SUBMITTED VERSION

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What does it take to deliver brilliant home-based palliative care? Using positive organisational scholarship and video reflexive ethnography to explore the complexities of palliative care at home

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Title

Bringing brilliance to light in home-based palliative care: A video reflexive ethnography

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Abstract

Background: Despite the increasing number of people requiring palliative care at home, there is limited evidence on how home-based palliative care works best for clinicians, patients, and carers. The Brilliance Project – an initiative to explore how positive organizational scholarship in healthcare can be used to study good, excellent, and brilliant health service management from the viewpoint of consumers and practitioners inspired this study.

Aim: The aims of this qualitative participatory study were two fold: To clarify the circumstances that give rise to 'brilliant' home-based palliative care. 2. To explore the effects of the research process itself in promoting brilliant home-based palliative care."

Design: This study combined positive organisational scholarship in healthcare with the participatory methodology video reflexive ethnography.

Setting/participants: Clinicians at home-based specialist palliative care services across two Australian states participated in the study. In keeping with a Video Reflexive Ethnographic approach clinicians were able to take part in the study at different levels. Clinicians at both sites were invited by the academic research team and in consultation with their clinical colleagues to be co-researchers alongside academic researchers for the duration of the study. Remaining clinicians could choose to participate in the study [or not] in accordance with their wishes and applying a situated ethical approach.

Results: Brilliant home-based palliative care was conditional on: connections between clinicians, patients, and carers; connections beyond the services with external colleagues; as well as connections between the two teams of interstate co-researchers.

Conclusion: Brilliant home-based palliative care is underpinned by clinician capacity to connect with patients, carers, each other, and colleagues beyond their own services. Greater emphasis on building these relationships is needed to promote brilliant home-based palliative care.

Keywords

1. Community Health Services
2. Quality of Healthcare
3. Qualitative Research
4. Patient Care Team

Key Statements

What is already known about the topic?

- Specialist home-based palliative care can improve symptom management and, quality of life, and prevent hospitalisation at the end-of-life
- There is significant variation in how home-based palliative care is delivered
- The clinical practices and contextual factors that enable exemplary palliative care are not well understood

What this paper adds?

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- Brilliant care is underpinned by the capacity of specialist home-based palliative care teams to connect with patients, carers, and each other

- Home-based palliative care is contingent on intentionally developing and sustaining these connections
- As co-researchers, clinicians who deliver home-based palliative care can use Positive Organisational Scholarship-Video Reflexive Ethnography to understand their own and others' practices

Implications for practice, theory or policy

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- Emphasising relational connections is important to promote brilliant home-based palliative care

Introduction

With ageing populations and the global rise of cancer, chronic illnesses, and multi-morbidities, the need for high-quality palliative care has never been greater. Correspondingly, the number of people requiring palliative care is expected to increase (1). Technologies continue to increase as debates about how Western health systems can remain economically sustainable. Hospital stays have become shorter, patients spend most time at home (2), and outpatient care has become increasingly complex with patients and carers expected to assume what were once clinician responsibilities (3). Although many people prefer to die at home (4), this preference can change (5) and is more complex than previously assumed (6). Nevertheless, home-based palliative care services are associated with: the reduced use of other health services; improved quality of life; reduced symptom burden (7); and better patient and carer satisfaction (8). Yet there are significant disparities in service provision, even among well-resourced countries (1, 9). Furthermore, there are large variations in the configuration of home-based palliative care services worldwide (10) (11), with a combination of geographically-dispersed public, private, and not-for-profit services. The needs of many people remain unmet with access to palliative care inequitable (12). Given these (and other) challenges, it is perhaps extraordinary when home-based, evidence-based palliative care does occur.

