Patients' perspectives on interprofessional collaboration between health care professionals during hospitalization: a qualitative systematic review

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ABSTRACT

Objective: The objective of this review was to gain a better understanding of the interprofessional collaboration between health care professionals from the patients' point of view during hospitalisation; the influence of interprofessional collaboration on patient care, safety, and well-being; and patients' perspectives of their role in the interprofessional collaboration process.

Introduction: Interprofessional collaboration is a key factor in improving patient health care outcomes and safety through better communication between health care professionals, better teamwork, and better care coordination. However, implementing interprofessional collaboration in the clinical setting can prove complex. Patients are increasingly interested in becoming partners within the health care system. They have the potential to contribute to their own safety and to observe professionals during the care process, thus gaining a better understanding of the interprofessional collaboration process and facilitating changes in the behavior of health care professionals.

Inclusion criteria: This review considered qualitative research and mixed-method studies. Participants were hospitalized patients. Studies were included when they explored i) patients' perceptions of interprofessional collaboration, ii) the influence of interprofessional collaboration on patients' care, safety, or well-being, or iii) patients' perceptions of their own role in interprofessional collaboration. Qualitative studies focusing only on the care process or families' points of view were excluded.

Methods: Searches of six databases including MEDLINE, CINAHL, Embase, Web of Science, PsycINFO, and Sociological Abstract, limited to English, French, and German were conducted from March 2017 to June 2018. Assessment of methodological quality of studies was performed using the JBI Qualitative Assessment and Review Instrument. Data were extracted using the standardized data extraction tool from JBI. Data synthesis following the JBI approach of meta-aggregation was performed. The level of confidence for each synthesized finding was established based on ConQual.

Results: A total of 22 studies were included, which resulted in 89 findings and 24 categories. Eight synthesized findings were generated: patients' perceptions of interprofessional collaboration based on personal experiences and observations; patients' experiences with effective or ineffective interprofessional communication; patients' experience with power imbalance and paternalistic attitudes; patients' perceptions of key factors for a confident relationship with the interprofessional health care team; patients' need for comprehension of discussions between health care professionals; patients' perceptions of their role in an interprofessional health care team; patients' perceptions of opportunities for empowerment in interprofessional health care teams; and patients' need for humanizing care from interprofessional health care teams. The level of confidence of synthesized findings varied from low to moderate according to ConQual.

Conclusions: This systematic review synthesized the perspectives of hospitalized patients regarding interprofessional collaboration and their perceived role in collaborative practices. Hospitalized patients observe interprofessional collaboration, either directly or indirectly, and the way interprofessional collaboration is performed may impact both their care and their well-being. However, little evidence has been found regarding the impact of interprofessional collaboration on patient safety. Patients' perspectives on their perceived role is not unanimous; some patients want to play an active role in the collaborative process, whereas others prefer to trust the health care professionals' expertise. Health care professionals should consider patients' preferences and act accordingly regarding both the collaborative process and the inclusion of the patients in collaborative practices.

Keywords Experience; interprofessional collaboration; multidisciplinary care team; perception; perspective

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Summary of Findings

Patients' perspectives on interprofessional collaboration between health care professionals during hospitalization					
Bibliography: Didier A, Dzemaili S, Perrenoud B, Campbell J, Gachoud D, Serex M, et al. Patients' perspectives on interprofessional collaboration between health care professionals during hospitalization: a qualitative systematic review. JBI Evid Synth. 2020; 18(6):1208-1270.					
Synthesized finding	**Type of research**	**Dependability***	**Credibility****	**ConQual score**	**Comments**
Patients' perceptions of interprofessional collaboration based on personal experiences and observations	Qualitative	Downgrade 1 level	Downgrade 1 level	Low	Downgraded 2 levels: 1 level for no statement locating the research or unclear acknowledgment of the influence on the research findings for the five included primary studies; 1 level for mix of unequivocal and credible findings
Patients' experiences with effective or ineffective interprofessional communication	Qualitative	Downgrade 1 level	Downgrade 1 level	Low	Downgraded 2 levels: 1 level for no statement locating the research or unclear acknowledgment of the influence on the research findings for 11 included primary studies; 1 level for mix of unequivocal and credible findings
Patients' experience with power imbalance and paternalistic attitudes	Qualitative	Downgrade 1 level	Downgrade 1 level	Low	Downgraded 2 levels: 1 level for no statement locating the research or unclear acknowledgment of the influence on the research findings for seven studies, and no statement of the congruity between the philosophical perspective and the methodology for one included primary study; 1 level for mix of unequivocal and credible findings
Patients' perceptions of key factors for a confident relationship with the interprofessional health care team	Qualitative	Downgrade 1 level	High	Moderate	Downgraded 1 level: 1 for no statement locating the research or unclear acknowledgment of the influence on the research findings for five included primary studies
Patients' need for comprehension of discussions between health care professionals	Qualitative	Downgrade 1 level	Downgrade 1 level	Low	Downgraded 2 levels: 1 level for no statement locating the research or unclear acknowledgment of their influence on the research findings for seven included primary studies; 1 level for mix of unequivocal and credible findings

Patients' perceptions of their role in interprofessional health care teams	Qualitative	Downgrade 1 level	Downgrade 1 level	Low	Downgraded 2 levels: 1 level for no statement locating the research or unclear acknowledgment of the influence on the research findings for five included primary studies; 1 level for mix of unequivocal and credible findings
Patients' perceptions of opportunities for empowerment in interprofessional health care teams	Qualitative	Downgrade 1 level	Downgrade 1 level	Low	Downgraded 2 levels: 1 level for no statement locating the research or unclear acknowledgment of the influence on the research findings for five studies, and unclear acknowledgment of the congruity between methodology and analysis of data for one included primary study; 1 level for mix of unequivocal and credible findings
Patients' need for humanizing care from interprofessional health care teams	Qualitative	Downgrade 1 level	High	Moderate	Downgraded 1 level: 1 level for no statement locating the research or unclear acknowledgment of the influence on the research findings for seven included primary studies

Introduction

Recommendations for the implementation of interprofessional collaboration (IPC) have increased since the publication of the seminal report "To Err Is Human" by the Institute of Medicine (IOM) in 1999,[1] highlighting negative patient outcomes and death due to errors and failures in the health care system. Interprofessional collaboration occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care.[2] However, two decades after the IOM report, patients are not yet safe in hospital, with 42.7 million adverse events, most of them avoidable, from 421 million hospitalizations each year worldwide.[3] This induces a global cost of US$42 billion and leads to a negative psychological impact on patients and their families, and a loss of trust in health care professionals and the health care system.[3] Switzerland is no exception to these safety issues, with a report by the Swiss Scientific Advisory Board estimating that 10% of hospitalized patients have been aware of errors committed during their hospitalization.[4]

A majority of errors across all types of industries are due to poor communication and lack of collaboration.[5,6] In the health care system, up to 70% of errors leading to adverse events are due to a breakdown in communication, ineffective communication, and disruptive behavior between nurses and physicians.[5,7,8] Organizations such as the IOM and World Health Organization (WHO) have recognized the importance of IPC as a key factor to ensure optimal patient outcomes and safety through better team coordination and communication.[2,9] A study conducted by Aiken and colleagues[10] echoes these results, showing that an improved work environment, including doctor–nurse relationships and interprofessional decision-making, among other factors, have been positively associated with improved patient satisfaction, quality of care, and safety. Interprofessional collaboration has the potential to enhance professional practice,[11] patients' quality of life,[12] health care professionals' satisfaction,[13] and job retention.[14] Some systematic reviews

associate IPC with better patient assessment and management, better comprehension of the patient's condition, improved care delivery,[15] and reduced mortality.[16] However, despite the existing body of knowledge concerning the possible positive outcomes of IPC, it remains a complex process to implement in the clinical setting[17] due to power imbalances between health care professionals,[18] divergent comprehensions of IPC, or different backgrounds and professional interests.[19] Furthermore, the concept or models of IPC has always been explored from health care professionals' perspective.[20,21] Health care professionals need to better understand effective or ineffective IPC processes and develop awareness that their actions matter to the patient.[22]

In previous decades, health care policies have been more interested in including patients' points of view. Patients have proved to be legitimate and active observers concerning the process around their care, including safety issues.[23,24] Despite patients generally feeling safe, up to 40% of them report being concerned with safety issues at some point during their hospitalization.[23] Patients who have faced safety issues generally relate them to a lack of team coordination.[10] Patients are recognized for their active participation[25] and their value as partners[26] and/or collaborators.[27] This is supported by the Canadian Interprofessional Health Collaborative,[27] which has provided a patient-centered definition of IPC, describing it as a process that maintains working relationships between health care professionals, patients, and patients' families, aiming for optimal patient outcomes. However, little is known about patients' preferences in terms of inclusion in the collaborative process[28] and their knowledge of IPC. Some studies reported that patients are not willing to accept professionals as unique experts and solely responsible for determining their future.[7,29] In another qualitative study, patients expressed a desire to be part of the team, but without giving any detail about their specific role.[30] Concrete results on patients' participation in collaborative practices concern mostly the process of decision-making,[17,31] which is only one part of IPC. Pullon et al.[30] found that patients appreciate observing effective IPC and having direct contact with the health care team. According to the authors,[30] IPC can be effective only if it is visible to the patients. The same authors found that despite appreciating effective IPC, patients were unaware of each professional's role within the team.[30] They considered the physicians as the unique leaders of the team.

There is a gap between appreciating effective IPC and being ready to or given the opportunity to become involved in the process. Some authors contend that patient participation in collaborative practices might be a utopia[32] or a health professional's fantasy.[17] Neither patients nor health care professionals seem ready to engage in collaboration for variable reasons.[28] On the one hand, patients may not have the necessary resources or understanding of IPC to take part in collaborative practices or in the decision-making process. On the other hand, the health care professionals may hold beliefs about the patient's role in the health care team that impede effective patient-centered IPC.[31] Some authors maintain that the patient's perspective should be a key component of any health care quality improvement strategy.[33] For any concept that is relevant for practice, such as IPC, patients' perspectives and expectations need to be considered.[34] Patients' accounts may help health care professionals to overcome their barriers regarding IPC in hospital settings, thus reducing disruptive behaviors that lead to adverse events. Health care professionals may then be able to tailor their interventions to provide optimal health care to patients. If the health care system and/or health care professionals intend to include patients in collaborative processes, a better understanding of how hospitalized patients comprehend IPC and how they perceive their role in the collaborative process are needed. Hence, this review addressed the perspectives of adult and pediatric patients about IPC during hospitalization.

A preliminary search was conducted in the *JBI Database of Systematic Reviews and Implementation Reports*, PROSPERO, the Cochrane Database of Systematic Review, PubMed, and CINAHL, and no review (published or in progress) on this topic was currently available.

Review objective

The objective of this review was to examine the available evidence on IPC from patients' perspectives, specifically i) IPC in adult or pediatric wards during hospitalization; ii) the influence of IPC on patient care, safety, and well-being in adult or

pediatric wards during hospitalization; and iii) patients' roles in the IPC process in adult or pediatric wards during hospitalization.

Inclusion criteria

Participants

This review considered studies including any adult and/or pediatric (≤18 years of age) hospitalized patient, regardless of diagnoses.

Phenomena of interest

Studies were considered for inclusion if they focused on patients' perceptions and perspectives of, and experiences with, the IPC process. Studies exploring perspectives on IPC and/or its influence on the care, safety, and well-being of patients hospitalized in adult and pediatric wards – and/or patients' perspective on their role in the IPC process – were identified and retrieved.

Context

This review considered studies conducted in any cultural or geographical context, including patients hospitalized in adult or pediatric wards.

Types of studies

This review considered qualitative evidence including, but not limited to, methodology such as phenomenology, grounded theory, ethnography, action research, and feminist research. During the building of the search strategy, the reviewers and librarian decided to specify and add mixed-method research, which included quantitative and qualitative data, in order to ensure the identification of these studies.

Methods

This systematic review was conducted in accordance with JBI methodology for systematic reviews of qualitative evidence.[35] An *a priori* protocol[36] was registered in PROSPERO (CRD42017077224).[36]

Search strategy

The search strategy aimed to find both published and unpublished studies. A three-step search strategy was utilized in this review. An initial limited search of MEDLINE and CINAHL was undertaken followed by analysis of the text words contained in the title and abstract, and of the index terms used to describe an article. A second search using all identified keywords and index terms was undertaken across all included databases, with a scientific librarian specialized in systematic reviews. The librarian matched the keywords, MeSH terms, and thesaurus results related to the concepts of IPC, patients' perspectives, and acute health care settings in each database. To identify the keywords, MeSH terms, and thesaurus results, a search in relevant articles was first conducted, followed by a test of the words in each database. The full search strategies are provided in Appendix I. Finally, the reference lists of included articles were hand searched for additional studies. The search was limited to English, German, and French publications or translations, from 1980 to 2018. The date limitation was motivated by the beginning of discussions on IPC and person-centeredness with the IOM-report "To Err Is Human" from the year 2000.[1] The reviewers and the librarian chose to search from 1980 onward to include early reflections on the involvement of patients or consumers in the health system before 2000.[37-40]

Information sources

The following databases were searched: MEDLINE (Ovid), CINAHL Complete (EBSCO), Embase (Embase), Web of Science (Clarivate Analytics), PsycINFO (OvidSP), and Sociological Abstracts (ProQuest). The sources for unpublished studies included Dart-Europe and ProQuest Dissertations and Theses A&I. An updated search from the end of 2017 to mid-2018 was also conducted.

Study selection

Following the search, all identified citations were collated and uploaded into EndNote X9 (Clarivate Analytics, PA, USA) and Rayyan (Qatar Computing Research Institute, Doha, Qatar) and duplicates removed. Titles and abstracts were screened by two independent reviewers for assessment against the inclusion criteria for the review (JC, AD). Potentially relevant studies were retrieved in full and imported into the JBI System for the Unified Management, Assessment and Review of Information 2017 (JBI SUMARI; JBI, Adelaide, Australia). Full-text studies that did not meet the inclusion criteria were excluded; reasons for their exclusion are provided in Appendix II. Any disagreements that arose between the reviewers (JC, AD) were resolved through discussion or with a third reviewer (BP).

Assessment of methodological quality

Qualitative papers were assessed by three independent reviewers (BP, AD, SD) for methodological quality prior to inclusion in the review using the standardized JBI Qualitative Assessment and Review Instrument.[41] The three reviewers are experienced nurses and academics. A consultation with a fourth reviewer (JC) to resolve any disagreements was available as a contingency but was not required. There was debate and discussion about the decisions concerning the evaluation of the methodological quality of studies. The critical appraisal focused mainly on the following aspects: philosophical position; study methodology and method; data collection and analysis; and possible influence of the researcher on the study, ethics, participants' voices, and conclusion. Before undergoing the appraisal, a cut-off point of a minimum of five "yes" responses to the 10 questions was established as a requirement for inclusion. This decision was based on an evaluation of the five first included studies by three reviewers (BP, SD, AD). Nevertheless, the participant's voice through their illustrations was an essential prerequisite for inclusion and an eliminatory criterion.

Data extraction

Qualitative data were extracted from papers using the standardized data extraction tool from JBI.[41] Data extraction concerned specific details such as the methodology, method for data collection and analysis, phenomena of interest, research setting, geographical and cultural context, data on participants, and authors' study conclusions. Data extraction was performed by one reviewer (SD) and checked by a second reviewer (AD).

Data synthesis

Data synthesis of the analytic texts from qualitative research included a three-step process: extracting findings, grouping findings into categories, and grouping categories into synthesized findings following the JBI meta-aggregative approach, regardless of the study methodology.

More specifically, qualitative findings were grouped based on similar meanings, descriptive or conceptual similarities using the JBI meta-aggregative approach. This involved the aggregation or synthesis of similar findings together to generate a set of statements. The findings were rated according to their level of credibility (i.e. unequivocal, credible, unsupported).

Unequivocal (U) relates to evidence beyond reasonable doubt, which may include findings that are matter of fact, directly reported/observed, and not open to challenge. Credible (C) findings are plausible in light of data and theoretical framework, although they are derived from the authors' interpretations. They can be logically inferred from the data. Because the findings are interpretive, they can be challenged. The findings are labeled as not supported (NS) when they cannot be supported by the data.

Once labeled, the findings were categorized based on similarity in meaning of ideas or concepts. These categories were then subject to a meta-aggregation to produce a single comprehensive set of synthesized findings to be used as a basis for evidence-based practice. Three reviewers performed the data synthesis (SD, BP, AD). Each reviewer individually read the initial 100 findings to determine their credibility compared to the patients' verbatim illustrations. The group subsequently discussed the credibility of the findings attributed by each reviewer. Based on the group discussion, the reviewers reached a consensus for each finding. The reviewers then grouped the unequivocal and credible findings into categories. Four meetings were necessary to reach a consensus on the classification of the findings and the naming of the categories. Another set of four meetings was required to synthesize the findings.

Assessing confidence in the findings

The final synthesized findings were graded according to the JBI ConQual approach for establishing the level of confidence in the output of qualitative research synthesis and presented in the ConQual Summary of Findings.[42] The ConQual Summary of Findings includes the major elements of the review and details how the ConQual score was developed. Each synthesized finding from the review is presented, along with the type of research informing it, scores for dependability and credibility, and the overall ConQual score. Credibility evaluates whether there is congruency between the author's interpretation and the original source data.[43] According to Guba,[44] the concept of dependability is related to the consistency of findings. Dependability is established if the research process is logical (i.e. the methods are suitable to answer the research question and are in line with the chosen methodology), traceable, and clearly documented.[42] The level of confidence provides the assessment of evidence produced from qualitative systematic review.

Results

Study inclusion

The structured search strategy was implemented from June 2017 to June 2018 (Appendix I). The results of the database searches were imported from EndNote X9 to Rayyan for title and abstract screening. Studies were retrieved for full-text review in EndNote X9 library for screening. A total of 11,369 papers were identified through electronic databases (Figure 1).[45] After duplicates removed and records screened, 107 full-text studies were included for eligibility assessment based on the inclusion criteria (e.g. participants, context, phenomena of interest, type of studies). After study selection and critical appraisal, 22 studies[46-67] were included, of which two papers were derived from the same authors and based on the same gathered data. For the current systematic review, these two papers were considered as two different studies because not all of the findings were presented in one paper. Both papers presented complementary data relevant for the objectives of this review. Across these 22 studies, all of them were qualitative studies,[46-51,54-67] one was a master thesis,[53] and one was a doctoral thesis.[52] As the phenomenon of interest was on the patient's perspective, only primary sources with patients' voices adequately represented were selected.

