload demands were high, sometimes exclusively and

to the detriment of process. As a consequence it was difficult to "seek out empathy or be able to provide someone else with empathy". Clinicians needed sufficient time to collaborate in order to provide effective patient care.

Closely related to the challenge of time was the issue of healthcare efficiency. As clinicians work in contexts that are increasingly focusing on efficiency, they are driven to potentially compete with each other because part of the strategy towards efficiency included fiscal cut backs, which meant the loss of healthcare jobs. Organizations must reassure clinicians that interprofessional teamwork and collaboration is not a strategy to downsize healthcare resources. Interprofessional collaboration is a strategy to enhance work relationships and enhance the quality of work life.

Figure 2. Contextual Supports for Interprofessional Empathy

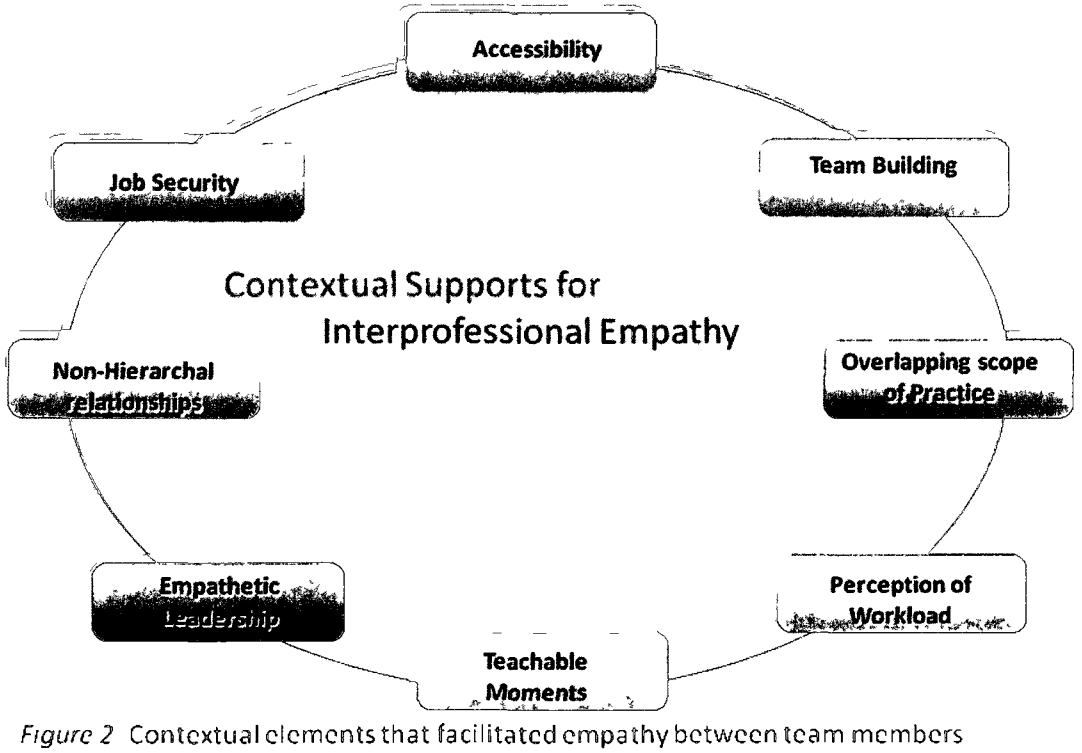

Figure 2 Contextual elements that facilitated empathy between team members

The Essence of the Experience

In phenomenological research, the textural and structural descriptions of the experiences being reviewed are synthesized into a composite description of the phenomenon. This description becomes the "essence" of the phenomenon called the essential, invariant structure, which captures the meaning ascribed to the experience. The essence is usually written as a descriptive passage, a long paragraph or two, and the reader should leave with an understanding of the phenomenon. As such, the following composite description of interprofessional empathy is proposed:

Interprofessional empathy is an approach to interprofessional collaborative relationships within healthcare that supports team members engaging in purposeful and intentional interactions with each other. Purposeful and intentional is defined as the consideration of empathetic interactions between interprofessional team members and the recognition of the potential to generate profound personal and professional impacts on each member. Relationships of an empathetic nature are supported by the creation of social spaces in which interprofessional team members see each other as equals, are easily accessible to each other for mutual teaching and learning, have the time to engage in consistent and regular dialogue, have the ability to witness and share each other's work, and are provided with formal team building opportunities where they learn to navigate and negotiate the challenging terrain of teamwork. Through creating these social spaces, leaders in organizations set the tone for the personal and professional growth of people and the strengthening of relationships.

An empathetic relationship between interprofessional team members is demonstrated by two-way dialogue comprised of mutual openness, non-judgmental

attitudes, active listening, and challenging personal assumptions. These attitudes and behaviors permit clinicians to move towards deeper understandings of each other, first as human beings, and then as actors within their professional roles. Through this shared interaction, individuals start to realize that their personal and professional growth is directly linked to the development of the team as a healthy community. This means that groups within healthcare communities have the enduring capacity to provide social support and resources for their members. Team members engage in mutually supportive behaviors that nurture the social, psychological, and emotional health of all members. A regard for members of the community as well as a respect for the uniqueness of personal and professional contributions are both essential if one is to support the other and in order for both to thrive.

Figure 3. Combined Structural and Textural Description of Interprofessional Empathy

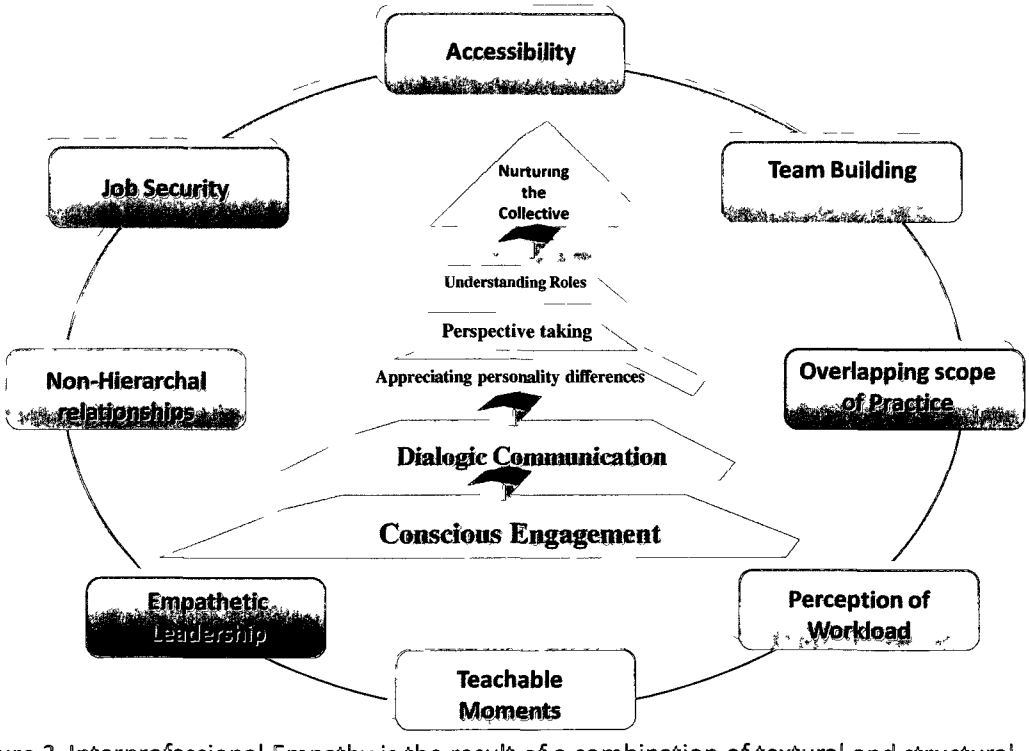

Figure 3. Interprofessional Empathy is the result of a combination of textural and structural components.

A Stage Model for Interprofessional Empathy

The research team identified six components of interprofessional empathy that were important to healthcare workers on interprofessional teams. In order to further articulate the emerging findings the researchers questioned whether the identified components of interprofessional empathy could be used to create an interprofessional model for empathy development. To test our ideas, the principal investigator shared the research findings with eight healthcare workers, one from each profession represented in the study. We asked these eight participants to look at and discuss all of the themes that had emerged from the data. They were then asked to comment on whether they saw all of the themes as co-existing side by side, all with equal value representing interprofessional empathy, or if they saw the themes as a progressive ladder towards the development of interprofessional empathy. All eight participants recommended that the themes be placed into a progressive, or stage, model, recognizing that themes appeared to be sequential. As one moved further up the hierarchy, it required more sophistication in one's ability and commitment towards being empathetic.

Though participants agreed that the themes were sequential in nature, there was less agreement on the order of themes within the hierarchy. Though there was variation in the reported order of the themes within the staged model, a common pattern appeared among participant responses. All participants except for one invariably placed engaging in conscious interactions and using dialogic communication within the first two stages. Knowledge of roles, perspective taking, and appreciating differences were found clustered closely together. The name given

to this cluster by the research team was *consolidation of understanding*, because much of the activity within this level dealt with negotiating differences. Nurturing the collective spirit was identified as the ultimate goal for interprofessional empathy. A four-stage model of interprofessional empathy therefore emerged:

Table 3

Interprofessional Empathy Stage Model

Level	Interprofessional Empathy Theme	Empathetic Level Description
Level I	Conscious Interactions	Consists of work relationships that are characterized by authenticity, warmth, and an inherent respect for each team member as a human being. This level represents the pre-requisite for an empathetic relationship, which emphasizes workers' belief that they have an altruistic obligation to assist other team members with attaining their needs. Consequently, any interaction with another member of the team would be based on a conscious desire of getting to know, support, and help teammates.
Level II	Dialogic Communication	Dialogue is a two-way interactive process. This form of communication favors" talking with" a team member as opposed to "talking to" a team member. It involves understanding the true nature of one's position and the position of others. Dialogic communication allows open and honest communication, requires reflective and active listening, nonjudgmental attitudes, and previous assumptions to be disregarded. This attitude towards communication sets the tone for high quality relationships, and is a key component to regulating Level II and III activities. This level represents the conceptualization of empathy as a form of verbal communication, whereby team members set the foundation to understand and be a part of the others world.
Level III	Consolidation of Understanding	This level represents the amalgamation of three components that seek to consolidate understanding. In this level clinicians exercise the ability to take another perspective, and to forgo momentarily their own view of an issue or standpoint in order to temporarily adopt another team member's worldview. In this level members share personal and professional insights that reveal aspects of their personalities and their professional roles. They grow to understand, appreciate, and eventually accept various differences amongst members of the team. As colleagues find acceptance within the team they feel more psychologically and emotionally secure with each other. It is at this level that team members

		are willing to compromise and accommodate their working habits in order to negotiate differences.
Level IV	Nurturing the Collective Spirit	Refers to any individual team member's behaviors or actions that contribute to the overall well-being of the interprofessional team. This level represents the ultimate altruistic goal of empathy, which is each person recognizing their social responsibility to the team. In this level, members have negotiated their individual differences and have recognized how to balance their individual goals against the group goals. They realize that there is a mutually beneficial relationship between each individual on the team and the group. Team members recognize that there are emotional, social, and psychological benefits to participation in the collective goals. As such, each member engages in a variety of behaviors that includes sharing the workload, being inclusive in their work, considering group goals, expressing vulnerability to each other, adopting a supportive presence, and working through difficult situations as a collective.

Participants saw all levels of this model as inter-related. Table 3 shows this model of interprofessional empathy. Level I represents the prerequisite, or the foundation, for the willingness of an individual to engage in an empathetic relationship. This level is characterized by a worker's belief that he/she has an altruistic duty to help other human beings attain their needs. In this first level, any interaction with another person would be based on a conscious desire and choice to get to know, support, and help the other individual(s). Level II represents the conceptualization of empathy as a form of communication, whereby having an open and transparent attitude and engaging in dialogue with the other person allows team members to set the groundwork for understanding and becoming a part of the other's world. Communication sets the tone for progression into the next stage and is a key component in holding the subsequent components of the model together. Once a

dialogue is initiated it must be constantly nurtured, because any shift in the quality of communication can have an effect on the progression of the relationship. In Level III, individuals get a closer view of the other's world. Members share personal and professional insights that reveal to others aspects of their personalities and their roles. Members start to appreciate each other's individuality and work contributions. It is in this stage that participants meet and compromise their working habits in order to appease each other. Finally, in Level IV, members have negotiated their individual differences and have recognized how to balance their individual goals against the group's goals. They realize that there is a mutually beneficial relationship between each of them and the group and that there are emotional, social, and psychological benefits to participation in the collective goals.

Figure 4. A Stage Model of Interprofessional Empathy

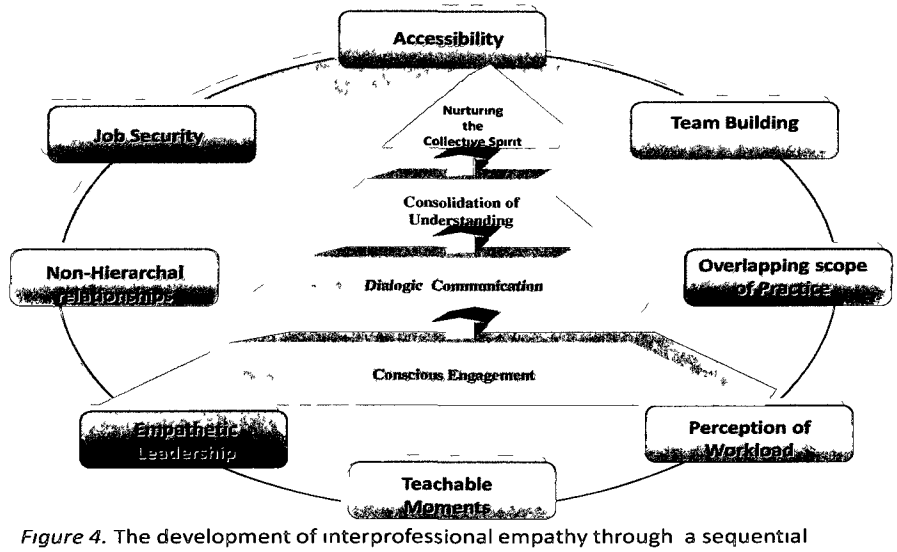

Figure 4. The development of interprofessional empathy through a sequential hierarchy supported by eight structural elements

Discussion

According to the selected literature review, this research is one of the first to explore the concept of interprofessional empathy as experienced by clinicians who

are working on healthcare interprofessional teams. Findings from this study inform us about how professionals who are part of interprofessional teams describe empathy among team members as encompassing six critical components which form a stage-model of interprofessional empathy. For these workers, employing this model is essential to forming quality relationships and collaborative partnerships at work. This finding is consistent with previous literature that reports components such as conscious engagement, communication, understanding of roles, and perspective taking. This research also adds new dimensions to the literature, specifically on personality differences and nurturing the collective spirit, as well as an ordering of these components. In addition to identifying components of interprofessional empathy, this study's findings document the factors that enhance or diminish the ability of healthcare providers to be empathetic with one another. The following factors are found to be crucial or key: perception of workload, teachable moments, empathetic leadership, non-hierarchal relationships, accessibility, team building, overlapping scopes of practice, and job security. The latter four work-place setting characteristics appear to be novel ones as previous literature has reported technology, staffing patterns, power dynamics, workload pressures, leadership styles, and interprofessional training opportunities as playing a large role in shaping interprofessional relationships.