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To improve access to palliative care, policies in several nations – including the United Kingdom, Australia, and New Zealand (13) – endorse home-based palliative care, irrespective of their diagnosis. These policies also support capacity-building among non-specialist clinicians to provide palliative care. Yet, how this is to be achieved and evaluated remains unclear (14) . Furthermore, these policies are part of a 'measure and manage' (15) approach to understand and improve palliative care by evaluating performance or 'impact' against a metric. However, given the complex interactions between patients, carers, and clinicians, causal relationships cannot always be established. When studies and meta-syntheses have attempted to evaluate the primary outcomes of specialist home-based palliative care services, investigators have found it difficult to ascribe the outcomes to one component of the service. This is largely due to significant variation in what was provided, how it was provided, when it was provided, as well as who and what were involved (11). Furthermore, common measures to evaluate home-based palliative care do not necessarily capture the concepts that are meaningful to patients and their carers, such as a sense of security (16). In other words, although there is evidence to support home-based palliative care, there is limited evidence on how it works best for those involved (10, 17) Given the complexities of healthcare, there is growing recognition that the measure and manage approach is limited (18). Compliance models such as guidelines, protocols, and care pathways often fall short in changing clinician behaviours (19). Given the complexities of home-based palliative care we have thus far described and the limitations of conventional research to study these complexities the aim of this study is to explore the circumstances in which home-based palliative care is 'brilliant' and to promulgate these circumstances. Here Brilliant care is that which …….

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We need a background overview, culminating in a conceptual definition, of what is meant by "brilliant" palliative care

Theoretical Framework

In tandem with the aforementioned limitations there is a growing emphasis on understanding what goes right in healthcare (20), giving rise to complementary ways to appreciate what works, for whom, and when (21, 22). The current study, inspired from these approaches draws from the field of patient safety and quality to investigate home-based palliative care – They include appreciative inquiry (AI) (23), exnovation (21), and safety-II (24). The assumption behind AI is that all organisations have something that works and that make it

Commented [AC7]: What are the theoretical underpinnings for this paper palliative care component of 'generalist' roles. But each of these messages would have a much stronger impact on knowledge if the reader could situate them within a specific theoretical or conceptual perspective. In other words, what is the 'lens' that enabled the researchers to discern, develop, and articulate these messages, and through which 'frame' should the reader appreciate them?

effective and successful. This approach seeks to engage people at all levels of a study to produce effective and positive change by identifying "what is positive, heightening energy, vision, and action for change". Similarly, Safety-II takes a proactive approach to safety and is focused in what goes right in health care with the aim of producing, managing and measuring successes. More precisely, Safety-II is the ability to succeed under varying conditions, so that the number of intended and acceptable outcomes is as high as possible. This is in contrast to Safety 1 whereby the focus on practices is how they fail. In earlier research Mesman (25) applies the term 'exnovation' to highlight the importance of making visible and foregrounding the accomplishment of mundane and 'taken for granted' elements of health care practice that contribute to the kinds of successes we have thus far described. All of these approaches reflect a theoretical underpinning valuing reciprocal relationships between researchers and participants.

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Methods

Thus, in order to 'make visible' the aforementioned mundane elements of home-based palliative care that lead to high quality care and, at the same time, engage closely with service providers, this research combined two methodologies. This study utilises positive organisational scholarship in healthcare (POSH) and video reflexive ethnography (VRE). Positive organisational scholarship in healthcare is 'the study of that which is positive, flourishing, and lifegiving in [healthcare] organizations' (26). Challenging the tendency to concentrate on all that is negative, POSH seeks to study triumphs and achievements because of their inherent appeal and allure (27, 28). It does not ignore negative organisational aspects (29-31); but rather, it represents 'an alteration in focus' (26) – a deliberate attempt to redress the preoccupation with the non-positive. This approach draws from the work of the Brilliance Group and its research program dedicated to promoting brilliant health service management (27, 32-34) to study home-based palliative care.

