

Contextual Barriers to Discussing a Schizophrenia Diagnosis with Patients and Families: Need for Leadership and Teamwork Training in Psychiatry

Sue Outram · Gillian Harris · Brian Kelly · Martin Cohen · Carma L. Bylund · Yulia Landa · Tomer T. Levin · Harsimrat Sandhu · Marina Vamos · Carmel Loughland

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Abstract

Objective This research sought to gain insight into the processes used by clinicians to discuss a schizophrenia diagnosis with patients/families, with the aim of informing the development of a communications skills training program.

Methods A generic qualitative methodological approach was used. Sixteen mental health clinicians were recruited. Semi-structured individual interviews were used to explore their perceptions and experiences communicating a schizophrenia diagnosis. Interviews were recorded, transcribed, and thematic analysis undertaken.

Results There were five key themes relating to the process of communication about a diagnosis of schizophrenia: (1) orientation to patient care, (2) planning of communication, (3) the impact of team leadership and inter/intra-professional functioning on communication tasks, (4) the roles of different clinicians in communicating about diagnosis and treatment, and (5) time and resource deficiencies. Despite expressing care and concern for vulnerable patients and embracing the concept

of multidisciplinary teams, communicating diagnostic information to patients and families was generally unplanned for, with little consistency regarding leadership approaches, or how the team communicated diagnostic information to the patient and family. This contributed to tensions between different team members.

Conclusion The findings demonstrated a number of issues compromising good communication around a schizophrenia diagnosis, both in terms of clinician skill and clinical context, and support the importance of education and training for all members of the multidisciplinary team about their role in the communication process.

Although effective communication is linked to improved patient outcomes such as satisfaction, adherence to treatment, patient health, understanding of illness and treatment, clinician confidence, and clinician burden/distress [1], data suggests that clinicians' communication skills are not always optimal and need to be improved [2]. Patients and families report unmet information needs, desire greater involvement in decision-making, and discussion of diagnosis, prognosis, and response to their distress [3].

Additionally, studies indicate the need to improve psychiatric communication [2]. Families feel excluded from the decision-making process, blamed for the patient's illness, that their knowledge and expertise is undervalued, that insufficient medical information is shared with them, and that they experience a general lack of support [4–9]. Consequently, there has been a push to strengthen the communication skills of mental health clinicians [2, 9, 10], building on the effectiveness of communication skills training in other fields such as

S. Outram (✉) · G. Harris · B. Kelly · M. Vamos · C. Loughland
University of Newcastle, Callaghan, Australia
e-mail: Sue.Outram@newcastle.edu.au

M. Cohen · H. Sandhu
Hunter New England Mental Health, Newcastle, NSW, Australia

C. L. Bylund
Hamad Medical Corporation, Dohar, Qatar

Y. Landa
Weill Cornell Medical College, New York, USA

T. T. Levin
Memorial Sloan Kettering Cancer Center, New York, USA

oncology [11]. Our group previously published a model for discussing a diagnosis of schizophrenia, based on that of discussing a cancer diagnosis [10]. We further studied the difficulties mental health clinicians experience with this communication challenge and found that many clinicians, although believing patients and their families should be given a diagnosis, were reluctant to convey a diagnosis in their practice [12]. The main reasons given included diagnostic uncertainty, a pessimistic prognosis, fear of patients' distress, and harm from stigma. That paper, using the same sample of clinicians as the current paper, focused on whether mental health clinicians thought a named diagnosis of schizophrenia should be given to patients and why they believed this.

Because clinician-patient communication does not occur in a vacuum, the current paper examines the contextual processes that impact on discussions of a schizophrenia diagnosis. This study is part of a larger qualitative investigation into the experiences and perspectives of clinicians, patients, and carers, navigating this complex communication challenge. Data generated will inform the development of a communications skills training framework that will be tested in this context. Only data collected from the clinician cohort are presented in this paper.

Method

Design

The current study used a generic qualitative approach, utilizing a combination of techniques and analytical strategies common to applied qualitative research [13]. Based broadly on the ethnographic tradition of social investigation, we sought to examine the experiences, thoughts, perceptions, beliefs, and attributed meanings of key mental health stakeholders about communicating a diagnosis of schizophrenia, and to make sense of these views through critical analysis of the data. This approach also takes into account relevant data that are invisible or unsaid [14].

