ORIGINAL ARTICLE

Expectations and desires of palliative health care personnel concerning their future work culture

Beate André[1], Endre Sjøvold[2], Marte Holmemo[2], Toril Rannestad[1], Gerd I. Ringdal[3]

1. Faculty of Nursing, Sør-Trøndelag University College, Trondheim, Norway, Research Centre for Health Promotion and Resources, The Sør-Trøndelag University College (HiST) and Norwegian University of Science and Technology (NTNU), Trondheim, Norway. 2. Department of Industrial Economics and Technology Management, Faculty of Social Sciences and Technology Management, NTNU, Trondheim, Norway. 3. Department of Psychology, Faculty of Social Sciences and Technology Management, NTNU, Trondheim, Norway

Correspondence: Beate André. Address: Faculty of Nursing, Sør-Trøndelag University College (Hist), 7004 Trondheim, Norway. E-mail: beate.andre@hist.no

Received: January 4, 2013 **Accepted:** March 3, 2013 **Online Published**: March 6, 2013
DOI: 10.5430/jha.v2n3p46 **URL:** http://dx.doi.org/10.5430/jha.v2n3p46

Abstract

Introduction: Exploring the work culture of health care personnel is important in order to understand the challenges they face and the issues they experience. Believing in and shaping their futures indicates a working culture influenced by promoting factors. The aims of this study were to explore how health care workers at a Palliative Medicine Unit perceive their future work culture would be and whether they perceive that their expectations and desires will be fulfilled.

Design: A correlational study.

Methods: Health care personnel, physicians, nurses, physiotherapists, and others (N = 26) at a PMU in Norway completed a questionnaire according to the two perspectives, expectations (*future*) and desire (*wish*). The findings in these two perspectives were compared. The method seeks to explore what aspects dominate the particular work culture and identifying challenges, limitations, and opportunities. The findings were also compared with a reference group of 347 ratings of well-functioning Norwegian organizations, named the "Norwegian Norm".

Results: The findings for the wish perspective showed significant ($p<0.05$; $p<0.01$) higher rates for nurturing and synergy dimensions and significant lower rates ($p>0.05$; $p>0.05$) for opposition and control dimensions than the findings for the *future* perspective.

Conclusions: It appears that the health care personnel wish for changes that they don't believe they will achieve. The changes the respondents *wish* for are fewer negative work culture qualities, such as assertiveness and resignation, and more positive work culture qualities, such as engagement and empathy. Changes must be made to give the health care personnel improved working conditions and empowerment in order to change their situations to reflect what they wish for. The present findings can give an indication as to the direction that research ought to follow in subsequent studies.

Key words

Work culture, Palliative care, Desires, Expectations and health care personnel

1 Introduction

There is a wide range of organizational conditions and work processes that have the potential to shape the work culture and environment at a health care unit. Earlier research has sought to understand the influence of organizational culture and organizational climate on health care quality [1, 2]. Both concepts, organizational climate and organizational culture, are used to illuminate the environmental work culture in health care. The need to operationalize these concepts properly in order to be able to measure them is necessary both for researchers and health care managers with responsibility for health service outcomes [1, 2]. Organizational culture has been defined as the norms, values, and basic assumptions shared by members of an organization [2, 3]. Organizational climate refers to members' perceptions of organizational features such as decision-making, leadership, and norms about the work [2]. These aspects are easier to measure due to their tangibility, while values and beliefs are intangible [1, 2]. In doing research where the aim is to explore the specific factors in one particular working culture, we decided to use a questionnaire, based on psychometric principles, that aims to describe all three different levels: the visible aspects, the norms, and the underlying assumptions [4-6].

Earlier research has shown that work unit climate is associated with empowerment [7], and that a positive social working environment plays an important role in reducing burnout [8]. In managing the cultural diversity exhibited in health care for active fit and synergy, the issues of power and legitimacy may be important [9]. Organization of the work environment, such as work pressure, work load, role ambiguity, and relationships are primary predictors of stress and burnout among social workers [10]. Earlier findings show that nurses experience work-related injuries that are attributed to the stressful nature of their jobs [11]. Workplace empowerment and nurse satisfaction have been found to be related to higher-quality care and reduced patient risk [12]. Shortell et al. isolated attributes of the work environment and showed that they influence performance in acute hospitals [13, 14]. Both working conditions and employee empowerment were seen as factors that may improve job satisfaction [15-19]. Participation, good communication, conflict resolution, and empowerment were reported to be related to resident outcomes in nursing homes [15-22]. These studies show that organizational culture is an important factor that is also related to patient risk, mortality, and quality of care. Organizational support for nursing has been found to be a key factor for improving the quality of patient care [23, 24]. How health care professionals perceive their work culture is therefore important, not only to avoid burnout and increase job satisfaction but also to ensure quality of patient care [25].

