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Evidence-Based Teamwork Models In Geriatric Palliative Care: Implications For Strengthening The Total Psychosocial Well-Being Of Patients In Nigerian Teaching Hospitals

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Abstract

Palliative care requires coordinated professional responses to the physical, psychological, social and spiritual dimensions of serious illness. In geriatric palliative care (GPC), the complexity of patients' needs makes effective teamwork particularly important. However, evidence on what and how teamwork functions within Nigerian tertiary hospitals remains limited. This study comparatively examined teamwork models in GPC across Ahmadu Bello University Teaching Hospital (ABUTH), Zaria; University College Hospital (UCH), Ibadan; and University of Nigeria Teaching Hospital (UNTH), Enugu, with particular attention to team structure, decision-making, outcomes and challenges affecting psychosocial care. A mixed-methods approach was employed. Quantitative data comprised 208 valid questionnaires retrieved from 220 administered, representing a 94.6% response rate. Qualitative evidence comprised 20 in-depth interviews and six key informant interviews, complemented by empirical observation and organizational ethnography. Quantitative data were analyzed using descriptive statistics, while qualitative data were thematically analyzed and triangulated with observational evidence. The multidisciplinary teamwork model was the most frequently reported at ABUTH (50.0%), UCH (45.8%) and UNTH (52.5%). However, observational evidence demonstrated important differences in how this nominally multidisciplinary structure functioned. UCH showed the strongest interdisciplinary characteristics. ABUTH demonstrated a predominantly multidisciplinary but hierarchical and physician-centred team, while UNTH reflected an adaptive, resource-constrained and predominantly interdisciplinary team with considerable pragmatic role overlap. Shared decision-making was reported by 57.6% of ABUTH, 59.0% of UCH and 66.1% of UNTH respondents, although qualitative evidence showed that final authority remained concentrated in senior medical staff. UCH recorded the highest patient satisfaction (87.1%), whereas ABUTH demonstrated stronger clinical orientation and UNTH experienced weaker continuity of care. The findings demonstrate that the presence of multiple professional disciplines does not necessarily constitute effective teamwork.

The study recommends that strengthening structured interdisciplinary collaboration, inclusive decision-making, institutional support and psychosocial integration is essential to improving the total well-being of older patients receiving palliative care in Nigeria.

Keywords: Geriatric Palliative Care, Multidisciplinary Teamwork, Interdisciplinary Teamwork, Transdisciplinary Teamwork, Psychosocial Well-Being, Decision-Making, Nigeria, Mixed Methods

1. INTRODUCTION

Globally, aging and the approach to end of life are inevitable, shaping the experiences of individuals, families, and health systems. As populations grow older, the need for compassionate, comprehensive care for those with life-limiting and life-threatening conditions has become a pressing public health concern. This demographic shift is closely tied to rising rates of non-communicable diseases such as cancer, organ failure, and dementia which are key drivers of palliative care demand (United Nations, 2022). An estimated 56.8 million people require palliative care each year, most of them older adults, yet only about 14% receive it (Global Atlas of Palliative Care, 2020).

Palliative care is concerned with improving quality of life for patients and families facing life-threatening illness by addressing suffering across physical, psychological, social and spiritual dimensions. The World Health Organization (WHO) identifies palliative care as an essential component of comprehensive care and emphasizes the importance of integrating it across health systems (WHO, 2022). The need for such comprehensive care becomes particularly significant among older persons. Geriatric patients frequently experience multiple chronic conditions, functional decline, complex treatment decisions, social dependency and changing family relationships. Consequently, their needs cannot be adequately addressed through a single professional perspective. Palliative care therefore depends substantially on the capacity of different professionals to communicate, coordinate and integrate their knowledge around the patient (WHO, 2014).

Teamwork in palliative care has traditionally been understood through three broad approaches: multidisciplinary, interdisciplinary and transdisciplinary. In a multidisciplinary model, professionals contribute from their separate areas of expertise while maintaining relatively distinct professional roles. Interdisciplinary teamwork involves greater communication, shared planning and integration of professional knowledge. Transdisciplinary teamwork extends this integration through greater flexibility and sharing of roles and competencies across professional boundaries. Crawford and Price describe interdisciplinary teamwork as central to palliative care because the field addresses the whole person and therefore requires contributions from multiple professional perspectives (Crawford, & Price, 2003).