Methodological quality

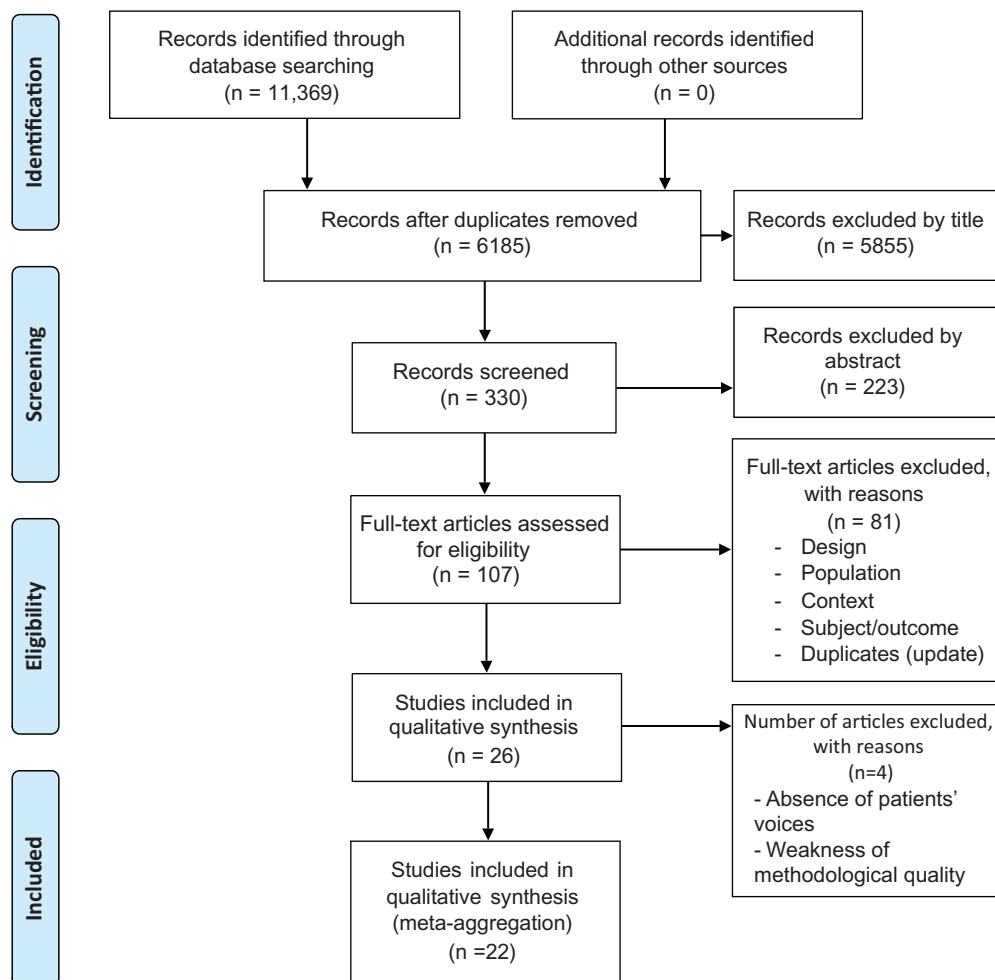The included studies were deemed to be of moderate to high methodological quality with scores of

Figure 1: Search results and study selection and inclusion process[45]

6/10,[63,64] 7/10,[58-60,62] 8/10,[46-51,54-57,61,66,67] 9/10,[52,65] and 10/10[53] based on the 10 questions of the JBI critical appraisal tool. All included studies were of qualitative design; however, four of them did not offer explicit statements on the design.[59,62-64] The aims, objectives, and data collection method were congruent with a qualitative study design, thus, the reviewers could infer the qualitative nature of the design and respond affirmatively to Q1, Q2, Q3, Q4, and Q5. Aside from Q6 concerning the researcher's cultural or theoretical background (18%) and Q7 concerning the influence of the researcher on the research, and vice-versa (14%),

the authors of the included studies responded adequately to the remaining questions with a high rate. All the included studies responded to Q8 concerning the illustration of the participant's voice, which was an eliminatory question. Three studies that did not address Q8 and one study that did not reach the minimum five "yes" responses to the 10 questions were excluded (Appendix III).

Characteristics of included studies

Among the 22 qualitative studies, most of the authors defined their methodology and/or their method (i.e. grounded theory,[52] action research,[53]

Table 1: Critical appraisal of eligible studies

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Aasen[46] (2015)	Y	Y	Y	Y	Y	U	U	Y	Y	Y
Aasen et al.[47] (2011)	Y	Y	Y	Y	Y	U	U	Y	Y	Y
Baillie et al.[48] (2014)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Berkwitt and Grossman[49] (2015)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Bilodeau et al.[50] (2015)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Conneeley[51] (2004)	Y	Y	Y	U	U	Y	Y	Y	Y	Y
Cotton[52] (1999)	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
Cracknell[53] (2006)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Henry et al.[54] (2013)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Hewitt et al.[55] (2015)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Howarth et al.[56] (2012)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Huby et al.[57] (2007)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Innes et al.[58] (2016)	Y	Y	Y	Y	Y	N	N	Y	N	Y
Jarrett[59] (2009)	N	Y	Y	Y	Y	N	N	Y	Y	Y
Kroll and Neri[60] (2003)	Y	Y	Y	Y	Y	N	N	Y	N	Y
Lamb et al.[61] (2014)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Maneze et al.[62] (2014)	N	Y	Y	Y	Y	N	N	Y	Y	Y
Mishra et al.[63] (2016)	N	U	Y	Y	Y	N	N	Y	Y	Y
O'Driscoll et al.[64] (2014)	N	Y	Y	Y	Y	N	N	Y	U	Y
Pellatt[65] (2007)	Y	Y	Y	Y	Y	Y	U	Y	Y	Y
Van Dongen et al.[67] (2016)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Zakzesky et al.[66] (2015)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Total %	82	95	100	95	95	18	14	100	82	100

N, no; U, unclear; Y, yes; JBI Critical Appraisal Checklist for Qualitative Research
Q1 = Is there congruity between the stated philosophical perspective and the research methodology? Q2 = Is there congruity between the research methodology and the research question or objectives? Q3 Is there congruity between the research methodology and the methods used to collect data? Q4 = Is there congruity between the research methodology and the representation and analysis of data? Q5 = Were those delivering treatment blind to treatment assignment? Q6 = Is there a statement locating the researcher culturally or theoretically? Q7 = Is the influence of the researcher on the research, and vice- versa, addressed?; Q8 = Are participants, and their voices, adequately represented? Q9 = Is the research ethical according to current criteria or, for recent studies, is there evidence of ethical approval by an appropriate body? Q10 = Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?
*10-8: high methodological quality; 7-6: moderate methodological quality; ≤5: low methodological quality

naturalistic approach,[66,67] phenomenology,[51,56,60] ethnographic approach,[57,65] or critical discourse method[46,47,55]). Some authors[48-50,54,58,61] defined their research in the frame of a qualitative design without further detail on the methodology. Four other studies did not provide any indication concerning the design.[59,62-64] Data were collected via interviews with open-ended questions,[46,47] interviews with open-ended questions and focus group,[61] in-depth interviews,[59] in-depth interviews and focus group,[52] semi-structured interviews and observations,[57,63,67] semi-structured interviews and focus group,[48,53,54,58] and semi-structured interviews.[49-51,55,56,60,62,64-66] Data were analyzed through critical discourse,[46,47] realist synthesis,[55] concept mapping,[60] constant comparative,[49,51,52,54,59,61,65] content analysis,[50,53,58,67] and thematic analysis,.[48,56,57,62-64,66] Data collection occurred in different health care settings such as palliative care,[59] geriatric,[57,67] obstetrics,[56] mental health,[60,67] pediatric,[49,63] oncology,[50,61,64] rehabilitation,[51-53,55,57,60,65] and acute care units (e.g. neurology, dialysis, surgery, medicine, intensive care unit, emergency department).[46-48,54,55,58,62,63,66] The most represented countries in this review were the United Kingdom[48,51,55,57,59,61,64,65] and the United States.[49,52,54,60,63,66] Studies were also conducted in Canada,[50,53] Australia,[58,62] New Zealand,[56] and Europe (e.g. Norway,[46,47] the Netherlands).[67] The majority of participants of the included studies were adults (n = 389). Only two of the studies included exclusively pediatric participants (n = 36).[49,63] One study included pediatric and adult patients but reported the illustration of the adult patients only.[65] The age range varied from 19 to 98 years for adult participants and from seven to 18 years for pediatric participants in the included studies. For one study, the age of adult participants was not available despite a correspondence with the first author of the article.[67] More characteristics about the included studies are described in Appendix IV.

Review findings

From the 22 qualitative primary research studies included in the review, 100 findings were extracted, with the majority of these findings graded as "unequivocal" (n = 76), some graded as "credible" (n = 13), and some graded as not supported (n = 11) (Appendix V). The findings graded as "not supported" were not included in the meta-aggregation because these findings were unsupported by the data. Once retained, the 89 findings were grouped based on their similarity in meaning, ideas, or concept into 24 categories named by the reviewers. The naming of these categories was based on the similarities of meaning, ideas, or concepts of the findings generated by the patients' illustrations. These 24 categories were merged to produce eight synthesized findings.

Categories and synthesized findings

A summary of 24 categories with an example illustration for each rated finding is presented in Table 2. The illustrations are available in Appendix V.

Table 2: Summary of categories with findings and illustrations

Category	Consequences of effective interprofessional collaboration	Summary: Some patients feel satisfied with big health care teams. The more they observe health care professionals around them working together, the more comfortable they feel. In this case, the efficiency of collaboration is related to the number of professionals working around them and their capacity to work in a collaborative fashion.
Finding	Decisions made by members of transdisciplinary teams were respected by all ED staff (U)[58]	
Illustration	"I was most impressed. They [doctor and the transdisciplinary team] came in together several times. They were very thorough and showed wonderful co-operation. We felt were getting exactly what the doctor wanted." p.29	
Category	Ineffective interprofessional collaboration	Summary: Patients may have negative experiences with interpersonal conflicts, or conflict of power between health care professionals may have a bad influence on patients' well-being and comfort.
Finding	In the middle of conflict between their midwives and doctors (U)[56]	

Illustration	"It was just a, a very horrible, stressful situation where I was in labour… and, and this complete conflict of advice… and it was just a lot of pressure, you know, a very stressful situation at a stressful time." p.492	
Category	Patients' assumptions about health care professionals' communication or collaboration	Summary: Patients are concerned with optimal functioning of interprofessional teamwork. Interprofessional communication and collaboration are two factors on which they often made assumptions and recommendations for improvement.
Finding	Patients had strong opinions on how to improve teamwork behaviors (U)[54]	
Illustration	"Instead of having each individual come in and ask you the same thing if they would just communicate it would be a lot easier… Teamwork if done properly creates far more efficiency that it seemed to be done." p.707	
Category	Unclear vision of interprofessional care from patients	Summary: Often, patients are not informed about the existence of the interprofessional team. They meet different health professionals without knowing their identity, their role, or whether they collaborate.
Finding	It is not being obvious which professionals staff belonged to (C)[55]	
Illustration	"It seems to be there's so many people, you know… somebody is going to teach me how to cope and somebody is going to do the therapy and yes, it just seems to be a lot of people." p.335	
Category	Effective interprofessional communication	Summary: Communication within an interprofessional team is a positive factor affecting the perceived quality of interprofessional teamwork. Patients feel comfortable when every health care professional is aware of their condition. Thus, they evaluate the communication between health care professionals as effective.
Finding	The team worked in synergy (U)[50]	
Illustration	"You can see there's communication, because, at times, they talk to you about something that's probably none of their business (…) but they know about it (…) I find this reassuring." p.33	
Category	Ineffective interprofessional communication	Summary: A lack of communication has an impact on patients' well-being. Patients may feel threatened if they perceive ineffective or lack of interprofessional communication and if they perceive that the health care professionals do not have sufficient knowledge about their (patients') condition.
Finding	Lack of communication among different providers (U)[60]	
Illustration	"One is doing their thing and the other one is doing theirs, and there's no communication between them about what's going on… but they don't follow-up… there's no-cross communication between them about what's going on." p.1111	
Category	Imbalance of power between health care professionals and patients	Summary: In hospital, patients may question difference of power between them and health care professionals. Professionals' knowledge can be experienced as an unbalance of power. Some health care professionals have a paternalistic or dominating relationship with patients (e.g. by having one-way communication or giving orders).
Finding	The staff member "dictated" what he was to do (U)[53]	
Illustration	"I was told that this is what you will do and that… I participated in it not knowing myself exactly why we were doing what we were doing but thinking that since you people knew what you were doing I was going to go along with it." p.88	

Category	Patients' lack of control	Summary: Sometimes during hospitalisation, patients do not have any choice concerning their treatment due to their health and status as a patient. Often, they are not sufficiently informed, or they don't feel involved in decision-making by health care professionals; hence, they lose control over their health care situation.
Finding	The less informed clients were regarding their condition, the more out of control they felt (U)[53]	
Illustration	"As long as I know what it is that has happened, is happening, or is going to happen, I'm in control of myself. It's when I'm being dangled at the end of that string without being given any specific information. I never did appreciate it, no." p.87	
Category	Lack of integration of patients' experience by health care professionals	Summary: Patients are willing to be partners and they feel they are reliable. Health care professionals do not yet rely on patients' experiences, while they could share valuable information concerning their health status or evolution.
Finding	Experience with co-morbidities not being taken in account (C)[61]	
Illustration	"I had recent inguinal hernia operation, and there was a large mesh in the way. I didn't find out until the last minute that they had not realized I had a mesh. I was told, 'Well, you can't have surgery now.' I kept telling them, and nobody seemed to take it into account." Table 2	
Category	Missed opportunities for patients to participate in shared decision-making	Summary: Patients perceive they are not at the same level of expertise as the health care professionals when it comes to making decisions; they cannot compete because they do not have the necessary knowledge or expertise. On the other side, they do not feel like they would be given the choice to decide or even refuse. In this way, professionals may contribute to patients' participation in shared decision-making.
Finding	Lack of ability to take part in decision-making (U)[57]	
Illustration	"Well, I don't know actually if the decisions, if I have decisions that other people are making for me I can't compete on it. You see, you can't say no, no, no, you're not doing that. But you see if it was decisions that belong to you… I couldn't do it." p.62	
Category	Patients' lack of involvement in goal setting	Summary: Patients need to set goals and care plans with the health care professionals. Being involved helps them to reach their goals more easily. Not being involved may provoke a disruption between health care professionals and patients.
Finding	Active involvement in goal setting [shortfalls in system] (U)[51]	
Illustration	"Goals have always been important to me and that was one thing that motivated me when I came here, having goals and knowing which direction I was going in, but not to have them set did disappoint me. I felt people didn't really know what I was aiming for and maybe we were working along different paths." p.252	
Category	Assessing interprofessional expertise influencing patients' trust in health care professionals	Summary: Health care professionals' knowledge, competencies, and expertise are decisive factors influencing patients' trust. If patients perceive those factors, they can have a blind trust in health care professionals.
Finding	Belief in the primacy of expert opinion and readiness to defer to the MDT's advice (U)[64]	
Illustration	"They're the experts, they know what is, what will produce the best outcome and producing the best outcome is the most important thing rather than, erm, doing what will please me most as it were, well not please me most but you know will fit in with my things best." p.5	
Category	Assessing lack of interprofessional expertise influencing patients' trust in health care professionals	Summary: Patients' trust in health care professionals is influenced by their assessment of health care professionals' knowledge and understanding about their health status.

Finding	A lack of disability-specific knowledge and understanding (U)[60]	
Illustration	"Especially in the area of cerebral palsy… That's mighty scary and to double that fear, the medical professional doesn't know what to do with us….. What do we believe? Who do we believe?" p.1110	
Category	Effective patient-professional communication	Summary: Patients feel cared for and considered when they assess effective communication between themselves and their health care professionals (i.e. by receiving clear, tailored, regular and frequent information). They need each health care professional to be available and responsive in meeting their expectations.
Finding	Frequent communication with health care team (U)[66]	
Illustration	"It was a very clear, simple discussion about me moving on and hopefully discharge to the next level of my health care… So they were all in the loop of communication with me getting into the rehabilitation centre, each providing for me and caring for me." p.235	
Category	Ineffective patient–professional communication	Summary: Patients feel disappointed and frustrated when they are not included in the communication. A miscommunication or ineffective communication have a negative impact on patient hospitalization and relationships with professionals. Information given to patients must be sufficient and adapted.
Finding	When communication was not frequent, participants expressed frustration (U)[66]	
Illustration	"Initially, when I first got here it was like here is a list of names of places…and all that conversation kinda dropped off. And again, that was a couple of weeks ago where they were going to move me right away and it's like well, we need a decision right away. And then it's kind of like all that other conversation kinda just dropped out…And like I was saying there was all the sudden conversations about where do you want to go but without any time frames for decision making until it was like, it looks like you are ready to move today…" p.237	
Category	Patients' perception of the interprofessional team dynamics	Summary: Patients can be intimidated by the team size, but they can also perceive their presence in meetings as a trouble for the health care professionals.
Finding	Feeling anxious and uncomfortable (U)[49]	
Illustration	"When they asked questions I had to address all of them, so that can get a little intimidating." p.359	
Category	Patients need an adapted medical language	Summary: Patients do not have the same professional knowledge as the health care professionals, so they may not understand specific medical terminology. They express the need to understand what is being discussed about themselves and their health status. They need to feel at least minimally included in the discussion regarding their care process.
Finding	The [health care professionals] need to avoid jargon and to simplify what they say (U)[52]	
Illustration	"Just explain yourself cause there's a lot of terms I don't quite understand, so I ask about. What's NPO? I get nothing by mouth, but NPO, that's beyond me" p.159	
Category	Patient's attitude and system mindset	Summary: Patients express their role within the health care system. That role is having a respectful and conciliatory attitude toward professionals if they want to be treated well.
Finding	Positive attitude/mindset will garner more favorable responses from the staff members (U)[53]	
Illustration	"I never complain very much about anything… I was a good patient…. I think if you complain you don't get the same care and if you treat them well, they'll treat you well…. I would have been sort of tactful about it cause you know, because it doesn't get you anywhere if you scream and yell and rant and rave but if you say it nicely you know it works, it helps." p.78	

Category	Patients' willingness to have a role in the collaborative process	Summary: Patients express that their role is to participate actively in the collaboration with health care professionals.
Finding	Patient played a decision-maker role (U)[63]	
Illustration	"They are the doctors and stuff, but I am actually the one that's sick, so I want to have a role in it." p.8	
Category	Opportunities for patients to participate in shared decision-making	Summary: Participating in shared decision-making implies being given sufficient information and time to do it. Patients gain some control over their situation and make decisions in collaboration with health professionals.
Finding	Sense of autonomy enhanced by the MDT's promotion of patient collaboration in decision-making (C)[64]	
Illustration	"I have been very impressed by the team at the [name of hospital] and in, in them getting me involved in the process, erm, you know, I've never felt that I've been pushed into doing something they've always given me time, they've always discussed it." p.7-8	
Category	Patient's inclusion into the interprofessional team	Summary: Some health care professionals within the interprofessional team work with patients and include them in the goal setting process. Patients appreciate being actively included and feeling a part of the team.
Finding	They collaborate with her [the patient] and other professionals in a team effort (U)[65]	
Illustration	"We all work together to get to a certain goal, but it's like they work for me, help me to get to that point."p.172	
Category	Patients' participation/involvement in goal setting	Summary: Some patients believe they have a role to play in their hospitalization. They benefit from health care professionals' knowledge to help them set realistic goals.
Finding	Setting goals that are realistic involves knowledge and understanding of the condition (U)[51]	
Illustration	"Goal planning was done at such an early stage, and everyone was saying, you're doing so well, I never thought I wouldn't make a complete recovery. So, in terms of the goals you can set yourself, perhaps you are unrealistic, but that's only because of your lack of knowledge." p.253	
Category	Patients need to be considered as a person by the interprofessional team	Summary: Patients may feel like they are left hanging, forgotten, or ignored when their needs and concerns are not considered. Health care professionals' attitude, such as a lack of consideration of the patient, may have a negative effect on patients' well-being.
Finding	Feeling on display for medical team (U)[49]	
Illustration	"I felt like I was on Grey's Anatomy. They had all doctors come in and observe me like I was a specimen. It was awkward because they were staring at me." p.359	
Category	Healthcare professionals ignore patients' concerns	Summary: Patients expressed the need to be considered and treated as a person and not as a number, illness, or condition. Professionals' attitude may have a negative effect on patient well-being if their concerns are not listened to. One contributing factor could be the quality of the health care professionals' communication, attitude, or behavior.
Finding	They felt they were not being listened to (U)[53]	
Illustration	"I couldn't get mad without crying and no one was listening" p.87	

MDT, multidisciplinary team

A synthesized finding consists of at least two categories. To constitute a synthesized finding, categories had to have similar meaning or illustrate a similar concept or idea. The eight synthesized findings include the following: patients' perceptions of IPC based on personal experiences and observations; patients' experiences with effective or ineffective interprofessional communication; patients' experience with power imbalance and paternalistic attitudes; patients' perceptions of key factors for a confident relationship with the interprofessional health care team; patients' need for comprehension of (interprofessional) discussions between health care professionals; patients' perceptions of their role in an interprofessional health care team; patients' perceptions of opportunities for empowerment in interprofessional health care teams; and patients' need for humanizing care within an interprofessional health care team.