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Video Reflexive Ethnography (VRE) is a well-established interventional methodology. It is a collaborative methodology comprised of participant observation and other traditional ethnographic methods. Uniquely however, video is used to invite ~~invites~~research participants ~~individuals~~ to: feature in and/or gather visual data (V) in collaboration with the researcher; interpret the data ~~pensively and openly~~ reflexively (R); and suspend and understand practices and experiences *in situ* (E). ~~VRE is a collaborative methodology comprised of participant observation and other traditional ethnographic methods.~~ Video reflexive ethnography~~It~~ involves the negotiated filming of practice and/or participant accounts of practices, supplemented by reflexive viewing to co-analyse the footage (35). Here reflexivity is distinct from reflection. Whereas reflection is individual and focused whereas reflexivity, in contrast, is collaborative, socially distributed, open-ended in purpose and immediate in effect (36). Reflexivity is concerned with perturbing, re-view and re-imagine practices. Thus VRE ~~VRE is interventional in nature. It~~ encourages the co-construction of new meanings by challenging assumptions – be they the researchers, managers, clinicians, patients, or carers (37, 38). By actively disrupting the *status quo*, VRE is inherently complex and produces challenges as well as opportunities (39). It requires researchers to embark on a journey with participants in directions that are uncertain, to: capture what are often contested perspectives; and produce footage that might have different meanings to different people at different times and in different settings (37).

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Commented [AC11]: Reference Taylor and Francis book forthcoming.

Field researchers in NSW were AD an experienced health care management researcher with expertise in POSH, and Mental Health~~,~~ a research assistant with a background in school education and experienced qualitative researcher. In South Australia, AC, a palliative care nurse researcher experienced in video reflexive ethnography led field research.

Setting and Participants

Following clearance from the relevant research ethics committees, clinicians from two home-based palliative care services in two Australian states – New South Wales (NSW) and South Australia (SA) – were invited to participate in a study as co-researchers using POSH-VRE. Despite the expressed focus on brilliant palliative care, an array of routine, as well as atypical practices were captured, given the exploratory nature of this study.

Data Analysis

Data analysis involved three phases (see Table 1). First, the academic and clinical researchers reviewed video-files, audio-files, and field-notes to construct key themes that epitomise brilliant palliative care, which were shared with the clinical teams. Footages of brilliant moments were edited in a way that did not sever the exemplar from its context. Second, the researchers invited clinical colleagues to participate in a reflexive session to analyse selected exemplars of footage that represented these themes. During six reflexive sessions across the two sites, clinicians were invited to describe: what they observed; how they felt while viewing the footage; whether and why the exemplar epitomised brilliant palliative care; and the factors that influenced these exemplars. Framed by POSH, this collaborative approach encouraged reflexivity (40) – it inspired the clinicians to: critically review their roles as a clinician and/or researcher, both individually and within their team; isolate those practices that epitomised brilliance; and/or identify opportunities for capacity-building. Further detail on how the study was operationalised is published elsewhere (withheld for blind review).

Table 1: Fieldwork

Setting	Model of Care	Data Sources	Participants		Fieldwork		Data Collected	Hrs
NSW: community health centre in outer metropolitan area, covering a large area	Consultancy model where public health, specialist palliative care nurses: • Are supported by palliative medical consultants • Support co-located generalist community health nurses who coordinate the care of palliative care patients • Collaborate with external GPs and not-for-profit organisations	Weekly case reviews; team discussions; delivery of home-based palliative care; conversations between clinicians, with patients, and/or with carers; interviews with clinicians and patients; and the documentation of clinical notes	Co-researchers	4	Start	Aug. 2015	Video recordings	49.36
			Consenting clinicians (who did not opt to be a co-researcher)	18	Cease	May 2017	Audio recordings	16.16
			Consenting patients	30				
			Consenting carers	16				
			Reflexive sessions					
			Number	4				
			Facilitators across all sessions	14				
			Participants across all sessions	33				
SA: hospital-based multidisciplinary specialist service covering an outer metropolitan area	Consultancy model where 2 co-located multidisciplinary teams: • Are comprised of: specialist palliative care nurses; a palliative care physician; a registrar or advanced trainee; and a social worker • Collaborate with external: ○ Occupational therapists ○ Physiotherapists ○ Volunteers ○ Generalist nurses employed by a private organisation ○ GPs	Daily clinical huddles; delivery of home-based palliative care; conversations between clinicians, with patients, and/or with carers; interviews with clinicians, patients, and carers; and the documentation of clinical notes	Co-researchers	4	Start	Nov. 2015	Video recordings	504
			Consenting clinicians (who did not opt to be a co-researcher)	31	Cease	Dec. 2017	Audio recordings	132
			Consenting patients	7				
			Consenting carers	6				
			Reflexive sessions					
			Number	3				
			Facilitators across all sessions	12				
			Participants across all sessions	60				