Medical developments, including an increase in palliative options, have led to new approaches in supporting the dying [26]. At the time that palliative medicine was established as a specialty, the goal was to attain as high a health related quality of life (HRQOL) as possible for both patients and their families [26, 27]. Particularly in the final phase of a person`s life, it is considered to be of utmost importance to address the dying person's specific questions, wishes, desires, and needs [28]. To reach the goal of optimal HRQOL in palliative care medicine, there is a constant need for assessment and control [29]. These are important factors to take into consideration when conducting this study.

In our earlier study, we found that health care personnel working in a Palliative Medicine Unit (PMU) reported low scores on the dimensions of synergy and control [30]. Health care personnel also reported high degrees of both resignation and self-sacrifice. To follow up that study, we wanted to explore how the expectations of health care personnel for the future are congruent with how they wish the future would be. To obtain an understanding of the culture in the palliative medicine unit and how the health care personnel perceive their influences on their own futures, we have focused on two different perspectives: how the health care personnel expect their future will be, and how they desire their own futures would be through the perspective wish. The following research questions were explored:

- How do health care personnel at a PMU expect the *future* work culture will be?
- How do health care personnel at a PMU *wish* the future work culture would be?
- What are the differences between these two perspectives?

2 Materials and methods

The study was carried out during spring 2004 to obtain knowledge about the work culture at a PMU at a University Hospital in Norway.

2.1 Subjects and data collection

Of the 36 health care personnel working at the PMU, 26 (70%) filled in and returned the questionnaire. The sample consisted of 18 nurses, 2 physicians, 2 physiotherapists, and 4 other professions, for a total 25 females and 1 male or 26 respondent in all. The health care personnel at the unit work as multidisciplinary teams. They have regular meetings and discussions at the unit and have a good communication across professions. The questionnaires were distributed and filled in at morning meetings (in approximately 10 minutes) or delivered to mailboxes for those who were not present at the meeting. Two follow- ups were made. The sociodemographic data were equal for the personnel who participated and those who did not. The personnel who worked night shifts were more likely to not participate in the study.

2.2 Study design

This study was designed as a correlation study. One of the basic assumptions in this study is that predominant behavior is an artifact of the typical work culture in the unit. We compared the results for two different perspectives, "our future work culture" and "our desired work culture." As a reference group, the "Norwegian Norm" is used, which consists of the average of 1,800 ratings from individuals working in well-functioning Norwegian organizations using the same scale. We display this reference group as a guide to qualities that are probably important in organizations and for developing a higher level of maturity, with the synergy dimension as the dominant behavior but not as an ideal or a norm. The "Norwegian Norm" is presented in more detail in an earlier article [30]. The findings in the present study will be a comparison between the two perspectives and the "Norwegian Norm."

Participation in this study was voluntary for the informants, and they could withdraw from the study at any point. They were informed about the aim and purpose of the study. All registration of the informants was anonymous. The management of the unit approved and supported that the study were carried out.

2.3 Description of the instrument

The Systematizing Person-Group Relations Instrument (SPGR) was used for data collection and analyses. The respondents were asked to describe the two perspectives, "our future work culture" and "our desired work culture" at the unit. Each of the 24 items was rated according to whether the behavior described occurred (i) never or seldom, (ii) sometimes, or (iii) often or always. The numbers describe a mean value on a linear scale from 1 to 9.

Table 1. Elements of group constitution based on SPGR instrument

Dimension	Group function	Short description
C-N	Control	Structure, logic, authority
	Nurture	Caring, social orientation, openness
O-D	Opposition	Criticism, rebellion
	Dependence	Loyalty, conformance, submission
W-S	Withdrawal	Passive resistance
	Synergy	Engagement, constructive goal-oriented teamwork

Each of the 24 SPGR items describe organization behaviors along three dimensions labeled: control and nurture (C–N), opposition and dependence (O–D), and withdrawal and synergy (W–S). Each dimension has two vectors applied (Table 1). The theoretical foundation for SPGR and its psychometrics have been elaborated in previous studies and a thorough discussion can be found in earlier publications [6, 31-33].