These distinctions are important because the presence of several professional groups in the same institution does not automatically mean that they function as an integrated team. A team may be formally multidisciplinary while remaining operationally fragmented, hierarchical or dominated by one profession. Conversely, a team may combine elements of multidisciplinary and interdisciplinary practice depending on patient complexity, available personnel and institutional arrangements (McPherson, 2024). Recent work also demonstrates continuing interest in transdisciplinary approaches to palliative care, particularly where workforce shortages and complex patient needs require flexible sharing of responsibilities (Terashita-Tan, 2013). However, such approaches require clear communication, mutual trust and recognition of professional competencies.

Within Nigeria, the practical functioning of MDTs is influenced by institutional hierarchy, workforce availability, resource constraints, cultural expectations and the organization of palliative services. The

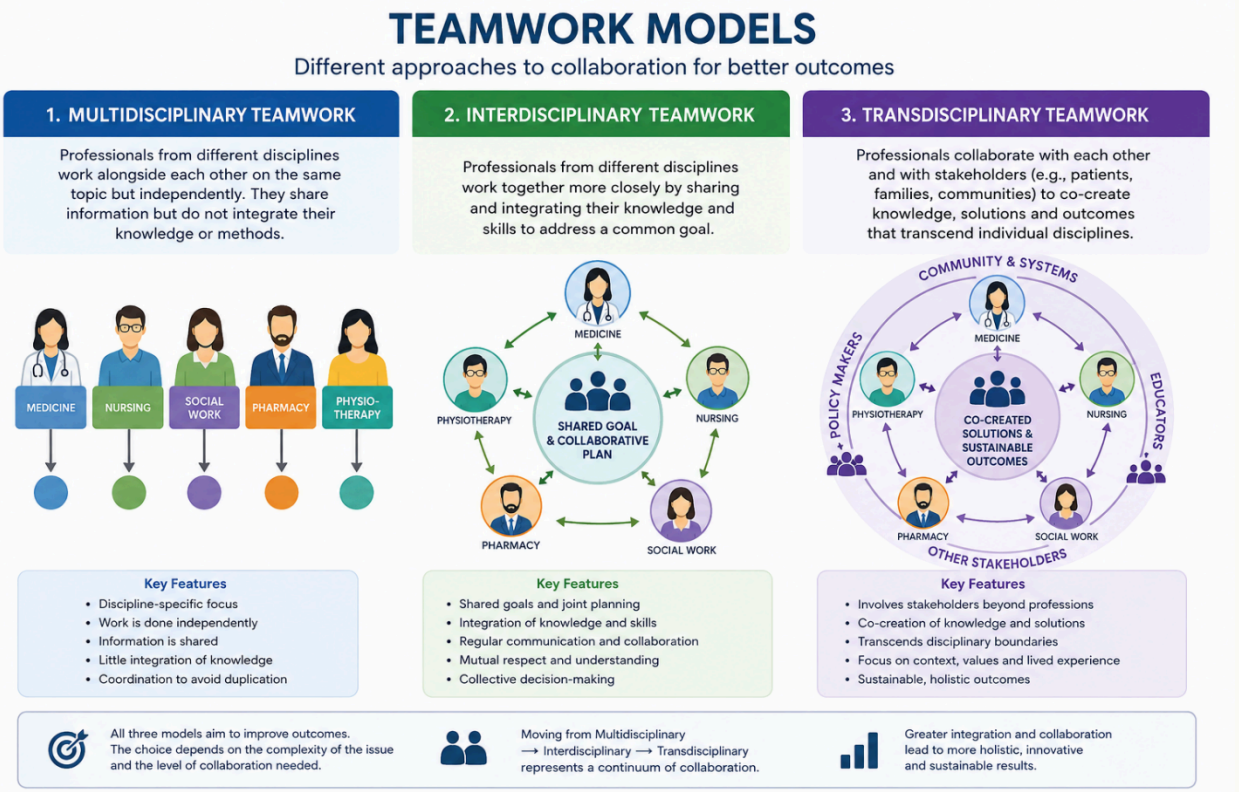
present study therefore moves beyond asking whether different professionals are present and examines how they actually work together especially for geriatric patients with palliative care needs. The study was undertaken in three major Nigerian teaching hospitals: Ahmadu Bello University (ABUTH Zaria), University College Hospital (UCH Ibadan), and University of Nigeria Teaching Hospital (UNTH, Ituku-Ozalla, Enugu).