Findings

By analysing the data across the two sites, and reflecting on this interstate study, the findings suggest that brilliant home-based palliative care is largely reliant on connections. Furthermore, the process as well as outcomes of the study contributed to these multilevel connections in a way that researchers and clinician had not foreshadowed. These connections manifest: with patients and carers; within the clinical team; beyond the clinical team with external colleagues; with external decision-makers and through the camera lens; each is addressed in turn.

Connections with Patients and Carers

According to the participating patients and carers, connections with clinicians underpinned brilliant palliative care. They valued associating with clinicians in a way that anticipated their individual needs and was responsive to symptom management in a timely manner:

> All of it's been brilliant… [The new palliative care nurse] has only just started, but I can tell what he's like already… I'm aware of who has got it… [He's got] empathy. [The clinicians]… have to be able to see [patients]… as their own person, but understand where each individual is coming from and I can pick that up with them… [I can detect that on the] first visit… [I consider] do they need me to do the talking or are they able to stimulate me to do the talking… [and can they] pick up when I'm covering up [issues and concerns]?... [He] was able to do that (*patient, SA*).

Carers valued knowing they were linked with the specialist palliative care team when supporting a person at home:

> Daughter: I think [it's] the way that they communicate… keeping tabs on how dad is going… [And] visits to [the] home; keeping mum up to date with dad's progress… I've been called as well… all it takes is a simple phone call and then we're on the right track, having an open line of communication and knowing exactly what's been going on and that's the brilliance that I've found… we are all on the same page. Even though it's been a learning curve… it just took me a few days to join those dots…
>
> Wife: It's like a big family… [And we] all communicate together – not just, "Oh you deal with that; oh who cares"… they're all connected… you don't need anybody else because they're all there (*carer interview, SA*).

Patients and carers described a weave of commitment, where all team members – regardless of the service they represented – were connected and aware of the goals of care.

By viewing their own and colleagues' practices on film, the clinicians across both sites were able to critique what were typically hidden, if not subconscious practices. Thoughtful consideration of the footage facilitated greater emotional awareness of non-verbal communication and of emotional connectedness with patients and carers:

> We have found it is not the voice in communication in our work that is brilliant. It is the threads of connection through… the basic connection of humanity, of oneself in the moment. To be brave and connect through silence, to ignore the noise of activity around us that

> brings the strongest connection in relationship and bonds of trust (*clinician, SA*).

Observing these filmed practices revealed the importance of non-verbal communication, and created shared moments, beyond those that focused on, and attempted to align clinician practices with clinical guidelines:

> You can't go by guidelines… it's got to fit right with you and it's got to fit right with the patients… I say to the students, 'One of the things is leaning forward and perhaps patting them on the shoulder or the knee'. [But] I don't think you can create a formula for a clinician to follow… it will fail every time, if you're following a script. The only way to be doing it properly, is [by] doing something that feels natural… [and by] letting the patient in some ways, lead the agenda, even though you've got that expertise… you need to be flexible… to go where the patient needs to go and then bring it back when you say, 'Look, also we need to do this, this, and this' (*clinician, NSW*).