The current study elucidates the various components of interprofessional empathy and the necessary contextual supports for developing and maintaining empathy among healthcare providers from different disciplinary backgrounds working on interprofessional teams in healthcare settings. Three observations may be

made. First, interprofessional empathy develops within an organized sequence of stages. Second, interprofessional empathy is a multidimensional and dynamic concept. Third, interprofessional empathy requires an ecological congruence between the empathic characteristics of the individual and the empathic characteristics of the larger system within which the individual is nested.

Interprofessional Empathy Develops Within an Organized Sequence of Stages

Few models of empathy use a stage or hierarchal model approach. In contrast, this study finds that the development and maintenance of interprofessional empathy is a stage-model that offers a concrete framework consisting of components wherein the order in which these occurs is essential. Our stage-model is consistent with Cliffordson's (2002) findings that empathy may be regarded as being hierarchically organized. Cliffordson examined the internal structure of empathy by using a hierarchal approach in order to contribute to the understanding of the nature of the concept. She concluded that the notion of a non-hierarchically organized, multidimensional approach implies various constructs are used as specific building blocks to define the general concept of empathy, but that explicit hierarchal models of empathy may afford a more parsimonious description of the concept.

Solli-Saether and Gottschalk (2010) suggested that stage models usually have four characteristics. These characteristics include: a given number of stages or phases, a dominant problem to resolve at each stage, a benchmark variable attached to each stage, and a clear evolutionary path. The present study on interprofessional empathy proposes a four-staged model for empathy development through which healthcare teams should pass in order to develop empathy between members on their teams. In

each stage team members confront and ideally master new challenges. Each stage builds on the successful completion of earlier dependent stages. The challenges of stages not successfully completed may prevent the development of empathy on interprofessional teams. For example, in the first stage of conscious engagement the clinician must be willing to acknowledge his/her co-worker as a person and recognize that the manner in which they engage this person may positively or negatively impact their collegial relationship. If a clinician does not see the value in recognizing their colleague as a person as well as a professional, then the clinician will regard the other as an object, and as someone who is there to execute the clinician's needs. This choice potentially reduces the relationship to one that is purely technical in nature. Consequently, the clinician may choose monologic communication as his/her predominant communicative pattern, and as a result may challenge the progression of their working relationship to the level of dialogic communication.

On the other hand, one may question whether interprofessional empathy develops sequentially and only in one set order or progression as we find in this study. There could be a debate as to whether one stage needs to happen before other stages can be completed or whether it is valid to conclude that the identified themes need to be organized in a staged model at all. For example, it is possible that out of the six components mentioned within the model that only three of them are necessary and sufficient for interprofessional empathy to take place and can occur without any specific phased progression. Nonetheless, the interprofessional empathy stage model in this context implies a belief that although boundaries between the stages may not always be distinct, there are four identifiable levels in the process of evolving

healthcare relationships described by those involved in an empathic interprofessional experience. The stage model suggests that there is a predictable progression from one level to the next as professionals describe the development of interprofessional empathy as an evolution in which subsequent stages develop out of the one that preceded it. Furthermore, the model is highly prescriptive in nature and delineates the specific actions and behaviors that should occur at each stage. As such, we are proposing the model serve as a pathway to improving relationships between providers within the healthcare system. While it is clearly recognized that the experience of each healthcare worker on a team would harbor unique features and follow a distinct path, the supposition made is that this description of four levels represents a useful conceptualization of reality. Further research is needed to determine the accuracy of the suggested evolutionary path or order of the components in a stage model of interprofessional empathy, as well as whether professionals move dynamic in and out of multiple stages with, or without, a pattern.

Interprofessional Empathy is a Multidimensional and Dynamic Concept

The current study echoes findings from the broader literature on empathy which recognizes empathy as being composed of many components. This model of interprofessional empathy offers a concrete framework consisting of components that are essential to forming quality working relationships. This finding is consistent with Morse et al.'s (1992) model of empathy that also proposed the following components of empathy: moral, affective, cognitive, and behavioral. Interestingly, a comparison of the interprofessional empathy stage model with that of Morse et al. (1992) suggests somewhat parallel notions among the components within both models. For example,

the components of conscious interaction, dialogic communication, and moral empathy speak to a universal willingness, attitudinal openness, and altruistic motive to engage another human being in a helpful, caring relationship. Understanding of roles, perspective taking, appreciating personality differences, and cognitive empathy address the need for individuals to understand the perspectives of others in order to build an understanding of the other's position or standpoint. Nurturing the collective spirit and affective empathy speak to the ability of individuals to subjectively experience and share emotions as well as intrinsic feelings with each other, while nurturing the collective spirit and behavioral empathy which both includes that behaviors and actions which convey understanding. Though interprofessional empathy is a separate concept onto itself, making this parallel demonstrates that it is consistent with other dominant models of empathy.

Despite various definitions and descriptions of empathy, Decety and Jackson (2006) suggested that there appears to be broad agreement on only two primary components in the literature: (1) an affective response to another person, which may include sharing that person's emotional state, and (2) a cognitive response that permits an individual to take the perspective of another person. They add that there is still some question as to whether behavioral empathy is an integral component of empathy as a whole, because individuals may experience and share the feelings of another person and yet not feel compelled to act in a supportive way. However, the ability to act is a key component within interprofessional empathy. The social and emotional situations eliciting empathy must be supported by individual or collective action. It is also important to consider that empathy is a dynamic concept. For

healthcare professionals, empathy responses seem to be influenced by the nature and length of the relationship between individuals, as well as the context within which the relationship takes place.

According to our findings, interprofessional empathy is multidimensional and the components within each stage of the model may have an important impact on the interprofessional collaborative relationships within healthcare. As such, it becomes important to further discuss and understand the various components that relate to the nature of interprofessional empathy. The following section offers an interpretation of the nature of empathy found in the four stages in relation to contemporary understandings of empathy within the healthcare environment.

Stage 1: Engaging in conscious interactions.

In the first stage of the model, conscious engagement is about healthcare workers recognizing each other as people first and co-workers second. It is concerned with acknowledging each other's presence and recognizing that through providing understanding, being open to getting to know each other (either by name or other ways of acknowledgment), and caring for each other as human beings. In this approach colleagues may have an indomitable impact on each other. This finding adds consensus to Suchman's (2006) view that assumes all behavior in the medical encounter is intentional. Intentionality means that individuals are conscious of their intent in the manner in which they approach and engage each other. This study however, shows that healthcare workers are still challenged in their clinical practice in being intentional with each other and more surprisingly, in recognizing the humanity of their colleagues. The ability of clinicians to authentically connect with

each other is further challenged by the varying degrees of empathy within each individual.

Despite these challenges, healthcare workers illustrated meaningful ways in which they attempted to mitigate the ragged edges of a sometimes impersonal system through the sharing of personal stories related to work or non-work related events with their colleagues. Story telling between clinicians had enormous empathetic value. This study finds that story telling between interprofessional team members humanized professional encounters, mitigated power differences, and facilitated team member's ability to meet the situational needs of their colleagues. Charon (2001), in writing about the power of narrative medicine in medical settings, has suggested that when physicians could tell their own stories and could understand the stories of others, it enabled them to practice medicine with empathy. This thinking could be further expanded to include other healthcare professionals on interprofessional teams, in the sense that the ability to acknowledge, absorb, interpret, and act on the stories and plights of others may permit interprofessional team members to acknowledge kinship and duties towards each other. This suggestion is further supported by Batson and Ahmad (2009), who noted that when clinicians shared personal stories and experiences and validated others, they felt heard, were aware of each other's needs, and contributed to the development of empathy.

Findings suggest that the power of story telling should be further explored to support the development of formal structures that encourage "story sharing" between clinicians within clinical settings. For example, some clinicians report that when they are in difficult work situations, either related to a patient or team crisis, that

participating in formal debriefing sessions or talking about the situation in subsequent team meetings with their colleagues, was extremely helpful in assisting them to feel supported emotionally and psychologically. This discussion about story- telling leads this research team to suggest that an exercise could be created and practiced within the context of a meeting or a debriefing, where clinicians could be asked to write about a clinical experience and then share their story with their interprofessional colleagues. To expand on this notion, it may be suggested that healthcare teams would not need a crisis at all in order to implement such a practice. Allocated clinical time for formalized storytelling events between team members on hospital units could become part of an organizational response in support of the development of healthy functioning interprofessional teams. Asking healthcare workers to write about their common clinical experiences, describe the role they each played in the situation and articulate how they personally and professionally experienced the event/situation, and then share it verbally with their interprofessional colleagues would help teams bear witness to one another's ordeals, recognize the empathetic needs of their colleagues, and represent one way to prompt individuals to engage with each other consciously within healthcare environments.

Finally, a long-standing debate is about the role of the personal dimension in professional setting. In the interprofessional collaborative model proposed by Oandasan and D'Amour (2004), the model stresses that healthcare team members need to know each other professionally and personally, however, to know each other personally was not defined within the model. Findings from the current study fill this gap and suggest that personal aspects be included in conscious engagement. It is

grounded in considering the needs of others, respecting the individuality of others, understanding each other's personal stories and understanding the unique requirements that make working relationships meaningful for each person.

Stage 2: Dialogic communication.

In the second stage of our model, communication is important to the development of interprofessional empathetic relationships. This study finds that communication is a critical factor in the sustenance and maintenance of interprofessional relationships. This finding is consistent with Kunyk and Olson's (2001) conceptualization of empathy that described the concept as an exceptional form of communication. The primary characteristic of their conceptualization is that healthcare providers be able to communicate their empathic stance either verbally or non-verbally. This is supported by a process where the healthcare provider perceives another's needs and situation, and expresses understanding in a manner that the individual receiving the communication perceives as helpful and understanding. However, contrary to Kunyk and Olson's conceptualization of communication, we suggest that empathy between interprofessional healthcare providers is based primarily on verbal communication.

This study identifies two types of communication patterns within interprofessional environments: monologic and dialogic. These two themes are deductive, as they were based on Martin Buber's theory of communication. Buber (1958) divided communication into two basic modes: the monologic mode is based on the classical one way communication model associated with the transmission of a message to the recipient, while the dialogic mode is based on an interactive

communication model that encourages participatory approaches. Buber's model was used to help frame how participants described forms of communication used within the healthcare environment.

Findings from this study suggest that monologic communication was the most prevalent form of communication within healthcare environments. Similarly, Zwarnstein et al. (2007) found that a substantial amount of interprofessional interaction lacked the key core element of solicitation of other professional perspectives. As such, they stated that interprofessional patient-related interactions passed information along routes that were seemingly one-way, unidirectional pathways, where there was little to no reciprocity among the various professionals. Zwarnstein et al. (2007) suggested breaking the monologic pattern by introducing a simple question into healthcare professionals' patient-related communications: "Do you have any concerns?" or "Is there something else I should consider?" Both these studies support the idea that monologic communication is strongly entrenched within the culture of healthcare communications.

In contrast, dialogic communication appears to be one of the primary foundations of the empathic interaction. This study finds that dialogic communication is of tremendous value to the clinical endeavor despite the fact that breaking out of the habit of one-way, unidirectional communications would require a significant shift in the communicative behavior of healthcare professionals. Despite the notion that some healthcare professionals believe that dialogic communication would require much effort and time to generate an appropriate degree of intimacy and trust between members to allow it to take place (and to be done effectively), we believe it is

important to consider that the use of good communication skills may have some connection with the availability of time but may have more to do with individual clinicians recognizing the opportunities or contexts within which it is appropriate to use the skill, and with whom they need to intentionally engage in a dialogic exchange. Clinicians may need to be educated about how to differentiate the circumstances under which dialogic communication is required.

An exemplar of dialogic communication is seen in this study by a physician who during his research interview, talked about how he dealt with a nurse who had a concern about a patient's oxygen saturation. The physician was intentional in the manner in which he chose to deal with the nurse's inquiry about a patient. Closer scrutiny of the scenario revealed that the physician and the nurse both appeared to display mutual openness, a non-judgmental attitude, active listening, and checked assumptions with each other. The nurse demonstrated mutual openness through being direct with her concern for the patient, despite past scorn from other physicians who may have disregarded her concerns. The physician demonstrated openness through his genuine concern for his colleague, recognizing the nurse's anxiety generated by the patient's condition and by acknowledging the courage it took to approach a hurried physician with a request to see a patient. The physician also engaged in checking the nurse's assumptions about the patient's condition, providing her with an opportunity to confirm her point of view and participate in problem solving. Most importantly, the physician did not disregard the nurse's input, but recognized that through active listening, both he and the nurse would be able to form a shared perception of the patient's state and create an appropriate collective response. The

physician "talked with" the nurse; he did not "talk to" the nurse. Talking with implies participation while talking to implies subjugation and compliance. Dialogic communication is as much an attitude as it is a skill (Thomlinson, 2008).

Stage 3: Consolidation of understanding.

In the third stage, understanding of roles, appreciating differences and perspective taking are clustered. Understanding of roles in this study entails healthcare professionals appreciating and knowing the roles of others on their teams. A key recommendation involved in building interprofessional teams focuses on valuing the expertise and perspectives of a variety of different healthcare providers (Orchard, Curran, & Kabene, 2005). There has been a strong orientation for professionals to teach each other about their roles and scopes of practice in order to enhance interprofessional understanding of contributions to patient care. However, findings from this study suggest that an understanding of the scope of practice of another's role may not be sufficient to enhance interprofessional relationships. An understanding of "what" other clinicians do represents an understanding of their scope of practice; however, understanding the working context of each professional should take into account "how" healthcare professions performed additional tasks attached to a specific role or duty. These additional tasks were the invisible activities attached to the role that tended to get overlooked by interprofessional team members and as a result led to unrealistic demands from other members. Unrealistic expectations between team members then became a source of potential contention and conflict on teams. For example, one social worker expressed frustration with members of her healthcare team who she believed thought her role in discharge

planning was primarily centered on filling out application papers for patients to be transferred to other healthcare facilities. In reality she described discharge planning as involving transition counseling, patient advocacy, information brokering, and negotiating with multiple stakeholders. The lack of understanding of the role of discharge planning from her interprofessional colleagues sometimes led to the team having unrealistic expectations for patient discharge. Healthcare discussions around understanding of roles must start with "what" conversations (to describe scope of practice) and eventually include a conversation around "how" each role is accomplished. This further understanding will leave clinicians feeling appreciated for their contributions.

Appreciating personality differences.