The comparative design provides an opportunity to examine how similar professional objectives are translated into different organizational practices. The study aimed to comparatively assess Teamwork approaches in GPC settings in the three hospitals. Specifically, it examined the structure of teams, teamwork models in practice, decision-making approaches, outcomes, challenges and implications for optimizing Teamwork practice.

2. CONCEPTUAL AND THEORETICAL CONTEXT

2.1 Teamwork and Teamwork Models

For this study, teamwork refers to the coordinated effort of professionals who communicate, collaborate and share responsibilities towards achieving a common patient-care goal. A teamwork model refers to the structured approach through which professionals organize their relationships, responsibilities, communication, decision-making and collaborative activities (WHO, 2014).



The three models examined were multidisciplinary, interdisciplinary and transdisciplinary teamwork.

a. Multidisciplinary teamwork

Multidisciplinary teamwork involves professionals from different disciplines working around the same patient or problem while largely retaining their professional boundaries. Information may be exchanged, but knowledge and responsibilities remain relatively discipline-specific (Daly, & Chavez Matzel, 2013). Global policy frameworks increasingly position the multidisciplinary team

(MDT) as essential to effective palliative care delivery, particularly in geriatric settings. International guidelines emphasize defined team structures, core competencies, and minimum staffing standards as the basis for quality care (World Health Organization, 2014). Typically, these teams include physicians and nurses supported by social workers, psychologists, pharmacists, and, in more comprehensive models, spiritual care providers and therapists. Such configurations reflect a shift from purely biomedical care to a more holistic model addressing physical, psychosocial, and spiritual needs of the patient and family (WHO/EURO, 2023; Doherty & Ferguson, 2024).

b. Interdisciplinary teamwork

Interdisciplinary teamwork represents a greater level of integration. Professionals communicate more actively, share knowledge, participate in joint planning and contribute to collective decision-making (Crawford, & Price, 2003).

c. Transdisciplinary teamwork

Transdisciplinary teamwork represents the most boundary-crossing approach. Professional roles become more flexible, with members sharing selected competencies and responsibilities while maintaining their specialist expertise. Contemporary palliative-care literature identifies this approach as potentially useful where complex needs and workforce limitations require greater flexibility (Daly, & Chavez Matzel, 2013). In practice, patients are transferred from one specialist to another for continuity of care.

The three models can therefore be viewed not simply as mutually exclusive categories but as different points along a continuum of professional integration. The present study nevertheless retains the distinctions used in the research instrument and participants' descriptions.

2.2 Theoretical Perspective

The study was informed by Talcott Parsons' structural functionalist perspective, particularly the AGIL framework. From this perspective, the MDT can be understood as an organizational social system whose effectiveness depends on its capacity to adapt to environmental conditions, pursue shared goals, integrate its constituent parts and maintain patterns of interaction.

This perspective is relevant to the study because differences between ABUTH, UCH and UNTH were not restricted to professional composition. They extended to leadership, communication, decision-making, institutional support, resource availability and organizational culture.

3. METHODOLOGY

3.1 Research Design

The study employed a mixed-methods design combining quantitative and qualitative approaches. The design was strengthened through empirical observation and organizational ethnography. Quantitative data provided comparative patterns across the three hospitals, while qualitative and ethnographic evidence provided explanations of how teamwork operated within institutional settings. The study's qualitative material was particularly important because several quantitative findings indicating "shared" or "collaborative" practice appeared differently when examined through interviews and observation.

3.2 Study Settings

The research was conducted at:

a. Ahmadu Bello University Teaching Hospital (ABUTH), Zaria;
b. University College Hospital (UCH), Ibadan; and

c. University of Nigeria Teaching Hospital (UNTH), Enugu.

These institutions were deliberately selected not only because they could meaningfully address the research questions, but also because they are widely recognized as regional centers for excellence in oncology and palliative care practice. Together, they offer a useful cross-section of Nigeria's healthcare system, reflecting differences in culture, socio-economic realities, and service delivery across the northern, southeastern, and southwestern regions. These sites provided contrasting institutional, geographical and organizational contexts for examining GPC teamwork.