2.4 Statistical analysis

Based on the SPGR results we conducted a two-tailed student t-test for significance between the two perspectives and the "Norwegian Norn".

3 Results

The mean value of the SPGR vectors state the work culture at the PMU unit for the perspective *future* and are compared with the "Norwegian Norm" and presented in Table 2. There were significant statistical differences in 10 of the 12 vectors.

Table 2. Ratings of "Future" versus "Wish" work culture along the twelve SPGR vectors compared with "Norwegian Norm"

Vector	Code	Typical behavior	Future	Wish	Future vs. Wish	N. Norm	Future vs. Norm	Wish vs. Norm
Ruling	C1	Controlling, autocratic, attentive to rules and procedures	3.03	2.07	*	3.58		**
Task-orientation	C2	Analytical, task-oriented, conforming	4.50	4.14		7.57	**	**
Caring	N1	Taking care of others, attentive to relations	6.26	7.47	**	7.40	**	
Creativity	N2	Creative, spontaneous	3.03	3.06		0.88	**	**
Criticism	O1	Critical, opposing	1.96	1.71		1.37		
Assertiveness	O2	Assertive, self-sufficient	3.42	0.99	*****	2.35	******	******
Loyalty	D1	Obedient, conforming	5.48	5.40		6.55	**	**
Acceptance	D2	Passive, accepting	5.18	6.03		7.60	**	
Resignation	W1	Sad appearance, showing lack of self-confidence	2.05	0.18	*	0.29	**	
Self-sacrifice	W2	Passive, reluctant to contribute	2.45	0.54	*	0.33	**	
Engagement	S1	Engaged, inviting others to contribute	6.95	8.46	*	8.29	**	
Empathy	S2	Showing empathy and interest in others	6.75	8.82	*	7.89	**	

* $p < 0.05$ ** $p < 0.01$ (2-tailed *t*-test)

The results revealed that the health care personnel working at the PMU describe their future working culture as characterized by high values on the vectors creativity (N2), criticism (O1), assertiveness (O2), resignation (W1), and self-sacrifice (W2). Furthermore, ruling (C1), task-orientation (C2), caring (N1), loyalty (D1), acceptance (D2), engagement (S1), and empathy (S2) have lower scores than the "Norwegian Norm."

The mean value of the SPGR vectors stating the work culture at the PMU unit for the perspective wish and are compared with the "Norwegian Norm" and presented in Table 2. There were statistical significant differences in 5 of the 12 vectors. The result revealed that the health care personnel working at the PMU describe their *wishes* for their working culture as characterized by high scores on the vectors caring (N1), creativity (N2), criticism (O1), self-sacrifice (W2), engagement

(S1), and empathy (S2). In the vectors ruling (C1), task-orientation (C2), assertiveness (O2), loyalty (D1), acceptance (D2), and resignation (W1), the scores were lower than the "Norwegian Norm."

The mean value of the SPGR vectors describing the work culture at the PMU unit for the two perspectives *future* and *wish* and the two perspectives are compared and presented in Table 2. There were significant statistical differences in 7 of the 12 vectors (Table 2).

In 6 of the vectors, i.e., ruling (C1), assertiveness (O2), resignation (W1), self-sacrifice (W2), engagement (S1), and empathy (S2), the difference was significant ($p<0.05$), and in one, caring (N1) ($p<0.01$) in the comparing the ratings of "Future" versus "Wish". In two of the dimensions, withdrawal and synergy, there were significant differences in both vectors ($p<0.05$) (Table 2).

4 Discussion

To obtain an understanding of the work culture in the palliative medicine unit and how the health care personnel perceive their influence on their own futures, we have focused on two different perspectives: how the health care personnel expect their futures will be and how they desire their future work culture would be. We wanted to explore research questions about how health care personnel at a PMU expect the *future* work culture will be, how health care personnel at a PMU *wish* the future work culture would be, and about the differences between these two perspectives.

Generally, the findings show that the unit was well balanced between being task-oriented and human-oriented. In the SPGR reference group, a good distribution between task orientation and human orientation is a sign of a well-functioning organization. However, when comparing an organization with the reference values for good functional organization, it is important to realize that these reference values cannot give specific guidelines for how a unit should function. It is natural that the values in an organization that cares for patients in their last phases of life are different compared to companies that are directed towards trade and the market, as one example. The factors that can illuminate the culture are the differences between the two perspectives *future* and *wish*, which represent what the respondents expect will happen in the future and what they desire for.

