Whanau meetings in the hospital: Uncovering the unique role of social workers

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Abstract

Social workers in health care settings frequently play a major role in working with patients, families and other health professionals to utilise family meetings to improve communication and outcomes. This article describes a quality related project undertaken by a group of hospital social workers to explore effective social work practice in family meetings. The study identifies five essential practice activities as significant in supporting effective whanau meeting practice.

Introduction

An opportunity to research the whanau meeting, as utilised in hospital settings, whilst firmly situated within this multidisciplinary context, provided an attractive option for a group of social workers. We suspected that this was an area of multidisciplinary health practice in which health social workers had a particular and unique contribution to make. 'Growing Research In Practice' (Fouché , Lunt & Yates, 2007; Lunt, Fouché & Yates, 2008), an initiative aimed at increasing social workers' capacity to research our practice, gave us the opportunity to focus our research attention on whanau meetings in the health environment. As a group of ethnically diverse social work researchers, it was this unique contribution to the whanau meeting endeavour that this quality initiative aimed to discover. This article will describe the research process and the discoveries we made, which we conceptualise as *The Five P's and the X-Factor*. Having been identified as critical components of effective whanau meeting practice, *Purpose, Preparation, Planning, Process* and *Power* provide a practice framework to support social work activity in this central area of hospital social work. Concluding with a discussion of the findings in the context of local literature and overseas research, we articulate the connection between this area of hospital social work practice and the opportunity to reduce health inequalities by greater engagement of the whanau on the margins.

Whanau meeting defined

In a rare social work article devoted to whanau meeting practice, Hansen, Cornish & Kaysar describe whanau meetings as important locations for decision making in hospital settings. We cite their definition of a whanau meeting:

> …a meeting which involves a number of family members, the patient and hospital personnel in discussions concerning the patient's illness, treatment and plans for their discharge or their care outside the hospital (Hansen, Cornish & Kaysar, 1998, p. 58).

This definition is satisfactory but requires the incorporation of critical decision making as it relates to end-of-life discussions and the use of meetings of family members and health professionals. For the remainder of this article , we have chosen to use the term whanau rather than family, or family/whanau for three reasons, firstly as an acknowledgement to Maori as Tangata Whenua in Aotearoa; secondly as a reflection of the widespread understanding and acceptance of its use in Aotearoa as a term to include all significant people in the life of a client, and finally for ease. We chose to describe Aotearoa New Zealand as Aotearoa for similar reasons; by way of an acknowledgement to Maori, and for ease.

Research question and process

As health social workers in the hospital environment we are the discipline which maintains a primary focus and interest on the patient within the context of their whanau. We sense that, as social workers, we are the profession in the multidisciplinary team who are most likely to call whanau together, to provide a collective opportunity to discuss the important aspects of the patient's situation. As is described in the literature (Beder, 2006) we aim to provide an effective link between the whanau and the wider multidisciplinary team. Therefore it seemed appropriate that we should ask whanau what they considered effective practice to be in these meetings, what was it that made the difference for them? As beginning researchers, however, the requirement to go through a complex ethics application precluded this option, and we therefore made the decision to rely on other sources of data. Health and disability ethics committees provide protection for participants in research in the health and disability sector (Ministry of Health, 2007). The preparation of an application requires a lengthy period of consultation, detailed planning and consent gathering. After careful consideration we estimated a six-month lead-in time to prepare a MOH ethics application and were unable to commit the time and resources to this activity. We discussed the project with our hospital board research office and decided to undertake a quality related project with our multidisciplinary colleagues which enabled us to undertake a series of focus groups without the requirement to undertake an ethics application.