3.3 Sample and Data Collection

A total of 220 questionnaires were administered, of which 208 were retrieved, producing a response rate of 94.6%. The final quantitative sample consisted of 66 respondents from ABUTH, 83 from UCH and 59 from UNTH.

The qualitative component comprised 20 IDIs and six KIIs, giving 26 interviews. The interviews involved professionals and relevant stakeholders with knowledge of GPC structures and processes. Patients, careers and family members were also interviewed.

The study was further complemented by empirical observation and organizational ethnography. The researcher observed MDT interactions, professional relationships, communication patterns, decision-making processes, physical and symbolic spaces, institutional routines and informal practices. At UCH and UNTH, the researcher participated in relevant MDT activities, while professional familiarity provided opportunities for observation within ABUTH.

3.4 Data Analysis

Quantitative data were processed and analyzed using SPSS, with descriptive statistics presented principally as frequencies and percentages. The broader study also employed regression procedures for specified hypotheses; however, the present paper focuses on the descriptive comparative findings directly relevant to teamwork models.

Qualitative data from IDIs and KIIs were analyzed thematically. Recurring themes were identified and compared across the three hospitals. Observation and ethnographic evidence were then used to corroborate, qualify or explain quantitative and interview findings.

The final interpretation therefore relied on triangulation rather than on any single data source.

4. RESULTS

4.1 Structure and Composition of MDTs

The quantitative findings indicate that MDT structures exist across the three institutions, but their institutional visibility and organization differ. Only 22.7% of ABUTH respondents, 14.5% of UCH respondents and 30.5% of UNTH respondents reported the presence of a specialized GPC subunit; substantial proportions either reported that no such subunit existed or were unsure. GPC specialist availability was also limited, with only 37.9% at ABUTH, 44.6% at UCH and 47.5% at UNTH reporting availability.

The format of MDT coordination also varied. Ward rounds were reported as the main format for meetings at ABUTH (47.0%) and UCH (51.8%), while sit-in/round-table meetings were most prominent at UNTH (50.8%). Qualitative evidence demonstrated that UCH had the broadest and most consistently inclusive professional composition. Participants identified doctors, nurses, pharmacists, social workers, physiotherapists, psychologists, chaplains and other professionals as part of the wider team. Written role

descriptions and scheduled meetings contributed to greater role clarity.

ABUTH also had a broad professional composition, but attendance and participation in meetings were less consistent. Doctors and nurses constituted the most reliable core, while other professionals were involved depending on availability and patient needs. UNTH on the other hand had the leanest and most variable composition. Resource constraints meant that doctors and nurses often carried the major workload, while other professionals were invited as cases required. Thus, the structural comparison suggests three distinct organizational patterns: ABUTH's hierarchical structure, UCH's inclusive and more institutionalized structure, and UNTH's pragmatic and resource-constrained structure.

4.2 Teamwork Models in Practice

The quantitative findings indicate that the multidisciplinary teamwork model was the most frequently reported model across the three institutions: 50.0% at ABUTH, 45.8% at UCH and 52.5% at UNTH. The "all of the above" response was also substantial, indicating that respondents recognized overlapping elements of multidisciplinary, interdisciplinary and transdisciplinary practice. This finding is important because the qualitative evidence demonstrates that the reported team work model did not always correspond to a single, consistently applied mode of practice.

At ABUTH, participants commonly described a mixed model. Professionals worked within defined disciplines, but communication occurred across units when necessary. One participant characterized the practice as a combination of multidisciplinary and interdisciplinary approaches, with multidisciplinary meetings occurring particularly for complex cases. Another nurse explained that patients were often transferred between units rather than jointly managed by the full team.

The ethnographic evidence reinforced the hierarchical character of this arrangement. Doctors were generally positioned at the centre of decision-making, while nurses, social workers and pharmacists contributed more cautiously.

UCH demonstrated the clearest interdisciplinary characteristics. Its MDT structure was institutionalized through scheduled meetings, broad professional participation and shared discussion. Participants described a culture in which professionals could challenge one another and collectively work towards a care plan. One participant described the team as functioning "as a family", with the professional most relevant to the presenting problem assuming greater responsibility.