Synthesized finding 1: Patients' perceptions of IPC based on personal experiences and observations
This synthesized finding was derived from 18 findings merged into four categories (Table 3). These findings and categories were similar in the ways in which the patients described the interactions between different health care professionals at their bedside. Patients' observations of IPC took place when health care professionals discussed and worked closely together while the patients observed this. Patients perceived and interpreted these interactions between the health care professionals as effective or less effective. Their perceptions, observations, and interpretations depended on aspects of communication, information sharing, the number of health care professionals interacting together, shared understanding of patients' conditions, and shared goals, as well as the health care professionals' work conditions. The perceived effectiveness of the interprofessional interactions depended strongly on the way the different health care professionals communicated one with another:

> "From my experience, they all seemed really in step with each other. They were all very friendly with each other. They seemed to communicate really well, knew each other very well".[54(p.701)]

The number of professionals communicating together was found to be an important factor for collaborative work and information exchange. For some patients, a large number of professionals interacting and communicating effectively together was perceived as an advantage:

> "I was most impressed. They [Dr and transdisciplinary team] came in together several times. They were very thorough and showed wonderful co-operation. We felt we were getting exactly what the doctor wanted."[58(p.29)]

A team with many health care professionals was perceived by patients to be more effective when discussing and working together on their health care issues.[49,55,58,62] A big team can be an efficient gain of time and work.[49] The patients felt, according to their observations, that the more health care professionals who took care of them, the more their health would improve.[49,62]

> "If there are more experts taking care of my diabetes like it is in the hospital and they do things on a big scale, then my diabetes will improve."[62(p.22)]

As such, some patients were very comfortable with the interprofessional team and valued them when they observed effective communication and information. Patients also observed interactions between the health care professionals that they perceived as ineffective, leading to ineffective IPC. This happened when patients observed a power struggle or conflict between health care professionals.[56,61] According to patients, time and workload were also two factors related to ineffective collaboration. These patients expressed that health care professionals were not able to do a good job because they were overwhelmed.[60] Some patients could neither observe nor infer the existence of an interprofessional team meeting and discussing their health status or health condition. These patients expressed being confused about the role and/or the function of each health care professional because they were not properly informed.[55,61] Other patients made assumptions, based on their observations, that health care professionals worked in parallel rather than together:

> "I just assumed that these links exist, but I didn't know they existed formally, and I don't think we were ever told as patients that there is an MDT (multidisciplinary team) team discussion."[61(Table 1)]

Table 3: Synthesized finding 1

Finding	Category	Synthesized finding
It is not obvious which professionals staff belonged to (C)	Unclear vision of interprofessional care from patients	Patients' perceptions of interprofessional collaboration based on personal experiences and observations
Initially not aware of MDT (C)		
Awareness of teamwork (U)		
Views of MDT care (U)	Consequences of effective interprofessional collaboration	
Providers working in a collaborative fashion to fix their problem (U)		
Decisions made by members of transdisciplinary team were respected by all ED staff (U)		
Collaboration and coordination (U)		
The bigger team added to overall efficiency and coordination by limiting repetition (U)		
Patient-centered approach in which patients were involved (U)		
Problems with IIPC [sometimes patients were unclear about the nature and extent of any communication between the different professionals] (U)	Patients' assumptions about health care professional's communication or collaboration	
Patients had strong opinions on how to improve teamwork behaviors (U)		
Team behaviors relate to patients' views of team effectiveness (U)		
Team processes do concern patients (U)		
A role as coordinating and supervising the work of other members of the team (U)		
Amount of choice should be tailored to patient (U)		
In the middle of conflict between their midwives and doctors (U)	Ineffective interprofessional collaboration	
Surgeons dominating meetings (C)		
Providers did not invest enough time and effort to coordinate their care (U)		

C, credible; ED, emergency department; IIPC, inter- and intra-professional care; MDT, multidisciplinary team; U, unequivocal

Some patients gave recommendations for an improved and effective IPC process.[54,61,65] There was a suggestion for having a leader within the interprofessional care team, someone who could be the key person (i.e. a supervisor or a reference person to improve the team functioning). Interestingly, some patients made reference to the doctors when talking about the health care team, giving

indication that these professionals occupy a specific role in the team.[49,63,64] Interprofessional communication was a critical aspect of the IPC process. Patients suggested certain means of communication, such as using the same communication tool (e.g. computer) to obtain complete information on patients.[54]

Synthesized finding 2: Patients' experiences with effective or ineffective interprofessional communication

The second synthesized finding was derived from six findings merged into two categories (Table 4). This synthesized finding revealed that patients experience effective or ineffective interprofessional communication during their hospitalization, and both types of communication have an influence on their well-being and trust in health care professionals. According to the patients' illustrations, effective communication included an efficient, open, and equitable communication:

> "There was... um a real sort of clarity and consistency... most of the time I'm talking to [Specialist Registrar]...if I get some sort of more like day to day things, that's not being addressed then maybe I go to [Specialist Nurse] and at the end of the day you know, on the whole big scale sort of you know guiding my care was [Consultant Haematologist]...there was a clear chain of command..." (51-year-old man).[64(p.7)]

Patients reported that effective communication minimized their uncertainty towards their care plan (e.g. concerning surgery) or the role of individual members of the patients' health care team.[50,55,64] They expressed being reassured when health care professionals were aware of their health care issues.[54] One patient observed that nurses shared information or discussed cases with physicians and students outside the patient's room.[50] This observation was interpreted by the patient that the nurses, physicians, and students worked as a team with effective functioning. Some patients assumed a lack of communication between health care professionals when they had little or no knowledge about the patients' health condition[53] or were not aware of decisions made with other health care professionals.[54]

Synthesized finding 3: Patients' experience with power imbalance and paternalistic attitudes

This synthesized finding was derived from 18 findings merged into five categories (Table 5). Patients indicated that they sometimes lost control of their condition in hospital. Patients felt they had no other choice than to comply with the interprofessional health care team's orders and/or decisions, and to act passively.[50,63] For the patients, the health care professional team held the power against the patients' lack of knowledge or expertise.[46,47,53] Some patients compared this to a loss of freedom. Patients reported that some health care professionals

Table 4: Synthesized finding 2

Finding	Category	Synthesized finding
Efficient, open, and equitable health team communication (U)	Effective interprofessional communication	Patients' experiences with effective or ineffective interprofessional communication
Uncertainty minimized by effective communication, clarity, and consistency of care (C)		
The team worked in synergy (U)		
Team communication occurred with patients directly witnessing it (U)		
Lack of communication among different providers (U)	Ineffective interprofessional communication	
Team communication occurred without patients directly witnessing it (U)		

C, credible; U, unequivocal

Table 5: Synthesized finding 3

Finding	Category	Synthesized finding
Unbalanced power between health care team knowledge and patient knowledge (U)	Imbalance of power between health care professionals and patients	Patients' experience with power imbalance and paternalistic attitudes
Patients felt they were bounded and had no freedom (U)		
Awareness of teamwork (U)		
The health care team's power and dominance: one-way communication (U)		
The staff member "dictated" what he was to do (U)		
Power and paternalistic discourse: feeling obligated to act passively and trusting the health care team (U)		
No choice but to accept the treatment if they wanted to survive (U)	Patients' lack of control	
The less informed clients were regarding their condition, the more out of control they felt (U)		
Not keeping track of what was going on with their care (C)		
Ceding control (U)		
Client power is closely linked to personality, attitude, and mind-set (C)		
Experience with comorbidities not taken into account (C)	Lack of integration of patients' experience by health care professionals	
Experience of being asked about social factors (U)		
The role of historian and act as backup information repository for clinicians (U)		
Lack of ability to take part in decision-making (U)	Missed opportunities for patients to participate in shared decision-making	
Struggling for shared decision-making (U)		
Lack of involvement in care transition (U)	Patients' lack of involvement in goal setting	
Surgeon's dominating meetings (C)		

adopted a paternalistic attitude or imparted information without adaptation to the patients or without taking into account the patients' knowledge. These patients thought that the less information they received about their condition, the more they felt out of control.[53]

> "As long as I know what it is that has happened, is happening, or is going to happen, I'm in control of myself. It's when I'm being dangled at the end of that string without being given any specific information, I never did appreciate it, no."[53] (p.87)

The power imbalance was visible in the patients' illustrations and in the findings when the patients described a lack of integration of their experiences by the interprofessional team. One patient felt that some medical errors could have been avoided if the patients were more informed and/or listened to.[61,63]

> "Like the heparin shot, I wish I would have known I was going to get that this morning, I would have told her… and they were like well, it was a mistake, he wasn't supposed to get it."[63(p.10)]

Some patients felt disappointed when not listened to by the health care professionals regarding their health status.[63] Missed opportunities in shared decision-making generated by health care professionals was another aspect of power imbalances that patients had to face. The patients expressed that they had not been able to challenge the decisions that the interprofessional team made for them and did not get the opportunity to participate in the decisions.[46,47]

> "Well, I don't know actually if the decisions, if I have decisions that other people are making for me I can't compete on it. You see, you can't say no, no, no, you're not doing that. But you see if it was decisions that belong to you… I couldn't do it."[57(p.62)]

Synthesized finding 4: Patients' perceptions of key factors for a confident relationship with the interprofessional health care team

This synthesized finding was derived from seven findings grouped into two categories (Table 6). This synthesized finding highlighted several factors that were perceived by the patients as contributing to their reliance on the interprofessional health care team. Patients felt they could trust the expertise of and decisions made by the interprofessional team. Patients were convinced that health care professionals had sufficient expertise and experience to do the best in their interest.[53,57,64] Conversely, when patients assessed a lack of

Table 6: Synthesized finding 4

Finding	Category	Synthesized finding
Confidence in the expertise underlying the MDT's decision-making (U)	Assessing interprofessional expertise influencing patients' trust in health care professionals	Patients' perceptions of key factors for a confident relationship with the interprofessional health care team
Belief in the primacy of expert opinion and readiness to defer to the MDT's advice (U)		
Trust in staff members' expertise and experience (U)		
Effect of certainty of MDT on trust (U)		
Trust in the recommendation and advice of staff (U)		
The staff did not always have the knowledge the client felt they should (U)	Assessing a lack of interprofessional expertise influencing patients' trust in health care professionals	
A lack of disability-specific knowledge and understanding (U)		

C, credible; MDT, multidisciplinary team; U, unequivocal.

knowledge, their relationship with health care professionals could be undermined. Loss of trust can result when patients perceive a lack of professional expertise or knowledge with respect to the health condition.[53,60]

"Especially in the area of cerebral palsy... That's mighty scary and to double that fear, the medical professional doesn't know what to do with us.... What do we believe? Who do we believe?" [60(p.1110)]

Synthesized finding 5: Patients' need for comprehension of discussions between health care professionals
The fifth synthesized finding was derived from 14 findings merged into four categories (Table 7). Patients claimed the need to understand the content of interprofessional communication. First, patients were convinced that health care professionals should stop using medical jargon when talking to them.[52]

Patients would then better understand their health care condition and have improved communication with health care professionals. Second, not understanding the discussion between health care professionals was a source of anxiety and fear for patients.[49] A lack of comprehension might either lead the patients to feel uncomfortable or to feel they were being a nuisance during interprofessional meetings or discussions.[49,61] For patients, the relationship with health care professionals depended on effective and frequent communication.[66] Hardly any communication or its absence led to frustration and sub-optimal quality of care for the patients.

"I was taught about diabetes by the nurses when I was diagnosed but I could not remember what she taught me, it was one session when I was in the hospital. So many health people visited me, I don't know who." [62(p.22)]

Table 7: Synthesized finding 5

Finding	Category	Synthesized finding
Communication important (C)	Effective patient-professional communication	Patients' need for comprehension of discussions between health care professionals
Frequent communication with health care team (U)		
Type of relationships established by medical team (U)		
Information given by health care professionals (U)		
Nurse easy to talk to (C)		
Interactions increased patient knowledge about timelines and expectations for discharge (U)		
When communication was not frequent, participants express frustration (U)	Ineffective patient-professional communication	
Gaps in coordination and communication (U)		
Many felt overwhelmed by the amount of information (C)		
Concerned that presence would disrupt discussion (U)	Patients' perception of the interprofessional team dynamics	
Feeling anxious and uncomfortable (U)		
Most patients' understanding of medical terminology would be insufficient (U)	Patients need an adapted medical language	
The health care professionals need to avoid jargon and to simplify what they say (U)		
Anxiety and fear when they did not understand what a physician was saying (U)		

C, credible; U, unequivocal

Other patients did not appreciate being provided with a large amount of information, being questioned in the presence of the whole team, or finding themselves in the middle of a discussion among health care professionals.[62]

Synthesized finding 6: Patients' perceptions of their role in an interprofessional health care team

The sixth synthesized finding was derived from eight findings formed into two categories (Table 8)

According to patients, the health care professionals' responses to their needs and concerns depended on the patients' own attitude and behavior. Some patients indicated that a positive and discrete attitude might help to win more favorable attitudes and behaviors from health care professionals.[53] On the other hand, some patients conceived their role and responsibilities as active participation in their care and in decision-making.[63] Learning and gathering information by themselves was part of this attitude.[52] These findings identified two types of patients: those playing a more passive role who were content to be on the receiving end of health care professionals' decisions,

and those actively participating, willing, and struggling to play an important role.

> "I think it is a combination, but I do feel it depends on the individual. You really need to make the staff aware of the fact that you want to be informed. I don't think that you should have to just dig for all of your information… but on the other hand, if you don't ask you might never find out."[52(p.108)]

Synthesized finding 7: Patients' perceptions of opportunities for empowerment in interprofessional health care teams

This synthesized finding was derived from 11 findings merged into three categories (Table 9). Both patients and health care professionals could promote patients' empowerment. The findings highlighted contributing factors to greater patient empowerment. These included being involved, being a member of the team, and being given choices or opportunities. From the patients' perspectives, health care professionals remained key and decisive

Table 8: Synthesized finding 6

Finding	Category	Synthesized finding
Positive attitude/mindset will garner more favorable responses from the staff members (U)	Patients' attitude and mindset	Patients' perceptions of their role in interprofessional health care teams
The effect of patient personality on the degree of active or passive participation of staff (C)		
Responsibility for information sharing was a joint responsibility (U)		
The reciprocal effect of the positive or negative attitude of health care professional or patient on the other's attitude and on patient participation (C)		
Patient played a decision-maker role (U)	Patients' willingness to have a role in the collaboration process	
Patients acted as team managers (U)		
Patient can contribute to meetings (U)		
Contentment with decision-making processes and preference not to attend MDT meetings (U)		

C, credible; MDT, multidisciplinary team; U, unequivocal

Table 9: Synthesized finding 7

Finding	Category	Synthesized finding
Sense of autonomy enhanced by the MDT's promotion of patient collaboration in decision-making (C)	Opportunities for patients to participate in shared decision-making	Patients' perceptions of opportunities for empowerment in interprofessional health care teams
Would rather be given choice of treatments (U)		
To experience more control of their treatment (U)		
Experience of sufficient time to decide (U)		
Patient had control over their participation (C)		
They collaborate with her [the patient] and other professionals in a team effort (U)	Patients' inclusion into the interprofessional team	
Patients were included as team members (U)		
Patients felt their inclusion was implicitly implied through the attitude of the health care providers (U)		
The meeting rounds as it stands now; every team member present, except the client (U)		
Setting goals that are realistic involves knowledge and understanding of the condition (U)	Patients' participation/ involvement in goal setting	
Goals developed on information from patient and on the parameters of the patient's medical condition (U)		

C, credible; MDT, multidisciplinary team; U, unequivocal

actors in the care process and/or in shared decision-making.[61,64] Patients felt they could only participate in collaboration if health care professionals allowed it. For some patients, health care professionals had to consider patients as team members[52] or give them the opportunity to do so.[61] Some of those patients defined the opportunities as having multiple choices and options for treatment, having complete information, and having enough time to think about the choices and make decisions.

> "I'm not taking the drug to which I am entitled; I chose not to take it, at the moment, anyway. I don't want the side effects, and I discussed it with the oncologist and the surgeon and the radiologist…they gave me that choice."[61(p.90)]

Some of the patients stated they needed to have control over the decisions.[51,52,61] Effective communication and collaboration between the health care

professionals and the patients enhanced and allowed empowerment to occur.