We did not expect appreciating personality differences to emerge as an important component of interprofessional empathy based on our initial literature review. This study finds, however, that being able to navigate the various personalities on a team is important to successfully working through interprofessional relationships. The interprofessional collaborative literature scarcely mentions personality as an important factor in professional collaboration. On the other hand, the understanding of roles has appeared to dominate discussions around interprofessional collaboration. Inflated importance has been given to the concept of understanding roles to the detriment of other elements critical to interprofessional relationships. Similarly, McCallin and Bamford (2007) stated that while individuals were welcomed onto a team because of their diversity and ability to carry out specific

tasks, sometimes the overemphasis on expertise and skills was at the expense of personality differences that were just as important for team functioning.

Findings from this study suggest that some interprofessional team members are challenged in dealing with other individuals who had personality traits opposite to their own. Individual team members on interprofessional teams should have an opportunity to know their personality profiles and the profiles of others on their team as a way of learning to negotiate and understand individual differences. A number of training programs have used a tool called the Myers-Briggs (Personality) Type indicator in forming and studying healthcare teams in the United States (Baldwin, Royer, & Edinberg, 2007). This type of tool should be integrated into interprofessional collaborative team building on a consistent basis.

Negotiating professional stereotypes was also critical to building empathetic relationships between interprofessional team members. This study finds that positive and negative professional stereotypes existed for all professionals, with the most negative stereotypes being directed towards physicians. In a study by MacKay (1992) on nurses' and doctors' perceptions of ideal types, Mackay suggested that personal characteristics were more important for nurses, while for physicians professional skills received a stronger emphasis than personality in defining a good doctor. This could account for the overwhelming description of health professionals outside of medicine addressing physician attitudes as negative. As a result, physicians may not grant much credence, or even pay attention to stereotypes that depict them as arrogant or controlling. Further studies on professional stereotyping need to be done in order to further understand the stereotypes between different professional groups, and to

create interprofessional interventions that will help negotiate professional stereotypes. Physicians and other healthcare professionals must be challenged to reflect on the stereotypes that they believe others hold about them and the stereotypes that they hold about others. Professionals need to effectively work to maintain the positive stereotypes and manage the negative ones. Hean and Dickinson (2005) argued that professionals only changed their views about another profession when the other groups' behaviors were not in line with their traditional stereotype.

Perspective taking.

Findings from this study suggest that interprofessional empathy could not take place without the ability of the healthcare worker to take on another's perspective. Perspective taking facilitates understanding between healthcare professionals from different disciplinary backgrounds. This finding is consistent with a study by Shih, Wang, Bucher, and Stotzer (2009) that found perspective taking manipulation could improve a participant's evaluations of another individual from an out-group or for someone who was perceived as different. It is for this reason that it becomes even more important for healthcare organizations to create spaces where clinicians may bear witness to each other's stories and experiences. Providing opportunities where there is a potential to elicit empathy by hearing and sharing the perspective of another healthcare professional may support the development of quality relationship on interprofessional teams.

The current study also suggests that perspective taking requires one to move beyond their point of view to sometimes consider a point of view with which they do not necessarily agree. In an article on building the emotional intelligence of groups,

Druskat and Wolfe (2001) suggested that a novel approach to perspective taking techniques on teams would be to ensure that team members saw each other making the effort to grapple with various perspectives. They continued to state that when members of a team openly demonstrated to each other that they were wrestling with views put forward by others and able to come to grips with the new perspectives introduced by other team members, the team had a better chance of creating the kind of trust that led to greater participation among members.

Stage 4: Nurturing the collective spirit.

In the fourth and final stage of the interprofessional empathy model, professionals nurture the collective spirit. Individual behavior contributes to an overall well-being of the interprofessional team. In fact, there is a cluster of caring behaviors that are reciprocal from the individual to the team but also from the team to each individual. Sharing the load, being inclusive, considering the higher purpose, accepting the expression of another's vulnerability, adopting a supportive presence, and celebrating a shared history are all important collective activities that require the commitment of each team member. Of all the caring behaviors mentioned, the hearing and sharing of feelings between co-workers is still seen as a challenge in healthcare environments. It is ironic that within the healthcare world, where clinicians deal with patient emotions on a daily basis and where life and death situations can generate intense feelings within the clinician, emotional work among clinicians remains relatively ignored. McCallon and Bamford (2007) came to a similar conclusion in their study on interdisciplinary teamwork, where they noticed that

practitioners refused to recognize the emotional component of working within their team.

We find that emotional work among team members does not happen often enough. Similarly, in a study on emotion work and interprofessional collaboration by Miller et al. (2008) it was found that displays of emotion work were rarely observed and poorly received during interprofessional rounds. Emotion work in the study was defined as the management of the emotions of self and others, as well as professional caring practices. The authors stated that when nurses did report on caring or non-medical issues, physicians were observed to lose attention and avoid eye contact. This finding is consistent with the current interprofessional empathy study in the sense that some staff tended to think that emotion work was "fluff" when individual healthcare professionals engaged in conversations around the emotional aspects of caring for patients. Ironically, with such a less than enthusiastic response to emotional cues within interprofessional team meetings, one would understand the reason for which interprofessional team members would not risk being "emotional" with each other.

Emotion work on interprofessional teams may be further challenged by the overwhelming acceptance of the concept of detached concern within the healthcare professional world. Halpern (2001) described detached concern as clinicians neutralizing their own emotions so as to not be influenced emotionally by their patients, in order that the healthcare clinician more precisely influence the patient therapeutically. In the same logic, detached concern may serve as a mechanism to ensure rationality during periods of interprofessional deliberation on teams and therefore emotional ways of viewing the world may be considered as generally

unreliable. This fundamental approach to therapeutic intervention, which is engrained in healthcare education and practice settings, may also potentially have an influence on the relationships amongst interprofessional team members. However, Charon (2001) suggests that healthcare workers must learn to practice their disciplines not with detached concern but with engaged concern. She concludes by saying that an engaged approach requires clinicians to be disciplined, and to slowly accept the intersubjective bonds among healthcare workers.

The notion that healthcare workers are embedded in a network of positive and supportive relationships is a cornerstone of interprofessional empathy. The stage of nurturing the collective spirit captures an aspect of interprofessional empathy work previously only suggested but not clearly articulated. The Canadian Health Services Research Foundation (2005) has suggested that an effective team contributes to each member's well-being. Well-being can be defined as a positive state of affairs brought about by the satisfaction of personal, relational and collective needs (Prilleltensky, Nelson, & Pierson, 2001). As such, nurturing the collective spirit has less to do with action, just for the sake of making each team member feel good, and more to do with building community on teams within healthcare organizations. Gravenkemper (2007) cited that community happens when an individual is willing to sacrifice and choose to be a part of something bigger than themselves. This willingness to sacrifice was also mentioned in our study on interprofessional empathy.

Interprofessional empathy requires ecological congruence between the empathic characteristics of the individual and the empathic characteristics of the larger system within which the individual is nested.

Interprofessional empathy is defined as an approach to collaborative relationships within healthcare that is supported by the creation of social spaces that provide the opportunity for personal and professional expressions of empathy. Social spaces within this definition refer to the healthcare work environment and its role in nurturing empathy. Analyzing this relationship between healthcare workers and their environment through an ecological lens reinforces the idea that empathy, though an important personal and professional endeavor, must be supported by contexts that facilitate its expression. Much of the existing literature on provider-patient relationships addresses the obligation of the provider to demonstrate empathy towards patients, neglecting the importance of empathy between providers and the supporting role of the healthcare system. Findings from the current study highlighted the need for healthcare organizations to understand that empathetic behaviors must go beyond what is done to the patient. Empathetic practice cannot take place at the patient's bedside alone. It must happen at all levels within the organizational system. Empathetic practice within a larger system of non-empathetic behavior paints a picture of a healthcare system that is fragmented.

Findings from this study generate three questions that need to be reflected upon when considering the healthcare environment's capacity to support and inspire empathy. The first question is whether interprofessional empathy can exist within a healthcare system that is increasingly moving towards corporatization. The second is

how does interprofessional empathy potentially influence patient outcomes? Finally, the third is what major considerations need to be made within organizations in order to promote the development of interprofessional empathy?

Can interprofessional empathy exist within a healthcare system that is increasingly moving towards corporatization?

Findings in this study suggest that healthcare workers are worried about the increased corporatization of the healthcare system and the negative effect that corporate values may have on their ability to maintain effective relationships with their patients and each other. Market rules of economic efficiency are driving much of the restructuring debates in Canadian healthcare, and restructuring the way that hospitals are doing business. McCurdy (2002) has stated that healthcare organizations are slowly transforming themselves from service organizations into business corporations. He goes on to say that the transformation is even apparent in the new hospital lexicon that describes patients as customers and healthcare workers as providers. He concludes that the new healthcare organization urges their providers to act in ways that will boost market share for patient services or enhance the organization's ability to compete in the market place rather than motivate clinicians with appeals to values inherent in patient care itself, such as care, compassion, and respect for human dignity. Janice Stein (2002) would support this assertion, as she has written widely about healthcare's obsession with efficiency and its effects on care providers. She suggests that the growing insistence on efficiency has caused healthcare workers to see patients as statistics that can drive efficiency ratings up or down. This shift both reflects and reinforces the fact that the humanitarian orientation

of the healthcare organization is giving way to business values and these values are shifting relationship patterns not only between patients and providers but potentially between clinicians as well.

Business values are inherently not meant to be altruistic or empathetic. They are meant to drive competition, and financial and market gain. Within healthcare organizations these values have an incredible influence on clinical life for clinicians. These values have transformed the way in which clinicians are expected to provide care. As a result, healthcare clinicians feel besieged by organizational requests for heavier workloads, quicker care, timely care, and calls for productivity. In a study on healthcare work environments Peter, Macfarlane, and O'Brien-Pallas (2004) addressed the impacts of the shift to corporatization and its influence on the delivery of healthcare services. In their study participants mentioned that they experienced value conflicts due to a work environment dominated by business values where caring values were marginalized and doing was more important than caring. Many individuals in that study talked about increasingly feeling like technicians and also felt a push to be more task oriented as opposed to being a caring professional. This is consistent with participants in this interprofessional empathy study who felt at times that they were so busy they referred to themselves as healthcare robots going through the technical aspects of curing individuals without taking the time to feel. The inescapable danger of predominantly adopting a corporate model for healthcare is that such a model potentially results in healthcare workers being depersonalized. When an individual is depersonalized they are bound to be compromised in their ability to demonstrate empathy to patients and their colleagues. As such, the on-going

corporatization of the present healthcare system holds little promise for interprofessional empathy to flourish and thrive, unless healthcare administrators recognize that there are tangible benefits to interprofessional empathy that have not yet been explored.

How does interprofessional empathy potentially influence patient outcomes?

Though findings from this study do not relate directly to patient satisfaction and outcomes, there may be an indirect link that is important to consider. Displays of empathy from provider to the patient have been known to improve patient satisfaction and outcomes (Bylund & Makoul, 2002). However, it has been suggested that empathy between providers can also have an impact on patient outcomes. Reynolds, Scott and Austin (2000) proposed that when clinicians felt cared for by other clinicians, this enhanced their ability to appreciate the meaning of the patients' experience. Another study by Wilkin and Slevin (2004) suggested that healthcare clinicians considered working closely with and supporting colleagues an important element in their work. The authors continued to say that information sharing was considered crucial to any team decision making process, enabling all concerned to make the right decisions and pursue the correct course of action. Although the study was based on intraprofessional teams, the principle of collegial support still holds value. This is further confirmed by Lemieux-Charles and McGuire (2006) who after performing an extensive literature review on healthcare team effectiveness have suggested that high functioning teams were characterized by positive communication patterns, cross-functional cooperation, high levels of participation, and coordination.

They also found that high functioning teams achieved better patient outcomes. These characteristics have all been mentioned or are related to components of interprofessional empathy, suggesting that interprofessional empathy may be reasonably connected to potential service improvements in healthcare.

Interprofessional empathy could be considered an employee-based strategy aimed at potentially improving patient satisfaction and outcomes. In a competitive healthcare market attracting and retaining patients or customers is essential to a healthcare organization's ability to survive and succeed. Customer satisfaction is now of the utmost importance in many business arena's including healthcare (Pan & Kuo, 2010). If interprofessional empathy can have a significant impact on employee satisfaction and outcomes, which in turn has an impact on patient satisfaction and outcomes, then organizations must give pause to think about the concept as not just "fluff", but as one that puts all business activities in the arena of service quality. Though for the purposes of this research project interprofessional empathy has been the term used to describe the components of how clinicians understand and support each other, a more appropriate business term may be "employee based customer service". This service model would set the expectation that employees need to treat each other as they would a customer, a notion that has received little attention within the healthcare world. For years the corporate customer service model for hospitals has focused on the patient. Protocols on how to enter a patient's room and how to address patient concerns are in place in many healthcare organizations. Caring service and going the extra mile are staples of every hospital orientation. However, there are few expectations as to how healthcare workers are supposed to treat each other outside of

those that are required by law. It is taken for granted that they know how to how to treat each other, but not the patient. The employee based customer service model would support the provider as well as the customer and ensure organizational wellness and customer satisfaction.

If healthcare organizations want teams that are consistent, cost-effective, and flexible they have to realize that investing in team relationships and paying attention to nurturing and developing healthcare teams will keep workers happy, and happy workers will keep patients happy. Happy employees may accord customers an enhanced customer service or patient care experience, which in turn serves corporate needs because it enhances their product. From this vantage point we may create an environment in which Interprofessional empathy can be initiated.

What major considerations need to be made within organizations in order to promote the development of interprofessional empathy?

Organizations must consider that interprofessional empathy is not a concept that is always driven by feelings of authenticity. Implementing interprofessional empathy means creating a healthcare workplace where the team depends on each person's capacity to contribute their talent, where people are working together towards a common goal; where people exchange stories as a means to gain knowledge and truth; where people are comfortable sharing joy, laughter, pain, and sorrow; and where each individual rises to the occasion in the explicit common knowledge of a team crisis or challenge. Health administrators may see these actions as idealistic because one may presume that interprofessional empathy is based on the notion that empathy, as one traditionally understands it, needs to be generated through

authentic feeling. In other words, in order to experience interprofessional empathy, the giving of this type of empathy must be genuine. Over the course of this study on interprofessional empathy, there was no evidence that suggested that it must be delivered with spontaneous authenticity. If we were to use the customer service model as a frame of reference, we would recognize that this model does not depend on authenticity either. Even though empathy may not always be genuine, the hope is that customers feel cared for. We also believe that healthcare workers can use various levels of empathy to engage each other. Hochschild (2003) introduced the concept of emotional labor to describe how workers in many service industries manage the experience of their customers and display emotions to present a certain image. Emotional labor requires one to induce or suppress feeling in order to sustain the outward expression that produces the proper state of mind in others—in this case a sense of being cared for. She describes two types of emotional labor: deep acting (i.e., generating empathy consistent with one's emotions and cognitive reactions) and surface acting (i.e., forging empathy absent of emotional and cognitive reactions). Although deep acting is preferred, healthcare workers may rely on surface acting when immediate emotional and cognitive understanding is not possible with each other. Organizations should recognize that healthcare workers are more effective healers when they engage in the process of empathy with each other whether it comes from deep or surface acting.