Sample

Participants were clinicians employed at public mental health services in an Australian regional city with inpatient- and community-based services. The sample consisted of 16 mental health professionals (seven female, nine male) including four nurses, a psychologist, a social worker, five psychiatrists in training ("registrars"), and five consultant psychiatrists. The participants had a range of experience in mental health (2 to 30 years; average 13 years) and worked in varied capacities and settings (mostly inpatient, but also rural, supported recovery, community mental health). The psychiatrists, nurses, and

allied health had many years of experience and held senior positions, and as would be expected, psychiatry trainees had the least experience.

Procedure

A combination of sampling techniques was used to select participants. All psychiatrists and psychiatric trainees were e-mailed an invitation to participate, while purposive sampling was used to recruit experienced clinicians from a variety of other professions and mental health services. Prospective participants were asked to contact the research team. Appointments were made at a time and place convenient to them.

Semi-structured individual interviews were used to explore the experiences and perceptions of mental health clinicians about their communication with patients with schizophrenia and their families concerning the diagnosis of schizophrenia and associated information. An experienced research assistant (RA) trained in qualitative research conducted the interviews between September 2010 and December 2011. Interviews lasted approximately 90 min and were recorded and transcribed verbatim. Ethics approval was obtained from the institutional ethics committee and written consent from all participants prior to participation.

Data Analysis

Data analysis was ongoing during data collection. Transcripts were read by two of us (SO, GH), a coding scheme agreed on, and data were coded, sorted, and organized using NVivo [15]. Broad categories and themes that were meaningful were developed, and relationships between themes relevant to the project were identified [16]. Summaries were prepared for each theme to facilitate discussion and analysis at regular team meetings. Pseudonyms were used for all participants. Different ethnicities were represented in the sample; however, to preserve anonymity, names were Anglicized, representing the majority ethnicity.

Results

Five key themes emerged in the analysis relating to the process of communication about a diagnosis of schizophrenia: (1) orientation to patient care, (2) planning of communication, (3) the impact of team leadership and inter/intra-professional functioning on communication tasks, (4) the roles of different clinicians in communicating about diagnosis and treatment, and (5) time and resource deficiencies.

Communicating diagnostic information to patients and families was generally unplanned for, with little consistency regarding leadership approaches, or how the team operated

with regard to the way diagnostic information was communicated to the patient and family. This contributed to tensions between different team members. Clinicians perceived time pressures to be a major cause of sub-optimal communication.

Orientation to Patient Care

The clinicians in this study expressed care and concern and recognized the vulnerability of their patients with schizophrenia. Clinicians spoke of the importance of being as approachable as possible, attending to the patient's needs during the interview being a priority, and rapport being the basis of therapeutic interaction: "If we don't have rapport, we don't accomplish anything" (Sue, nurse) and "... my practice is to try wherever possible to be as down-to-earth and approachable as I can be ... you try and be empathetic, you try to be sympathetic and reassuring, and ... try to give them hope as well" (Erwin, psychiatrist).

Some participants were critical, however, of the way in which other clinicians communicated with patients and families: "I have trepidation at times in terms of their approach, their manner, without consideration or implication of what crisis they could create in an individual with giving a diagnosis of schizophrenia" (Kevin, psychiatrist).

Planning Communication of a Diagnosis

Clinicians voiced support for a multidisciplinary team approach and clinical meetings as a prelude to disclosing a schizophrenia diagnosis. They made statements about the need to ensure a consistent message to patients across services and health care providers, including clinicians with whom the person with schizophrenia had built up a rapport. They advocated for consideration of the "power play" disparity between clinicians and patients and family in the meeting. Nevertheless poor planning often resulted in the lack of a cohesive, team-based approach to communicating diagnostic information.

Trish (nurse) was unusual in her consideration around planning, which she approached in a more comprehensive way taking into account the physical setting of the room, the way in which people were positioned, the number of people and relationships between those people, and the support and care of the patient. She felt that the need for sensitivity in these issues was common to all diagnoses in accord with the "principles of therapeutic communication." Despite this, there was no apparent preparation with regard to how the discussion might proceed, or agenda setting for the meeting:

There's no sort of discussion about "How are we going to present this?" and I don't think I've ever seen that in any diagnosis I've given, team discussion that I've been involved with, and I've been involved in my career in many, not only in mental health, certainly in the general

system as well with, you know, terminal illness and so forth, I don't think I've ever seen a team discussion prior to that (Trish, nurse).

The apparent lack of agenda setting was also consistent across clinicians with the process of disclosing a diagnosis tending to evolve: "In the past I haven't ... set agendas or been very planned in my approach to delivering the news ... it kind of evolves to a certain extent itself (Fiona, registrar). Jasmine told of the confusion that can occur as a consequence of a poorly organized approach to communication:

I'm a big fan of those sort of multidisciplinary staff, um, but it means you really need to sort of have a meeting beforehand to plan and discuss what you're going to say. Because I have also been in a situation where we've been sort of delivering that news of the diagnosis to someone, and the, one of the social workers didn't agree with us, and sort of piped up in front of the patient, and it was like "hang on a minute!" It just disintegrated (Jasmine, registrar).