We explored a number of possible questions and after lengthy deliberations settled on the question: *How would you describe effective social work practice in a whanau meeting in an acute hospital setting?* This research question emerged as we engaged in a particular type of listening, sharing and storytelling that is not always possible in an acute and busy environment. We were guided by two important concepts, those of reflexivity and collaborative inquiry (Savin-Baden, 2004). Savin-Baden invites researchers to recognise the influence of our identity not only on the people and context in which we are working, but also on our research activity. In doing so, she encourages researchers to disclose our value base, work with our research partners collaboratively, and take time to share perspectives, whilst undertaking research. Supporting the value of this reflexivity, de Souza (2004) maintains that researchers have an essential role in influencing the research encounter through various means, including the theories we take up; equally importantly are our personal and cultural frameworks. de Souza poses the question 'how do we faithfully represent the voices of the researched', and, citing Lamb (1989), she 'suggests that a process of critical thinking

using reflexivity can be utilised to consider the reciprocal influence of the researcher and the researched' (de Souza, 2004, p. 473).

We recognised the value of this experience and the idea to engage both our social work and medical colleagues in a similar reflective process was born. It was important for us to ensure that our research methodology was able to take account of, and reflect, our different world views. These world views are most easily described as being those of Maori, Pacifica and Pakeha social work practitioners and researchers, with a collective practice wisdom informed by 80 years of social work experience. Whilst valuing these inherent differences in world view, and the likely impact they would have on our social work practice connected to whanau meetings, we also wanted to identify if any of the social work practices we uncovered reflected a universal approach.

How did this reflexivity manifest in our research practice? Firstly, we understood that there was a risk that some voices would be heard above others and took active steps to try and mitigate this risk. This began with the knowledge that our beginning point was to get to know each other, to tell stories of early whanau life, to eat together, to hear what research actually meant to one another. Over time we went on to name and explore the important perspectives to include and capture in our research. We also identified the methods of inquiry that would best support the bringing forward of social work knowledge which reflected the diversity of the profession and the diversity of worldviews which we collectively valued. This relationship building could be called by many names; however, what we knew instinctively was that in order for the voices on the margins to be heard, the beginning point was to nurture and privilege the development of a culture that would form a solid relational foundation required for a collaborative research endeavour.

Given that the research team was made up of Maori and Samoan, men and women, heterosexual and lesbian, practitioner and professional leader we had some complex power relationships which required careful attention. In the forward to their book whilst exploring accounts of decolonising research practices, Mutua & Swadener (2004) discuss the issue of silence and powerfully quote Adrienne Rich;

> Where language and naming are power, silence is oppression, is violence (p. x).

It was this silence we aimed to avoid. We understood that in order for some voices to be heard, others needed to be quiet, to pause, to inquire, to wonder about meaning, to ask questions, to wait and to listen.

Research methods and design

According to Gibbs (2001) the importance of adopting a culturally appropriate research methodology is one of a number of conceptual issues that arise when undertaking cross-cultural collaborative research. What this meant for us was to start with a methodology and design that were not only likely to support our ethical and heart-felt commitment to bring forward those voices that are at risk of being excluded from research activity, but also to sustain ourselves as beginning researchers. Whatever we did, *we needed to be able* to do it! It needed to be a process that was meaningful to us, that provided a real opportunity *for all of us* to participate. Critically we needed to engage in research practices that were more likely to attract a diversity of participants to the study. We knew reasonably well what western

models of whanau meeting practice looked like; the significant gap in the literature was those meeting processes that related specifically to Maori and Pacific social work practice. In considering the design we maintained a focus on a series of questions similar to these:

What will make it more possible for this research to uncover the practice of a diverse group of social workers? How do we ensure that it will not be dominated by Pakeha voices but rather reflect a variety of worldviews? What do we need to do as researchers to have it speak of this land, and our people? How do we make sure the research will be able to help identify, name and describe the important elements of what we do, as social workers in this hospital?

These questions helped us to settle on a qualitative research design which was made up of distinct, but linked data collection and data analysis processes. Social work research, by its very nature:

...seeks to increase understanding of processes, meanings and actors' definitions within complex, open-ended domains, and this is often more naturally suited to the fine-grained qualitative inquiry (Shaw & Gould, 2001, p. 10).

Our fine-grained inquiry was constructed around the following steps, described in Table 1.

Table one. Steps in the research process.