Interprofessional empathy is an important endeavor within healthcare organizations and as such, healthcare workers should receive organizational training on how to be interprofessionally empathetic. Healthcare workers may benefit from

training that includes conscious efforts to develop the skills attached to the various components of the proposed interprofessional empathy model. The goal of training would be to heighten clinician awareness of the importance of interprofessional collaborative skills. Price and Archbold (1997) suggested that though self-awareness enhances an individual's ability to empathize, in order for it to develop within the individual it must be nurtured by external influences. In addition to interprofessional empathy training further contextual supports will be required.

Contextual Supports for Interprofessional Empathy

Organizations must work hard towards creating an environment that supports the expression of varying degrees of empathy, because not everyone is naturally empathetic, or skilled at exhibiting empathy. Contextual supports that facilitate and encourage the development and expression of empathy are critical in order for interprofessional empathy to blossom.

Empathetic leadership.

This study finds that empathetic leadership is a critical factor in developing and nurturing empathy among members on interprofessional teams. In a paper on empathy and leadership, Kellet, Humphrey, and Sleeth (2002) found that emotional relationships are the lifeblood of any organization. They cited studies that demonstrated how high quality relationships stemming from empathy were likely to enhance perceptions of a leader's integrity, or credibility and engendered cooperation and trust from the team. Essentially, there is a growing belief that the leadership that is required to nurture effective quality relationships and empathy on interprofessional teams is one that embraces a commitment to the growth of people and community

building. Hammick, Freeth, Copperman, and Goodsman (2009) suggested that the integration of servant leadership principles in practice would support the strengthening of relationships on teams, because servant leaders support team members in meeting their needs and foster the use of shared power in an effort to enhance effectiveness.

Team building.

In the current study we find that healthcare teams did not receive sufficient formal learning opportunities on how to work together. The unfortunate part about this finding is that it is not novel. Even Fry et al. (1974) pointed out the need to support the development of organizational teams:

> First, it is naïve to bring together a highly diverse group of people and to expect that, by calling them a team, they will in fact behave as a team. It is ironic, indeed, to realize that a football team spends 40 hours per week practicing teamwork for those two hours on Sunday afternoon when their teamwork really counts. Teams in organizations seldom spend two hours per year practicing, when their ability to function as a team counts 40 hours per week (p. 56).

More recently, in a paper on the maintenance of healthcare teams, Baldwin, Royer, and Edinberg (2007) suggested that teams should periodically have an opportunity to diagnose their own state of health and to prescribe their own therapy. They continued to say that team building in these circumstances would be like a planned maintenance activity (like a periodic lubrication of a car) to prevent major problems or breakdowns in team functioning. Through anecdotal evidence however, it is well known that

healthcare teams usually receive attention and team building interventions only when it is perceived that the team is gone far beyond the ability to cure itself and outside consultants are needed to "solve the problem".

Non-hierarchal relationships.

Non-hierarchal relationships are a cornerstone of collaborative practice. Our findings suggest that a clinician's ability to be aware of the power that he or she had and the manner in which they empowered those around them was critical to the development of empathetic work relationships. This is consistent with much of the interprofessional literature that speaks to the importance of power-sharing and non-hierarchal relationships in promoting good team working. For example, in a study by Gaboury, Bujold, Boon, and Moher (2009) in a project that studied the relationship between physicians and alternative healthcare practitioners within an interdisciplinary system called integrative healthcare, equitable power relationships resulted in modified burden of work and higher affective commitment toward the clinic team.

Overlapping scopes of practice.

This study finds that an overlap in scopes of practice created an opportunity for a shared experience among clinicians. This experience was connected to a common task or function, but provided room for shared learning, knowledge exchange, and a mutually supportive sharing of labor. This finding is supported by Shultz and Napoli (2003), who found that shared responsibilities between registered nurses and respiratory therapists facilitated timeliness in patient care delivery and increased negotiation with workload. Furthermore, the authors noticed a marked improvement in the latter and former areas secondary to those made in

communication between the nurses and the respiratory therapists. It is therefore possible that cooperative models of care lead to improved communication because tasks are not pre-determined but rather negotiated on an ongoing basis, which may account for improvements in communication. Strong communication is part of interprofessional empathy.

Accessibility.

In this study, accessibility to interprofessional team members is an important factor in developing interprofessional empathy. This finding was supported by Sinclair, Lingard, and Mohabeer (2009), who found that a key structural feature in support of collaborative relationships was staffing consistency. In a study of rehabilitation teams, Sinclair, Lingard, and Mohabeer (2009) found that on units with fewer staff rotating in and out of the team, deeper relationships seemed to develop between professionals, supporting trust-based interactions.

The current interprofessional empathy study suggests that when team members were assured of permanency within their work relationships, they made a consistent effort to engage in intentional relationship building with their colleagues. If relationships were to be short-lived, such an investment was not mentioned. This claim was reinforced in a study by McCallin and McCallin (2009) whose findings suggests that when short-term rotation individuals entered new teams, they were usually given a job description, but the team processes, team orientation, or staff development, were not discussed at all.

Limitations of the Interprofessional Empathy Study

The current study has a few limitations to consider. One limitation to this study was that interprofessional empathy was investigated in one academic community teaching hospital in Toronto, Canada. The findings may therefore not be transferable to other institutional settings such as non-teaching hospitals, ambulatory care hospitals, or long-term care facilities where differences may exist in patterns of staffing, staff turnover, hospital culture or the levels of collaborative practice that already exist within the organization. However, this does not negate the idea that empathy should be an important aspect of care within most of these healthcare facilities and as such, some of the learning from this investigation may anchor conversations around staff relationships and empathy.

Another limitation is the representativeness of the self-selected sample. This selection process may have resulted in participants with a more "extreme" view (either positive or negative) of interprofessional empathy within the health centre. However, given that the sample was heterogeneous with regards to an interprofessional group of participants, the findings represented a detailed description of each case and shared patterns that cut across a broad range of professions and derived their significance from having emerged out of that heterogeneity.

A weakness within the interprofessional empathy model is that it does not address provider-patient empathy. However, most of the research on empathy addresses the clinician-patient relationship (Safran, Miller, & Beckman, 2006). As such, the interprofessional empathy model sheds some light on an area that has not received as much attention in the healthcare literature.

Implications of the Interprofessional Empathy Model for Healthcare Team Relationships

Limitations aside, the findings of the current study have implications for healthcare workers and organizations. The insights and understandings that emerge as a result of the study have potential for utilization from a practice, organization and education perspective. Our findings point to the following practice-based implications:

1. Healthcare workers need to recognize that their empathetic efforts should not be primarily directed toward patient care. It includes empathy towards healthcare colleagues within the healthcare environment, and that the emancipation of empathy to other concentric systems within a given setting lends to the notion of a "healing environment". The healing environment cannot be limited to a patient's bedside.
2. Emotional work, which is defined as the hearing and sharing of feelings between co-workers, is an important part of teamwork. The ability of a team member to be receptive to such feelings is a building block to trusting relationships. As such, providing time for emotional work during structured interprofessional meetings is one method of supporting and caring for each other.
3. Mutual interpersonal knowledge of given names and surnames should be present. Staff members need to be able to acknowledge each other. Healthcare workers need to introduce themselves before diving into patient care activities.

4. Basic communication skills are critical for interprofessional empathy. Interprofessional related interactions should pass information along routes that are two-way, bidirectional pathways, where there is reciprocity. The use of simple prompts within the interaction such as "Is there anything else I should consider?" may encourage dialogue that supports participatory decision making, empowerment and mitigates conflict.
5. Understanding another health professional's role and understanding the effort that goes into a task associated with the role are two different but related skills. Understanding what a job is and how it is done requires team members to be sensitive not only to the other's role but their working contexts and the expended effort to carry out the role as well. Outside of emergencies, it would be prudent to extend to other professionals inquiries about their expected timelines to produce specific work when engaged in collaborative work.
6. Though not comfortable for everyone, there is value in sharing "stories" about each other within the context of work. Stories help individuals make sense of their environment and their surroundings. Stories may potentially create connections between people, because they establish common ground.
7. Individual professionals are diverse and each member of the team makes a unique contribution in terms of the style and attitudinal patterns they adopt over the course of doing work. The ability of each team member to recognize the divergence, accept the divergence and learn about their preferred style—

but also the style of others—is an important skill to have in negotiating relationships within a team.

These findings also highlight the important role that context plays in supporting interprofessional empathy. This interprofessional empathy study points to the following organization-based implications:

1. Healthcare organizations should implement regular and customary team building sessions for interprofessional teams. These sessions should be geared toward supporting the development of individual and group competencies for teamwork consistent with the components of the interprofessional empathy model. Business organizations have long understood the importance of investing in team building as a way to reach organization financial targets. Healthcare organizations that deal in life and death have not entertained the same approach. Healthcare organizations appear to have embraced many business strategies in terms of dealing with their operations and fiscal policies but have neglected to embrace the people strategies as well.
2. As part of the process for planning strategically around team building, regular team audits could be a vital process by which the team's effectiveness and processes could be evaluated in order to sustain performance or signal areas of opportunity for improvement.
3. The interprofessional empathy model calls for organizations to recognize that all individuals involved in the process of care bring who they are to the table, and that employees need to be supported as well as patients. Many healthcare

organizations impress upon their healthcare workers that "the patient comes first", a common slogan within healthcare today. However, the interprofessional empathy model suggests that putting patients first also means taking care of the healthcare provider creates a strong core from which to provide patient care. This shift would allow healthcare to meet a patient's needs more completely. Essentially, moving from a narrow singular focus on the patient, to include relationships that shape the context of the care given to the patient, produces an ecologically coherent environment for healing. Understanding the need for ecological congruence between what is done for the patient and what is done for the worker creates an environment that is empathetically coherent. This wider focus would permit healthcare organizations to meet their obligations in providing healthy workplace environments, which potentially may positively influence worker and patient satisfaction. Healthcare organizations must consider that healthy interprofessional relationships have much to do with creating healthy workplaces.

4. The reality in many hospitals is that teams change, and there are many health workers who are members of many teams without having a home team. Wide ranging responsibilities to several teams in an organization may compromise relationships and collaborative teamwork. Attaching those professionals to a specific team could go a long way to supporting a team in developing quality supportive relationships.

5. Organizations must ensure that their leaders are at least knowledgeable about the importance of empathetic leadership. The literature is inundated with evidence that employees work well together when they have a leader that is able to understand them, listen to them, and set expectations for collaborative practice. Healthcare leaders need to integrate a servant leadership approach to their other management styles in dealing with their employees if empathy is to be supported in healthcare environments.
6. Organizations must be aware that to develop strong empathetic relationships workloads of healthcare workers must be reasonable and manageable. In a 2010 report by Accreditation Canada (2010), a voluntary member organization through which healthcare institutions evaluate their respective services, it was reported that care providers felt like they did not have sufficient time to deliver high quality patient care. Accreditation Canada implores healthcare organizations to do what is necessary to ensure appropriate "time" to do the job right.
7. Organizations must provide venues for communication between interprofessional team members. These venues may take the form of regular team meetings or more formal venues where staff come together to discuss difficult cases or cases that are challenging for the team. One practical step that healthcare organizations may take to help staff feel supported is to provide them with an opportunity for caring conversations. The purpose of these conversations is to provide opportunities for staff to feel supported by each other in their work environments. An excellent example of this was

provided by participants in this study when they mentioned having debriefing sessions with the bio-ethicist after traumatic cases within their service area. Activities such as debriefing provide opportunities for healthcare teams to share their stories and perspectives. This activity in itself may induce empathy from one worker to another, as they bear witness to each other's respective realities.

This interprofessional empathy study also points to the following education-based implication. Professional healthcare schools must reevaluate how they teach the concept of empathy. If they persist in teaching empathy from the "detached concern" perspective, which emphasizes a professional distance, then it will be challenging for healthcare professionals to fully engage in teamwork—an activity that requires a range of empathetic responses. Empathy needs to be discussed within the context of healthcare school curriculums. However, Garden (2008) suggested that actual clinical practice often undercuts classroom discussions on the importance of empathy. Furthermore, she cited studies that suggested schools should commence training students and practitioners in empathy through the study of literary texts and narrative techniques.

Personal Reflection on Interprofessional Empathy

Research is not a passive endeavor. Researchers choose topics that excite them, that bring them to the tip of their curiosity, and that open a realm of possibility into the unknown. When I initially started my research I was manager of interprofessional practice at St. Joseph Health Centre. My initial interest in wanting to understand interprofessional empathy was generated through my experience of

managing an incredible interprofessional team. As part of my role, I managed a team of interprofessional practice advisors that were all trained to support the organization in the implementation of interprofessional collaborative practice. There were five team members and each person had their own strengths and limitations. However, one thing that I remember most about this team was that we worked really well together. We allowed each other to be who we were, without any pretense. We understood each other's roles, appreciated each other's personalities, and as a matter of fact, recognized this and attempted at every opportunity to capitalize on the strengths of individual gifts. For example, the team was successful in getting several huge government grants to fund our interprofessional collaborative initiatives. My role in the construction of many of the grant proposals was to create the framework for the project and various individuals on the team would take my framework, carve out the details, and enhanced an idea or two. The gift or skill that they recognized in me was that of creating the overall big picture plan. There were others on the team whose gifts were oriented towards being expert detail-oriented individuals. The team did not fault me for not being able to do the detail work and I did not fault them for not being able to come up with the overall plan. We just respected our various gifts, and worked within that framework. When we disagreed with each other, we were not afraid to deal with it, because ultimately, we trusted that conflict would not lead to rebuke or scorn. Although we were strong on the relationship side of work, our outcomes were no less incredible. As a matter of fact, strong relationships made us consistent at being successful in the objectives we established for ourselves. The relationship potentiated the output. As I reflect on how this great experience fed my original

passion to know more about interprofessional empathy, the research process and outcome has opened my eyes to three points. The first is that over the course of discovering the nature of interprofessional empathy, I grew somewhat skeptical of its possibility to live fully within healthcare environments. The second is that interprofessional empathy must be exercised in those moments when you least want to perform it. And the third is that leaders are critical to the implementation of empathy in the workplace.

When I initially started my research I was so excited about understanding this new concept of interprofessional empathy, but that excitement was tamed shortly thereafter. I thought that the rest of the world would see that empathy between healthcare providers was an important part of the work in healthcare and that I would be delighted by the stories of camaraderie and teamwork. I also realized that my natural disposition is to be collaborative and empathetic, to care about people and expect people to also care about me. This is not a perspective that everyone entertains, however, and I have to learn to respect that. Furthermore, I learned more about some of the personal experiences of healthcare workers on their teams as I heard their stories of environments that were not always conducive to team work. Ironically, through all of this, I was going through my own professional challenges, where I was in a new job and was part of a new team where my experiences and interactions with members on the team were less than empathetic. I became more conscious of the fact that there were significant gaps in the system which were not going to be easy to navigate, and that healthcare environments were not inherently empathetic. As a result, though I remain fervent in my resolve to prove that

interprofessional empathy has merit and value to the healthcare system, I will proceed with cautious optimism. I have also learned that knowing more about something could sometimes make one feel more helpless about it, because one now understands the enormity of the challenge.