4.1 How do health care personnel at a PMU expect the future work culture will be?

It seems as though the respondents imagine that their *futures* will be influenced by a high degree of creativity (N2), criticism (O1), assertiveness (O2), resignation (W1), and self-sacrifice (W2), but less influenced by ruling (C1), task-orientation (C2), caring (N1), loyalty (D1), acceptance (D2), engagement (S1), and empathy (S2). Task-orientation (C2), caring (N1), creativity (N2), engagement (S1), and empathy (S2) can be characterized as positive qualities in the work culture, as long as they do not contribute to unbalance related to the other vectors. Furthermore, criticism (O1), assertiveness (O2), resignation (W1), and self-sacrifice (W2) represent more negative qualities in the work culture. The respondents imagine that their *future* work will be highly influenced by these negative qualities in their work culture. However, both working conditions and employee empowerment were different factors that may improve job satisfaction [15-19]. As mentioned earlier, i.e., resignation (W1), self-sacrifice (W2), criticism (O1), and assertiveness (O2) are negative qualities for the work culture that can lead to lack of empowerment. Participation, good communication, conflict resolution, and empowerment were reported to be related to resident outcomes [15, 16, 18-21]. Furthermore, Shortell et al. isolated attributes of the work environment and showed that they influence performance in acute hospitals [13, 14] and that organizations with positive cultures were more likely to have adopted and internalized continuous quality improvement programs [25]. To achieve both better job satisfaction and quality of care in palliative care, the negative qualities that respondents perceived in the work culture in this study must be minimized, and focus must be given to the qualities that are positive for the work culture.

4.2 How do health care personnel at a PMU wish the future work culture to be?

It seems as though the respondents *wish* for a work culture that is characterized by caring (N1), creativity (N2), criticism (O1), self-sacrifice (W2), engagement (S1), and empathy (S2), and that they *wish* for less ruling (C1), task-orientation (C2), assertiveness (O2), loyalty (D1), acceptance (D2), and resignation (W1). The respondents *wish* for a work culture closer to the "Norwegian Norm," and they seem to be engaged concerning the positive qualities that promote a constructive work culture, with high scores on caring (N1), creativity (N2), engagement (S1), and empathy (S2) and low scores on ruling (C1), assertiveness (O2), acceptance (D2), and resignation (W1). This is important because a positive social working environment plays an important role in alleviating burnout [8]. With higher scores on both the vectors in the synergy dimension, the respondents in this study *wish* for a work culture with engagement and constructive goal-oriented behavior. These factors are important in developing a dynamic work culture [33].

4.3 What are the differences between these two perspectives?

The *wish* and *future* perspectives show significant differences in 7 of the 12 vectors. The most interesting differences are in the vectors assertiveness (O2), resignation (W1), engagement (S1), and empathy (S2). In these vectors, the differences also indicate a difference according to how the findings related to the "Norwegian Norm." In the perspective *future*, the vectors assertiveness (O2) and self-sacrifice (W2) have higher scores than the "Norwegian Norm," but in the *wish* perspective, they have lower scores than the reference group. For the vectors engagement (S1) and empathy (S2), the findings show that the respondents had lower scores than the reference group in the *future* perspective and higher than in the *wish* perspective. The respondents imagine that their *future* work culture will be influenced by a high degree of assertiveness and resignation, but they *wish* for the opposite. They imagine that their *future* work culture will not be influenced by engagement and empathy, but they *wish* for the opposite. The respondents expressed a *wish* for changes in their current situations, but in their answers for their *future* situations, these attitudes were not expressed, which is natural if the respondents know that their wishes for the future cannot become reality. Caring for patients who are expected to die in a relatively short time could also influence this view. It might be easier for health care personnel working in these kinds of units to have hopes and wishes but not concrete plans for the future, when their patients have a short life expectancy.

As mentioned earlier, in order to manage the cultural diversity exhibited in health care for active fit and synergy, the issues of power and legitimacy may be important [9]. It seems as though the respondents in this study did not have the necessary power or legitimacy to change their work culture in the direction they *wish* for. In making those changes, the health care personnel must experience that their wishes and hopes for the future are important. This is important not only for giving the health care workers empowerment and legitimacy in their working situations but also to avoid stress and burnout [10]. It is important also for the quality of the care in these units because organizations with positive work cultures are more likely to have adopted and internalized continuous quality improvement programs [25].