Steps in the research process	Key tasks
Step 1 - Critical reflection	Critical reflection, brainstorm, story-telling and rich descriptions of our own experience of whanau meeting practices. This allowed our own practice wisdom to be situated within the research.
Step 2 - Searching the literature	Searching the literature and critically reviewing articles which we identified as potentially influential and relevant to our own study.
Step 3 - Thematic analysis (I)	Thematic analysis of the literature, and the practice wisdom data, recognising that what 'stood out' for us in the literature reflected and reinforced some of our own practice experience and what was 'silent' about hospital whanau meeting practice were Maori and Pacific perspectives.
Step 4 - Developing and implementing	Developing an interview guide, and conducting focus group discussions with participants and researchers 'matched' to reflect ethnicity of researcher and researched. A Maori social work group, a Pacifica social work group, a Pakeha social work group and a fourth focus group, to capture the experience of our medical colleagues, provided a very rich source of data.
Step 5 - Thematic analysis (II)	Thematic analysis of the four focus group transcripts strengthened by reflexive discussions regarding differences and similarities which emerged from the data.

This design, although significantly limited by the absence of patients and whanau accounts of effective whanau meeting practice, is strengthened by the application of triangulation. Triangulation in social science research, according to Davidson & Tolich (2003) is referred to as '....using different research methods to hone in on an event from two or three different angles' and citing Fetterman (1989) argue that triangulation '...is at the heart of qualitative research's validity' (p. 34). The triangulation is evident via a number of activities including the sources of data, i.e. practice wisdom of researchers, literature and focus group information, the triangulation of research team members, and the variety of data collected via three different culturally bound social work focus groups.

One of the central features of our design was built on our key strength: as a diverse research team our research design, approach and methods must maximise the potential inherent in this diversity. One key element was that each cultural group represented on the research team would take primary responsibility for accessing and analysing knowledge, recruiting participants and hosting and facilitating the focus groups for 'our own people'. This strategy was highly effective with *all* potential Maori and Pacific social work participants contributing to the focus group.

It was important to us that the participants we identified held significant cultural knowledge which was likely to be different from the more common western constructions of whanau meeting processes. Prominent Maori researcher Tuhiwai Smith maintains that research 'is probably one of the dirtiest words in the indigenous world's vocabulary' and that 'when mentioned in many indigenous contexts, it stirs up silence and conjures up bad memories …' (1999, p. 1). The fact that Maori social workers participated in our research so fully is significant and perhaps suggests something about the effectiveness of the design.

Ethical considerations for our research centred largely on the issues outlined above; this could be described as an ethic of participation. Ethical issues related to the minimisation of harm were assessed as minimal; hence our capacity to engage in this practice based inquiry without undertaking an ethics application. This ethic of participation and how it was demonstrated in practice is summed up by Matalau Loli in her reflection about the focus group for Samoan and Tongan participants:

> What really stood out for me was the willingness and the confidence for all the participants to talk and respond to the questions. Because of the already established relationships and connections as PI practitioners they were talking, and others were listening so more information was offered as a result – almost like prompts and because the participants have similar values and principles they were able to identify with what others were saying.

The five P's framework

Having aggregated the themes, which were identified and confirmed via triangulated data collection and analysis processes, five essential practice activities were identified as significant in supporting effective whanau meeting practice. These activities will be described, and then the findings we made concerning significant practice variances between groups will be highlighted and explored.

Purpose
The findings consistently emphasise three central motivations for holding a whanau meeting: the sharing of information, decision making and planning. Informing the patient and whanau

about the diagnosis, prognosis, current challenges and future needs was also of primary importance to all groups. This is best summed up as '*clarifying, getting the full picture, and ensuring everyone is on the same page*'. For the social work groups, decision making and planning were primarily focused on creating opportunities that supported collaborative decision making *with* whanau about what type of ongoing care to provide to a patient, withdrawal of life support and discharge planning. The social work emphasis was consistently oriented towards reaching agreement and supporting a process more likely to result in consensus decision making. Less emphasis was placed on shared decision making by the professional group, with specific attention being paid to '*sharing information, breaking bad news, and complex discharge planning*'. In this group, the apparent emphasis was on conveying information and ensuring consistent follow-up for the whanau.