I also learned that collaboration is really not an easy process. One aspect of the collaborative puzzle that I had ignored before the research was how people who did not necessarily like each other work together. I think that I was under the assumption that interprofessional empathy manifested itself over the course of working with individuals that one liked. The challenge of interprofessional empathy is not about collaborating with those individuals that one is naturally compatible with, but with those individuals with whom compatibility must be forged. I suspect that this is where the whole idea of being conscious becomes so important. To be able to monitor how you feel about a particular situation, and consciously choose to act in a helpful way is a powerful demonstration of professional ethics.

Healthcare leaders must balance between process, where relationships are formed, and results. Over and over again, I was touched and moved by stories of individuals who perceived their leaders as not empathetic, which in turn affected the worker's ability to be productive and happy at work. I truly believe that leaders emit culture. One can try to change an organization as much as he/she wants but if the leaders within that organization are not committed to that particular culture change, then change will not happen. In a conversation I was having with another healthcare leader recently, I was talking about my research and trying to impress on them the importance of interprofessional collaborative relationships. As I was telling him a

personal story, where I thought a particular organization did not capitalize enough on the worker's passions, relationships, and energy for the work, but bullied workers into producing a specific result, he stopped the conversation, and looked me in the eye and said "relationships can never replace results". This statement shocked me, because I realized how deeply entrenched the results-oriented mentality was embedded within healthcare, and that healthcare leaders needed to understand the merits of focusing on employee wellness, which includes healthy collaborative relationships. Even more, as evidenced in this research is that good quality relationships may inform good patient care. The existence of good relationships in the process of providing care or working towards a common goal is not mutually exclusive. The most I can do is to work towards recognizing that as a leader, myself, I will work towards strengthening relationships between team members and being empathetic to the best of my ability in order to potentiate healthcare outcomes. My perspective as a leader is that results in the absence of a relationship make the outcome less meaningful.

Future studies as an outcome of the research

As interprofessional empathy is a relatively new concept, or at least a novel framework for discussing old values, future research should focus on developing the concept. This study suggests that there are four stages of interprofessional empathy and that there was a staged development of these components on teams. Studies intended to explore the existence of the identified six components would strengthen the evidence for interprofessional empathy. For example, using an ethnographic methodology, a researcher could study a single healthcare team with consistent membership. It also would be interesting to study the formation of a new team as they

go through their stages of team development and see how that development relates back to the four-staged model of interprofessional empathy. Ethnographic research could involve dwelling in the site, becoming familiar with the patterns of activity among participants, and discussing with participants their understandings of identified patterns. Data could be collected by trained observers by means of field observations and interviews, to collect both objective and subjective understandings of interprofessional empathy practices.

This study focused primarily on the similarities between how clinicians saw empathy. However, there may also be differences in the way professionals see empathy and though it was not the subject of this phenomenological research study, future studies may want to explore this aspect of interprofessional empathy.

Conclusion

This study suggests that interprofessional empathy is an important part of interprofessional collaborative relationships. As a matter of fact, interprofessional empathy may be used to leverage interprofessional collaborative work among healthcare professionals. Our findings reflect the aspects of relationships that healthcare workers consider to be important in their connections at work and the organizational structures that support the development of quality relationships. The results provide a description of those components that influence the day-to-day activities of healthcare providers on their interprofessional teams. Interprofessional empathy is a key component to leveraging interprofessional collaborative teamwork, through identifying elements that are critical to the evolution of collegial relationships.

Interprofessional empathy also speaks to the importance of provider wellness. Practitioners are concerned about the nature of relationships with their co-workers and are interested in learning how to build team cohesion and teamwork that benefit the workplace environment and also the quality of care provided to patients. Additionally, organizations can no longer ignore the idea that taking care of healthcare workers means "good care "for patients. Essentially, healthcare organizations need to find a balance between results oriented management and people management. People are the greatest asset an organization has, and consistent outcomes are what is generated when investments are made in people for the sake of nurturing and supporting professional, personal, and team growth. Furthermore, as the need for efficiency and productivity reduce the time available for conversation and limit the stability of the clinical relationship, healthcare organizations and workers must begin to affirm the importance of interprofessional empathy. As the healthcare environment speeds up, practice will also speed up, and therefore interprofessional healthcare teams will need powerful frameworks and methods to achieve empathetic and effective collaborative relationships.

Appendix A: Interprofessional Empathy Interview Questions

Healthcare providers may experience empathy when they are working within their interprofessional teams. I am interested in knowing what that experience is like for you.

1. What does empathy mean to you personally?

2. Can you describe your experience of empathy on your interprofessional team?
   a) How do you know when it is present? Can you give me an example of when empathy was working on your team?

3. When working with the interprofessional team, how would you describe the ways in which you show empathy to each other? (use the following prompts if necessary)
   a) How do you care for each other?
   b) How do you understand each other?
   c) How do you support each other?

4. What factors might make it challenging for interprofessional team members to show empathy to each other?
   a) Can you tell me about a time when any of these factors affected empathy between providers?

5. Imagine that there was more empathy on interprofessional teams. What would be different or better?

6. We are almost finished: three more questions. Imagine that there was more empathy on interprofessional teams. What would an organization have to do to support the development of empathy on teams?
   a) What other supports (internally or external to the organization) would facilitate the development of empathy on interprofessional teams?

7. How can empathy between providers support patient care? Please provide an example.

8. I appreciate that you have shared your experiences and reflections of interprofessional empathy. My last question is to ask you to define interprofessional empathy?

Appendix B: Depth Interview Guide

Interprofessional Empathy Depth Interview #2

Introduction

(Name of Participant) thanks for coming back and having a second interview with us. Today we want to continue our conversation around interprofessional empathy. And in this second round of interviews, we want to see if we captured what you told us about interprofessional empathy. We have listened to all the stories, plus your story about interprofessional empathy, and we've tried to organize them into themes. And today I want to share with you what we learned, find out if it reflects your perspective, and to know if there is anything missing from our understanding of interprofessional empathy. So I may ask you to help me understand certain themes, even further.

An explanation of each theme was given to each participant. Open discussion ensued after each question.

1) What is your appreciation for the theme of conscious engagement?
2) What is your appreciation for the theme of dialogic communication?
3) What is your appreciation for the theme of personality differences?
4) What is your appreciation for the theme of understanding of roles?
5) What is your appreciation for the theme of perspective taking
6) What is your appreciation for the theme of nurturing the collective spirit?
7) Is there any other information you think we should know about interprofessional empathy?

I would like you to think about all the themes we just spoke about. I want you to think whether all of the themes should co-exist side by side, all with equal value representing interprofessional empathy or whether you see the components as a progression, a hierarchy that leads a path towards interprofessional empathy?

Appendix C: Invitation to participation in a study on interprofessional practice

(Email to be sent to staff)

Dear (name of professional group)

This message is an invitation to participate in a study about interprofessional empathy conducted at St. Joseph Health Centre in association with an independent researcher. We are looking for 24 volunteers to participate in an approximately one-hour interview on this topic. If you decide to participate you will be given a $40 honorarium. The independent researcher will ensure that you remain anonymous (i.e., no identifying information will be revealed). More information about the study follows along with information about how to volunteer.

As you probably know, interprofessional collaboration is emerging as a key factor in reshaping healthcare practices in Canada over the last eight years. Collaboration in healthcare necessarily implies health providers sharing responsibility and partnering with each other in order to provide comprehensive patient care. As such, empathizing with other members of the team and understanding frameworks different from your own is fundamental to collaborative teamwork in healthcare.

In order to further understand the nature of empathy among interprofessional team members, we are seeking St. Joseph Health Centre staff and physicians to participate in a study on teamwork. The aim of the study is to understand the nature of empathy among members of interprofessional teams within a hospital environment. Interprofessional empathy in the context of this study is preliminarily defined as the ability and willingness of healthcare providers to listen to, understand and care for each other, but will ultimately be defined by participants in this study. We would like to recruit 24 healthcare professionals.

We are looking to describe the nature of interprofessional empathy based on healthcare providers lived experience with empathy. As such, we would like to ask you questions about your experience with empathy on your interprofessional teams. By participating in this study your experiences and reflections on those questions will help us educate healthcare workers on how to better care for each other and hospital administrators on how to create environments that nurture interprofessional empathy. The study will also enable healthcare providers to develop a greater understanding of experiences that influence them in their day-to-day activities within their interprofessional teams.
We recognize that participation in the study will incur on your time. As such, you will be compensated $40 for your participation in the study. Please take your time to make your decision about participating.

Your participation in this research is entirely voluntary and will be held to the strictest confidence. Your decision to participate, or not, will not be known to St. Joseph Health Centre.

Every effort will be made to keep your personal information confidential.

- your name will not be used in any reports about the study
- you will be identified only by a study code and pseudonym
- all study materials will be kept behind locked doors and on password protected computers
- All information will be retained for seven years in accordance with the American Psychological Association publishing conventions, in the event of a study audit to ensure that data reported are from original interviews.

If you are interested in participating in this research, please contact the principal investigator Keith Adamson (who is not an employee of St. Joseph Health Centre) at 416-530-6400 ext# 3103, or by email at: keith.adamson@wchospital.ca

Appendix D: Informed Consent

ST. JOSEPH'S HEALTH CENTRE | TORONTO

INTERPROFESSIONAL EMPATHY
INVESTIGATOR: Keith Adamson
PARTICIPANT INFORMATION AND INFORMED CONSENT FORM

The purpose of this consent form is to protect you the research participant from any known or unintended harm by participation in this study. Below are more details about this study and your role in it. In the unlikely event that a problem arises in the research or if you have further questions contact information is provided below. Please review the material carefully before consenting with your signature at the end of the document.

STATEMENT OF RESEARCH

The purpose of this study will be to describe the nature of interprofessional empathy based on healthcare providers lived experience with empathy. Interprofessional empathy in the context of this study is the ability and willingness of healthcare providers to listen to, understand and care for each other. As such, we would like to ask you questions about your experience with empathy on your interprofessional teams. It is important in healthcare systems that staff be supported socially and emotionally in order to improve their ability to meet the needs of patients as well as to enhance the personal benefits derived through meaningful, high quality work/professional practice. By participating in this study your opinions will help us educate healthcare workers on how to better care for each other and hospital administrators on how to create environments that nurture interprofessional empathy. The study will also enable healthcare providers to develop a greater understanding of experiences that influence them in their day-to-day activities within their interprofessional teams. Please take your time to make your decision about participating. You may choose to discuss it with your co-workers. Your participation is voluntary and St. Joseph Health Centre will have no record of your decision to participate or not. Your decision on participation in this study will in no way impact your current or future career at St. Joseph Health Centre.

You are being invited to take part in this study because you are a professional health discipline staff or physician working on interprofessional teams at St. Joseph Health Centre.

WHY IS THIS STUDY BEING DONE?

Empathy is becoming an important focus in organizational research. The study of empathic behaviour in the workplace is important, not only for the purpose of advanced service quality, but also for the team spirit, the working environment in general, and your work satisfaction in particular. Furthermore, shared empathy among professionals within the healthcare environment may have significant benefits for empathy that patients experience over the course of their clinical treatment. If clinicians feel cared for and supported, we may see an enhancement in the quality of empathic responses towards patients. As such, strategies can be developed to support clinicians and organizations in creating environments conducive of interprofessional empathy.

HOW MANY PEOPLE WILL TAKE PART IN THE STUDY?

About 24 people will take part in this study.

WHAT IS INVOLVED IN THE STUDY?

If you agree to participate, you will be asked to meet with a researcher to talk about your team experience, particularly about your perception of interprofessional empathy. This interview will take place at St. Joseph Health Centre or at a location that is convenient for you, and it will take about 60-90 minutes of your time. The interview will be audio recorded, transcribed and anonymized (i.e., identifying information will be removed).

After the first 24 interviews are done, transcribed and analyzed, the researcher may have more questions to answer or may need clarification on some ideas. As such, 8 individuals who participated in the first set of interviews will be invited to participate in a second set of interviews that will be 60 minutes in length. Therefore, you may be asked to participate in these interviews also. The second interview will be audio recorded, transcribed and anonymized.

It is important to note that some of the questions in the interviews are personal and you can refuse to answer these if you wish. The information you provide is for research purposes only and will remain strictly confidential. The individuals (i.e., team mates, managers or directors) directly involved or connected to you from an operational or practice perspective will not see your responses to these questions.

WHAT ARE THE RISKS OF THE STUDY?

Aside from reflecting on both positive and negative aspects of your team interactions, there are no known risks of participating. Some questions may remind you of unpleasant events during your team interactions, therefore counseling will be made available at your request, if needed.

ARE THERE BENEFITS TO TAKING PART IN THE STUDY?

If you agree to take part in this study, there may or may not be direct benefit to you; however, we hope the information we learn from this study will benefit healthcare workers and healthcare environments in general.

WHAT ABOUT CONFIDENTIALITY?

Every effort will be made to keep your identity unknown.

- your name will not be used in any reports about the study
- you will be identified only by a study code
- all study materials will be kept behind locked doors

HOW LONG WILL MY INFORMATION BE KEPT?

The American Psychological Association asks researchers to maintain data for seven years. This is for your protection. For example, if there were a claim of falsified data or research misconduct the interviews would provide evidence that the data were authentic. All paper data will be locked in a file cabinet in an office on-site at Women's Hospital College. All electronic data will be maintained in password protected files at Women's College Hospital.

ARE THERE COSTS OR COMPENSATION ASSOCIATED WITH THE STUDY?

You will be provided with $40.00 dollars for participation in each interview you do within this research study. We appreciate the commitment that it will take to participate in the interview. It is only appropriate then to offer to pay you, as a participant, for your time and effort.

WHAT ARE MY RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. Taking part in this study, or not taking part, will not affect your relationship with St. Joseph Health Centre. You may withdraw your consent at any time or refuse to answer specific questions. Also, in the final publication of results of the study, it is helpful to use participants' own words in order to illustrate an idea or a position, allowing readers to judge whether the data support the interpretations and conclusions the research makes. If you prefer that your words are not directly quoted you may indicate that choice below and the researcher will paraphrase your interview responses.

WHOM DO I CALL IF I HAVE QUESTIONS OR PROBLEMS?

If you have any questions about the study at anytime, please call **Keith Adamson** at **416-530-6400, ext 3103.** Also, if you wish to be sent a final copy of the research report, please contact Keith Adamson. If you have any **concerns regarding your rights** as a research participant, you can talk to someone who is not directly involved in the study, who is supervising the researcher or this project. **atWilfrid Laurier University, Dr. Colleen Loomis, 519-884-0710, ext. 2858, or the SJHC ethics review board : Dr.Hazel Maxwell, at 416-530-6000, ext 6750**

APPROVAL PROCESS

The Research Ethics Board has reviewed the ethical aspects and financial aspects of this study and has approved it.

PUBLICATION

I consent to allow use of my direct quotations in a published document (Please circle **Yes** or **No**)
Participants will be assured of the confidentiality of their responses.