UNTH presented a different pattern. Participants frequently described the model as interdisciplinary because a primary unit retained responsibility of care for the patient while inviting other specialties to contribute. At the same time, staff shortages encouraged pragmatic role flexibility. A radio-oncology participant explained that a unit might retain the patient while bringing in surgery, nutrition or another specialty when required. This was supplemented by evidence of occasional role substitution when professionals were unavailable. The evidence therefore suggests that multidisciplinary teamwork is the dominant formal description, while interdisciplinary practice represents the principal direction of functional integration. Transdisciplinary elements exist but remain limited and situational rather than fully institutionalized.

4.3 Communication and Participation

Communication was reported as occurring mainly when there was an identified need: 51.5% at ABUTH, 45.8% at UCH and 47.5% at UNTH. Weekly communication was reported by 18.2%, 19.3% and 18.6%, respectively. The qualitative evidence, however, revealed substantial differences in the quality and direction of communication. At ABUTH, communication was predominantly vertical. Observation showed that consultants generally spoke first and junior or allied professionals were less likely to intervene unless

invited. The ethnographic account describes strong chain-of-command relationships and limited open dissent.

At UCH, communication was more multidirectional. Professionals discussed cases openly, challenged suggestions and used both formal meetings and digital communication channels to maintain contact. Weekly MDT meetings were particularly important. At UNTH, communication was more situational. When a full team was present, collaboration improved; otherwise, communication often occurred through telephone calls, notes or informal exchanges. The quantitative data therefore show reasonably functional communication across all three institutions, but ethnographic evidence demonstrates that communication effectiveness is not equivalent to communication inclusiveness.

4.4 Team Decision-Making Approaches

Shared decision-making was the most frequently selected formal decision-making model: 57.6% at ABUTH, 59.0% at UCH and 66.1% at UNTH. However, triangulation revealed an important difference between formal perceptions of shared decision-making and actual decision-making authority. At ABUTH, the consultant generally remained the final decision-maker. Other professionals provided input but were less likely to openly disagree. The ethnographic evidence showed that dissent was frequently expressed privately rather than during formal discussions.

UCH demonstrated the strongest convergence between quantitative and qualitative evidence. Professionals described open disagreement, negotiation and consensus-seeking. The consultant could retain final authority where disagreement persisted, but other professionals could influence the eventual decision. This represented a more genuinely interdisciplinary decision-making process. At UNTH, the quantitative finding of the highest reported shared decision-making was not fully supported by qualitative evidence. Participants described discussions involving several professionals but indicated that final authority commonly remained with the senior doctor. Family preferences could also become decisive in difficult cases. This represents one of the study's most significant mixed-method findings: shared participation in discussion does not necessarily mean distributed decision-making authority.

4.5 Ethical, Cultural and Family Considerations

Ethical frameworks were reported as being used "always" by 31.8% of ABUTH, 38.6% of UCH and 30.5% of UNTH respondents, while a further 37.9%, 32.5% and 40.7%, respectively, reported that ethical frameworks were used "often". The most frequently identified combination of ethical considerations involved end-of-life, religious and cultural issues: 28.9% at ABUTH, 22.9% at UCH and 30.5% at UNTH.

Family dynamics also influenced decision-making. They were reported as influencing decisions occasionally by 57.6% of ABUTH respondents, 50.6% of UCH respondents and 50.9% of UNTH respondents. Qualitative evidence showed that UCH incorporated family conferences more systematically, while ABUTH and UNTH tended to involve families more selectively or when major decisions and crises occurred. At UNTH particularly, cultural expectations surrounding death and dying could significantly influence discussions. These findings emphasize that MDT decision-making in Nigerian GPC is not purely clinical. It is simultaneously shaped by professional authority, ethical considerations, family expectations, cultural values and institutional practices.

4.6 Outcomes of MDT Approaches

The study found differences in how outcomes were evaluated. Periodic assessment of decision impact was reported by 43.9% of ABUTH respondents, 38.6% of UCH respondents and 40.7% of UNTH respondents. Regular patient-outcome monitoring was strongest at UCH (44.6%), followed by ABUTH (34.9%) and UNTH (28.8%). The qualitative evidence suggests that UCH integrated clinical and psychosocial

outcomes more consistently. Patient satisfaction was reported at 87.1%, accompanied by evidence of improved symptom control and stronger family engagement. ABUTH demonstrated clinically meaningful outcomes, including a reported reduction in readmissions of 22.6%, but psychosocial follow-up was less consistently integrated. UNTH achieved core clinical outcomes but demonstrated weaker continuity of care. Limited follow-up and pressure on available beds influenced how patients transitioned after discharge.