For Maori the importance of '*hearing and responding to news together, building a platform for korero (talking) and maintaining the wellness of whanau*' was constantly emphasised. This finding may indicate a particular attention on the part of Maori practitioners to supporting a particular process and/or structure of a meeting. The need to create a whanau meeting environment that was '*empowering to whanau*' was also a crucial point. Whilst ensuring understanding was a key focus for all the social work groups, it was the Pacifica group that stressed '*the need for clear messages, checking patient and family understanding*' and creating a venue for '*the asking of questions and the questioning of decisions in order to seek family wishes*'. Pacifica social workers consistently described a proactive approach to supporting all medical professions, especially doctors to '*use plain language*'.

Preparation and planning

A common understanding of the social work role identified two types of preparation, one which was quite practically focused, such as securing a room, ensuring an interpreter was booked, coordinating a suitable day and time, and making sure social workers were well informed by reading the clinical notes. A second type of planning was more complex and involved assisting with '*the preparation of questions,*' '*spending time with the whanau and the patient to ensure clarity regarding issues and expectations*'. Whilst all social workers identified a need to ensure the 'right people' were there, Maori specifically drew on explicit cultural knowledge to ensure appropriate kaumatua, or other key figures, were present. Maori social workers were specifically attempting to balance social work best practice and Tikanga, reflected in this quote from an experienced Maori social worker who said:

> I have one side thinking about best practice, and the other side thinking about Tikanga, and if I sit in that balance I know it's (the whanau meeting) going to work.

Pacifica social workers had an added emphasis on '*ensuring consent*', '*making sure the family understood why the meeting was occurring*', and '*gathering the right information to share with the family*'. Ensuring the right people attended was also a feature of the findings from this group. The consistent preoccupation in the Pacifica group was on ensuring whanau understanding.

Medical professionals were primarily focused on their specific preparation which largely related to ensuring they were '*able to speak coherently and consistently about what was occurring*' and '*the need to get this right for the family.*' Of particular note in this group were risks associated with '*junior*' doctors making errors in meetings or consultants '*taking over and making decisions*'. This finding suggests that without the concerted professional support

from social workers, the purpose of whanau meetings to provide a forum for empowered, well-informed decision making were at risk of being diminished.

Process

The value of opening the meeting appropriately, taking time for introductions, welcoming participants and providing an opportunity for a prayer were consistent among the groups. There was an absence of consensus beyond this however, with both Maori and Pacifica social workers describing different processes depending on who had called the meeting, the whanau or the medical team. This may indicate a greater appreciation of the power relation inherent in the calling of a meeting, with Maori and Pacifica workers making an explicit link between purpose and process. Maori also emphasised the need to negotiate roles, and be competent to take up whatever role was appropriate in any given meeting.

Whilst medical professionals identified openings, welcomes and introductions as important processes, they relied primarily on social workers to ensure these fundamentals occurred. Prayer, the use of cultural support, and input were highly valued by all the teams, with the medical team discussing '*the times meetings go wrong*', including '*consultants taking over and making decisions*'. This group also expressed concern about '*family being bombarded*' which was also reflected in the social work groups by a consistent focus on '*slowing the meeting down', 'dealing with tensions*', and taking time to '*stop, pause and chat*'. It was the social workers who appeared to take responsibility for facilitation and '*steering the meeting'* which was identified as critical to getting a good outcome. It was the medical team's data which highlighted the value of appropriate endings, which included the provision of '*a summary of decisions made, action plans, time frames and further questions'*.