Synthesized finding 8: Patients' need for humanizing care within an interprofessional health care team
The eighth synthesized finding was derived from seven findings forming two categories (Table 10). Patients expressed the need to be considered and treated as a person and not as a number or as an object by interprofessional teams.[47]

> "They treat you like a person. They respected me. They asked me what my goals and expectations are and seemed to care if I was tired."[52(p.80)]

In certain cases, patients felt ignored, neglected, and not listened to by the interprofessional team during hospitalization.[53] Patients illustrated a lack of humanized care when describing themselves as "a

Table 10: Synthesized finding 8

Finding	Category	Synthesized finding
Professionals were interested in them as a person (U)	Patients need to be considered as a person by the interprofessional team	Patients' need for humanizing care from interprofessional health care teams
Feeling on display for medical team (U)		
Sufficient time to communicate (U)		
Patients felt that the health care team might have forgotten about them (U)	Health care professionals ignore patients' concerns	
Patients felt they had been left hanging (U)		
Clinicians ignore her [patient] medical concerns (U)		
They felt they were not being listened to (U)		

U, unequivocal

piece of furniture,"[47] "specimens,"[49] or "a pill chaser"[63] for health care professionals. Patients valued when the health care professionals took time to provide them with information. Conversely, patients expected at least one member of the interprofessional care team to take time for them and provide them with the necessary information. They did not appreciate running after each health care professional to obtain missing information on their health status.[50]

"It took time before I asked the question [about when I was going to die] and I feared the answer. But I was not told (…) what my life expectancy was. I did not know if I was buying myself a few more years (…) because we don't know how long I am going to take it [the treatment] (…) what is next? (…) what are the signs that it [the cancer] is coming back or not coming back?"[50(p.34)]

Discussion

This review examined the available evidence on IPC from the patients' perspective in order to gain an understanding of IPC; its influence on patients' care, safety, and well-being; and the role of the patients in the collaborative process. Data on the influence of IPC on patient safety were limited, but patients' accounts indicated that they had full confidence in health care professionals' decisions and expertise. This may support the finding of

Guijarro et al.[23] showing that patients generally feel safe in hospital.

The most propitious moments for patients' observations were during ward rounds, medical meetings, or during the process of decision-making. Patients understood IPC in terms of coordination, communication, and relationships between health care professionals. The IPC process was visible to some patients and less to other. Thus, hospitalized patients have the same concerns as patients in other health care settings (e.g. primary care or community care).[30,68] Interprofessional collaboration is not always visible to patients, but when it was visible and effective, patients were reassured and satisfied.[50,64] The patients in the primary care setting reported appreciating "regular contact" with the health care team, effective coordination, and information sharing among the members of the health care team.[30] This was supported by another study that was conducted in various hospitals in different European countries, associating a positive working relationship of health care professionals with patient satisfaction and quality of care.[10] When not visible, IPC was not necessarily perceived or assessed as ineffective. This is in contrast with Pullon's conclusion,[30] which found that IPC was more effective when visible to patients. The findings of this review showed that patients tried to find indicators to assess effectiveness of IPC (e.g. care process, care coordination, information sharing, knowledge of health care professionals about patients' health condition, and/or communication between the health care

professionals). If these indicators were positively assessed, patients assumed that effective IPC was the foundation of an effective care process.[49,52] When suboptimal, patients assumed IPC was ineffective due to lack of communication, lack of time, or work overload. Ineffective IPC (i.e. ineffective care coordination, ineffective interprofessional communication) may cause patients fear, stress, or frustration. Guijarro et al.[23] found that patients associated adverse events with a lack of team coordination, making them afraid, threatened, or feeling loss of control.

When IPC is visible, patients are attentive to the following indicators: interprofessional communication, relationships between the health care professionals,[49,54-56,59,61] and the coordination of care.[54,60] Patients stressed the importance of communication and relationships between the health care professionals, reinforcing that these are determinants of successful IPC.[21] The way in which health care professionals communicate and work together can enhance or impede effective collaboration and team functioning. Simply acting as a group at the patient's bedside was not enough to appear as an effective interprofessional team. Health care professionals needed to introduce their functions and roles to patients, otherwise the patients felt confused or intimidated about the number of health care professionals or their roles. Interestingly, some patients considered that a health care team should have a leader or a reference person to coordinate the team.[65] Some patients named the physician when referring to the whole team[49,63,64] or defined effective collaboration as perceiving that the whole team was following the medical advice.[9] Other patients observed conflicts[56] or power issues between physicians and other health care professionals.[61] These accounts from adult patients are in line with the findings of Holyoake[69] whose pediatric participants reported that physicians were in charge. Holyoake's findings[69] and the findings of this systematic review differ in that nurses are not necessarily perceived as being positioned hierarchically lower than the physicians.[68] However, viewing the physicians as leading the interprofessional team and referring to the physicians while designating the whole team indicates the hierarchical position patients assign to the physicians.

Patients' perspectives concerning their perceived role was not unanimous. Some patients wanted to play an active role in the decision-making process and in their goal setting. This resonates with Bakker's[29] findings, which reported that patients do not want health care professionals to be the unique holders of knowledge and expertise. Despite the patients' willingness to play an active role, health care professionals did not necessarily integrate patients in the care process or in the collaborative process.[32] Longtin et al.[31] identified health care professionals' characteristics (i.e. their beliefs, attitudes, and behaviors) that facilitate or impede them from including patients in decision-making or in the care process. The patients' preferences and characteristics are also important to consider[31]; for example, the findings of the present systematic review highlighted that some patients expressed their reticence to participate in important decisions or team meetings due to their perceived lack of expertise.

Different points are thus highlighted: hospital-based health care teams can only adopt a patient-centered view of IPC if patients and health care professionals change their beliefs, attitudes, and behavior toward the patients' role within an interprofessional health care team. Patients need to know that they can be part of the team. They need to be informed and involved in interprofessional practices such as decision-making and goal setting. Health care professionals need to evaluate systematically the degree to which patients want to take part in collaborative moments. A patient-centered IPC, or partnership with patients in hospital settings, cannot take place if patients and health care professionals remain in an asymmetric relationship. On the other hand, power imbalances due to knowledge and expertise differences between patients and health care professionals are inevitable. Thus, health care professionals need to work in an interprofessional and collaborative fashion while providing patients the opportunity to feel part of the team, adapting their language depending on with whom they are speaking. Integrating patients as health care team members needs to be balanced and personalized according to patients' preferences.

Humanized care constituted another aspect of care pointed out by the participants. This did not constitute the initial focus of this review; however, this aspect was retained as patients described it in the context of IPC. Humanized care was viewed to be the responsibility of each health care professional and the whole team. A humanized approach of care was sometimes lacking. This indicates that IPC must be more than risk- and safety-oriented. Otherwise,

patients may feel they are a separate entity handled by others. Patients need to feel that they are at the center and part of the interprofessional health care team. In other words, patients' care should not be seen as a fragmented process, sometimes explored under the lens of quality and sometimes under the perspective of interprofessionality or humanized care. Care should be holistic. This might find resonance in a person-centered IPC; however, further investigations are needed to correlate interprofessional care with more personalized, humanized, and optimized care.

Strengths and limitations

This systematic literature review provides an overview of the perception of hospitalized patients and their understanding of IPC based on their direct or indirect observations of and experiences with IPC. The participants related IPC to a complementary and humanized aspect of care.

Based on the JBI critical appraisal tool, the methodological quality of the included studies was high, and most of the studies were recent. The confidence of the synthesized findings was low to moderate based on the ConQual approach.

However, not all studies were conducted in the hospital setting, which made some findings difficult to evaluate. Numerous discussions and verifications were necessary to determine the exact context of the finding. Findings illustrating the perspectives and experiences of patients outside the hospital setting were excluded.

Some patients discussed the health care team in terms of "the doctors." The reviewers had to thoroughly consider the context of the study and examine the patients' accounts in order to determine whether they were talking about an interprofessional team, an intraprofessional team, or individual health care providers.

The studies did not all focus on the three objectives of the present systematic review; therefore, the number of findings in some articles was limited to one.[66]

Another limitation was related to the geographical setting of the studies. Most of the studies were conducted in English-speaking countries. The health care system and context of these countries might be different from some other countries; patients' literacy may vary due to a different health care policy. The concept of "patient-partner" was launched and developed in North America[26] and the United Kingdom.[31] Patient partnership and involvement might be more encouraged in those countries; thus, patients may have a more active approach toward their health care. In English-speaking countries, patients may also be more active due to technological innovation, enhancing their access to health care information and to more person-centered health care policies.[32] Hospitalized patients may be less active as they are in an environment they do not fully control and where the health care professionals are more powerful in number and in knowledge. However, this would require further studies comparing hospitalized patients' characteristics, attitudes, and behaviors toward their health care in European and English-speaking countries.

Conclusions

Despite a low to moderate ConQual grade due to a mix of unequivocal and credible findings, the findings of this qualitative systematic review, derived from studies of high-to-moderate methodological quality, highlighted hospitalized patients' unique perspectives of IPC. These findings are in line with and support the recommendations of organizations such as the World Health Organization and the Institute of Medicine, which encourage optimized interprofessional teamwork, coordination, communication, and patient-centered care.[2,3,9] In addition, these findings provide a complementary understanding of IPC from the point of view of patients, and the role that patients assume or wish to assume in IPC.

The patients have observed aspects of IPC (e.g. the relationship between health care professionals, interprofessional communication, coordination, information sharing), which have been defined as critical concepts by researchers in health care literature.[21,70-72] Patients appreciate observing effective IPC; however, not all patients are necessarily willing and able to participate in collaborative practices or processes, such as decision-making, discussions about the choice of treatments, goal setting, ward rounds, interdisciplinary meetings or interdisciplinary discussions at the bedside of the patients. It is difficult to anticipate patients' preferences concerning collaborative practices. For this reason, it is important to evaluate the preference of each patient individually and to work accordingly. Some aspects

should be systematically applied in order to be visible as an interprofessional team and to be effective at the patient's bedside or when performing IPC in the presence of the patient. The following propositions would allow patients to participate in the interprofessional communication held at their bedside: the interprofessional team should introduce the function of each professional to the patient, avoid medical jargon if discussions take place at the patient's bedside, tailor the amount of information provided to the patient at one time, and allow the patient enough time to make a decision, if he or she is willing to participate in decision-making.

Recommendations for practice

The accounts of the participants and the findings of the 22 included studies gave indications for some recommendations. Interprofessional collaboration is a process that is directly or indirectly assessed. When IPC is not visible to patients, they seek indicators to assess it through information exchange or care coordination. Interprofessional collaboration may influence patients' care, experience, and participation to some extent. This means that the actions and behaviors of the health care professionals, as a team and toward the patients, influence the way the patients perceive IPC, their care, and their role in an interprofessional health care team within a hospital ward. Some patients need to be actively involved in the collaborative process, whereas others prefer to receive care without taking an active part in the decisions, assigning their confidence to the expertise of the health care professionals. Thus, health care professionals should consider patients' preferences individually and facilitate their comprehension of the collaborative process. The following recommendations have been graded B according to the moderate to low level of ConQual grade of the synthesized findings.[41] The recommendations are in line with the opinions and recommendations of authors and experts who have covered the topics related to person-centered approaches,[26,31,32,73] patient participation, or patients as partners models, which are proximate concepts of patient-centered IPC. The following recommendations are made for health care professionals:

- Health care professionals should introduce themselves and their respective roles to the patients in order to i) avoid any confusion concerning the role or the function of the professional, and ii)

avoid patients feeling intimidated by the presence of a large number of professionals at their bedside. (Grade B)
- Health care professionals should adopt effective interprofessional communication (clear, respectful, without jargon) and ensure care coordination in order to avoid stressful situations as reported by the patients (feeling uncertainty about decisions, feeling out of place during interprofessional encounters, not understanding the shared information). (Grade B)
  - The interprofessional discussions held at the bedside of the patients should be adapted to patients' understanding, avoiding medical terms the patients do not understand; the communication should be tailored to the patients' levels of knowledge and expertise.
  - The interprofessional relationships should enhance a trustful and respectful atmosphere between the health care professionals.
- Health care professionals should systematically assess the expectations of patients regarding the amount and the type of information they want to receive. (Grade B)
- Health care professionals should assess patients' preferences regarding their participation in interprofessional meetings, goal setting, discharge planning, or decision-making process. (Grade B)
- Health care professionals should recognize and valorize patients' experiences and give them the opportunity and space to take part in their health care–related discussions. (Grade B)
- Health care professionals should adopt a patient-centered approach of IPC and care process, in which every health care professional values the patient as a person at every stage of the hospital stay. (Grade B)

For some patients, it is important to observe a leader in the team, while others prefer to know that the health care professionals are complementary (i.e. that there are no power relationships between the health care professionals).

Recommendations for research

Most of the findings of this qualitative systematic review are derived from English-speaking studies. Thus, the transferability of the results might be limited in countries with a different health care

policy, where patient partnership and/or participation in health care processes or collaborative processes are not widely practiced, such as in European countries. Patient participation in collaborative process depends on a set of factors: social norms,[31] health care policies, and interactional structure.[74] A deeper understanding of Swiss social norms related to patient participation in collaborative processes, patient characteristics, and patient preferences is needed. Little is known about whether health care professionals consider these factors when deciding how to include patients, and whether patients' perspectives have an impact on interprofessional processes. The following recommendation is proposed for future research:

- Additional explorative qualitative studies and mixed-method studies combining interviews with the main health care stakeholders (i.e. patients, health care professionals, and the general public) to help gain a local and European view of IPC and the implication on patients' perspectives and preferences.

Additional observations of collaborative moments at patients' bedsides or during medical meetings, discharge planning, or goal setting would help to highlight successful collaborative processes and help health care professionals to adapt these behaviors.

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Appendix I: Search strategy

Searches conducted July 26, 2017

MEDLINE (Ovid)

Search	Query	Records retrieved
#1	Patient Care Team/	60,703
#2	exp Interprofessional Relations/	64,593
#3	((doctor$1 or physician$1) adj1 nurse$1 adj2 (collaboration or communication or cooperation or relation$1 or round$1)).ab,ti,kf.	513
#4	((interprofessional or inter-professional or interdisciplinary) adj2 (care or collaboration or communication or cooperation or healthcare or management or relation$1 or round$1 or team$1)).ab,ti,kf.	11,910
#5	(team$1 adj1 (care or healthcare)).ab,ti,kf.	11,937
#6	teamwork.ab,ti,kf.	7722
#7	(((collaboration or communication or cooperation or relation$1) adj2 (provider$1 or clinician$1)) not (patient$1 adj2 (provider$1 or clinician$1))).ab,ti,kf.	2278
#8	or/1-7	137,468
#9	exp Patient Satisfaction/	78,081
#10	Patient Participation/	22,422
#11	((patient$1 or inpatient$1 or client$1 or user$1 or wom#n$1) adj3 (participation or perspective$1 or view$1 or viewpoint$1 or perception$1 or satisfaction or experience$1 or attitude$1 or role$1 or preference$1 or expectation$1 or involve$1 or involvement or engagement or dissatisfaction$1)).ab,ti,kf.	294,954
#12	or/9-11	354,810
#13	(qualitative or interview* or findings or focus group* or themes or mixed method*).mp. or exp qualitative research/	2,121,298
#14	8 and 12 and 13	2810
#15	limit 14 to yr = "1980 -Current"	**2802**
Limited to 1980-current, language limits English, French, German		

Embase

(((('doctor nurse relation'/de) OR ('teamwork'/de) OR (((doctor OR doctors OR physician OR physicians) NEAR/1 (nurse OR nurses) NEAR/2 (collaboration OR communication OR cooperation OR relation OR relations OR round OR rounds)):ab,ti) OR (((interprofessional OR 'inter professional' OR interdisciplinary) NEAR/2 (care OR collaboration OR communication OR cooperation OR healthcare OR management OR relation OR relations OR round OR rounds OR team OR teams)):ab,ti) OR (((team OR teams) NEAR/1 (care OR healthcare)):ab,ti) OR (teamwork:ab,ti) OR ((((collaboration OR communication OR cooperation OR relation OR relations) NEAR/2 (provider OR providers OR clinician OR clinicians)):ab,ti) NOT ((patient OR patient) NEAR/2 (provider OR providers OR clinician OR clinicians)):ab,ti)) AND (('patient attitude'/de) OR ('patient preference'/de) OR ('patient satisfaction'/de) OR ('patient participation'/de) OR

(((patient OR patients OR inpatient OR inpatients OR client OR clients OR user OR users OR woman* OR women*) NEAR/3 (participation OR perspective OR perspectives OR view OR views OR viewpoint OR viewpoints OR perception OR perceptions OR satisfaction OR experience OR experiences OR attitude OR attitudes OR role OR roles OR preference OR preferences OR expectation OR expectations OR involve OR involves OR involved OR involvement OR engagement OR dissatisfaction OR dissatisfactions)):ab,ti))) AND (qualitative OR interview* OR findings OR 'focus group*' OR themes OR 'mixed method*' OR 'qualitative research'/exp) AND [1980-2017]/py

Records retrieved: 2317

CINAHL Complete (EBSCO)

Search	Query
S1	MH "Multidisciplinary Care Team"
S2	MH "Interprofessional Relations+"
S3	MH "Teamwork"
S4	(doctor## or physician##) N0 nurse## N1 (collaboration or communication or cooperation or relation# or round#)
S5	(interprofessional or inter-professional or interdisciplinary) N1 (care or collaboration or communication or cooperation or healthcare or management or relation# or round# or team#)
S6	team# N0 (care or healthcare)
S7	teamwork
S8	((collaboration or communication or cooperation or relation#) N1 (provider# or clinician#)) NOT (patient# N1 (provider# or clinician#))
S9	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8
S10	(MH "Patient Attitudes")
S11	(MH "Patient Satisfaction")
S12	(MH "Consumer Participation")
S13	(patient## or inpatient## or client## or user## or woman# or women#) N2 (participation or perspective# or view# or viewpoint# or perception# or satisfaction or experience# or attitude# or role# or preference# or expectation# or involve# or involvement or engagement or dissatisfaction#)
S14	S10 OR S11 OR S12 OR S13
S15	qualitative or interview* or findings or "focus group*" or themes or "mixed method*" or MH "Qualitative Studies+"
S16	S9 AND S14 AND S15 + Limiters - Published Date: 19800101-20171231

Records retrieved: 2239

PsycINFO (OvidSP)

Search	Query
1	work teams/
2	((doctor$1 or physician$1) adj1 nurse$1 adj2 (collaboration or communication or cooperation or relation$1 or round$1)).mp.
3	((interprofessional or inter-professional or interdisciplinary) adj2 (care or collaboration or communication or cooperation or healthcare or management or relation$1 or round$1 or team$1)).mp.
4	(team$1 adj1 (care or healthcare)).mp.
5	teamwork.mp.
6	(((collaboration or communication or cooperation or relation$1) adj2 (provider$1 or clinician$1)) not (patient$1 adj2 (provider$1 or clinician$1))).mp.
7	or/1-6
8	client participation/
9	exp client attitudes/
10	((patient$1 or inpatient$1 or client$1 or user$1 or wom#n$1) adj3 (participation or perspective$1 or view$1 or viewpoint$1 or perception$1 or satisfaction or experience$1 or attitude$1 or role$1 or preference$1 or expectation$1 or involve$1 or involvement or engagement or dissatisfaction$1)).mp.
11	or/8-10
12	(qualitative or interview* or findings or focus group* or themes or mixed method*).mp. or exp qualitative research/
13	7 and 11 and 12
14	limit 13 to yr = "1980 -Current"