Clinicians indicated the role of non-verbal communication to connect with patients and gauge, or sense the conversations they wanted, or preferred to have. The use of non-verbal communication in this way seemed to incite brilliant home-based palliative care:

> You need to be able to connect with people. Some of the most brilliant doctors [have]… terrible bedside manner and [are] terrible clinicians and they end up doing what suits their knowledge… you can be all knowledgeable and a good diagnostician; [it] doesn't mean you care for the patient *(clinician, NSW)*.

The participating clinicians recognised a difference between clinical brilliance – as conventionally defined by patient outcomes – and brilliant palliative care. They considered *bona fide* connectedness with patients and carers as fundamental brilliant palliative care, where clinicians where attuned to the needs and preferences of patients and carers. The ability to view the patient as a person augured relational connectedness. This was aided by a capacity to view the self as a person, rather than an expert:

> it's a very special thing to be in that moment when patients allow you to care for them in their most vulnerable time in their lives. I think it's very special… despite the suffering… you see them as people… with medicine, what happens is we see them as diseases and that's when we lose out on the experience of what medicine is… you treat people, not the disease. So, if you look at it that way, I think you'll never go wrong, even as a curative person… the opportunity… to care for a person in their most vulnerable time; not everyone gets that… It's not easy but it's beautiful, to a certain degree (*clinician, NSW*).

These connections did not magically appear. The clinicians exercised agency to establish and sustain them, even if this required them to, at times, flout organisational conventions and protocols:

> Clinician 1: There's some really important data that we need to collect, but because we are attached to a hospital, we live under that system…
>
> Clinician 2: It's hospitalised, it's not personalised…

> Clinician 3: But we gotta do it… ’cause some hobnob’s gotta find it when we are being accredited.
>
> Clinician 1: We’re supposed to go through all this information with the… [patients]. But… if you’re building a rapport with someone, there is… trust happening. [Flicking pages]… we have to ask them all this – ‘Have you got a machete in the house? Have you got drugs in the house? Are your steps slippery?’ My problem is, you’re supposed to ask them this before you’ve established a rapport with them (*clinicians, SA*).

Through the reflexive sessions, the clinicians reconsidered how they approached patients and carers to promote the kind of connections that promoted brilliant home-based palliative care:

> It’s about the therapeutic relationship we have… we needed to engage with [the patient]… to get her to listen to us… [And] to be able to do that, it’s about being interested in what she is interested in. And she loves her garden; that’s her space, that’s where she finds peace and calmness… it’s really important to her… Really, her roaming around the garden is about assessing her pain and her mobility (*clinician, SA*).

The reflexive sessions also provided the multidisciplinary teams with a shared space to view patient and carer experiences with the whole service, over time:

> The other thing that garden scene tells me… what did you do between that visit and the first visit so that she could climb around in her garden?... [The clinician] is [also]… reinforcing the sense of, ‘You are a whole person’; that’s what that says to me and… that helps you [to] manage the pain and the anxiety and all the other things and for that time, she thinks, ‘This [clinician]… understood me and valued me as a friend’ (*clinician, SA*).

Analysing the footage during reflexive sessions enabled the teams to discuss how brilliant care is experienced differently, by different people at different times. Furthermore, they explored how such care might be achieved, given these variations:

> The other thing I think about, is the skill… [of the nurse. Her] *modus operandi* was one of informality and… it fitted for this woman… but for some people, that would not fit… so I think the skill is… fitting with individuals (*clinician, SA*).

Connections: the clinical team

Clinicians at both sites indicated how their relationships with fellow team members evolved during the study. These relationships were manifested through a greater understanding of, and appreciation for each other’s roles, regardless of discipline. The reflexive sessions encouraged team members to see themselves and each other with greater clarity:

> I want to do more joint visits… because I never have someone to debrief with… [because] I think, ‘Shit, have I even done close to the right thing?’ Because I’ve got no clue about diseases and what’s happening – I’m a specialist palliative care [allied health professional]… I’m not a doctor and I’m not a nurse… I just need someone to come with me… for my skillsets… reflection [and]… good client care (*clinician, SA*).