Power

All participants acknowledged '*power dynamics'* in both the medical team and the whanau and took responsibility for attempting to share power in the meeting whilst also recognising the limits of this within the hospital context. This is best summed up in a quote from a medical professional who said '*we don't give patients power – we tower over them*'. The same professional expressed an understanding that '*10 people in a room affects patients' power*'. All groups acknowledged the risk of patients and whanau having less power than the medical team, and this desire to acknowledge and share power was linked to the efforts social workers made in appropriate pre-meeting preparation. For example, social workers had an important role in '*assisting family to prepare questions', 'ensuring the right people attended the meeting'*, and '*briefing/coaching the medical team*'.

Some medical professionals focused on the need for the family to understand that '*we are all in this together*'. This was expressed as a desire '*to get family on board with the medical team'* and assisting them to '*understand the message from the team*'.

One of the specific contributions social workers make to effective whanau meetings is the '*building a relationship'* which was described by our medical colleagues as a feature of meetings which achieved positive outcomes. Although not apparent in the findings regarding purpose, it was encouraging that when the medical team explored power relationships the focus was on '*getting agreement, negotiation, talking about bad news, empathy, positive language, kindness, openness and mutual learning*'. This is summed up by one professional's desire to '*engage in a process which symbolically says you're important*'.

Reflecting on the use of the word 'power', one Maori social worker preferred to use the word mana and linked this concept to '*allowing the korero (talking) to occur*'. This linkage is embodied in the quote:

> …just keeping the mana and allowing that in the korero, allowing everything to occur, whether it's positive, negative or whatever and for me if you want to talk power, that's power, its allowing all that to happen, to come out.

The x-factor

Reflecting on their sense that a meeting had been successful and achieved an effective outcome, collectively the groups identified '*feelings in the room'* as the important outcome measure. These feelings included '*a sense of warmth, connection, kindness, affection and happiness'* that '*let everyone know something positive had been achieved*'. Resolution of previous hurts also featured as a positive outcome of a successful whanau meeting. A focus on '*whanau empowerment'* and a sense that expectations had been met, '*whanau having a voice'* and empowered decisions had been made was a second dominant theme. This is well summed up by this quote from a Maori social worker:

> …they've made a decision and it's actually seeing them (whanau) taking control over the next step or what the next process is going to be.

Humour also featured as an indicator of the x-factor having occurred, which included '*chocolate cake being provided'* and '*all 12 whanau members going off and kissing the doctor*!'.

Contemplating the hazards of whanau meetings with poor outcomes, one medical professional spoke at length about the lack of training, or preparedness, she had received in her undergraduate training to participate and assist with a difficult whanau meeting. Reflecting on how she had learnt these skills she described having '*learnt from social workers'* and a process of '*taking from here and there, like a magpie, picking out what I thought worked well for different situations*'.

Summary and conclusion from findings

The way the focus groups were structured provided a valuable opportunity to appreciate the consistent whanau meeting understandings and practices across four professional groupings, three of which were social work practitioners separated into cultural groups, and the fourth, a group of medical professionals. The analysis indicates that multiple common understandings are evident in the domains of purpose, planning, process, power relations and the x-factor, associated with the hosting of effective whanau meetings in this practice context. What is also evident however is the proactive and seemingly unique role the social worker plays in attending to significant cultural content, attention to communication issues and reducing the risks associated with unequal power relations. The way in which the social work activities are undertaken consistently demonstrate a profound understanding of the challenges whanau face in order to engage and participate in the hospital environment. These activities make evident social workers taking up their responsibility to support client participation, and in the case of Maori patients, 'acknowledge and support the whanau as the primary source of care and nurturing of its members' (ANZASW Code of Ethics, p. 17). These findings will now be discussed within the context of the local and national literature.

Discussion

In this discussion we will focus on a number of distinct areas of literature which will help situate our study in a professional, local and a contemporary health environment. The whanau meeting literature emphasises both the value of, and the significant challenges associated with, effective communication with patient and whanau. When these findings are linked with documented health inequalities, in part as a result of cultural marginalisation, the critical role social workers aim to play in supporting social justice via improved access and participation of marginalised groups is proposed.