Records retrieved: 594

Web of Science (Clarivate Analytics)

TS = ((("doctor" or "doctors" or "doctor's" or "physician" or "physicians" or "physician's") near/0 ("nurse" or "nurses" or "nurse's") near/1 ("collaboration" or "communication" or "cooperation" or "relation" or "relations" or "round" or "rounds")) or (("nurse" or "nurses" or "nurse's") near/0 ("doctor" or "doctors" or "doctor's" or "physician" or "physicians" or "physician's") near/1 ("collaboration" or "communication" or "cooperation" or "relation" or "relations" or "round" or "rounds")) or (("collaboration" or "communication" or "cooperation" or "relation" or "relations" or "round" or "rounds") near/1 ("doctor" or "doctors" or "doctor's" or "physician" or "physicians" or "physician's") near/0 ("nurse" or "nurses" or "nurse's")) or (("collaboration" or "communication" or "cooperation" or "relation" or "relations" or "round" or "rounds") near/1 ("nurse" or "nurses" or "nurse's") near/0 ("doctor" or "doctors" or "doctor's" or "physician" or "physicians" or "physician's")) or (("interprofessional" or "inter-professional" or "interdisciplinary") near/1 ("care" or "collaboration" or "communication" or "cooperation" or "healthcare" or "management" or "relation" or "relations" or "round" or "rounds" or "team" or "teams")) or (("care" or "collaboration" or "communication" or "cooperation" or "healthcare" or "management" or "relation" or "relations" or "round" or "rounds" or "team" or "teams") near/1 ("interprofessional" or "inter-professional" or "interdisciplinary")) or (("team" or "teams") near/0 ("care"

or "healthcare")) or (("care" or "healthcare") near/0 ("team" or "teams")) or "teamwork" or ((((("collaboration" or "communication" or "cooperation" or "relation" or "relations") near/1 ("provider" or "providers" or "clinician" or "clinicians")) or (("provider" or "providers" or "clinician" or "clinicians") near/1 ("collaboration" or "communication" or "cooperation" or "relation" or "relations"))) not (((("patient" or "patients") near/1 ("provider" or "providers" or "clinician" or "clinicians")) or (("provider" or "providers" or "clinician" or "clinicians") near/1 ("patient" or "patients")))))) and

TS = (((("patient" or "patients" or "patient's" or "inpatient" or "inpatients" or "inpatient's" or "client" or "clients" or "client's" or "user" or "users" or "user's" or "woman" or "woman's" or "women" or "women's") near/2 ("participation" or "perspective" or "perspectives" or "view" or "views" or "viewpoint" or "viewpoints" or "perception" or "perceptions" or "satisfaction" or "experience" or "experiences" or "attitude" or "attitudes" or "role" or "roles" or "preference" or "preferences" or "expectation" or "expectations" or "involve" or "involves" or "involvement" or "engagement" or "dissatisfaction" or "dissatisfactions")) or (("participation" or "perspective" or "perspectives" or "view" or "views" or "views" or "viewpoint" or "viewpoints" or "perception" or "perceptions" or "satisfaction" or "experience" or "experiences" or "attitude" or "attitudes" or "role" or "roles" or "preference" or "preferences" or "expectation" or "expectations" or "involve" or "involves" or "involvement" or "engagement" or "dissatisfaction" or "dissatisfactions") near/2 ("patient" or "patients" or "patient's" or "inpatient" or "inpatients" or "inpatient's" or "client" or "clients" or "client's" or "user" or "users" or "user's" or "woman" or "woman's" or "women" or "women's")))

And

TS = ("qualitative" or "interview" or "interviews" or "findings" or "focus group" or "focus groups" or "themes" or "mixed method" or "mixed methods")

Refined by: Databases: (WOS)

Timespan = 1980-2017

Search language = Auto

Records retrieved: 2066

Sociological Abstracts (ProQuest)

((SU.EXACT("Interdisciplinary Approach") OR SU.EXACT("Interprofessional Approach") OR SU.EXACT("Teamwork") OR ALL((doctor OR physician) NEAR/1 nurse NEAR/2 (collaboration OR communication OR cooperation OR relation OR round)) OR ALL((interprofessional OR inter-professional OR interdisciplinary) NEAR/2 (care OR collaboration OR communication OR cooperation OR healthcare OR management OR relation OR round OR team)) OR ALL(team NEAR/1 (care OR healthcare)) OR ALL(teamwork) OR (ALL((collaboration OR communication OR cooperation OR relation) NEAR/2 (provider OR clinician)) NOT ALL(patient NEAR/2 (provider OR clinician)))) AND (SU.EXACT("Client Satisfaction") OR ALL((patient OR inpatient OR client OR user OR woman OR women) NEAR/3 (participation OR perspective OR view OR viewpoint OR perception OR satisfaction OR experience OR attitude OR role OR preference OR expectation OR involve OR involvement OR engagement OR dissatisfaction))) AND (SU.EXACT.EXPLODE("Qualitative Methods") OR ALL(qualitative OR interview* OR findings OR "focus group*" OR themes OR "mixed method*"))) AND pd(19800101-20171231)

Records retrieved: 103

ProQuest Dissertations & Theses A&I

(su.Exact("interdisciplinary aspects" OR "interprofessional cooperation" OR "teamwork") OR ALL((-doctor$ or physician$) near/1 nurse$ near/2 (collaboration or communication or cooperation or relation$ or

round$)) OR ALL((interprofessional or inter-professional or interdisciplinary) near/2 (care or collaboration or communication or cooperation or healthcare or management or relation$ or round$ or team$)) OR ALL(team$ near/1 (care or healthcare)) OR ALL(teamwork) OR OR (ALL((collaboration or communication or cooperation or relation$) near/2 (provider$ or clinician$)) NOT ALL(patient$ near/2 (provider$ or clinician$)))) AND (su.Exact("patient satisfaction") OR ALL((patient$ or inpatient$ or client$ or user$ or woman$ or women$) near/3 (participation or perspective$ or view$ or perception$ or satisfaction or experience$ or attitude$ or role$ or preference$ or expectation$ or involve$ or involvement or engagement or dissatisfaction$))) AND (su.Exact("qualitative research") or ALL(qualitative or interview* or findings or "focus group*" or themes or "mixed method*")) AND pd(19800101-20171231)

Records retrieved: 338

DART-Europe E-theses Portal

Search	Query	Records retrieved
# 1	interprof* AND qualitati*	29
# 2	interprof* AND interview*	42
# 3	interprof* AND findings	38
# 4	interprof* AND focus	27
# 5	interprof* AND mixed	5

Updated search conducted March 22, 2018

MEDLINE (OvidSP)

Search	Query	Records retrieved
1	Patient Care Team/	59,968
2	exp Interprofessional Relations/	64,193
3	((doctor$1 or physician$1) adj1 nurse$1 adj2 (collaboration or communication or cooperation or relation$1 or round$1)).ab,ti,kf.	515
4	((interprofessional or inter-professional or interdisciplinary) adj2 (care or collaboration or communication or cooperation or healthcare or management or relation$1 or round$1 or team$1)).ab,ti,kf.	12,409
5	(team$1 adj1 (care or healthcare)).ab,ti,kf.	12,214
6	teamwork.ab,ti,kf.	7928
7	(((collaboration or communication or cooperation or relation$1) adj2 (provider$1 or clinician$1)) not (patient$1 adj2 (provider$1 or clinician$1))).ab,ti,kf.	2310
8	or/1-7	137,051
9	exp Patient Satisfaction/	77,819
10	Patient Participation/	22,170
11	((patient$1 or inpatient$1 or client$1 or user$1 or wom#n$1) adj3 (participation or perspective$1 or view$1 or viewpoint$1 or perception$1 or satisfaction or experience$1 or attitude$1 or role$1 or preference$1 or expectation$1 or involve$1 or involvement or engagement or dissatisfaction$1)).ab,ti,kf.	297,535
12	or/9-11	356,609

(*Continued*)		
Search	Query	Records retrieved
13	(qualitative or interview* or findings or focus group* or themes or mixed method$1).mp. or exp qualitative research/	2,143,621
14	8 and 12 and 13	2835
15	limit 14 to yr = "1980 -Current"	**2828**

Embase

((('doctor nurse relation'/de) OR ('teamwork'/de) OR (((doctor OR doctors OR physician OR physicians) NEAR/1 (nurse OR nurses) NEAR/2 (collaboration OR communication OR cooperation OR relation OR relations OR round OR rounds)):ab,ti) OR (((interprofessional OR 'inter professional' OR interdisciplinary) NEAR/2 (care OR collaboration OR communication OR cooperation OR healthcare OR management OR relation OR relations OR round OR rounds OR team OR teams)):ab,ti) OR (((team OR teams) NEAR/1 (care OR healthcare)):ab,ti) OR (teamwork:ab,ti) OR ((((collaboration OR communication OR cooperation OR relation OR relations) NEAR/2 (provider OR providers OR clinician OR clinicians)):ab,ti) NOT ((patient OR patient) NEAR/2 (provider OR providers OR clinician OR clinicians)):ab,ti)) AND (('patient attitude'/de) OR ('patient preference'/de) OR ('patient satisfaction'/de) OR ('patient participation'/de) OR (((patient OR patients OR inpatient OR inpatients OR client OR clients OR user OR users OR woman* OR women*) NEAR/3 (participation OR perspective OR perspectives OR view OR views OR viewpoint OR viewpoints OR perception OR perceptions OR satisfaction OR experience OR experiences OR attitude OR attitudes OR role OR roles OR preference OR preferences OR expectation OR expectations OR involve OR involves OR involved OR involvement OR engagement OR dissatisfaction OR dissatisfactions)):ab,ti)) AND (qualitative OR interview* OR findings OR 'focus group*' OR themes OR 'mixed method*' OR 'qualitative research'/exp) AND [1980-2018]/py

Records retrieved: 2555

CINAHL Complete (EBSCO)

Search	Query
S1	MH "Multidisciplinary Care Team"
S2	MH "Interprofessional Relations+"
S3	MH "Teamwork"
S4	(doctor## or physician##) N0 nurse## N1 (collaboration or communication or cooperation or relation# or round#)
S5	(interprofessional or inter-professional or interdisciplinary) N1 (care or collaboration or communication or cooperation or healthcare or management or relation# or round# or team#)
S6	team# N0 (care or healthcare)
S7	teamwork
S8	((collaboration or communication or cooperation or relation#) N1 (provider# or clinician#)) NOT (patient# N1 (provider# or clinician#))
S9	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8
S10	(MH "Patient Attitudes")

Search	Query
(Continued)	
Search	Query
S11	(MH "Patient Satisfaction")
S12	(MH "Consumer Participation")
S13	(patient## or inpatient## or client## or user## or woman# or women#) N2 (participation or perspective# or view# or viewpoint# or perception# or satisfaction or experience# or attitude# or role# or preference# or expectation# or involve# or involvement or engagement or dissatisfaction#)
S14	S10 OR S11 OR S12 OR S13
S15	qualitative or interview* or findings or "focus group*" or themes or "mixed method*" or MH "Qualitative Studies+"
S16	S9 AND S14 AND S15 + Limiters - Published Date: 19800101-20181231

Records retrieved: 2489

PsycINFO (OvidSP)

Search	Query
1	work teams/
2	((doctor$1 or physician$1) adj1 nurse$1 adj2 (collaboration or communication or cooperation or relation$1 or round$1)).mp.
3	((interprofessional or inter-professional or interdisciplinary) adj2 (care or collaboration or communication or cooperation or healthcare or management or relation$1 or round$1 or team$1)).mp.
4	(team$1 adj1 (care or healthcare)).mp.
5	teamwork.mp.
6	(((collaboration or communication or cooperation or relation$1) adj2 (provider$1 or clinician$1)) not (patient$1 adj2 (provider$1 or clinician$1))).mp.
7	or/1-6
8	client participation/
9	exp client attitudes/
10	((patient$1 or inpatient$1 or client$1 or user$1 or wom#n$1) adj3 (participation or perspective$1 or view$1 or viewpoint$1 or perception$1 or satisfaction or experience$1 or attitude$1 or role$1 or preference$1 or expectation$1 or involve$1 or involvement or engagement or dissatisfaction$1)).mp.
11	or/8-10
12	(qualitative or interview* or findings or focus group* or themes or mixed method*).mp. or exp qualitative research/
13	7 and 11 and 12
14	limit 13 to yr = "1980 -Current"

Records retrieved: 652

Web of Science (Clarivate Analytics)

TS = ((("doctor" or "doctors" or "doctor's" or "physician" or "physicians" or "physician's") near/0 ("nurse" or "nurses" or "nurse's") near/1 ("collaboration" or "communication" or "cooperation" or "relation" or "relations" or "round" or "rounds")) or (("nurse" or "nurses" or "nurse's") near/0 ("doctor" or "doctors" or "doctor's" or "physician" or "physicians" or "physician's") near/1 ("collaboration" or "communication" or "cooperation" or "relation" or "relations" or "round" or "rounds")) or (("collaboration" or "communication" or "cooperation" or "relation" or "relations" or "round" or "rounds") near/1 ("doctor" or "doctors" or "doctor's" or "physician" or "physicians" or "physician's") near/0 ("nurse" or "nurses" or "nurse's")) or (("collaboration" or "communication" or "cooperation" or "relation" or "relations" or "round" or "rounds") near/1 ("nurse" or "nurses" or "nurse's") near/0 ("doctor" or "doctors" or "doctor's" or "physician" or "physicians" or "physician's")) or (("interprofessional" or "inter-professional" or "interdisciplinary") near/1 ("care" or "collaboration" or "communication" or "cooperation" or "healthcare" or "management" or "relation" or "relations" or "round" or "rounds" or "team" or "teams")) or (("care" or "collaboration" or "communication" or "cooperation" or "healthcare" or "management" or "relation" or "relations" or "round" or "rounds" or "team" or "teams") near/1 ("interprofessional" or "inter-professional" or "interdisciplinary")) or (("team" or "teams") near/0 ("care" or "healthcare")) or (("care" or "healthcare") near/0 ("team" or "teams")) or "teamwork" or (((("collaboration" or "communication" or "cooperation" or "relation" or "relations") near/1 ("provider" or "providers" or "clinician" or "clinicians")) or (("provider" or "providers" or "clinician" or "clinicians") near/1 ("collaboration" or "communication" or "cooperation" or "relation" or "relations"))) not (((("patient" or "patients") near/1 ("provider" or "providers" or "clinician" or "clinicians")) or (("provider" or "providers" or "clinician" or "clinicians") near/1 ("patient" or "patients")))))) and

TS = ((("patient" or "patients" or "patient's" or "inpatient" or "inpatients" or "inpatient's" or "client" or "clients" or "client's" or "user" or "users" or "user's" or "woman" or "woman's" or "women" or "women's") near/2 ("participation" or "perspective" or "perspectives" or "view" or "views" or "viewpoint" or "viewpoints" or "perception" or "perceptions" or "satisfaction" or "experience" or "experiences" or "attitude" or "attitudes" or "role" or "roles" or "preference" or "preferences" or "expectation" or "expectations" or "involve" or "involves" or "involvement" or "engagement" or "dissatisfaction" or "dissatisfactions")) or (("participation" or "perspective" or "perspectives" or "view" or "views" or "views" or "viewpoint" or "viewpoints" or "perception" or "perceptions" or "satisfaction" or "experience" or "experiences" or "attitude" or "attitudes" or "role" or "roles" or "preference" or "preferences" or "expectation" or "expectations" or "involve" or "involves" or "involvement" or "engagement" or "dissatisfaction" or "dissatisfactions") near/2 ("patient" or "patients" or "patient's" or "inpatient" or "inpatients" or "inpatient's" or "client" or "clients" or "client's" or "user" or "users" or "user's" or "woman" or "woman's" or "women" or "women's")))

And

TS = ("qualitative" or "interview" or "interviews" or "findings" or "focus group" or "focus groups" or "themes" or "mixed method" or "mixed methods")

Refined by: Databases: (WOS)

Timespan = 1980-2018

Search language = Auto

Records retrieved: 2377

Sociological Abstracts (ProQuest)

((SU.EXACT("Interdisciplinary Approach") OR SU.EXACT("Interprofessional Approach") OR SU.EX-ACT("Teamwork") OR ALL((doctor OR physician) NEAR/1 nurse NEAR/2 (collaboration OR communication OR cooperation OR relation OR round)) OR ALL((interprofessional OR inter-professional OR interdisciplinary) NEAR/2 (care OR collaboration OR communication OR cooperation OR healthcare OR management OR relation OR round OR team)) OR ALL(team NEAR/1 (care OR healthcare)) OR ALL(teamwork) OR (ALL((collaboration OR communication OR cooperation OR relation) NEAR/2 (provider OR clinician)) NOT ALL(patient NEAR/2 (provider OR clinician)))) AND (SU.EXACT("Client Satisfaction") OR ALL((patient OR inpatient OR client OR user OR woman OR women) NEAR/3 (participation OR perspective OR view OR viewpoint OR perception OR satisfaction OR experience OR attitude OR role OR preference OR expectation OR involve OR involvement OR engagement OR dissatisfaction))) AND (SU.EXACT.EXPLODE("Qualitative Methods") OR ALL(qualitative OR interview* OR findings OR "focus group*" OR themes OR "mixed method*"))) AND pd(19800101-20181231)

Records retrieved: 103

ProQuest Dissertations & Theses A&I

(su.Exact("interdisciplinary aspects" OR "interprofessional cooperation" OR "teamwork") OR ALL((-doctor$ or physician$) near/1 nurse$ near/2 (collaboration or communication or cooperation or relation$ or round$)) OR ALL((interprofessional or inter-professional or interdisciplinary) near/2 (care or collaboration or communication or cooperation or healthcare or management or relation$ or round$ or team$)) OR ALL(team$ near/1 (care or healthcare)) OR ALL(teamwork) OR OR (ALL((collaboration or communication or cooperation or relation$) near/2 (provider$ or clinician$)) NOT ALL(patient$ near/2 (provider$ or clinician$)))) AND (su.Exact("patient satisfaction") OR ALL((patient$ or inpatient$ or client$ or user$ or woman$ or women$) near/3 (participation or perspective$ or view$ or perception$ or satisfaction or experience$ or attitude$ or role$ or preference$ or expectation$ or involve$ or involvement or engagement or dissatisfaction$))) AND (su.Exact("qualitative research") or ALL(qualitative or interview* or findings or "focus group*" or themes or "mixed method*")) AND pd(19800101-20181231)

Records retrieved: 361

DART-Europe E-theses Portal

Search	Query
# 1	interprof* AND qualitati*
# 2	interprof* AND interview*
# 3	interprof* AND findings
# 4	interprof* AND focus
# 5	interprof* AND mixed

Records retrieved: 147

Appendix II: Studies ineligible following full-text review

1. McWilliam CL. From hospital to home: elderly patients' discharge experiences. Fam Med. 1992;24(6):457-68.
   Reason for exclusion: The research topic was not focused on patients' perception of interprofessional collaboration (IPC), but only on health care professionals' perceptions.