When it came to including family members in the diagnostic interview, there was also a lack of consistency, despite all but one psychiatrist and a trainee citing a preference for family attendance. Time constraints and family availability were cited as barriers. Some clinicians stated that they involved the families of most patients across multiple interviews, while others stated that family members were included in as little as 30 % of interviews. Jane (nurse) told of how communication between the patient and the treating psychiatrist often took place on ward rounds and families rarely got to speak to the psychiatrist:

... it should be a routine thing, it's like, it's in our policies and that, but the reality of the situation is that their time is so limited, they've got so many responsibilities, that it doesn't happen. So we only do it on an ad hoc basis" (Jane, nurse).

Teams, Leadership, and Inter/Intra-Professional Tensions

Most participants said they preferred a multidisciplinary approach to communicating a schizophrenia diagnosis. Two consultant psychiatrists stated that they tried to include other team members, and Aaron (registrar) felt that closer cooperation between team members, and the inclusion of psychologists, social workers, and other health professionals when discussing a diagnosis, helped to reduce patient anxiety and suffering.

There was a general consensus, however, that the person in charge was the consultant psychiatrist, even if others were designated team leader. One registrar referred to the consultant

psychiatrist as “the boss”, and a nurse manager told of being overridden when it came to planning meetings with both family and psychiatrist present.

... but I, as much as I want that to happen, and I've raised it through all the avenues I can, it's ultimately a medical decision, and I have no authority to sort of direct people and say “You have to do this.” ... and [this person] clearly objects to the family meetings happening during the ward rounds (Jane, nurse).

Registrars and nurses told of the lack of consistency in the leadership approaches of the consultant psychiatrists and how the teams were drawn together, operated, or were managed. One registrar told of having to adapt to the individual leadership style of each consultant psychiatrist; some were more collaborative, others more authoritative. Thus, it was hard for individual team members to know of their role in the diagnostic discussions or indeed if the patient had even been told a diagnosis. Two registrars spoke of a need to improve team leadership so that a more structured approach could be taken toward communicating with patients:

... there needs to be good team leadership to make sure that there's a structured approach to patients But there's no structure like that at the moment, it's just whatever anyone thinks is a good idea at the time (George, registrar).

An example of an individualized approach to leadership was provided by one consultant psychiatrist. Although he led a multidisciplinary team, he favored not telling patients of a diagnosis: “... I don't know how a label of schizophrenia helps patients at all, so in that sense, I don't usually hand it out, because there's so many misconceptions in the community about schizophrenia ... So obviously I wouldn't want to tell [the patient] that [diagnosis] straightaway, so I ... let it slip in ever so slowly, and ... do it over a few sessions.”

While statements like this reflect the desire of practitioners to be sensitive to patient and family distress, and to provide diagnostic information progressively over time, it leaves other team members uncertain as to how to proceed and adds to the ad hoc nature of communication in this setting. The limitations of an overly uniform approach that is seen to limit tailoring information to individual needs was also expressed, highlighting the ambivalent and strongly contrasting views sometimes expressed by clinicians.

But what happens when it's structured is then it can become like a set pattern ... So if your routine is that you tell the diagnosis to the patient, it'll be done, irrespective of whether they're ready or not. So in a sense, it's good that it's not structured... it's better that each case is taken by itself (Harry, psychiatrist).

When thinking about areas of improvement, some of the clinicians interviewed articulated the need for clarification and training around team functioning.

I don't think it's about more printed materials or anything like that. There's lots of good material available on the Internet and at websites. It's more about the structure of the interactions between the treating team and patients and family... I think it comes back to the general problems with the psychiatric system, and more and better leadership within teams, and a stronger focus on giving everyone [patients and families] the opportunity to get information (George, registrar).

The Roles of Different Team Members in Communicating About Diagnosis

Respondents were in favor of the consultant psychiatrist (or registrar) taking responsibility for communicating a schizophrenia diagnosis because they were perceived to be appropriately qualified and trained to deliver a diagnosis, carried more authority, and patients and families were perceived to prefer the diagnosis to come from these physicians.

I imagine that it would usually be the consultant, or the registrar, to be delivering that news. Um, maybe I'm being too paternalistic, but I don't think it's appropriate for nursing staff to be delivering that kind of news... I don't think that most nurses would have the clinical experience, or the understanding of actually, um, what the illness is, to be giving a diagnosis. Again, maybe I'm being too paternalistic about my view of nursing staff, and we have got some amazing, fantastic nurses in our service (Fiona, registrar).