The study also assessed holistic care. Respondents rated MDTs as providing excellent integration of physical, emotional, social and spiritual care at 18.2% in ABUTH, 13.3% in UCH and 25.4% in UNTH. Adequate ratings were 39.4%, 36.2% and 37.3%, respectively, while "well" ratings were 34.9%, 36.2% and 30.5%. These findings should not be interpreted as demonstrating that one teamwork model alone caused better outcomes. Rather, the qualitative evidence indicates that the depth of integration, communication, family engagement and institutional support influenced how MDT practice translated into perceived outcomes.

4.7 Challenges

Resource limitations were the most frequently identified challenge to effective MDT decision-making: 45.5% at ABUTH, 47.0% at UCH and 50.9% at UNTH. Differing opinions among team members were second, at 30.3%, 28.9% and 25.4%, respectively. Communication difficulties ranged from 14.5% to 17.0%. Significant GPC-specific challenges such as lack of GPC specialists were reported by 62.1% of ABUTH respondents, 59.0% of UCH respondents and 64.4% of UNTH respondents. The qualitative findings add depth to these statistics. ABUTH was affected by workload, hierarchy, inadequate resources and limited empowerment of some team members. UCH experienced workload pressure despite stronger organizational support. UNTH faced particularly visible resource, staffing and infrastructural constraints.

Burnout was also evident. The quantitative field data reported "prevalent" burnout among 30.3% of ABUTH respondents, 28.9% of UCH respondents and 37.3% of UNTH respondents, with a further approximately 10% at each site reporting burnout as "very prevalent". Thus, resource scarcity was not simply a material problem; it influenced attendance, communication, role flexibility, continuity, staff stress and the capacity to sustain integrated teamwork.

5. Mixed-Methods Triangulation

The central value of the study emerges most clearly when the quantitative and qualitative findings are considered together.

Domain	Quantitative Pattern	Qualitative/Observational Evidence	Integrated Interpretation
Teamwork model	Multidisciplinary dominant: ABUTH 50.0%, UCH 45.8%, UNTH 52.5%	UCH more interdisciplinary; ABUTH hierarchical; UNTH adaptive	Formal classification masks different levels of functional integration
Decision-making	Shared decision-making >57% in all centres	Consultant authority persists, especially ABUTH/UNTH	Participation does not necessarily equal distributed authority
Communication	Mostly need-based	UCH multidirectional; ABUTH vertical; UNTH situational	Frequency alone does not capture communication quality

Domain	Quantitative Pattern	Qualitative/Observational Evidence	Integrated Interpretation
Holistic care	Majority rated MDT care well/adequately	UCH more consistently integrates psychosocial/family dimensions	Similar quantitative ratings may reflect different organizational processes
Outcomes	UCH strongest regular outcome monitoring	UCH combines clinical, psychosocial and family follow-up	Institutional integration appears important to outcome monitoring
Challenges	Limited resources largest challenge	Resource shortages shape attendance, role overlap and continuity	Material constraints directly affect teamwork functionality
Staff well-being	Burnout evident across sites	Strongest qualitative concern at UNTH and ABUTH	Team functioning and staff support remain interconnected

The triangulation demonstrates that MDT effectiveness is not determined simply by the number of professional disciplines represented. Rather, it is shaped by how those disciplines communicate, participate, negotiate authority, share responsibility and respond to institutional constraints.

6. DISCUSSION

The study demonstrates that multidisciplinary teamwork is the dominant formal model of GPC practice across ABUTH, UCH and UNTH. However, the qualitative and observational findings show that the three hospitals occupy different positions along a continuum from parallel professional practice to more integrated interdisciplinary collaboration. The quantitative dominance of the multidisciplinary model is consistent with the continued importance of discipline-specific professional roles in palliative care. Multidisciplinary structures can provide access to diverse expertise while retaining professional clarity. However, the study shows that such structures can become fragmented when communication is predominantly referral-based or when professional authority remains concentrated within one discipline.

This was most evident at ABUTH. The hospital possessed a relatively broad MDT structure, but strong hierarchy affected participation and decision-making. The result was a model that was formally multidisciplinary but functionally less integrated. This distinction is consistent with established descriptions of multidisciplinary teamwork as posited by Crawford, & Price (2003), in which professionals retain distinct identities and leadership commonly remains hierarchical.