2. Barry B, Henderson A. Nature of decision-making in the terminally ill patient. Cancer Nurs. 1996;19(5):384-91.
   Reason for exclusion: The research topic was not focused on patients and interprofessional team communication, but only on patient-physician/nurse communication.

3. Otte DI. Patients' perspectives and experiences of day case surgery. J Adv Nurs. 1996;23(6):1228-37.
   Reason for exclusion: The research topic was not focused on patients and interprofessional team communication, but only on patient-physician/nurse communication and outpatient participants.

4. Unsworth C. Clients' perceptions of discharge housing decisions after stroke rehabilitation. American J Occup Ther. 1996;50(3):207-16.
   Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and their experience with the health condition.

5. Edwards D. Head and neck cancer services: views of patients, their families and professionals. Br J Oral Maxillofac Surg. 1998;36(2):99-102.
   Reason for exclusion: The research topic was not focused on patients' perception of IPC, but only on health care professionals' perception, and patients are studied only on their experience with their health condition.

6. Nemeth L, Hendricks H, Salaway T, Garcia C. Integrating the patient's perspective: patient pathway development across the enterprise. Top Health Inf Manage. 1998;19(2):79-87.
   Reason for exclusion: The research topic was not focused on patients and interprofessional team communication, but only on patient-physician/nurse communication.

7. Edwards C. A proposal that patients be considered honorary members of the healthcare team. J Clin Nurs. 2002;11(3):340-8.
   Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and their experience with the health condition.

8. Gee L, Lackey J. Service evaluation of the teenage clinic. Br J Midwifery. 2002;10(9):560-4.
   Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and their experience with the health condition.

9. Wagstaff K, Solts B. Inpatient experiences of ward rounds in acute psychiatric settings. Nurs Times. 2003;99(5):34-6.
   Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process, their experience with health condition, and the assessment of the professionals' role.

10. Bostrom B, Sandh M, Lundberg D, Fridlund B. Cancer-related pain in palliative care: patients' perceptions of pain management. J Adv Nurs. 2004;45(4):410-9.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and pain management.

11. Kimberlin C, Brushwood D, Allen W, Radson E, Wilson D. Cancer patient and caregiver experiences: communication and pain management issues. J Pain Symptom Manage. 2004;28(6):566-78.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but relatives' point of view.

12. Baker E. Working together to improve ward rounds. Clin Psy Forum. 2005(152):9-12.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but only on health care professionals perceptions.

13. Claveirole A. Listening to the voices in four Scottish adolescent mental health units: young people, their carers and the unit cultures: Napier University (United Kingdom); 2005.
    Reason for exclusion: The research topic was not focused on patients and interprofessional team communication, but only on patient-physician/nurse communication and patients' experience of their health condition.

14. Lefebvre H, Pelchat D, Swaine B, Gélinas I, Levert MJ. The experiences of individuals with a traumatic brain injury, families, physicians and health professionals regarding care provided throughout the continuum. Brain Inj. 2005;19(8):585-97.
    Reason for exclusion: The research topic was not focused on patients and interprofessional team communication, but only on patient-physician/nurse communication and health professionals' point of view.

15. Tutton EMM. Patient participation on a ward for frail older people. J Adv Nurs. 2005;50(2):143-52.
    Reason for exclusion: The research topic was not focused on patients and interprofessional team communication, but only on patient-physician/nurse communication.

16. Cavanagh S, Millar A, McLafferty E. The recognition and use of patient expertise on a unit for older people. Nurs Older People. 2007;19(8):31-7.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process.

17. Fletcher KE, Furney SL, Stern DT. Patients speak: what's really important about bedside interactions with physician teams. Teach Learn Med. 2007;19(2):120-7.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the intraprofessional team.

18. McMurray A, Johnson P, Wallis M, Patterson E, Griffiths S. General surgical patients' perspectives of the adequacy and appropriateness of discharge planning to facilitate health decision-making at home. J Clin Nurs. 2007;16(9):1602-9.
    Reason for exclusion: The research topic was not focused on IPC but on patients' discharge.

19. Oliffe J, Thorne S, Hislop TG, Armstrong EA. "Truth telling" and cultural assumptions in an era of informed consent. Fam Community Health. 2007;30(1):5-15.
    Reason for exclusion: The research topic was not focused on patients and interprofessional team communication, but only on patient-physician/nurse communication.

20. Pompeo DA, Pinto MH, Cesarino CB, de Araújo RRD, Poletti NAA. Nurses' performance on hospital discharge: patients' point of view. Acta Paul Enferm. 2007;20(3):345-50.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on nurses' performance.

21. Forbat L, Cayless S, Knighting K, Cornwell J, Kearney N. Engaging patients in health care: an empirical study of the role of engagement on attitudes and action. Patient Educ Couns. 2008;74(1):84-90.
    Reason for exclusion: The research topic was focused on patients' perspective and patients' roles, but the topic was not clear.

22. Wahlin I, Ek AC, Idvall E. Empowerment in intensive care: patient experiences compared to next of kin and staff beliefs. Intensive Crit Care Nurs. 2009;25(6):332-40.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patients' experience with their health condition.

23. Lee AV, Moriarty JP, Borgstrom C, Horwitz LI. What can we learn from patient dissatisfaction? An analysis of dissatisfying events at an academic medical center. J Hosp Med. 2010;5(9):514-20.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patient-physician/nurse communication.

24. Ringstad O. Interviewing patients and practitioners working together in teams. A multi-layered puzzle: putting the pieces together. Med Health Care Philos. 2010;13(3):193-202.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patient-physician/nurse communication and professional collaboration outcome.

25. Stajduhar KI, Thorne SE, McGuinness L, Kim-Sing C. Patient perceptions of helpful communication in the context of advanced cancer. J Clin Nurs. 2010;19(13):2039-47.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patient-physician/nurse communication.

26. Vaismoradi M, Salsali M, Turunen H, Bondas T. Patients' understandings and feelings of safety during hospitalization in Iran: a qualitative study. Nurs Health Sci. 2011;13(4):404-11.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process, patients' experience with their health condition, and patient-physician/nurse communication.

27. Walsh J, Young JM, Harrison JD, Butow PN, Solomon MJ, Masya L, *et al.* What is important in cancer care coordination? A qualitative investigation. Eur J Cancer Care. 2010;20(2):220-7.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on health care professionals' perception of IPC.

28. Groene RO, Orrego C, Sunol R, Barach P, Groene O. "It's like two worlds apart": an analysis of vulnerable patient handover practices at discharge from hospital. BMJ Qual Saf. 2012;21: i67-75.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on health care professionals' perception of IPC.

29. Mazor KM, Roblin DW, Greene SM, Lemay CA, Firneno CL, Calvi J, *et al.* Toward patient-centered cancer care: patient perceptions of problematic events, impact, and response. J Clin Oncol. 2012;30(15):1784-90.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patient-physician/nurse communication.

30. Buttigieg SC, Cassar V, Scully JW. From words to action: visibility of management in supporting interdisciplinary team working in an acute rehabilitative geriatric hospital. J Health Org Manag. 2013;27(5):618-45.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on health care professionals' perception of IPC.

31. English CAD. Ontario's Home First approach, care transitions, and the provision of care: The perspectives of Home First clients and their family caregivers. Ann Arbor: Queen's University (Canada); 2013.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patients' experience with their health condition.

32. Lariviere-Bastien D, Bell E, Majnemer A, Shevell M, Racine E. Perspectives of young adults with cerebral palsy on transitioning from pediatric to adult healthcare systems. Semin Pediatr Neurol. 2013;20(2):154-9.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patients' experience with their health condition.

33. Stephens C, Sackett N, Pierce R, Schopfer D, Schmajuk G, Moy N, *et al*. Transitional care challenges of rehospitalized veterans: listening to patients and providers. Popul Health Manag. 2013;16(5): 326-31.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patients' experience with their health condition.

34. Attanasio LB, McPherson ME, Kozhimannil KB. Positive childbirth experiences in U.S. hospitals: a mixed methods analysis. Matern Child Health J. 2014;18(5):1280-90.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patients' experience with their health condition.

35. Taylor C, Finnegan-John J, Green JS. "No decision about me without me" in the context of cancer multidisciplinary team meetings: a qualitative interview study. BMC Health Serv Res. 2014;14:488.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on health care professionals' perception of IPC.

36. Acher AW, LeCaire TJ, Hundt AS, Greenberg CC, Carayon P, Kind AJ, *et al*. Using human factors and systems engineering to evaluate readmission after complex surgery. J Am Coll Surg. 2015;221(4):810-20.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process, patients' experience with their health condition, and patient-physician/nurse communication.

37. Beaussant Y, Mathieu-Nicot F, Pazart L, Tournigand C, Daneault S, Cretin E, *et al*. Is shared decision-making vanishing at the end-of-life? A descriptive and qualitative study of advanced cancer patients' involvement in specific therapies decision-making. BMC Palliat Care. 2015;14:61.
    Reason for exclusion: The research topic was not focused on patients and interprofessional team communication, but only on patient-physician/nurse communication.

38. Bilodeau K, Dubois S, Pepin J. Interprofessional patient-centred practice in oncology teams: utopia or reality? J Interprof Care. 2015;29(2):106-12.
    Reason for exclusion: The research setting is not clear; participants could be outpatients or inpatients.

39. Mazurenko O, Zemke D, Lefforge N, Shoemaker S, Menachemi N. What determines the surgical patient experience? Exploring the patient, clinical staff, and administration perspectives. J Healthc Manag. 2015;60(5):332-46.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC or patient participation in IPC.

40. Belanger E, Rodriguez C, Groleau D, Legare F, MacDonald ME, M, *et al*. Patient participation in palliative care decisions: an ethnographic discourse analysis. Int J Qual Stud Health Well-being. 2016;11:32438.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patients' experience with their health condition and patient-physician/nurse communication.

41. Chaboyer W, McMurray A, Marshall A, Gillespie B, Roberts S, Hutchinson AM, *et al*. Patient engagement in clinical communication: an exploratory study. Scand J Caring Sci. 2016;30(3): 565-73.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patient-physician/nurse communication.

42. El-Haddad C, Damodaran A, Patrick McNeil H, Hu W. The experience of patients admitted to hospital with acute low back pain: a qualitative study. Int J Rheum Dis. 2016;29:29.
    Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on back pain management.

43. Farmer SA, Magasi S, Block P, Whelen MJ, Hansen LO, Bonow RO, *et al.* Patient, caregiver, and physician work in heart failure disease management: a qualitative study of issues that undermine wellness. Mayo Clin Proc. 2016;91(8):1056-65.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patients' experience with their health condition.

44. Garfield S, Jheeta S, Husson F, Lloyd J, Taylor A, Boucher C, *et al.* The role of hospital inpatients in supporting medication safety: a qualitative study. PLoS ONE. 2016;11(4).
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on medication management.

45. Goebel J, Valinski S, Hershey DS. Improving coordination of care among healthcare professionals and patients with diabetes and cancer. Clin J Onc Nurs. 2016;20(6):645-51.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on health care professionals' perception of IPC.

46. Ion A, Greene S, Mellor K, Kwaramba G, Smith S, Barry F, *et al.* Perinatal care experiences of mothers living with HIV in Ontario, Canada. J HIV/AIDS Social Serv. 2016;15(2):180-201.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patients' experience with their health condition and patient-physician/nurse communication.

47. Jangland E, Kitson A, Muntlin Athlin Å. Patients with acute abdominal pain describe their experiences of fundamental care across the acute care episode: a multi-stage qualitative case study. J Adv Nurs. 2016;72(4):791-801.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patients' experience with their health condition.

48. Kilpatrick K, Jabbour M, Fortin C. Processes in healthcare teams that include nurse practitioners: what do patients and families perceive to be effective? J Clin Nurs. 2016;25(5):619-30.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patients' assessment of health team effectiveness.

49. LeBlanc TW, Fish LJ, Bloom CT, El-Jawahri A, Davis DM, Locke SC, *et al.* Patient experiences of acute myeloid leukemia: a qualitative study about diagnosis, illness understanding, and treatment decision-making. Psycho Oncol. 2016;15:15.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patients' experience with their health condition and patient-physician/nurse communication.

50. Liu W, Gerdtz M, Manias E. Creating opportunities for interdisciplinary collaboration and patient-centred care: how nurses, doctors, pharmacists and patients use communication strategies when managing medications in an acute hospital setting. J Clin Nurs. 2016;25(19):2943-57.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on health care professionals' point of view.

51. Mako T, Svanang P, Bjersa K. Patients' perceptions of the meaning of good care in surgical care: a grounded theory study. BMC Nurs. 2016;15:47.
Reason for exclusion: The research topic was not focused on patients' perception of IPC.

52. Rosewilliam S, Sintler C, Pandyan AD, Skelton J, Roskell CA. Is the practice of goal-setting for patients in acute stroke care patient-centred and what factors influence this? A qualitative study. Clin Rehabil. 2015;30(5):508-19.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patient-centred care.

53. Stacey G, Felton A, Morgan A, Stickley T, Willis M, Diamond B, *et al*. A critical narrative analysis of shared decision-making in acute inpatient mental health care. J Interprof Care. 2016;30(1):35-41.
Reason for exclusion: The research population is not adult or pediatric inpatients.

54. Bahrami M, Namnabati M, Mokarian F, Oujian P, Arbon P. Information-sharing challenges between adolescents with cancer, their parents and health care providers: a qualitative study. Support Care Cancer. 2017;25(5):1587-96.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on parent-children-physician/nurse communication.

55. Cousino MK, Rea KE, Mednick LM. Understanding the healthcare communication needs of pediatric patients through the My CHATT tool: a pilot study. J Comm Healthcare. 2017;10(1):16-21.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patient-physician/nurse communication.

56. Stutzman SE, Olson DM, Greilich PE, Abdulkadir K, Rubin MA. The patient and family perioperative experience during transfer of care: a qualitative inquiry. AORN J. 2017;105(2):193-202.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the intraprofessional team.

57. Burdick K, Kara A, Ebright P, Meek J. bedside interprofessional rounding: the view from the patient's side of the bed. J Patient Exp. 2017;4(1):22-7.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the intraprofessional team.

58. Kvarnström S. Collaboration in health and social care: service user participation and teamwork in interprofessional clinical microsystems. Jönköping: School of Health Sciences; 2011.
Reason for exclusion: The research topic was not focused on patients' perception of IPC.

59. Pinelli V, Stuckey HL, Gonzalo JD. Exploring challenges in the patient's discharge process from the internal medicine service: a qualitative study of patients' and providers' perceptions. J Interprof Care. 2017;31(5):566-74.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patient-physician/nurse communication.

60. Congdon JG. Managing the incongruities: the hospital discharge experience for elderly patients, their families, and nurses. Appl Nurs Res. 1994;7(3):125-31.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on nurses' point of view.

61. Garth B, Murphy GC, Reddihough DS. Perceptions of participation: child patients with a disability in the doctor-parent-child partnership. Patient Educ Couns. 2009;74(1):45-52.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on health care professionals' point of view and patient-physician/nurse communication.

62. Malley AM, Young GJ. A qualitative study of patient and provider experiences during preoperative care transitions. J Clin Nurs. 2017;26(13):2016-24.
Reason for exclusion: Ineligible research setting.

63. Gainer RA, Curran J, Buth KJ, David JG, Legare JF, Hirsch GM. toward optimal decision making among vulnerable patients referred for cardiac surgery: a qualitative analysis of patient and provider perspectives. Med Decis Making. 2017;37(5):600-10.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but patient-physician communication and participation in decision-making.

64. Lindberg C, Sivberg B, Willman A, Fagerstrom C. A trajectory towards partnership in care–patient experiences of autonomy in intensive care: a qualitative study. Intensive Crit Care Nurs. 2015;31(5):294-302.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patients' autonomy in intensive care unit setting.

65. Benham-Hutchins M, Staggers N, Mackert M, Johnson AH, deBronkart D. "I want to know everything": a qualitative study of perspectives from patients with chronic diseases on sharing health information during hospitalization. BMC Health Serv Res. 2017;17(1):529.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patient-provider relationships.

66. Nimmon L, Backman C, Hartford W, Kherani R, Ma J, McKinnon A, *et al.* Experiences of patients with inflammatory arthritis negotiating power on their healthcare team. J Rheum. 2017;44(6):936.
Reason for exclusion: Not a qualitative or mixed-method study but a poster.

67. Bahr SJ, Siclovan DM, Opper K, Beiler J, Bobay KL, Weiss ME. Interprofessional health team communication about hospital discharge: an implementation science evaluation study. J Nurs Care Qual. 2017;32(4):285-92.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the implementation of training.

68. Granstein JH, Creutzfeldt CJ. A qualitative look at end-of-life care in the ICU. Crit Care Med. 2017;45(12):2109-10.
Reason for exclusion: Not a qualitative or mixed-method study but a poster.

69. Handel E, Bichsel-von Arb B, Stefania S, Staudacher D, Spirig R. Der Behandlungspfad als Wegweiser: Evaluation des interprofessionellen ?Behandlungspfads Brandverletzte" am Universitätsspital Zürich. Pflegewissenschaft. 2017;19(11):539-48.
Reason for exclusion: The research topic was not focused on patients' perception of IPC.

70. Karam M, Tricas-Sauras S, Darras E, Macq J. Interprofessional collaboration between general physicians and emergency department teams in Belgium: a qualitative study. Int J Integr Care (IJIC). 2017;17(4):1-16.
Reason for exclusion: The research topic was not focused on patients' perception of IPC but on patient-physician/nurse communication.

71. Ryan T, Harrison M, Gardiner C, Jones A. Challenges in building interpersonal care in organized hospital stroke units: the perspectives of stroke survivors, family caregivers and the multidisciplinary team. J Adv Nurs. 2017;73(10):2351-60.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the care process and patient-physician/nurse communication.

72. Pomey MP, Clavel N, Chiu-Neveu M. How patients-as-partners can help increase patient safety at the bedside. Int J Qual Health Care. 2016;28:38.
Reason for exclusion: Not a qualitative or mixed-method study but a poster.

73. Vaughan VC, Harrison M, Dowd A, Goonan J, Martin P. Evaluation of an interdisciplinary Cachexia and Nutrition Support Clinic–the patient and carers perspective. J Cachexia Sarcopenia Muscle. 2017;8(6):1062.
Reason for exclusion: Not a qualitative or mixed-method study but a poster.

74. Brand S, Pollock K. How is continuity of care experienced by people living with chronic kidney disease? J Clin Nurs. 2017;27(1):153-61.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on continuity care of outpatients.

75. May EA, McGill BC, Robertson EG, Anazodo A, Wakefield CE, Sansom-Daly UM. Adolescent and young adult cancer survivors' experiences of the healthcare system: a qualitative study. J Adolesc Young Adult Oncol. 2017;7(1):88-96.
Reason for exclusion: The research topic was not focused on patients' perception of IPC but on the care process.