But there were caveats. George (registrar) and Trish (nurse) stated that it depended on the patient and family. If, for example, the patient was suspicious of doctors, then it might be better for someone else to lead the diagnostic discussion. Coupled with this was a lack of confidence in the delivery of “bad” diagnostic news, undermining the potential value of diagnostic information. For example, if the team expected a patient to respond negatively or aggressively to diagnostic news, some clinicians appointed team members to the roles of “good cop, bad cop” so the patient felt the support of at least one team member during the meeting, usually not the doctor. Despite this, both the psychologist and social worker stated that they felt excluded from diagnostic discussions. Others commented on the practice of the “psychiatrist and/or registrar going off and doing it together,” excluding others from participation. Some clinicians provided a further caveat, stating that the discussion of the diagnosis by the doctor was only a small part of the whole process; that such discussions involves a whole multidisciplinary team interacting with patients

and families during the length of a significant admission and beyond.

When it came to the overall treatment for patients with schizophrenia, there were other tensions around roles and responsibilities. For many psychiatrists, treatment was synonymous with medication, while others spoke of treatment more broadly to include emotional and instrumental support, psychotherapy, and “psycho-education”:

Ah, generally I'd mention that the treatment of schizophrenia involves support; it involves some sort of encouragement, rehabilitation and so forth ... they may have trouble with things they were able to do previously, like budgeting, maintaining employment, arranging accommodation (Kevin, psychiatrist).

While most psychiatrists felt they had some responsibility for “psycho-education”, others felt they did not have enough time to discuss these things with patients and families and delegated this to non-medical staff.

Many non-medical clinicians perceived education to be an important and underdeveloped role of psychiatrists. For example, Trish (nurse) stated that while medication was usually decided before the diagnostic meeting with patients, she felt patients were not given sufficient information at these meetings:

... if it was me, if I was the patient, I'd like to know all the treatment options for schizophrenia. I'd also like to know the long-term prospects and what I can expect in regards to side-effects, and how it will affect my life and my lifestyle and my body... So there's factors about their life, their work, can they continue in their job, what supports they might need, all of those things that should be discussed ... so it's about planning I guess. And if something good comes out of this, a little checklist for ..., clinicians to have, to know what to discuss with their client and how to link them into services that are appropriate, would be really a vital thing to do (Trish, nurse).

Time and Resource Deficiencies

Resource deficiencies in health services were deemed by many clinicians to impact upon the capacity to discuss a schizophrenia diagnosis well with patients and families. As described earlier, most clinicians supported a collaborative multidisciplinary treatment approach; however, time constraints often prevented team meetings from taking place. For one psychiatrist, getting a team together in one room to present a diagnosis was often not realistic. He considered it a “practicality issue”. Another psychiatrist worked part time in two different settings. Although he would have liked to have formal discussions with a team present, lack of time meant

that 60 to 70 % of meetings with patients occurred with only him present.

Nurses also discussed the frustrations and “reality” of time and resource limitations in the health care system. Jane (nurse) told how lack of time meant discharge planning meetings rarely took place. Jim (community nurse) stated that he had disagreed (not openly) with a consultant psychiatrist's diagnosis that was presented at a formal meeting with a patient, but when asked why the diagnosis had not been discussed with him prior to the meeting, he responded: “Time, it's all about time. It's all about clinical capacity to follow through with the best practice approach, and that just does not exist” (Jim, community nurse).

The two junior medical clinicians who discussed time constraints experienced those constraints in a much more “chaotic way”. Aaron and George (registrars) both felt that their ability to provide quality care and education was impacted by a pressure to “discharge people as quickly as possible”.

If you are working in an inpatient unit ... there's a lot of work to be done, a lot of patients to see. So the time to really comfort, and to sit down with the family and the patient, and slowly go through at a pace good for them, sometimes it's not possible (Aaron, registrar).

Discussion

This study provides data supporting the vital role that the clinical context and environment plays in promoting or inhibiting optimal communication around a schizophrenia diagnosis. Although the study sought to examine diagnostic communication practices among clinicians, participants articulated their frustrations about team functioning and leadership when discussing the processes involved. Contextual and environmental barriers to discussing a schizophrenia diagnosis with patients include poorly functioning multidisciplinary teams, differing models of leadership, and lack of planning resulting in ad hoc communication and tensions between team members, which ultimately has practice implications for the provision of quality health care to patients and families.