As ‘sole-traders’, the clinicians did not have regular opportunities to observe, and learn from fellow team members, when conducting home visits. The reflexive sessions thus offered an opportunity to respectfully peer into each other’s working day and recognise the importance of joint visits and peer reflection of a shared experience.

Clinicians at both sites noted that the study had positively impacted: relationships within the specialist palliative care teams; as well as the relationships between the specialist and generalist teams:

> Traditionally, it has always been palliative care versus community health nurses and sometimes it comes from the staff themselves. I think [the study] has cemented our relationship that we are a team, and… by their reflection on being videoed [the generalist nurses have]… been able to see the brilliant work they’ve done and it’s validated that they are doing good work, and it’s cemented us as a team (*clinician, NSW*).

By viewing themselves with specialist clinicians, the generalist clinicians legitimised and validated the palliative care component of their role. This reaffirmed the complementary roles of the generalist and specialist clinicians, thereby bolstering teamwork.

During the reflexive sessions, the clinicians recounted their refined understandings of the interface between generalist and specialist clinicians, and their role at this nexus. Akin to a picturesque jigsaw, they described they ways in which different pieces fitted together to present a coherent ensemble:

> I think that makes a difference to the team, when you’ve got [a]… very holistic… view of the clients… it’s not just about, ‘Oh, he needs that medication’. It’s about… organis[ing]… a social worker and a physio because of his mobility (*clinician, NSW*).

Connections: external colleagues

The clinicians recognised links between different services and how no single service facilitated brilliant care for any one patient or carer. This web of connections encompassed other public health services, not-for-profit agencies, and private services, including general practices and pharmacies. A facilitatory role to join these (and other) services was deemed critical to support patients and carers to live well, as self-defined:

> One of the great teams [is]… the [extended care paramedics]… they’re just brilliant. For the last couple of years, I think we have relied on them quite heavily after hours… [They’re] one of the main reasons why we have been able to keep… [patients] at home (*clinician, SA*).

The multiple services and practitioners (broadly defined) involved in patient care required the palliative care teams to serve as brokers to connect, otherwise disparate stakeholders. This often mean ‘going the extra mile’ to support patients with a life-limiting illness:

> One of the things that would be lovely to capture is the personal cost to the staff. The community nurses donate extra hours and at odd times… seeing each branch of the service – it’s not just the community [health service], it’s not just the ward, and it’s not just isolated in the unit… I think a lot of the value in what the service does is from those who donate time. So, it’s going that extra step (*clinician, SA*).

Connections: external decision-makers

According to some clinicians, the footage provided a way to meaningfully communicate the complexity of home-based palliative care to those they regarded as 'the bean counters'. They suggested the footage can be used to connect palliative care clinicians – those front-line clinicians delivering direct care– with those responsible for policy development and service budgets. Given the seeming disconnect between those 'up the hill' with those 'in the real world', the footage might be used to bridge this divide:

> Clinician 1: I'd like to show [the senior executives]… who might not understand… I'd like to see some senior people see it, you know the financial officer and [those]… within the division…
>
> Clinician 2: I think we are carrying the torch to fight the fight… to have that time with patients and to do things well (*reflexive session, SA*).

Connections: through the camera lens

Connections thus far described were made tangible by bringing them to light 'on screen'. IN turn clinicians at both sites came to view themselves and their fellow clinicians through the lens of the camera:

> I had this brilliant moment today; I wish I had the camera with me (*clinician, SA*).
>
> Now, when I visit patients, I have this kind of eagle I view from above, a bird's eye view. I take a wide-angle lens from above (*clinician, SA*).
>
> Looking at yourself on video, it's like, you don't even recognise your own voice. There's little things you don't even realise you do and you say to yourself, 'I'm not going to do that next time'. Or by looking at other nurses' videos you say, 'You know what, I really like how they did that and I'm going to do the same' (*clinician, NSW*).