76. Naldemirci O, Wolf A, Elam M, Lydahl D, Moore L, Britten N. Deliberate and emergent strategies for implementing person-centred care: a qualitative interview study with researchers, professionals and patients. BMC Health Serv Res. 2017;17(1):527.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the implementation of training.

77. Redley B, McTier L, Botti M, Hutchinson A, Newnham H, Campbell D, *et al.* Patient participation in inpatient ward rounds on acute inpatient medical wards: a descriptive study. BMJ Qual Saf. 2018;23:23.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the assessment of professionals' roles and outcomes.

78. Wray CM, Farnan JM, Arora VM, Meltzer DO. A qualitative analysis of patients' experience with hospitalist service handovers. J Hosp Med. 2016;11(10):675-81.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on the assessment of intraprofessional collaboration.

79. Chow SK. The value of collaborative fracture liaison service as experienced by people with osteoporosis: an exploratory focus group study. J Clin Densitom. 2018;21(1):22.
Reason for exclusion: Not a qualitative or mixed-method study but a poster.

80. Hamilton DW, Heaven B, Thomson RG, Wilson JA, Exley C. Multidisciplinary team decision-making in cancer and the absent patient: a qualitative study. BMJ Open. 2016;6(7):e012559.
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but on patient-physician/nurse communication.

81. El-Haddad C, Damodaran A, Patrick McNeil H, Hu W. The experience of patients admitted to hospital with acute low back pain: a qualitative study. Int J Rheum Dis. 2016;29:29
Reason for exclusion: The research topic was not focused on patients' perception of IPC, but only on intercollaboration into pain back.

Appendix III: Studies excluded on methodological quality

1. Beaudin CL, Lammers JC, Pedroja AT. Patient perceptions of coordinated care: the importance of organized communication in hospitals. J Healthc Qual Res. 1999;21(5): 18-23.
Reason for exclusion: Weak methodological quality; cut-off point of a minimum of five ''yes'' responses out of the 10 questions of methodological appraisal was not reached.

2. Chin GS, WarrenN, Kornman L, Cameron P. Patients' perceptions of safety and quality of maternity clinical handover. BMC Pregnancy Childbirth. 2011;11(1): 58.
Reason for exclusion: Patients' illustrations missing.

3. Holyoake D. Who's the boss? Children's perception of hospital hierarchy. Paediatr Nurs, 1999; 11(5):33.
Reason for exclusion: Patients' illustrations missing.

4. Tierney A, Worth A, Close SJ, King C, Macmillan M. Older patients' experiences of discharge from hospital. *Nurs Times*, 1994;90(21):36-39.
Reason for exclusion: Patients' illustrations missing.

Appendix IV: Characteristics of included studies

Study	Country	Data collection methods	Data analysis	Participants and setting	Phenomena of interest	Authors' conclusion
Aasen[46] (2015)	Norway	Interviews with open-ended questions	Critical discourse	11 patients all stable with renal disease, 7 next of kin, and 10 nurses Patients' age: 72-90 years Patients' gender: F = 4, M = 7 Setting: dialysis unit	Older patient participation in hemodialysis treatment decision	Participation of older patients and their next of kin was not well integrated in the social practices of hemodialysis unit
Aasen et al.[47] (2011)	Norway	Interviews with open-ended questions	Critical discourse	11 patients all stable with renal disease Age: 72-90 years Gender: F = 4, M = 7 Setting: dialysis unit	Perspective of elderly patients with hemodialysis on health decision participation	Participation of elderly patients in their treatment did not seem to be well incorporated in the social practices of hemodialysis unit
Baillie et al.[48] (2014)	United Kingdom	Semi-structured interviews Focus group interview	Thematic analysis	4 patients, 17 key staff Patients' age: 78-98 years Patients' gender: F = 3, M = 1 Setting: acute hospital wards	The care transitions of frail older people from acute hospital wards to community health care services	Boundaries between staff in different settings remained a barrier to transitions, as did capacity issues in community health care and social care.
Berkwitt and Groassman[49] (2015)	USA	Semi-structured interviews	Constant comparative method	22 participants of school-aged and adolescent inpatients Age: 7-18 years Gender: F = 10, M = 12 Setting: pediatric ward	Family-centered rounds and patients' perception	Pediatric patients prioritized themes relating to team size, physician interaction styles, content discussed, setting expectations, timing and location as the most notable elements contributing to their family-centered round experience.
Bilodeau et al.[50] (2015)	Canada	Semi-structured interviews	Content analysis	8 patients, 3 loved ones Patients' age: 23-74 years Patients' gender: F = 6, M = 2 Setting: oncology	Patient-centered practice with interprofessional oncology teams	Interprofessional patient-centered practice is variable within teams. Patients can experience breakdowns in the continuity of care and more difficult transitions between oncology continuum periods.
Conneeley et al. (2004)	United Kingdom	Semi-structured interviews	Constant comparative method	18 patients and their significant others Age: 19-61 years Gender: F = 10, M = 8. Setting: neurological rehabilitation hospital	The perceptions of patients on the collaborative goal planning	Collaborative goal planning impacts on patient motivation, increases opportunities for the involvement of relatives, improves the clarification of goals, and provides a focus for treatment. However, some challenges also emerged relating to true collaboration with certain groups of patients.

(*Continued*)						
Study	Country	Data collection methods	Data analysis	Participants and setting	Phenomena of interest	Authors' conclusion
Cotton[52] (1999)	USA	In-depth interviews Focus group interviews	Constant comparative method	56 patients, 74 health care professionals and 6 family members Patients' age: 18–98 years Gender not stated Setting: rehabilitation facilities	Interdisciplinary health care team	The patients' perspective on participation related to individual factors (e.g. age, motivation, attitude). An exchange of information between and among health care professionals and patients generated the knowledge both groups needed to engender patient participation. The joint goals of health care professionals and patients, bounded by the parameters of the patients' medical condition, directed the team activities. Patient participation was supported by the task and socioemotional behaviors of health care professionals.
Cracknell[53] (2006)	Canada	Semi-structured interviews Focus group interviews	Content analysis	8 patients Age: 44–89 years Gender: F = 4, M = 4. Setting: rehabilitation unit	Client-centered care and interdisciplinary team	The greatest variables affecting client-centered care are client and staff mindset. Client mindset is influenced by, and influences, staff mindset and approach to treatment, and these are affected by the system limitations of time and human resources.
Henry et al.[54] (2013)	USA	Semi-structured interviews Focus group interviews	Constant comparative method	25 patients and caregivers. Mean age: 48 years Gender: F = 17, M = 8. Setting: emergency department	The patient awareness of teamwork	Many patients perceived the health care team within the context of their expectations of an emergency department visit and their treatment plan. Analysis also indicated that patients viewed health care team members' interactions with each other as proxy for how team members actually felt about patients.
Hewitt et al.[55] (2015)	United Kingdom	Semi-structured interviews	Realist synthesis	50 patients and 33 carers Patient age: 29–97 years Patient gender: F = 28, M = 22 Carer age: 23–84 years Carer gender: F = 10, M = 23 Setting: acute unit, rehabilitation unit, community	Interprofessional teamwork	Participants identified several mechanisms of teamwork, but it was not a subject discussed readily. This suggests that interprofessional teamwork is not a concept that is particularly important to stroke patients and carers; they do not readily perceive any impacts of teamwork on their experiences.

		Data collection methods	Data analysis	Participants and setting	Phenomena of interest	Authors' conclusion
Study	**Country**					
Howarth et al.[56] (2011)	New Zealand	Semi-structured interviews	Thematic analysis	10 first-time mothers Age: 24–38 Setting: maternity unit	Midwives and doctors relationship from mothers' perspectives	A core theme was relationship issues. Two subthemes were delineated: lack of relationship between mothers and midwives and doctors; and the conflict between midwives and doctors.
Huby et al.[57] (2007)	United Kingdom	Observations Semi-structured interviews	Thematic analysis	22 patients and 11 staff Patient age: 60–90 years Patient gender: M = 13, F = 9 Setting: stroke unit, rehabilitation unit, and general medical ward	Decision-making and interprofessional practice	Patients' and staff's understanding of "decision-making" and their priorities for discharge were different, but patients' perspectives fragmented and became invisible. Care routines, which centered around assessments and the decisions that flowed from these, tended to exclude both staff and patients from active decision-making.
Innes et al.[58] (2016)	Australia	Semi-structured interviews Focus group interviews	Content analysis	11 interviews were conducted with patients and their carers. No additional information was stated. Setting: emergency department	Transdisciplinary care coordination team	The transdisciplinary model of care provided an essential service, where staff members were capable of delivering care across all disciplines. The ability to perform comprehensive patient assessments ensured safe discharge, with follow-up services in place.
Jarrett et al.[59] (2009)	United Kingdom	In-depth interviews	Constant comparative method	22 patients Age: 22–88 years Gender: F = 7, M = 13 Setting: 2 specialist palliative care units	Patients' experiences of IIPC	Examples of good IIPC practice described by participants are shared in this study. The involvement of patients and family/carers within IIPC and planning continuity of care is important, but the nature and extent of IIPC is not always clear to patients and family/carers.
Kroll and Neri[60] (2003)	USA	Semi-structured interviews	Mapping concept method	30 patients Mean age: 44.8 years Gender: F = 16, M = 14 Setting: mental health and rehabilitation services	Patients' experiences with care coordination	Study findings reveal few differences in the care coordination experiences among people with cerebral palsy, multiple sclerosis, or spinal cord injury in both plan types. All providers need to become more literate about the health care needs of people with physical disabilities, and health plans need to reward communication among providers and the time and effort invested in care coordination.

Study	Country	Data collection methods	Data analysis	Participants and setting	Phenomena of interest	Authors' conclusion
(*Continued*)						
Lamb et al.[61] (2014)	United Kingdom	Focus group with semi-structured interviews	Constant comparative method	21 individuals Age: 60–81 years Gender: F = 2, M = 19 Setting: oncology	The purpose of a MDT and the patients' views	Patients are positive towards MDT working, but improvements must be made regarding informing patients about the MDT and representing their interests in MDT meetings. Nurses have an important role as patient advocates and in promoting the interests of patients at MDT meetings.
Maneze et al.[62] (2014)	Australia	Semi-structured interviews	Thematic analysis	13 participants Age: 37–80 years Gender: F = 5, M = 8 Setting: Emergency department with patients with diabetes	Multidisciplinary care and chronic care model	Patients did not perceive their diabetes care as integrated. Their care appeared to be disorganized and fragmented. The patients were confused and overwhelmed by the processes involved. Personal biophysical and psychosocial issues, such as poor English language skills, transportation, socioeconomic issues, and competing priorities of comorbidities, are important barriers for patients, compounding their difficulties in participating in their health care. The poorly coordinated and "unintegrated" services made these barriers even more challenging.
Mishra et al.[63] (2016)	USA	Semi-structured interviews Observations	Thematic analysis	48 participants (14 pediatric patients; 14 adults patients; 16 parents of pediatric patients, 4 adults carers) Age: 7–16 and 20–80 years Gender: not stated Setting: children's hospital and adult hospital (medial or surgical ward)	Patient behavior and engagement in the hospital environment	Five distinct roles that patients and caregivers assume when interacting with their hospital care team are described. These roles included bedside monitor, apprentice, decision-maker, historian, and team manager.

(Continued)						
Study	**Country**	**Data collection methods**	**Data analysis**	**Participants and setting**	**Phenomena of interest**	**Authors' conclusion**
O'Driscoll et al.[64] (2014)	United Kingdom	Semi-structured interviews	Thematic analysis	20 patients Age: 33–86 years Gender: F = 7, M = 13 Setting: oncology and mental health	MDT decision-making process	The experiences of the physical health of patients interviewed were consistently very positive. By contrast, several mental health patients described uncertainty and disenchantment. Authors have highlighted the importance of facilitating a shared understanding of illness experience between patients and professionals, and suggested specific measures to help improve MDT care within mental health services.
Pellatt[65] (2007)	United Kingdom	Semi-structured interviews	Constant comparative method	12 patients Age: 16–44 years Gender: F = 5, M = 7 Setting: spinal cord injury rehabilitation	Health care professionals and patients' perception of professionals' roles	Findings suggest there is generally congruence between patients, physiotherapists, occupational therapists, and doctors about what these professionals do and how they support the rehabilitation process. There are some tensions regarding professional roles, and communication and flexibility are important in the professional/patient relationship.
Van Dongen et al.[67] (2016)	Netherlands	Semi-structured interviews Observations	Content analysis	9 patients Age: not stated Gender: F = 4, M = 5 Setting: nursing home, hospital, mental health residential care, social team, family practice	Interprofessional team meetings	Professionals and patients appreciated patient participation during team meetings. A tailored approach to patient involvement during team meetings is preferable. When considering the presence of patients in team meetings, it is recommended to pay attention to patients' willingness and ability to participate, and the necessary information shared before the meeting. Participating patients seem to appreciate support and preparation for the meeting.
Zakzesky et al.[66] (2015)	USA	Semi-structured interviews	Thematic analysis	14 participants Age: 19–91 years Gender: F = 3, M = 11 Setting: trauma unit	Multidisciplinary rounds process	Participants identified timelines and tasks, communication, social support, and motivation as helpful and medical setbacks, insurance limitations, and infrequent communication as hindrances to the discharge.

IIPC, inter- and intra-professional communication; MDT: multidisciplinary team.

Appendix V: Study findings and illustrations

Study: Aasen et al.[47] (2011)	
Finding	1. Patients felt that the health care team might have forgotten about them (**U**)
Illustration	"They probably have got tired of me after so many years. Probably, they aren't that interested anymore. It's like I've become a piece of furniture." p.65
Finding	2. Unbalanced power between health care team knowledge and patient knowledge (**U**)
Illustration	"I want more information…. Nurses do not tell me anything, other than the blood percentage…. They could talk more about the illness and how it develops" (P 5) p.65
Finding	3. The health care team's power and dominance: one-way communication (**U**)
Illustration	"One would think that it had to be in their interest to know what we think, and maybe we could get some indications about how they think … to have a little bit of communication then." … [Researcher's question] "No … oh no … oh no … no, it is much one-way communication. … I haven't experienced being asked about what we feel about different things—no." p.64
Finding	4. Struggling for shared decision-making (**U**)
Illustration	"No, no, it's decided for us…. Yes because I think I have naturally gained a little weight so that my dry weight ought to be increased a little bit, but it's not easy to get approval for that…. No, no, no. I just do what they say." p.66
Finding	5. Patients felt they were bounded and had no freedom (**U**)
Illustration	"It is mostly a mental strain…. If one could use an ugly word like that." p.64
Finding	6. The health care team's power and dominance: Being in prison: no freedom (**NS**)
Illustration	"We get a contact person. I call them guardians… and they don't walk. It's more like a race walking." p.64
Study: Aasen[46] (2015)	
Finding	7. Power and paternalistic discourse: feeling obligated to act passively and trusting the health care team (**U**)
Illustration	"If you begin dialysis, then you should listen to the staff who talk to you because they know what they are doing. Even if we want to decide what should happen, it doesn't mean that we could… I don't know, but I started trusting the ones who were treating me." p.345
Study: Baillie et al.[48] (2014)	
Finding	8. Lack of involvement in care transition (**U**)
Illustration	"My point of view wasn't even asked for. I wasn't aware of anyone planning my discharge." p.7

Study: Berkwitt and Grossman[49] (2015)	
Finding	9. Providers working in a collaborative fashion to fix their problem (U)
Illustration	"I had 4 doctors, and they were bouncing ideas off each other and thinking of the best way to help me. I felt comfortable because I knew that these doctors were going to find the best course of action." p.359
Finding	10. The bigger team added to overall efficiency and coordination by limiting repetition (U)
Illustration	"One doctor at a time is slow and you have to explain your story to each of them. This is much more efficient." p.359
Finding	11. Feeling anxious and uncomfortable (U)
Illustration	"When they asked questions I had to address all of them, so that can get a little intimidating." p.359
Finding	12. Type of relationships established by medical team (U)
Illustration	"It was at first kind of weird, because 8 other people came in, and they were surrounding my bed. It wasn't bad because they introduced themselves and they were really friendly." p.359
Finding	13. Feeling on display for medical team (U)
Illustration	"I felt like I was on Grey's Anatomy. They had all doctors come in and observe me like I was a specimen. It was awkward because they were staring at me." p.359
Finding	14. Anxiety and fear when they did not understand what a physician was saying (U)
Illustration	"It was a little scary, because some of the things I didn't really understand." "For some of big words that kids won't understand, they should describe the word or ask the kids if they know what the words mean." p.359
Finding	15. Expectations for FCR [family centered rounds] (NS)
Illustration	"I don't know much about why all those people came into my room. It seemed like only 2 or 3 people were talking, but there was like 12 people in here." p.360
Study: Bilodeau et al.[50] (2015)	
Finding	16. No choice but to accept the treatment if they wanted to survive (U)
Illustration	"There was not really any decision to be made by me(…) it was prompted [by prof]: you're going to get chemo, you're going to get radiation therapy." p.33
Finding	17. The team worked in synergy (U)
Illustration	"You can see there's communication, because, at times, they talk to you about Something that's probably none of their business (…) but they know about it (…) I find this reassuring." p.33
Finding	18. Patients felt they had been left hanging (U)

Illustration	"It took time before I asked the question [about when I was going to die] and I feared the answer. But I was not told (…) what my life expectancy was. I did not know if I was buying myself a few more years (…) because we don't know how long I am going to take it [the treatment] (…) what is next? (…) what are the signs that it [the cancer] is coming back or not coming back?" p.34

Study: Conneeley[51] (2004)

Finding	19. To experience more control of their treatment (U)
Illustration	"It helped me understand what I'd got to set out and do, the things they really wanted me to do, it gave me my goals, it just gave me the freedom to say I wanted to do things, that freedom to think I was making decisions in my own right" p.251
Finding	20. Active involvement in goal setting [shortfalls in system] (U)
Illustration	"Goals have always been important to me and that was one thing that motivated me when I came here, having goals and knowing which direction I was going in, but not to have them set did disappoint me. I felt people didn't really know what I was aiming for and maybe we were working along different paths" p.252
Finding	21. Setting goals that are realistic involves knowledge and understanding of the condition (U)
Illustration	"Goal planning was done at such an early stage, and everyone was saying, you're doing so well, I never thought I wouldn't make a complete recovery. So in terms of the goals you can set yourself, perhaps you are unrealistic, but that's only because of your lack of knowledge." p.253

Study: Cotton[52] (1999)