UCH presented a different pattern. Its scheduled MDT meetings, broad participation, role clarity and open debate created conditions more consistent with interdisciplinary practice. The qualitative findings were especially important because they showed that professional integration occurred not simply because different cadres were present, but because they could influence discussions and decisions. This finding is important in relation to psychosocial care. GPC involves needs that extend beyond biomedical treatment. When social workers, nurses, pharmacists, physiotherapists and other professionals are able to contribute meaningfully, the patient's situation can be considered from multiple perspectives. WHO (2022), similarly emphasizes the multidimensional nature of palliative care and its role in addressing physical, psychosocial and spiritual needs. UNTH demonstrated an adaptive form of teamwork. Its interdisciplinary orientation

was often driven by necessity: the primary unit retained responsibility while other professionals were invited when required. Staff shortages also encouraged role overlap. Such flexibility can help sustain services under constrained conditions, but it may also create uncertainty about responsibility and continuity.

The findings regarding transdisciplinary teamwork require particular caution. Although respondents acknowledged elements of transdisciplinary practice, especially when professionals substituted for unavailable colleagues or shared responsibilities, the evidence does not demonstrate a fully institutionalized transdisciplinary model at any of the three hospitals. The appropriate conclusion is therefore that transdisciplinary elements are emerging rather than dominant. This interpretation is consistent with contemporary palliative-care literature by Yoshida, Yamauchi, & Suyama (2026), describing transdisciplinary practice as requiring deliberate role sharing, mutual learning and clear communication.

The findings on the decision-making approach of the teams also provide another important insight. Quantitatively, shared decision-making was reported by more than half of respondents in all three hospitals. Yet the qualitative evidence showed that the meaning of "shared" differed. At UCH, shared decision-making involved genuine discussion and negotiation. At ABUTH and UNTH, other professionals often contributed information but the consultant retained final authority. This distinction is particularly important in geriatric palliative care, where ethical decisions may involve patient autonomy, family preferences, cultural expectations and end-of-life choices. Family influence was substantial across all three hospitals, demonstrating that decision-making extends beyond professional boundaries.

The findings of the study on outcomes further indicate that institutional teamwork culture matters. UCH's higher patient satisfaction and stronger combination of clinical and psychosocial monitoring coincided with a more inclusive teamwork culture. ABUTH's clinically focused approach was associated with measurable clinical benefits but less consistent psychosocial follow-up. UNTH's resource constraints affected continuity. These findings should not be interpreted causally. The study design does not establish that one teamwork model directly produced a specific patient outcome. Rather, the evidence indicates that greater integration of teamwork coincided with more comprehensive approaches to patient and family care.

The challenges identified across all three hospitals reinforce this interpretation. Limited resources were the most commonly identified challenge in every institution. This finding is important because teamwork itself requires organizational resources: time for meetings, staff availability, communication systems, documentation, training and institutional support. This agrees with contemporary palliative-care literature as evidenced by Yoshida, Yamauchi, & Suyama (2026), who similarly identified workforce and resource pressures as significant challenges to maintaining high-functioning teams.

7. CLINICAL IMPLICATIONS

The principal clinical implication is that optimizing geriatric palliative care outcomes in Nigeria requires movement from fragmented multidisciplinary practice towards structured interdisciplinary teamwork that strengthens coordinated decision-making and holistic psychosocial patient care. The findings suggest that simply adding professional disciplines to an MDT will not necessarily produce integrated care. Clinical practice needs mechanisms that allow those professionals to communicate, contribute, deliberate and coordinate around shared patient goals.

8. IMPLICATIONS FOR STAKEHOLDERS

a. For health policymakers, there is a need for clearer institutional and national support for MDT-based palliative care, particularly for older persons with complex needs.

b. Hospital Management support should include protected time for MDT meetings, appropriate staffing, adequate infrastructure, communication systems and professional development.
c. Palliative-care professionals should strengthen interdisciplinary communication, shared planning and recognition of each discipline's contribution.
d. Professional training institutions should incorporate practical interprofessional collaboration, ethical decision-making, communication and psychosocial care.
e. Patients and families should remain active participants in care planning, particularly where decisions involve prognosis, treatment goals, cultural values and end-of-life preferences.