People with schizophrenia and their carers have reported clinicians to be cold and distant when giving a diagnosis of schizophrenia [5]. Nevertheless, being caring and developing rapport with patients was important to many clinicians. It is possible that the intentions of the clinicians to convey empathy and care is not always successful, as others have noted [17].

The benefits of effective multidisciplinary teams for both service providers and users are well documented [18, 19]. However, there needs to be clearly defined and negotiated roles for any team to function effectively [20]. The issue of leadership within a multidisciplinary team has been addressed

by the Royal Australian and New Zealand College of Psychiatrists (RANZCP), who state that while “Clinical authority is vested in the psychiatrist by virtue of training and experience and can be enhanced by good teamwork”, the “management of a multidisciplinary team is not necessarily the domain of the psychiatrist” [21]. Our results showed that a hierarchical model of leadership operated, with psychiatrists at the top. Even when decisions were in conflict with organizational protocol, it appeared the decisions of the psychiatrist took precedence. Core elements of clinical care are especially vulnerable to unaddressed tensions or lack of clarity in roles within teams, with few mechanisms available to resolve the lack of clarity or differing views.

Leadership was in many cases problematic and inconsistent (both within and between teams). There appears to be a lack of guidance about whose role it is to plan, set agendas, and to organize for patients and families to come together with clinicians. There was a lack of clarity about what should be said, the amount of information that should be given, and even whether a patient diagnosed with schizophrenia ought to be told of their diagnosis. There was also ambiguity in terms of the definition of roles, with a number of clinicians feeling others did not fulfill their obligations in terms of providing “psycho-education”. This led to the impression among team members that organization was “ad hoc” and chaotic, creating tensions between professions.

Clinicians used the term “psycho-education” in different ways and it sometimes appeared as though psycho-education was a treatment modality in itself. Coupled with the expectation that non-medical staff should carry out this function, there is a risk that discussions about the illness become relegated to a specific intervention rather than integrated into good routine clinical practice.

Lack of time in a poorly resourced public mental health system is a commonly stated reason for poor care; however, some have challenged the idea that it necessarily results in poor team functioning. The RANZCP position paper #47 states that effective teamwork requires agreed goals, agreed approach (including philosophy of care and collaborative understanding), and effective communication [21]. Barriers to effective teamwork include ambiguity or conflict over roles and conflict and confusion of leadership—all of which were present in this study. A semi-structured approach to discussing a diagnosis of schizophrenia [10] provides a checklist for organizing this communication challenge in a more efficient way. In particular, this suggests that consensus for discussing a schizophrenia diagnosis—what, when, why, how—should be garnered ahead of the consultation with the patient, to maximize the efficiency of the process and to prevent the ad hoc communication described by the participants in this study.

There were several limitations in this study. In particular, what clinicians say they do, and what they actually do, may differ substantially. Discrepancies have been noted between stated beliefs and actual practice in psychiatry [17]. An observational or ethnographic study would be necessary to verify practice. The range of different professional backgrounds of the clinicians interviewed meant that there were only small numbers in each category. A larger sample of clinicians, across diverse clinical settings, might provide different data. Additionally, the number of services involved, from early intervention, to acute inpatient, and through community and rehabilitation, meant that patients were seen at very different time points on their illness trajectory. However, this broad sweep was also a strength eliciting different viewpoints. Cross validation was achieved by some clinicians providing comments on the practices of other professionals. Specifically, team members lower down the medical hierarchy were more critical of the practices of senior psychiatrists. Perhaps data specifically obtained from early psychosis programs would provide perspectives on current practices. Nevertheless, the data provided in this study may also be indicative of how services without a dedicated early psychosis focus operate.

Planning how a diagnosis of schizophrenia should be discussed with patients and families within the context of a multidisciplinary team requires a clear vision and leadership and this should be addressed in “top down” and “bottom up” communication training of the whole team, in addition to the more traditional one-on-one clinician-patient communications training.

Implications for Academic Leaders

- Patients and their families prefer a named diagnosis of schizophrenia rather than uncertainty, despite the grief it may cause.
 - Most participants said they preferred a multidisciplinary approach to communicating a schizophrenia diagnosis; however, poor planning often resulted in the lack of a cohesive, team-based approach.
 - Individualized leadership styles of senior psychiatrists led to uncertainty, feelings of exclusion, and tensions over roles in some members of the team.
 - Time and resource deficiencies were perceived to negatively impact best practice care in communication with and education of patient and families.
 - Clinicians at all levels, and across all professions, should receive training on how teams, individuals, and leaders collaborate to facilitate the discussion of a schizophrenia diagnosis with patients and their families.
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