SIGNATURES

My signature on this consent form means the following:

- The study has been fully explained to me and all of my questions have been answered
- I have read this consent form
- I understand the requirements and the risks of the study
- I agree to have my interview audio recorded
- I agree to take part in this study

_____
Name of Participant (Print)

_____ _____
Signature of Participant Date

_____
Name of Person Obtaining Consent (Interviewer)

_____ _____
Signature of Person Obtaining Consent (Interviewer) Date

_____ _____
Signature of Witness Date

Appendix E: Face Sheet Examples

Face Sheet
Participant 4 – Interprofessional Empathy

Give a brief overview of the interview including key insights & issues:

This participant's definition of personal empathy and interprofessional empathy is not different. She describes personal empathy as an ability to sense what is going on with other people. She clarifies her definition of empathy by not only speaking to the notion of sympathy, where you feel sorry for someone, but frames her definition within the idea of a supportive presence, where one is able to identify with another's situation, (by not getting too caught up in it as to make the helper immobilized) offer some form of assistance to create a solution to the situation or provide a solution through instrumental action. As such, she does not have a distinct separation between her personal and professional definition of empathy.

The powerful feature of this interview had to do with the participant's view of interprofessional empathy as getting to know the "personal stories" of the others that she worked with. Outside of the fact that each member of the team is responsible for carrying their load, and focusing on the various tasks that the member has in respect to the group goals, this participant was emphatic that none of this could be done, without team members knowing each other professionally but most importantly personally. The area of "the personal" in interprofessional work is defined. This participant helps us frame what that could look like by contextualizing how understanding the personal enhances the professional. Individual team members provide a "snapshot" of who they are to their team members every day, but this is based on a story that started long before the team met as a group of individuals. Individual life stories, impact how people respond to various situations, how they respond to each other and ultimately contribute to who they are. And who they are cannot be separated from what they do, because everything they do involves a part of who they are. That is the unique "marker" that they each bring to the execution of their common professional duties. This participant believes that in order to be a good team member you must be interested in knowing these stories and how these stories impact one's ability to carry through with their work responsibilities. Understanding these stories permits the team to readjust process and work, based on individual team member's psychological, social and emotional needs.

Dynamic reciprocity might be a good term to use when trying to describe the ability of a team to continually adjust its workload and output based on the needs of the individuals in the group.

> You move where the energy is, you move where the need is knowing that if it goes this way for a while, that player, when that's resolved we'll also be available to lend whatever's needed to the others, so everybody's got that

> freedom to be able to flow toward and away whatever it is it needs to have" (Example #1)
>
> You'll see this in group processes all the time where people are giving each other time and space. And sometimes issues are very similar and each person, if they're really doing that process of empathizing, they're doing whatever healing they need to do because they're learning from that process, even though they don't necessarily think it's the same content, the process is very similar.(Example #2)
>
> There's things that are happening that you might not be able to fix, but you can maybe figure out ways of working so that, for some particular time period, or some way you can shape the work so that person can do things differently and the team can function, because otherwise everybody is sort of saying well, she's not pulling her weight, and you don't know what's going on, right? (Example #3)

An interesting thought that came to me in this interview was that this participant did not refer to her manager as part of the team. She did mention that her manager was very good at choosing people who would fit into the team, and that her manager was helpful in providing perspective as to what was happening in the other services within the hospital, to which this team refers many patients, but are not always able to accommodate requests from this team. In a sense this manager, was role modeling empathy.

What did this participant experience in terms of interprofessional empathy? How did they describe it? (State themes and substantiate with quotes)

Knowledge of roles/ Intellectual understanding of practice activities ("blind spots")

So if we're sitting down at rounds and a person is presenting, they're not presenting it necessarily from a social work perspective or an OT perspective, they're doing a generalized assessment that includes a whole bunch of things and the doctor may sort of say, well, tell me more about that, or what did you ask about that? Or why didn't you ask about that? That kind of thing, so the recommendations. So the recommendations can be a compilation of all kind of people's input, including the CCAC worker and the [incomp] worker, who are there just the one day, because they're busy with their own case loads.

It's um, it's like, oh good because what else can I do here? So most of the time we're saying, you know, we'll present and say these are the things that I think and anybody else got any ideas? And we're like, really hopeful that somebody else has an idea. And then that's worked out, you know? Because people will come up with some really neat ideas, like the occupational therapist was suggesting to me that one of the clients I had might benefit from CBT and I said, oooh, yeah, I forgot about that because one of the [incomp] workers can do CBT, so...

Supportive presence
What you do it you say I can see that you're in a bunch of shit, like you're in a real mess here, and how can I, how can I either, you know, a way of saying things or a way of being, give you the support you need so that our family, our team, our group, can function the way it needs to function.

But then you start having the dynamics of how different people work and then when you're really, when you're looking at the empathy part of it, you're wanting your team to develop that ability to see what's going on, like is that person being quiet? What's going on? Is there a problem that's happening? Is there something that's being triggered? Is there something that they've learned long ago won't work so they're no going to try again? So you've got, you want to have your team being able to recognize what's going on with different players and no necessarily judge it, but to be able to work with it and draw it out and see what needs to have to support it because otherwise your team's just going to be a bunch of players acting individually.

Proactive support
But if they're really doing more, doing that engagement thing that I talked about, then they're gonna see what's needed and not have to be asked, like, they don't have to be told to take the garbage out, they would just do it for a change because that would make their partner feel better, you know, that kind of stuff.

Personalization of the work
I mean, there's different ways people have learned to work and that's become part of who they are, but if you start getting down to the quick and dirty where people are talking about specific content things that they're trying to resolve, they all go down to some of these basic, basic common issues that people have, and they're all very basic in terms of workplace, you know, every boss has specific staff they know are always late coming in, you know, the person who can't get up on time, there's a particular pattern there that, it's the story for that person, but what's beneath the pattern would be a common issue that a lot of people have, they just learn to deal with it differently.

And there will be tons of people in, in the workplace who have very much common underneath issues, as opposed to the individual's content of the story, so you know, people don't have time, usually, in the workplace to know each other's specific story, if they know that something's happening for somebody, the actual story may be helpful for drawing it out and helping somebody, if a person does want answers or does want ways of working, that's where that comes in, you know,

You know, it's partly, so the others on our team didn't know St. Joe's staff, so why would they go down to the cafeteria, but we've got a little table in our room, we like talkin' food and men and shopping, and that's what lunch is about, so we talk, and one of the staff is 25 and I'm 59, you know, we've got quite a range of ages in our staffing, and that doesn't matter, you know, like our secretary's in Vegas this week and we're all going to wonder what happened.

But you don't have time to sort of say, how you doing? Are you feeling okay? Whereas if you did have the time, if you were spending a little more time rather than just that in passing, you'd have a chance either to diffuse what's happening, or clarify it so that person doesn't sort of take it out on everybody else in the world, because that sort of tends to happen when people aren't feeling very good, they'll sort of, there's this black cloud that proceeds them and everybody else gets out of the way and doesn't do anything about it, so we all have these situations where we just go whoa, not going there, and we avoid it, well she's in one of those moods today,

Sharing the workload

You know, for example, that person may have a couple of kids that are sick, they may be doing home renovations, they may have a husband who's an alcoholic, there's things that are happening that you might not be able to fix, but you can maybe figure out ways of working so that, for some particular time period, or some way you can shape the work so that person can do things differently and the team can function, because otherwise everybody is sort of saying well, she's not pulling her weight, and you don't know what's going on, right?

We have another player who's got some stuff going on at home that makes it a little bit difficult for her to get things done in a timely way, so the person who coordinates the referrals has tried to allow her a little extra time here and there, and she's touched base with me, so we've actually planned that, I said pfft, I don't pay attention to other people's case loads, I mean, she could have, she could be doing very different amounts of work and I wouldn't know, I just don't pay attention to that, so that meant that when there's, she didn't have to worry about how I feel about somebody else having a different amount of time to do things and we're all trying to help that person, uh, get to a point where she can work a little faster.

Well, one of the ways I mentioned is if one worker is having a little bit of trouble getting some things done or has some complicated cases, we adapt it so that person has a bit more time, like next week would have a bit more time to get caught up.

You have a sense of what's going on for a person, and what makes their life work, and how do things work for me, like if I know for example that the social worker can't get papers done and the doctor really gets his act in gear and does this, this and this, if I'm helping with that I know the social worker is going to be helping with things that I need later on, I mean, that's the way your team is going to work, and if you've got, um, if you've got two nurses that are assigned really complicated bunches of patients, if you, if you have other nurses that can give them a little bit of assistance knowing that the favour's going to get returned, then people will start doing that, but if it's just well, you know, I've had families tell me that they've asked for somebody to help change a diaper and the staff will say that's not my room, well, that's, I mean, how are other staff going to be empathetic when that person needs to have some help, or has something going on, I mean you're looking at a, it's like when people are trying to do something extraordinary, or just a little bit extra and there's peer pressure

not to do that, well, that's the opposite of how it should work. It should work so oh, that's great, you know?

I think it helps because people are tuned in to each other, we see people's ups and downs, you see how people typically react to a situation, or proact to a situation, so if people, if people are the type of person who will proactively do something a little bit for another person, that's contagious, it's just as contagious as bad behaviour, so if you've got a bunch of players that start doing things to pay forward type of things that spreads, you know, similarly people who refuse to acknowledge what's going on with others and refuse to take that extra little step, like I'm sorry, I can't do that for you, that spreads too and then you've got a really bad unit, so um, you know, I think that piece is really, really important. **(important quote)**

Behavioural/ supportive gestures

I'm really, really, busy can I just come in one day? And we're saying, if you want, you can come in more days, like we're trying to be more inclusive. So, um, we didn't get into too much of the gory details, we did get into some and we heard from some other people, because we dug a little bit, that she had had a chat with this worker who had been sent packing and she was really kind of concerned about how we would perceive her ability to do the work, right?

So, we've just made a real effort to be real inclusive and in terms of body language, you know, I sit really close to her and we, you know, kick each other's feet, and you know, you do some things with humour and you do some things that are body language things, and we've made efforts to say do you have anybody that you want to put on the rounds list? We know that normally you kind of wait until we're done, but is there somebody else?

Appreciating different personality styles

It's a very different process involved, so our task is to get somebody back to clinic, but for some reason, we're still grappling with the process around that and the players, the personalities are a big part of it, so we're, you're trying to figure out, okay, I happen to know the players, so I'm teaching our team how some of the players are and what might work. Some people would choose to spend the time to do that, other people would say eh, I don't have time for that, if they can't tow the line or do whatever, I'm not gonna, you know, I'm not gonna waste my time, well, you don't get, you don't get things accomplished if you don't always take that time, like I learned when I wanted to work with the coordinator of the ECHS clinic, um, I mean, she's very changeable in her moods and I figured out some ways to work with her.

Because I could, I figured it out, it took me some time, but I figured it out and a colleague I was working with didn't have the time for that at all, she said I'm not gonna do it, so the two hated each other. Well, where is that in terms of being functional? That doesn't work. But, so, if you have a chance to sort of see how it's working for the other person, you're not in their shoes, but you get a glimmer of what their life is like and you can change how you are and they have to be different, right?

You know, so, in her case I figured out some ways to work with her and it's been very successful, but it, yeah, some people would say, well, why would you bother? And I figure, well, if I'm going to be working in the program, I want the team to work together to some degree, then that's important, right?

Sense of teamness

There's an inclusiveness that happens and it's not something you can put into words, it's a, when you walk into the room you can feel it, you know, if a team is a cozy team that's working together as opposed to one that's full of rifts, you can feel it, you know, it's a tangible feeling when you're walking into that setting, it's like coming home, you know that, okay, when I sit down here, we're going to get something accomplished. You get that feeling, so there's an inclusiveness that happens, I mean, it's part of the bonding that happens with the team, it's not like you have to all want to go out for a beer after work, it's just that you know when you're with each other, you know each other's ways, you know each other's kind of what's going on-ish stuff and you've had time to sort of check in the morning and say how is everybody?

Perspective taking

Carla wanted us, when she first came on board, she said I need to know how ECHS is different from any other, how is it different from CCAC? And how is it different from other programs? And the staff were all like really uptight, because they made assumptions that she didn't want people to be doing certain things, and I said okay, she's new, maybe she needs to know what we do. Maybe she needs to know what other people do. Maybe she needs to know how are we different? So let's kind of start where we do things, like, and why do we do those things, and what is it about CCAC that they don't do those things? That's an easier thing, that's a task, but, there's a process to doing that, but. Whereas they were just sort of going along and one of them wanted to quit, and, and it was really serious, people were just getting worked out and I was just like oh, I think it's a great idea that she asks this information because a, we really need to do it for ourselves, and b, it helps her know what we're doing, but there was an, people had made an assumption because they don't have enough time to get to know what's, you know?

Communication

There was some things going on, she was a very don't tell anybody anything kind of person, so she went to the boss and said I want to down size my hours, so she downsized her hours without telling anybody, our boss at the time didn't tell us either, so all of a sudden we're talking about some things, we find out that she's only with us for like .3 instead of .5, and then not much later she quit because she was unhappy, not anything to do with us we found that out later, but she quit because she was upset that she was being told to do some administrative stuff that wasn't appropriate for her profession and we were left there kind of like totally not knowing what to do because she was already gone and we didn't know what had happened, and our bopss had done- I mean, there's a team that wasn't, I mean the rest of the team was pretty cohesive and pretty happy and everybody was thinking things are going fine and all

of a sudden she quit and we're going what the hell happened? **(Thought: open and honest communication)**

l like, none of us knew that that had happened, it happened behind the scenes, we had made one referral, somebody else had done the other thing, so we didn't know about that but all of a sudden the rest of the team is going ah, this is what's been going on, okay (drums fingers on the table), but the two then didn't get particularly that they just knew that both of them, their feathers were ruffled, right? But the rest of us kind of figured it out because we know the players, we know how they work, so...[incomp, both talking]

Checking assumptions
I was talking to the files about my inability to, you know what I mean? Somebody made the assumption that I, you know? So there is, if we could all sort of lay off the assumption stuff, that would be grand, so you know, I think people need to really communicate in a, in a more direct and clearer way, but in a softer way? I don't know how to say that, but there's so many things about institutions where you're not allowed as a front liner to talk to some other department's boss.

Ability to manage conflict
I think we talk about it. Like I think we, we really talk about it, but in a very gentle way, we have a, we have a coordinator who has a very, very diplomatic way of talking and saying things and it just seems to gently help people to be able to say what's going on, and people, we try to make sure everybody's had something to say, like if anybody hasn't said anything, we'll say, you know, do you have anything to add? And it seems to work, you know?

What context or situations influenced the participant's experience of interprofessional empathy? (State themes and substantiate with examples from the transcript).

Work culture
You can't stereotype – but there are a lot of common issues, and the same in the workplace when you've got, you know, when you're trying to corral a heard of cats and you've got a bunch of staff that have different ways of being and you're trying to get them to work together, you start out with, well, you start out with the common work rules, like no one talks over each other and you're polite.