The value of achieving a common and realistic understanding with the patient and their whanau about the illness and subsequent treatment issues has been clearly identified as a critical element of the provision of quality health care (Curtis, Patrick, Shannon, Treece, Engelberg & Rubenfeld, 2001). Finberg's 2005 view is that the whanau meeting provides a powerful clinical tool for communicating with whanau and patients. She also acknowledges, however, that few clinicians are adequately prepared to conduct whanau meetings effectively, whilst other studies claim poor communication as a frequently identified reason for compromised clinical care (Meyer, Sellers, Browning, McGuffie, Solomon and Truog, 2009).

Undertaken in a hospital intensive care context, another study found that 54 percent of participants were unable to understand the diagnosis, prognosis or treatment being provided to them or their whanau member. Of these, prognosis was identified as the most difficult to comprehend. This lack of comprehension was linked to cultural difference, young people, the unemployed, foreigners with limited health experience, and the absence of a health professional amongst the relatives (Azoulay, Chevrt, Leleu, Pochard, Barboteu, Adrie, Canoui, Le Gall, Schlemmer, 2000).

Also reporting dissatisfaction with whanau-clinician communication, another study suggests that allowing whanau members more opportunities to speak during whanau meetings may advance whanau satisfaction (McDonagh, et al., 2004). Researching what they describe as missed opportunities in whanau meetings, Curtis and his colleagues (2005) also identify the failure to listen and respond to whanau, opportunities to acknowledge and react to emotions, and ethical issues in part associated with patient and whanau decision making, were the most common flaws. Of all of these weaknesses, failure to listen and respond to whanau and patients were the most dominant.

The thrust of the conclusions from all these studies adds significant weight to the merit of the social work preparation and process activities identified in our research. The efforts social workers made to: assist whanau to prepare and ask questions, the coaching of medical staff to keep language simple, ensuring the availability of interpreters and encouraging the right people to be present are clearly professional activities oriented chiefly at supporting increased patient and whanau understanding and participation.

The family meeting research conclusions outlined above focused on poor communication and whanau comprehension, and physicians' lack of preparedness to undertake whanau meetings. Combined with Maori and Pacifica accounts of their poor experiences in the health system (see for example Cram, Smith, & Johnstone, 2003) they help explain the significant efforts social workers described to prepare members of the medical team, the patient and

whanau prior to a whanau meetings, with the overall aim of supporting the development of *a shared understanding* of the issues. The health literature describes the invaluable role social workers play in assisting other health professionals to understand the spiritual, cultural, psychological and social impacts on individuals and whanau (see, for example, Miller & Nilsson, 2008). This was reinforced in our study by the social workers detailing the considered processes they undertake to actively support effective whanau meetings. These process efforts included: culturally informed openings and introductions, slowing the meeting down, answering whanau questions and *steering* the meeting. These process-focused activities were also clearly aimed at reducing the impact of power relationships, aiming to create an environment in which whanau and patients '*had an effective voice*'. The particular responsibilities Maori social workers took to create a meeting context in which information could be shared and responded to collectively was a strong feature of Maori social work practice, perhaps aimed at reducing the risks associated with cultural difference.

Summary, recommendations and conclusion

Whilst reflecting on the hospital practice context it is imperative we situate our discussion within the context of interdisciplinary approaches to practice. McCallin's local research reinforces the view that:

> …[i]nterdisciplinary teamwork calls for clinicians from different disciplines to interact, solve problems and make decisions together, whilst sharing responsibility for client-centred care (McCallin, 2006, p. 6).

The concept that each discipline in a hospital has a specific professional part to play, and that collectively we are able to contribute to client/patient/people-centred care is an integral element of our findings and one we believe is essential to highlight. Situating patient-centred care at the core of social work whanau meeting practice, and thereafter gathering the threads of improved access, equity and cultural safety together, we are able to powerfully demonstrate the unique contribution social workers are aiming to make to improve the patient/whanau experience and actively contribute to improved social justice outcomes. In order for social workers to take maximum advantage of the opportunities inherent in the effective whanau meeting they will require training, supervision, access to cultural advice and support.

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