By imagining the presence of the camera, the clinicians reflexively viewed what they, and others did, and how they did it. This eagle-eye view was demonstrated beyond the data collection phase of this study.

Discussion

The need for high-quality palliative care for people at home has never been greater, particularly given the constrained public health budgets of many Western nations. This study demonstrates that establishing and maintaining relationships: between clinicians, patients, and carers, among clinicians; and across disparate services underpin brilliant home-based palliative care. These findings reflect a meta-synthesis of the critical components of home-based palliative care from the perspective of patients and carers. These were found to include: security – that is, on-call availability and home visits; competence – effective symptom control; and skilful communication (16). This study suggests that these critical components of home-based palliative care are contingent on intentional connections to facilitate effective teamwork. These findings support those of a recent investigation of 11 specialist home-based palliative care services in Canada, whereby intrateam communication and teambuilding were viewed as more important than: clinical tools; standardised processes; specialised expertise;

timeliness; physical symptom; psychosocial support; spiritual management; education; peace and fulfilment; as well as patient advocacy (10). The findings also align with those in other fields. For example, in the field of patient safety relationships between health professional groups have been shown to contribute to or directly inhibit patient safety (41, 42). For example, a realist review suggested that relationships between care home staff and healthcare staff partly determine the effectiveness of interventions for patients (43). Thus organisational wellbeing along with collective efforts to deliver safe care is likely to depend on the nurturing of professional networks (44).

Interprofessional teams that care for people with high-level needs and operate in complex situations need to be able to adapt to rapidly changing environments. The findings from this study suggest that home-based palliative care teams do this by engaging with systems and processes to make them work. Rather than make isolated clinical decisions based on cognition, the two interstate palliative care teams – irrespective of jurisdictional differences – engaged in adaptive practices, even if that meant flouting organisational rules and processes to get what they needed for the patients and carers they worked with – for further detail, see (withheld for blind review).

The practices revealed in this study were promulgated via POSH-VRE. Encouraging clinicians to view their own work provided insights and understandings of each other's roles heretofore taken for granted. Furthermore, clinicians came to appreciate each other and their contributions to the team in new and tangible ways. For instance, some identified an increased capacity to critique their own practices, and those of their team. Finally, some clinicians were better able to convey the complexities of what they did to other clinical specialties, managers, and senior executives. Together with academic researchers, home-based palliative care clinicians demonstrated what Nicolescu (45) referred to as transdisiplinarity. They worked together to create new and integrative knowledge to address complex issues and problems 'through the practice of one's profession and discipline in concert with others, instead of alone' (46 p10).

Limitations

The focus on brilliance might have privileged findings towards those practices that were deemed to be so. Although the study deliberately looked at brilliance, it did not negate the clinician ability to systematically scrutinise their own and others' practices. A further limitation was the omission of patients and carers from the reflexive sessions. Nevertheless, patients and carers were provided opportunities to view footage and were involved in decisions about who should view footage in which they were depicted. Furthermore, due to institutional ethics processes, it was beyond the scope of this study to include external clinicians who were not employed by the two services.

Commented [AC12]: what are the authors' thoughts about what might have been captured/omitted as a result of these decisions?

Conclusion

The findings demonstrate that brilliant home-based palliative care is underpinned by a team's capacity to relationally connect with patients, carers, and each other – be they within or beyond the palliative care service. As such, placing greater emphasis on building these relationships, and growing agency and team intelligence are needed along with conventional codified clinical evidence to produce brilliant palliative care. Using POSH-VRE to investigate this brilliance enabled the clinicians to unveil the complexities of their work, and to go beyond the conventional methods of researching care. The challenge now is to understand how this camera-view of care might be used in other settings and with others, including (but not limited to) patients, carers, and clinicians who have a limited understanding of, and limited familiarity with home-based palliative care services.

[Reinsert declarations following peer review]

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