Finding	22. Patients were included as team members (U)
Illustration	"Yeah, I do feel that we [patients] are part of the rehab team." p.75
Finding	23. Patients felt their inclusion was implicit through the attitude of the health care providers (U)
Illustration	"I would say just the general attitude probably, not really saying or doing. You just feel included" p.77
Finding	24. Professionals were interested in them as a person (U)
Illustration	"They treat you like a person. They respected me. They asked me what my goals and expectations are and seemed to care if I was tired." p.80
Finding	25. The effect of patient personality on the degree of active or passive participation (C)
Illustration	"I did go against some of the doctors and go ahead with my surgery because I was practically, well, I was a cripple. I couldn't move. It was bad. And I wanted to do better… Then when I came here, they asked me what my goal was, and I told them mostly to take care of myself and go and enjoy other things" p.82
Finding	26. The reciprocal effect of the positive or negative attitude of health care professional or patient on the other's attitude and on patient participation (C)

Illustration	"There's no real need to bite their [HCP] head off, but if they come in with a snobbish attitude from the day one, then you're going to have one right back at them. So as long as they treat you like a human being instead of a slab of meat… But if they come in all glum and say, 'Well, we could do this and it may work', why am I going to get all excited about it? It's just going to make me feel worse." p.87
Finding	27. Patient had control over their participation (C)
Illustration	"This was definitely my decision. I could either go home and wait a few days, or I could go to rehab, whatever was my choice. I felt I would be safer and better cared for if I came to rehab." p.91
Finding	28. Information given by health care professionals (U)
Illustration	"They talked to me about my condition and gave me some pretty clear-cut information about things that happened to people who had this condition, what the statistics were and what could happen." p.115
Finding	29. Responsibility for information sharing was a joint responsibility (U)
Illustration	"I think it is a combination, but I do feel it depends on the individual. You really need to make the staff aware of the fact that you want to be informed. I don't think that you should have to just dig for all of your information… but on the other hand, if you don't ask you might never find out." p.108;
Finding	30. Goals developed on information from patient and on the parameters of the patient's medical condition (U)
Illustration	"With me it wasn't an issue of trying to decide what my goals are because I already knew. I think I was pretty open and knew pretty much what I would like to see done and I expressed that to my team of doctors and therapists and they put a plan together for me so that I could obtain those goals" p.116
Finding	31. Patient-centered approach in which patients were involved (U)
Illustration	"What I mean by that is that the rehab process is rehabilitating the whole person: whatever is broken physically and whatever, is hurt emotionally. I really think the rehab people, the PTs and OTs, the physical doctors and nurses, work toward putting Humpty Dumpty back together again" p.135
Finding	32. The [health care professionals] need to avoid jargon and to simplify what they said (U)
Illustration	"They use language we can understand. I'm not saying they revert to where we are, no, but talk in language where we can understand to tell us what they want us to do or how to perform. It is more, I guess we could say, patient's language." p.160
Finding	33. Information exchange in acute care vs rehab facilities (NS)
Illustration	"I would have much preferred it if they would have told me that, 'I'm not sure exactly what this procedure is going to do to you.'" p.106
Study: Cracknell[53] (2006)	
Finding	34. Positive attitude/mindset will garner more favorable responses from the staff members (U)

Illustration	"I never complain very much about anything… I was a good patient…. I think if you complain you don't get the same care and if you treat them well, they'll treat you well…. I would have been sort of tactful about it cause you know, because it doesn't get you anywhere if you scream and yell and rant and rave but if you say it nicely you know it works, it helps." p.78
Finding	35. If a person wants to progress and improve then it is up to that individual to help themselves (**U**)
Illustration	"I just made myself learn very quickly because I was so determined I was going to get better" and "I was looking for more, I wanted to do more. I wanted to be more active in my recovery." p.78
Finding	36. Client power is closely link to personality, attitude, and mindset (**C**)
Illustration	"I hated a lot of things because I didn't have control." p.81
Finding	37. The less informed clients were regarding their condition, the more out of control they felt (**U**)
Illustration	"As long as I know what it is that has happened, is happening, or is going to happen, I'm in control of myself. It's when I'm being dangled at the end of that string without being given any specific information, I never did appreciate it, no." p.87
Finding	38. They felt they were not being listened to (**U**)
Illustration	"I couldn't get mad without crying and no one was listening." p.87
Finding	39. The staff member "dictated" what he was to do (**U**)
Illustration	"I was told that this is what you will do and that… I participated in it not knowing myself exactly why we were doing what we were doing but thinking that since you people knew what you were doing I was going to go along with it." p.88
Finding	40. Trust in staff members' expertise and experience (**U**)
Illustration	"Physiotherapy-wise, I mean, I was going in and getting, getting work every day and I didn't know any better of what to expect so I definitely just trusted the staff there that they knew what they were doing… and I needed guidance to do that because I didn't know, you know, what is the… what to do. How I could get back on my feet. Whether I would even get back on my feet." p.90
Finding	41. The meetings round as it stands now; every team member present, except the client (**U**)
Illustration	"Some type of informal meeting perhaps once a week, or every other week, where all of the team members got together, including the patient, to talk about: what had happened and what the diagnosis was; what the projected outcomes were; how things were progressing, were there any problems. It would have been useful. I got the feeling that meetings like that were happening but without me being there." p.104
Finding	42. The staff did not always have the knowledge the client felt they should (**U**)
Illustration	"I don't think (he/she) understood the injury." p.98
Finding	43. No communication: perception of client (**NS**)

Illustration	"It was early in my treatment and I suspect they didn't recall the fractured shoulder, or it was not on the care plan." p.93
Study: Henry et al.[54] (2013)	
Finding	44. Team communication occurred with directly witnessing it (U)
Illustration	"I saw the charge nurse talk to the attending physician maybe a few seconds about the assessment and outside the patient room, the nurses seem like they hang with each other and talk to each other and the attending physicians and the students, they are in their own little group." p.707
Finding	45. Team communication occurred without directly witnessing it (U)
Illustration	"So, the communication piece, that didn't happen, like when somebody leaves room they don't tell the next person what they have done." p.707
Finding	46. Patients had strong opinions on how to improve teamwork behaviors (U)
Illustration	"Instead of having each individual come in and ask you the same thing if they would just communicate it would be a lot easier… Teamwork if done properly creates far more efficiency that it seemed to be done." p.707
Finding	47. Gaps in coordination and communication (U)
Illustration	"I was actually there for 5h… I maybe saw someone three times in that 5h period… I got my X-rays and no one really came in to tell me anything about it until about an hour and a half to 2 h later… That I thought was kind of bizarre…. I thought that was unreasonable." p.709 Table 3
Finding	48. Team behaviors relate to patients' views of team effectiveness (U)
Illustration	"From my experience, they all seemed really in step with each other. They were all very friendly with each other. They seemed to communicate really well, knew each other very well." p.710 Table 3
Finding	49. Team processes do concern patients (U)
Illustration	"If the information is in the computer then, why do they ask us? There is no method for them to communicate the information to their team member" p.709 Table 3
Study: Hewitt et al.[55] (2015)	
Finding	50. It is not obvious which professionals staff belonged to (C)
Illustration	"It seems to be there's so many people, you know… somebody is going to teach me how to cope and somebody is going to do the therapy and yes, it just seems to be a lot of people" p.335
Finding	51. Efficient, open, and equitable health team communication (U)
Illustration	"Obviously [the therapists] communicated with the nurses on the ward because they all knew that I could get up and go to the loo and use the stick." p.335
Finding	52. Collaboration and coordination (U)

Illustration	"[The physiotherapist and OT] spoke to each other about what they were going to do and then they sort of demonstrated to each other with me which was brilliant really." p.336
Study: Howarth,[56] 2012	
Finding	53. In the middle of conflict between their midwives and doctors (U)
Illustration	"It was just a, a very horrible, stressful situation where I was in labour… and, and this complete conflict of advice… and it was just a lot of pressure, you know, a very stressful situation at a stressful time." p.492
Finding	54. Lack of relationship with doctors (**NS**)
Illustration	"I would just feel like the co-ordination, and it just worries… there is a risk there that something is going to happen… 'Does anyone really know what's [happening]?'" p.491
Study: Huby et al.[57] (2007)	
Finding	55. Trust in the recommendation and advice of staff (U)
Illustration	"Well again any decisions and that they make it's in my interest, my best interests so, ken [you know] what I mean, I don't interfere wi' [with] anything like, ken what I mean? Whatever decisions they make they're making it in my best interest, so I just leave it." p.59
Finding	56. Lack of ability to take part in decision-making (U)
Illustration	"Well, I don't know actually if the decisions, if I have decisions that other people are making for me I can't compete on it. You see, you can't say no, no, no, you're not doing that. But you see if it was decisions that belong to you… I couldn't do it." p.62
Study: Innes et al.[58] (2016)	
Finding	57. Decisions made by members of transdisciplinary team were respected by all ED staff (U)
Illustration	"I was most impressed. They [doctor and the transdisciplinary team] came in together several times. They were very thorough and showed wonderful co-operation. We felt we were getting exactly what the doctor wanted." p.29
Finding	58. Sufficient time to communicate (U)
Illustration	"took such time and care in explaining, it made us feel as if we were private patient." p.29
Study: Jarrett[59] (2009)	
Finding	59. Problems with IIPC: sometimes patients were unclear about the nature and extent of any communication between the different professionals (U)
Illustration	"I don't know if they do [communicate], that's a bit like this starting business I think I tend to think that they work in parallel rather than together, but I'm not sure about that you know because I've no, no need I suppose to look at that side of things." p.56
Study: Kroll and Neri[60] (2003)	
Finding	60. A lack of disability-specific knowledge and understanding (U)
Illustration	"Especially in the area of cerebral palsy… That's mighty scary and to double that fear, the medical professional doesn't know what to do with us…. What do we believe? Who do we believe?" p.1110

Finding	61. Providers did not invest enough time and effort to coordinate their care (**U**)
Illustration	"I don't see where he or she [providers] would have the time or the caring to really do a good job [coordinating care]." p.1111
Finding	62. Lack of communication among different providers (**U**)
Illustration	"One is doing their thing and the other one is doing theirs, and there's no communication between them about what's going on... but they don't follow-up... there's no-cross communication between them about what's going on." p.1111
Study: Lamb et al.[61] (2014)	
Finding	63. Initially not aware of MDT (**C**)
Illustration	"Felt like a parcel being handed carefully along from one person to the other." Table 1
Finding	64. Awareness of teamwork (**U**)
Illustration	"I just assumed that these links exist, but I didn't know they existed formally, and I don't think we were ever told as patients that there is an MDT team discussion." Table 1
Finding	65. Experience with comorbidities not being taken in account (**C**)
Illustration	"I had recent inguinal hernia operation, and there was a large mesh in the way. I didn't find out until the last minute that they had not realized I had a mesh. I was told, 'Well, you can't have surgery now.' I kept telling them, and nobody seemed to take it into account." Table 2
Finding	66. Experience of being asked about social factors (**U**)
Illustration	"I was never asked about family or anything else." Table 2
Finding	67. Patient can contribute to meetings (**U**)
Illustration	"The patient can actually add in value to the discussion, not just tick the box." Table 3
Finding	68. Concerned that presence would disrupt discussion (**U**)
Illustration	"My problem is if I'm sitting there, and I am putting professionals off frank discussion." Table 3
Finding	69. Surgeons dominating meetings (**C**)
Illustration	"That's a worry, and I think it probably does happen in some places where the surgeon is the prima donna, and it's not worth upsetting them or whatever." Table 3
Finding	70. Communication important (**C**)
Illustration	"Keep me informed and do what you have to do." Table 4
Finding	71. Amount of choice should be tailored to patient (**U**)
Illustration	"It's part of the assessment whether the patient is going to be stressed out by being offered choice." Table 4
Finding	72. Nurses easy to talk to (**U**)

Illustration	"Nurse is person in whole NHS I sit down and actually talk to. I get the impression that surgeons are busy and clock watching. Nurses give the impression of having more time." Table 4
Finding	73. Experience of sufficient time to decide (**U**)
Illustration	"I was given three options and told go away and think about it. I made my mind up and went back some time later and said this is what I want." Table 4
Finding	74. Effect of certainty of MDT on trust (**U**)
Illustration	"And if the MDT says, 'We're all absolutely certain that now's the time for surgery,' for example, then I would probably go along with it because they've obviously come to an informed decision." Table 5
Finding	75. Would rather be given choice of treatments (**U**)
Illustration	"I'm not taking the drug to which I am entitled; I chose not to take it, at the moment, anyway. I don't want the side effects, and I discussed it with the oncologist and the surgeon and the radiologist…they gave me that choice." Table 5
Study: Maneze et al.[62] **(2014)**	
Finding	76. Views of MDT care (**U**)
Illustration	"If there are more experts taking care of my diabetes like it is in the hospital and they do things on a big scale, then my diabetes will improve." p. 22
Finding	77. Many felt overwhelmed by the amount of information (**C**)
Illustration	"I was taught about diabetes by the nurses when I was diagnosed but I could not remember what she taught me, it was one session when I was in the hospital. So many health people visited me, I don't know who." p.22
Study: Mishra et al.[63] **(2016)**	
Finding	78. Not keeping track of what was going on with their care (**C**)
Illustration	"I can't even tell you what medicines I'm on, I just don't know." (A11) p.6
Finding	79. Patient played a decision-maker role (**U**)
Illustration	"They are the doctors and stuff, but I am actually the one that's sick, so I want to have a role in it." (Y11 age 12) p.8
Finding	80. The role of historian and act as backup information repository for clinicians (**U**)
Illustration	"Like the heparin shot, I wish I would have known I was going to get that this morning, I would have told her… and they were like well, it was a mistake, he wasn't supposed to get it." (A11) p. 10
Finding	81. Patients acted as team managers (**U**)
Illustration	"Having people work for you who are not straightforward with you is not really good. You've got to manage your team. If you don't manage your team, it can backfire real quickly. You can't have a loose cannon out there." (A01) p.11

Finding	82. Ceding control (**U**)
Illustration	"…felt it was time to, like they say, put the cotton in your mouth and open the ears…. I thought it was time to listen to others." (A02) p.12
Finding	83. Clinicians ignore her [patient] medical concerns (**U**)
Illustration	"At the risk of being a total cat here, it really didn't seem like it was being taken very seriously in [place], to be perfectly honest. They were just kind of treating me like a pill chaser and sending me back out the door when I would show up at the emergency room…" (A13) p.15
Finding	84. Engagement influenced by relationship with clinicians (**NS**)
Illustration	"I usually think about it. …is it that important to bother them? Or something that worries me, then I want to ask them and try to be polite as possible. If they look like they're too busy, they're walking fast or they're behind, I don't ask." (A03) p.13
Study: O'Driscoll et al.[64] (2014)	
Finding	85. Confidence in the expertise underlying the MDT's decision-making (**U**)
Illustration	"I have always had absolute, absolute faith in the doctors I met… they obviously knew what they were doing. They obviously ran their place well… I never felt that I needed a, a second opinion on anything." p.5
Finding	86. Belief in the primacy of expert opinion and readiness to defer to the MDT's advice (**U**)
Illustration	"They're the experts, they know what is, what will produce the best outcome and producing the best outcome is the most important thing rather than, erm, doing what will please me most as it were, well not please me most but you know will fit in with my things best." p.5
Finding	87. Most patient's understanding of medical terminology would be insufficient (**U**)
Illustration	"I wouldn't really know what they're talking about… so it would be 100% a waste of time." p.6
Finding	88. Uncertainty minimized by effective communication, clarity, and consistency of care (**C**)
Illustration	"There was um a real sort of clarity and consistency… most of the time I'm talking to [Specialist Registrar]… if I get some sort of more like day to day things, that's not being addressed then maybe I go to [Specialist Nurse] and at the end of the day you know, on the whole big scale sort of you know guiding my care was [Consultant Haematologist]… there was a clear chain of command…" p.7
Finding	89. Sense of autonomy enhanced by the MDT's promotion of patient collaboration in decision-making (**C**)
Illustration	"I have been very impressed by the team at the [name of hospital] and in, in them getting me involved in the process, erm, you know, I've never felt that I've been pushed into doing something they've always given me time, they've always discussed it." p.7–8
Finding	90. Contentment with decision-making processes and preference not to attend MDT meetings (**U**)

Illustration	"I don't think that I would want to or would want anybody else [friend or family member] to erm, sort of get involved [in the MDT meeting]… if the Doctors want to have a meeting in private then that's fair enough… if they discuss something and they find something out, I'm sure somewhere along the line they will inform me." p.6
Finding	91. Trust in MDT: confidence and belief (quality of care) (**NS**)
Illustration	"I think if I was, which I'm not, a multi-millionaire, I don't think I'd want to go anywhere else you know er to be seen and treated." p.5
Finding	92. Empowerment: uncertainty minimized by effective communication (**NS**)
Illustration	"Before you start to have these procedures done… they get a heart failure nurse to come in to see you to explain erm what the procedure is, erm how invasive it is, how long you'll be in Hospital, erm how long the recovery time is and it tells you how it will or will not improve er your state of erm, of life…I think having these heart failure nurses coming round and explaining things to you, I think is a great idea." p.7
Finding	93. Disenchantment: MDT's decision-making (diagnosis) (**NS**)
Illustration	"I've been told that I've got Borderline Personality Disorder, but I've never ever sat down with someone and done a proper assessment which like has gone through diagnostic criteria or whatever… when I read the criteria myself I'm like I don't think I fit." p.8
Study: Pellatt[65] (2007)	
Finding	94. A role as coordinating and supervising the work of other members of the team (**U**)
Illustration	"There's got to be someone in charge of all the nurses and in charge of all the medical side." p.172
Finding	95. They collaborate with her [the patient] and other professionals in a team effort (**U**)
Illustration	"We all work together to get to a certain goal, but it's like they work for me, help me to get to that point" p.172
Finding	96. Communication (**NS**)
Illustration	"The doctors do what the consultants do which is to be standoffish and give very vague answers to your question in a rather imperial manner" p.173
Study: Van Dongen et al.[67] (2016)	
Finding	97. Group composition at the meeting (**NS**)
Illustration	"… there are so many people staring at me." p.728
Study: Zakzesky et al.[66] (2015)	
Finding	98. Interactions increased patient knowledge about timelines and expectations for discharge (**U**)
Illustration	"So, every morning they had their agenda. The first morning when they came in before the operation, they told me all about the operation…. They said we think this is going to happen today, but we would like for you to have a bowel movement." p.235

Finding	99. Frequent communication with health care team (U)
Illustration	"It was a very clear, simple discussion about me moving on and hopefully discharge to the next level of my health care… So, they were all in the loop of communication with me getting into the rehabilitation centre, each providing for me and caring for me." p.235
Finding	100. When communication was not frequent, participants express frustration (U)
Illustration	"Initially, when I first got here it was like here is a list of names of places…and all that conversation kinda dropped off. And again, that was a couple of weeks ago where they were going to move me right away and it's like well, we need a decision right away. And then it's kind of like all that other conversation kinda just dropped out…And like I was saying there was all the sudden conversations about where do you want to go but without any time frames for decision making until it was like, it looks like you are ready to move today…" p.237

ED, emergency department; IIPC, inter- and intraprofessional communication; MDT, multidisciplinary team; NHS, National Health Service.