And there's this corporate posturing about, you know, individual disciplines cannot say nasty things or do things about other disciplines, that's totally a no no, and we're going, no no, we're talking process, that's not, that's not where we're going, we're not going to do anything, you did this and you did that because that's what it wsn't about, it was about process, so we had a couple of meetings about.

Social equality
It's just that she can kind of talk down to people, and the nurse practitioner won't accept that, you know, so there's, we may have a little bit of stuff to iron out around that, but we're very aware, because we've talked about it as a group.

One person said okay, how be I do this and everybody else said, oh, that makes sense, I can do this, and I can do this, and boom we did it, you know? So when you look at that, I mean those are the kinds of things that really help teams, if you get one team member that says I'm sorry, I'm too busy, the rules don't apply to me, it's not going to work.

Like, if I want to set up a meeting with um, infection control, I can't do that. I have to talk to my manager, my manager has to talk to their manager and their manager has to talk to the front line to get a meeting set up. Our nurse got her ass in a sling because she happened to email somebody in infection control who was on holidays, so the manager answered, no big deal. All of sudden she's in trouble.

Organizational philosophical belief about work
Well, a lot of organizations are very task focused and, I mean, there's a reason for that (**thought: lack of process focused on people: healthcare workers are organizational robots**) so I just find that that, the task orientation nature of work, I mean it's great for stats and things, but it doesn't, it doesn't always help people develop that cohesiveness that in turn gives them the ability to work together so they can get the taks done.

Program structure/work processes
Well, the program is set up so that we're all generalists first and then our profession comes next, like our discipline comes next, so we're supposed to be really primary focus is for elderly, shut ins, those kind of people, so that's our knowledge. Any of us can go out and do the assessment, so we automatically um, haven't got boundaries that might happen if you were on a team with somebody who was strictly doing their own discipline and nothing else, k, so, you know, our nurse is doing nursing, but she's also coordinating, she's also screening referrals, she's you know, she's going to some meetings and things, she's doing that, our occupational therapist is doing generalized assessments.

I mean, it was set up so that we would do, sort of a psycho-geriatric referral, and that our involvement would be short term, so it's a consult assessment model. So there's a need for one practitioner to go in, doesn't matter who we may.

So she's, she perhaps does less actual nurse practitioner stuff than she could be doing. But anyway, that's how the model works. So if we'ere sitting down at rounds and a person is presenting, they're not presenting it necessarily from a social work perspective or an OT perspective, they're doing a generalized assessment that includes a whole bunch of things and the doctor may sort of say, well, tell me more about that, or what did you ask about that?

Workload issues
I don't have an answer for that either, but the workloads keep people so busy that they don't have time to do anything but what their task says and you know, Carla was saying the other day we might have to do grasp (?) if she can't convince people at the funding source about our workloads and I said well, we can't do grasp (?), grasp (?) **(Thought: making time to meet and then there is being too busy to care)**

Think part of the workload issue for me is that if you have, if you have a reasonable workload, and the ministry isn't on board with any of this stuff, but if you have a work load, then you have the chance, you have the opportunity to look beyond yourself, like if you're always saying, like don't talk to me I can't get this done, you know, you don't have time to look beyond yourself at all and if the whole team's doing that, like if everybody on the unit is like so wrapped up in just panicking to get their workload done they can't, they just haven't got the potential to look beyond themselves and to look how either their behaviour is affecting anybody or look at how other people's behaviour is affecting them, unless it's somebody who's absolutely rude and says I'm not going to help you, I'm going on break, you know, but that happens on the unit sometimes, somebody will say, you know I really would like to do x when everybody else was saying gosh, you know, now I noticed the other day at the humour workshop with the nursing staff they were there for an hour, that must mean on their units that they were trading around because somebody could go one day for an hour and somebody else could go another day for an hour because most of the time the staff don't have a full hour, so I was thinking out loud, I was like ooo I wonder how that worked, because on those units it must have been that the staff decided that they would do something like that, which is exciting, you know, it's really nifty.

Blame free environment
So you've got, you want to have your team being able to recognize what's going on with different players and no necessarily judge it, but to be able to work with it and draw it out and see what needs to have to support it because otherwise your team's just going to be a bunch of players acting individually.

So the people saying well, she's not pulling her weight, that's not recognizing, that's making a lot of judgments, and you know, sometimes systems have to, you know, you've got a cap that says you've been off too many days this year, we have to see a certificate every time, and all that does is add more stress for somebody to have to go to their doctor and get a certificate when the can't get an appointment for two weeks (laughs) you know, you can't come in until...

How does our process work? How do we feed each other the referrals? How does the process work? And try to get the other ones from away from trying to talk about the client where there had been a particular hang up about one of the clients, so that we were giving support about looking at how the process works, so you know, we're

successful in the process rather than um, having her feel she had to defend what she had done about one particular case. (Focus on process not people)

Spending time together
It's really hard over the phone, it's really hard if you're in different parts of the building, you know, it makes it really difficult when people don't visibly have a chance to be with each other for a few hours at a time. People get together at meetings, but do they have time to talk? I mean, all the managers have meetings all the time and they're worried about emerg being on escalation, I mean, they're not, you know, they don't have time really to go further than they, even if they want to. They might recognize vaguely somebody's got something going on, you know.

Very little time for meetings, so again, you're trying to do this task focused thing and there isn't that much time to talk about how things work, like why isn't it happening, we're coming yet again for the fifth meeting to talk about what our goals are, and it's not happening. Why is it not happening? Because people just don't know how to get at stuff, you know?

Well, some of it has sort of a direct relationship to what I've been saying before, I really think it helps to have people to, um, being together at least for a good chunk of times, not just once a week for your meeting, or one every mont for your meetings, but to really have a chance to check in with one another and I'm not, I'm not saying it has to be anything in depth, it's like how was your weekend? You know, and people have a chance to know that each of us are interested in each other.

Team building
Anyway, that's, again, it's a little bit different from, but I think um, you know people do need opportunities for team building and the team building opportunities I've had in this place I, I don't, I don't think they've been as effective as they might be and um, and I'm not talking about the kind of team building where, you know, you have this exercise, you go to the moon and these are the supplies and what ones would you take, and fight each other about it, I'm not talking about that, I'm talking about different, you know, ones that really look at how you work together and how you, what works and what doesn't work in terms of working together.

Proximity of space
Can we take some of the referrals for you and can we, so we do that, again, a lot of that is because we're in the same room and you can see how somebody is acting, how they're being, so it just makes a heck of a lot of difference, I mean, I think part of it is just because we all happen to like each other, but, you know, we've been able to kind of shift how we do things.

I really think the physical location has a lot to do with the...in terms of staff being able to see each other. It's, I really believe it's difficult to know what's going on.

Um, I mean there's lots of things around here that kind of either go to a dead end because people don't think that they can take it further because of all the assumptions they've put in their head, so physical location I think is a biggie. It's just so much easier to, to sense what's going on with somebody if they're in your life more, you know, and I, whether it's work or wherever, you know, it just, it just, it's kind of a given. I mean, people can tell you that somebody's going through a hard time, but you can't really read it how intensively it's happening until you've had a chance to see that person, you know, um, time is a big deal too,

Length of time team is together

Somebody will have an idea and somebody will say oh, I've been thinking of that too, so the longer you're together, you start evolving kind of in the same direction, too, and it makes it easier to have conversations with others, you know, if you have sort of a, an idea of how the evolution of the program can go, which also is a process, too, then it flows much more easily when everybody's tuned it.

Overlapping roles

Same with when we had our physio therapist it would be the same, and me, if I'd gone out and I think that one quickie, one quick visit from the occupational therapist would set this family up for being able to move forward, then I'll ask her to come with me, a lot of the OT stuff I can do, a lot of the social work stuff she can do, so we're all, we all of blended roles, we don't have any turf stuff at all, like it's just not come up.

But there's a lot of blending that can happen in terms of some of the things that are, and I think with the development of programs rather than departments, there has been, on some of the units anyway, that has helped because the staff are much more aware of each other's roles and, and much more in tune with the kind of information somebody might want, which is, you know, sort of connected with empathy, isn't it?

Years of clinician's experience in the role

Not that we see that as a problem, depending on who came, on board, but it would be a problem to somebody who's young and still wanting to learn specifics about physio rather than being a generalist. I think when you reach the age of you know, sort of middle career, it's kind of a blessing to be generalizing, but when you're first starting out I think people are still trying to learn and, you know, be in their specific, narrow focus.

Willingness to participate

Dr. B. was not really interested in the whole process, he didn't do much with us, but, um, and they've seen her when she is really good, it's just that she can kind of talk down to people, and the nurse practitioner won't accept that, you know, so there's, we may have a little bit of stuff to iron out around that, but we're very aware, because we've talked about it as a group.

Professional territorialism/tribalism
One of the thoughts I had that it's like your boundaries disappear. If you're talking about interdisciplinary teams, it's your, it's like that whole boundary thing isn't and issue because then people kind of have the freedom to shift, shape shift should you want to, so it's um, in ECHS, it was kind of like if a nurse were on holidays, I run the clinic, who cares if I was a social worker and she was a nurse?

Personal definition of professionalism
I wouldn't do, but they were things that the doctor could do, you know, there were some things that kind of worked well, um, people I think would be able to empathize with each other without, without worrying about how that other discipline is going to think about them, you know, right now a lot of what we do in our work is observed and critiqued by somebody else in a different discipline, and that's not allowed here. So it's like whoa, you know?

Manager role model Empathy
I think Carla's been really good in terms of manager to get the fracture room and the clinics and the clerical staff and the booking all to be working together, like to see how really each other's roles are and how can they work together better? It's made a big difference.

Combine a composite description of interprofessional empathy for this participant that includes an integrated description of what participants describe as interprofessional empathy and the contexts in which it happens.

This participant's definition of interprofessional empathy is based on a consistent and profound blending of roles supported by work structure and processes that permit reciprocal support between team members. The driving principle in this definition is that it focuses less on what people do than who people are and how this influences what each person contributes to the team. This definition is grounded in team members providing emotional and tangible support for each other over the course of their working day. This dynamic reciprocation can only take place in teams that have strong communication (so that everyone knows what is happening most of the time with patients or just a general understanding /awareness of issues in their immediate environment, a consistent membership, that are non-hierarchal structure, that have structured times to meet and talk about process team issues, which includes "check in" times. This team focuses less on what we have to do and more and how we have to do it.

Face Sheet
Participant 10 – Interprofessional Empathy

Give a brief overview of the interview including key insights & issues:

This participant is a respiratory therapist in the Intensive care unit. He works within an interprofessional team primarily composed of doctors, nurses, and social workers.

For him there exists no distinction between interprofessional empathy and personal empathy. He sees empathy as the ability to connect with another person on a deeper level, which though not stated explicitly may refer to affective empathy. For example he speaks to a situation where his father was going through a physical illness and how his sharing his feeling and anxieties with the social worker on his unit really made a difference to his coping strategies in this situation. Sharing his personal story with the social worker was essential to him being able to work and cope with this personal stressor. He speaks to some very important qualities within this relationship that he had with the social worker that engender and support the development of empathy between professionals. He describes the social worker as showing a genuine interest in what was happening with his father, asking questions, being inquisitive, sensing his needs and responding appropriately. One message that is clear and consistent throughout this transcript is that the support is mutual. There is an expectation of reciprocity, and if this does not happen then the connection with the other is lost. He also speaks broadly about how his Intensive care team deals with death and the whole notion of how the team manages these situations. He describes a particular situation which was hard for him when he was a student and he a baby died in his presence. He stated that there was no opportunity to debrief with the team and up to this day he still has an image of the baby holding the mothers hand, slowly on its way to death. He underscores the importance of team members being able to find a "safe place to talk" about their feelings, their challenges and rely on each other for emotional and informational support. He states that often feelings of guilt and sadness follow losing a patient in the ICU, especially when the patient is young or there is a unique social circumstance with which all the professionals identify. He claims that being able to have open communication, being given the opportunity and permission to express oneself, helps each team member develop an appreciation for others struggles and previous experiences.

This Respiratory therapist experience of interprofessional empathy appears to be anchored on the theme of communication and the dimensions of that communication that makes empathy possible between healthcare professionals. He speaks of non-judgmental attitudes, trust and respect, active listening, the ability to manage conflict, comforting messages, accessible language

What did this participant experience in terms of interprofessional empathy? How did they describe it? (State themes and substantiate with quotes)

Intellectual understanding of practice activities
Being able to explain why we do the things we do, in a very um, you know matter of fact way to you, would help to improve understanding and uh, see things in a different perspective, so, those two big things I think for me.

Personalization of the work interaction
Over time I become more and more open to describing some of the, you know, challenges that we're facing at home because um, unfortunately some of my family do not have uh good coping strategies for you know, this kind of news.

There's a lot of commonalities, it could be, it could be a TV show, right, it could be you know, you have a child the same age as you know I do, or you know you grew up in the same town, but like, find those commonalities because people like to talk about themselves right, they want to talk about their stories so we have a situation whether you're you can find a connection with that person, it doesn't have to be about like, you know, your same political views or same religious beliefs it could be, you know, the simplest thing but you got to built that, that connection with a person.

Perspective taking

But I know now there's been a real push towards having this debriefing time in the moment so that it's not lost and brushed under the table. Allow the people to grieve, allow the people to be um, you know, discuss them, and then on the flip side, also allowing people a chance to empathize and understanding why people may be feeling this way, and we have these groups and you can hear some of the people's struggles or their challenges with the situation, you get a better appreciation for people's previous experiences and a better understanding for where they may be coming from in their, um, work life.

Being available

Another thing too, um, is that, there aren't as frequent um, just informal discussions about cases or about you know, uh, challenging situations um, things that certain units, so even having that formal time, it's not like, ok we're going to meet on Wednesday and we're going to discuss, we're going to debrief about something so think about it, it's those in the moment challenges, or in the, you know on the spot discussions sometimes, people need to talk about, at that time, not you know that's a great point let's talk about that next week at our meeting, let's talk about it now. so sometimes we get too bogged down with you know, check my calendar, see when I'm available and we can talk about it from there.

Appreciating personality differences

Personal differences

So, I mean it shows in different ways and I know we'll get to that in a second but, just being able to see beyond the superficial personality that sometimes we put on um and really understand why some people may be feeling or acting um, to situations the way that they do.

Professional differences

Different professions deal with difficult, uh challenging situations differently, right, so the way that we're taught in school, um, is very different depending on what profession your in, be it nursing, pshysio, RT, social work, how you relate to the patients, and how you handle death dying or how you communicate to the patient is not always the same. You know there just not, it's not the same focus, right, some programs.

Now, each team is different though right, you know, if you're dealing with um, it depends on the professionals that you're working with, right, so sometimes professionals are going to be very um, close and um, very uh, touchy feely some of them are going to be a little bit more distant even though they're empathising and trying to understand your feelings um, it may you know, it may look a little different so...