9. STRENGTHS AND LIMITATIONS

A major strength of the study is its comparative design across three tertiary hospitals and its integration of quantitative, interview, observational and organizational ethnographic evidence. This allowed the study to identify differences that would have been less visible from questionnaire data alone. The mixed-method approach was particularly valuable in revealing the distinction between reported shared decision-making and actual distribution of authority.

The study also has limitations. The cross-sectional nature of the quantitative component limits causal interpretation. The findings represent the selected institutions and should not automatically be generalized to all Nigerian hospitals. Self-reported data may also be influenced by respondents' perceptions and institutional sensitivities. In addition, the qualitative evidence demonstrates that teamwork models can overlap, making rigid classification difficult. These limitations reinforce the value of triangulation rather than reliance on a single measure of teamwork.

10. CONCLUSION

a. This study demonstrates that the multidisciplinary model remains the dominant formal approach to geriatric palliative care teamwork in ABUTH Zaria, UCH Ibadan and UNTH Enugu, reported by 50.0%, 45.8% and 52.5% of respondents, respectively. However, the practical functioning of MDTs differs substantially across the three institutions.
b. UCH demonstrates the strongest evidence of interdisciplinary practice, characterized by greater professional inclusion, structured meetings, shared deliberation, role flexibility and more consistent integration of clinical and psychosocial care. ABUTH demonstrates a broad but predominantly hierarchical multidisciplinary structure, while UNTH operates a pragmatic and adaptive model shaped strongly by resource limitations.
c. The study also demonstrates an important distinction between formal teamwork arrangements and actual teamwork functionality. Although shared decision-making was reported by more than half of respondents in all three institutions, qualitative evidence showed that senior medical authority remained influential, particularly at ABUTH and UNTH.
d. Transdisciplinary practice remains limited and emergent, appearing mainly through situational role flexibility rather than as a fully institutionalized model.
e. Ultimately, strengthening the total psychosocial well-being of patients requires more than assembling multiple professionals around the same patient. It requires an organizational culture in which professional knowledge is integrated, communication is inclusive, decisions are genuinely deliberative, patients and families are meaningfully engaged, and institutional systems provide the resources necessary for teams to function effectively.

11. RECOMMENDATIONS

Based directly on the findings, the study recommends that:

1. Hospitals should institutionalize regular, structured MDT meetings with protected time and documented outcomes.
2. Interdisciplinary teamwork should be strengthened, particularly through shared care planning, open communication and joint decision-making.
3. MDT leadership should encourage meaningful participation from non-medical professionals, particularly nurses, social workers, pharmacists, physiotherapists and other allied professionals.
4. Training in interdisciplinary collaboration and decision-making should become more regular, since current training was reported as predominantly occasional or rare.
5. Resources and staffing should be strengthened, because limited resources were consistently identified as the largest challenge across all three hospitals.
6. Family and cultural considerations should be formally incorporated into GPC decision-making, rather than being addressed only when crises arise.
7. Outcome monitoring should include psychosocial and family outcomes alongside clinical indicators, particularly continuity, family engagement and patient satisfaction.
8. Staff support and burnout-prevention mechanisms should be strengthened, especially in settings experiencing substantial workload and resource constraints.
9. Communication and documentation systems should be improved, including appropriate use of electronic records and other communication technologies.
10. Transdisciplinary elements should be developed cautiously and systematically, with clear role boundaries, mutual learning and communication mechanisms rather than informal substitution alone.

12. Contribution of the Study

The principal contribution of this study is its demonstration that teamwork models in Nigerian geriatric palliative care cannot be understood solely from formal team composition alone. The comparative evidence shows that the same label "multidisciplinary team" can describe substantially different organizational realities. The study therefore contributes a more nuanced understanding of MDT practice by showing three related but distinguishable patterns:

a. ABUTH: Multidisciplinary, hierarchical and medically centred
b. UCH: Multidisciplinary with stronger interdisciplinary integration
c. UNTH: Adaptive interdisciplinary practice under resource constraints

The findings consequently support understanding teamwork as a continuum of integration rather than merely a count of professional disciplines. This interpretation is consistent with the broader palliative-care literature, which distinguishes multidisciplinary, interdisciplinary and transdisciplinary approaches according to the depth of professional integration and role sharing. See Crawford, & Price, (2003).

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