Oh phsh, I'm fine, like it's, he just kicked the bucket you know, it's just the way it is, um, the professionals don't always want to divulge their feelings, whereas if I talk to maybe somebody in social work or nursing, they may be a bit more um, they may have a bit more compassion, or a bit more openness to divulging their feelings, so, that's where the interprofessional empathy kind of comes in, you have to understand that certain professions aren't conditioned to divulge their feelings, so you have to know what kind of professionals you're dealing with when you're trying to empathize with them, right, and um, understanding where they may be coming from with their, with their jokes or in my example lack there of.

Engaging in Dialogic communication

A lot of people say that the empathy, you know, you know it's happening when you know, somebody puts their arm on you or gives you a hug or gives their hand on your lap, but it can be more then that right, it could be the way, it could be your body language, you know, the leaning in, right, you know, I know you do that with the leaning in um when you're trying to understand, relate to somebody, it could be moving closer to the person so you, you know, you're making that eye contact, it's the active listening right, um, is so important right, as opposed to you know, just questioning it, and you know, berating people with those things or providing them with advice, it's not about providing with advice, it's giving them that chance to express their concerns, express their feelings, um, why they're feeling this way, um, and you being the one to listen, right, and understand what's happening, so how do you know if it's happening, well, it could be a lot of ways right, there's the verbal parts where, with how the person is um you know, communicating with that individual, it's also the nonverbal right, the um, the body language, the positioning with that person, you know, it's not like you're talking to me and my back is turned to the side, looking around, seeing what else is happening, I'm right there with you, in that moment, face to face, you know, eye contact is so important, um, uh, that, or some clues.

You know we had a good working relationship for many years, but I think the way that he was able to approach it, the way he listened, the way that he you know just asked questions, not probing questions, but just you know, asked me how I felt about it, um, was there anything that you know could be done, how did like, to really kind of allow me an opportunity to divulge if I wanted to. Not pressing and saying well you know you really should get it out, but allowing that opportunity to say you know, if there is a time where you'd like to talk about this.

Well there's always that fear of being judged right. There's always that fear of somebody you know, maybe you don't know as well thinking you know, wow, I didn't know they felt that way, that's a bit weird you know and fear of not being understood, not being heard so they become a bit more introspective as opposed to like expressive about their feelings so, you know, I think before you think about interprofessional empathy.

Presence is big. I think we've got too bogged down with technology and we've lost a lot in just the text of words, as opposed to being present in the moment and discussing and communicating verbally. You know, when we, when we send a communication out, on paper or through a computer, it gets lost. People can read you know, um, things very differently you know, you could say have a nice day, but they may read it as, yeah, go have a nice day (sarcastically).

The other dimension that is important, it's, it's verbage, you know, (incomp) speak to an individual be it in another professional, be it in non-regulated health professions, we can't forget about that too right, but using the appropriate language, so not talking down to the individual but also not trying to self actualize yourself by talking at this, you know, PhD level um that nobody understands, right, I'm not saying you or anything like that but, you know, you're not using all this crazy terminology that, or acronyms and people are going.

The way we communicate would be different, right, um, there would be a lot more face to face dialogue, there wouldn't be this, you know the electronic messaging for how things are going to be done, um, there would be a lot more, you know it's funny, there would be a lot more conflict but good conflict. I think, people would, they would address their disagreements more because they have that trust and respect, they empathize, they know what people's back, they understand where people may be coming from, and they'd be ok with disagreeing, so the conflict that would occur would be very short lived because it we would have those discussions, it wouldn't be harboured internally and fester along the way, we could address some of those concerns because we would be able to understand and relate where that person may be coming from and be able to have discussions in a nice, uh, free way.

So it just festers negative thoughts as opposed uh, addressing it with the appropriate people they say what's the point? And don't address it, you know. I have the same problem at home too with my family. My family take a matter that's of conflict and they sweep it under the table like it never happened. So I was never really taught how to cope with conflict until I did the interprofessional courses right, so, that's why I think some of those people need to go through those developments because I know if I haven't had this.

I was talking about, like, um, the conflict resolution, sometimes they need the hard development on that, right, they, now I don't think everyone has been properly trained on that because some [incomp] school that they focus and sometimes you

learn on the job training and we know how much on the job training occurs, right, so, I think sometimes that has to be, I think that's something that needs to be addressed,

Promoting a sense of teamness

Anticipatory intervention
Right and relating to see where he's coming from and you know, um, subtle clues now communicate to say that it's the right time, so I'll give you an example of that for me, you know, the other day he was, I saw him checking his phone because his dad was going into very basic surgery and I you know, realized that that was the cutest thing, you know what, he's nervous, he's worried, he's anxious, maybe this is the time for me to ask him you know, is there anything I can do you know, how are you doing this time and offer the same respect, listening opportunity that he had provided for me the previous, you know, last year. So I thought that was really kind of a neat thing, I was actually thinking about that yesterday when were meeting for something else.

Common (crisis) experience
We have our social worker or our ethics staff come in to do debriefing sessions and look for times when those staff who were on during that difficult time to make sure that they, that staff can address their um, their situations in a more timely manner. Um, especially when there's kids involved you know, like young, young kids, you know you always have a hard time when those come in, but, sometimes they just, they don't, they don't know how to, um, discuss that situation and so we need to have that moment, sometimes we may need to have just one on one with the ethics and social person and talk about it, right, because, but with employee systems there are some external source, it doesn't always um, address the situation in a timely manner, and by that point, the, the raw emotion and the raw um, feelings are gone and it just becomes a different scenario where sometimes they really need to discuss that in the moment. Right, or within the next couple of days when its still fresh in their, their minds, to um, you know, discuss ways to um, you know, express their feelings and so as, and we do these in larger groups, right, so that like, with nursing staff and uh physicians and RTs and pharmacists and phsyios so that they have that opportunity that have an open forum to discuss some of those um, uh feelings.

Very unified, very um, there was a meeting with um, the head (incomp) the manager, nursing, RT, physio, the doctor and all discussed their challenges and, and frustrations and they were able to kind of find a commonality as to why they were feeling this way, they were able to, also discuss potential plans in a very open forum and so, yeah we were able to discuss them um, interprofessionally ok, um, but it takes time.

Having a higher purpose
It took time for them to actually uh, discuss all of the true scenarios and get past all the negative aspects of the case and actually focus on the um, the hire purpose.

Being able to express vulnerability

How, well the focus is on a couple things, focus on the process of how the code went, because sometimes people feel guilty like, how could this baby die? Did we do everything we could? Right, so they talk about the process, the physician will usually take a lead on it, and they'll discuss like, where things went well and you know if there were gaps, where were they, right, but, also, not just from a process standpoint, they do want to talk about um, you know the feelings and you know, you know give the people a chance to cry, give the people a chance to you know um, uh, express their thoughts, so sometimes (incomp) and the managers, they can empathize with what's going on, they've, they're usually the ones who have, who have seen this or experienced this situation on a more regular basis.

But I know now there's been a real push towards having this debriefing time in the moment so that it's not lost and brushed under the table. Allow the people to grieve, allow the people to be um, you know, discuss them, and then on the flip side, also allowing people a chance to empathize and understanding why people may be feeling this way, and we have these groups and you can hear some of the people's struggles or their challenges with the situation, you get a better appreciation for people's previous experiences and a better understanding for where they may be coming from in their, um, work life.

Emotional connection

The discussions will be very um, succinct and very um professional, they, but there will be that, there will be that, uh, an emotional connection that, it won't be like, no not that holding your hand while we're going to see the patient but respect can be, can be conveyed in so many ways, in just the way I talk to you.

Sharing the workload

If you aren't showing the respect for your colleague to boost a patient up to the bed or to help turn them over, um, to you know, deliver them a piece of paper that they may need, like, what, what are we in this for? Right, there's a great deal of humility in healthcare and we're all under a great deal of stress all the time because there's a lot of demands placed upon us, but why does that mean that we have to, we can't be police and civil to one another and they don't, there isn't that taking care of one another, to the same extent in certain areas,

People would be helping each other without having to ask right, they would just know to do it, to help each other out. There'd be that support, there'd be that common searching to see where they can be of help, as opposed to waiting to be called on, called on, right um, there would be this uh, uh, I don't know there would just be this happiness to come to work.

What context or situations influenced the participant's experience of interprofessional empathy? (State themes and substantiate with examples from the transcript).

Lack of venue for communication

What happened was, the way he related to me when I was going through a tough time with my dad, and now his dad was going through a similar situation, I was able to, you know, learning from him, how he was, how he um, showed the respect and the understanding for me and wanting to give me an opportunity to you know, express some of my feelings that sometimes you don't always um, there's not always a venue to do so, I felt that you know, I could offer that same um, respect and opportunity to you know, open up, in a trusting environment.

There's not that time to divulge that, so, and um, so something at work, it's not always the easiest thing to speak about, but too at home um, especially for me, having two young kids, there's not always that time, or that, space where you could, you know, if you had to cry or you know, really express your true feelings about a situation because you know, what, you have other responsibilities that you need to attend to at that time, and you need to put those feelings that you're having on the back burner until there's an opportunity to do so, which is why I really was grateful to have this individual um, provide me with that opportunity to kind of, express those feelings that you know, sometimes there's not always that opportunity to do so.

Workload/time

There's not that time to divulge that, so, and um, so something at work, it's not always the easiest thing to speak about, but too at home um, especially for me, having two young kids, there's not always that time, or that, space where you could, you know, if you had to cry or you know, really express your true feelings about a situation because you know, what, you have other responsibilities that you need to attend to at that time, and you need to put those feelings that you're having on the back burner until there's an opportunity to do so, which is why I really was grateful to have this individual um, provide me with that opportunity to kind of, express those feelings that you know, sometimes there's not always that opportunity to do so.

Teachable moments

I remember as a student when first of all patients died, I was you know, devastated, and I couldn't relate to the family, you know I couldn't I didn't know what to say to them, you know, um, when it happened, and I myself, didn't know how to you know, um, communicate that, but also then didn't know how to share my feelings with somebody else, whereas now, over the years, I've definitely been able to improve those skills by learning from other professionals.

Another case that just arose was around a patient that we have where there's a bit of a, there's a very difficult family, very aggressive, very um, combative, and stuff and raising concerns and so they took the time to uh during one of our education days to uh, with the social worker and the ethicist to learn more about why, why are they behaving this way, what circumstances are occurring and they wanted to get more in details and the staff had a chance to be heard, right because all of them were affected and you know, how the staff um (incomp) can seem quite harsh or very matter of fact, but they were able to uh check their assumptions or why they were feeling this way and they got, come to the ultimate understanding, they were worried because um, it

was ultimately affecting the care of the patient that they are primarily here to um, here to treat so, there was um, a real understanding that happened and even in that case too where they weren't talking about grieving but they were talking about, you know, concerns and frustrations that, that the staff, individuals were feeling, and they were able to take it to that higher purpose and empathize with their situation and they dealt with it accordingly which is really a nice, staff, you know, they felt heard, they felt understood, they felt that they were able to,
(he speaks to opportunities in interprofessional education/orientation)

You know even empathizing with a student or a new staff member is just equally as important, you want the person to be able to feel secure and safe when they come here as a student or new staff so, being able to empathize with their situation and how it relates where they've been coming from will help to enrich their uh experience as well.

Trust
I don't always think we're the best at that. And you know, I'll give you an example that really upset me, there was um, in one of the areas that I work in, they were doing a survey on low moral, right, which already takes away the AI part that you know, and so people were feeling in surveys about why they feel that there's low moral and one of the staff members was taking tweezers and trying to pull out um, surveys to read other people's surveys that were suppose to be confidential and anonymous, why they felt that there was low moral. So how are we taking care of each other there?

Inconsistent staffing
I find that you will see in certain areas where um, the staff are more um, [incomp] in like an out patient clinic that they have a bit more of a team cohesion because they, you know they may have the opportunity to go out on the weekend or evening because they work the same shifts, whereas when you do shift work, and sometimes and the staffing is so mixed and you put in agency staff and you know all that, you, you loose that, there's that disconnection uh, in personality so they don't, they don't uh, spend the time to learn more about each other and take care of each other from that perspective,

Proximity of Space
Well you always maybe wonder, [incomp] limiting factors is space. It's funny, there's almost too much space between rooms, so there's this disconnect there, so in the unit that I use to work in, in ICU, the rooms were very, very close to one another, right, so there was that, opportunity to kind of have a social aspect or social discussion while you were still performing the patient care, the rooms now become, are so silo-ed, and so distant space becomes a challenge towards that interprofessional empathy because um, your limited with, you're not just going to go down the hallway to speak to that person, because they're actually like, miles away almost, like obviously figuratively speaking but like, um, literally they're quite a long ways away so that's um, played an impact on the ability or the opportunities for the interprofessional empathy to be occurring.

Opportunities to get together
Another thing too, um, is that, there aren't as frequent um, just informal discussions about cases or about you know, uh, challenging situations um, things that certain units, so even having that formal time, it's not like, ok we're going to meet on Wednesday and we're going to discuss, we're going to debrief about something so think about it, it's those in the moment challenges, or in the, you know on the spot discussions sometimes, people need to talk about, at that time, not you know that's a great point let's talk about that next week at our meeting, let's talk about it now.

Technology
Presence is big. I think we've got too bogged down with technology and we've lost a lot in just the text of words, as opposed to being present in the moment and discussing and communicating verbally. You know, when we, when we send a communication out, on paper or through a computer, it gets lost. People can read you know, um, things very differently you know, you could say have a nice day, but they may read it as, yeah, go have a nice day [sarcastically].

Celebrating achievements
I went up to the specifically I found them out that day and I said you know I saw your name on the thing, congratulations that's so great, you totally deserve it, and you know they come to me and they said you know, like, thank you , that really means a lot of me, you know for you to say that. And did it cost me anything?

Leaders who are empathic
Maybe we need to have some, maybe our coach champions that we've built up in our institution that are still with us, maybe we look to have them be leaders with um, you know empathizing, like empathy, not courses by being able to educate them on the value of empathy and counselling or um, you know, human behaviour, who knows, to health, to don't have to be running (incomp) but if they're the leaders by example, they're the leaders that everyone's looking at, maybe we look to change the culture more indirectly, by using those leaders um, by an example, but you know, that's just a thought.

Combine a composite description of interprofessional empathy for this participant that includes an integrated description of what participants describe as interprofessional empathy and the contexts in which it happens.

Interprofessional empathy is a reciprocal process: meaning that there is an expectation that if you give it, that you will get it back. This participant sees interprofessional empathy as the coming together of various disciplines to learn about with and from each other with two purposes: maximizing patient care outcomes and professional interactions. The latter focuses on healthcare professionals being able to appreciate the various conceptual models and practice experiences between the various professional disciplines, and stresses the importance of open, honest and supportive communication between disciplines to create this understanding. It is

predicated by strong interpersonal connections between team members that help them understand each other as "human beings" first and professionals second. The ability to reveal aspects of oneself outside of the work environment sets the stage for the formation of deeper working relationships, characterized by strong emotional ties, voluntary self-expression, respectful communication exchanges and the ability to manage crisis and conflict. A working environment where professionals have the opportunity to meet regularly, have consistent membership and have empathic leadership leads to the development of empathy on interprofessional teams.

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