4.4 Limitations of the present study

The sample in this study was quite small, with few respondents in each profession, and generalizing on this basis, therefore, will not be possible. This study also represents point estimation with the limitations that are involved. Furthermore, the study has been carried out in a field where this focus has not been described earlier. The present findings can give an indication as to the direction that research ought to follow in subsequent studies. This study was conducted in Norway on a Norwegian population. In Norway, work conditions are usually favorable for workers, so the results of this research could not be generalizable to other contexts without taking that into consideration.

5 Conclusions

The results of this study show that health care personnel have wishes for the future work culture that they don`t believe will come to pass. The respondents presented views and hopes for the *future* but expressed little faith in believing that the

future will be any different from the perspectives they experience today [30]. The changes the respondents *wish* for are fewer negative work culture qualities, such as assertiveness and resignation, and more positive work culture qualities, such as engagement and empathy. Organizational support, working conditions, and employee empowerment are factors that may improve job satisfaction [15, 17-19, 21, 23], and it seems as though the respondents in this study *wish* for a work culture that they don't expect to experience; that is not a satisfactory situation. Changes must be made to give the health care personnel at the PMU organizational support, better working conditions, and empowerment to change their own situations to those that they *wish* for. On the basis of this study future research can focus on how the variable used in this study may contribute to better understanding of work culture in different contexts.

Conflict of interests

We have no conflict of interests to report as regards this research, nor do we have any financial disclosures to make.

References

[1] Stone PW, Harrison MI, Feldman P, Linzer M, Peng T, Roblin D, et al. Organizational Climate of Staff Working Conditions and Safety-An. 2005.

[2] Gershon RRM, Stone PW, Bakken S, Larson E. Measurement of organizational culture and climate in healthcare. J Nurs Adm. 2004; 34(1): 33-40. http://dx.doi.org/10.1097/00005110-200401000-00008

[3] Sjøvold E, editor Group and Organizational Culture from the Viewpoint of Polarization 1998: Proceedings from the National Conference on Group and Social Psychology,Link"ping Universitet,Link"ping 7-8 may 1998

[4] Bales RF. Social interaction systems theory and measurement: New Brunswick: Transaction Publishers; 1999.

[5] Bales RF, Cohen SP. SYMLOG a system for the multiple level observations of groups. New York: The Free Press; 1979.

[6] Sjøvold E. Maturity and effectiveness in small groups. Nordic Psychology. 2006; 58(1): 43-56.

[7] Spreitzer GM. Social structural characteristics of psychological empowerment. Acad Manage J. 1996; 39(2): 483-504. http://dx.doi.org/10.2307/256789

[8] Leiter MP, Laschinger HKS, Day A, Oore DG. The Impact of Civility Interventions on Employee Social Behavior, Distress, and Attitudes. J Appl Psychol. 2011; 96(6): 1258-74. http://dx.doi.org/10.1037/a0024442

[9] Davies HTO, Nutley SM, Mannion R. Organisational culture and quality of health care. Quality in Health Care. 2000; 9(2): 111-9. http://dx.doi.org/10.1136/qhc.9.2.111

[10] Lloyd C, King R, Chenoweth L. Social work, stress and burnout: A review. Journal of Mental Health. 2002; 11(3): 255-65. http://dx.doi.org/10.1080/09638230020023642

[11] Hemingway MA, Smith CS. Organizational climate and occupational stressors as predictors of withdrawal behaviours and injuries in nurses. J Occup Organ Psychol. 1999; 72: 285-99. http://dx.doi.org/10.1348/096317999166680

[12] Purdy N, Laschinger HKS, Finegan J, Kerr M, Olivera F. Effects of work environments on nurse and patient outcomes. J Nurs Manag. 2010; 18(8): 901-13. http://dx.doi.org/10.1111/j.1365-2834.2010.01172.x

[13] Shortell SM, Rousseau DM, Gillies RR, Devers KJ, Simons TL. ORGANIZATIONAL ASSESSMENT IN INTENSIVE-CARE UNITS (ICUS) - CONSTRUCT DEVELOPMENT, RELIABILITY, AND VALIDITY OF THE ICU NURSE-PHYSICIAN QUESTIONNAIRE. Medical Care. 1991; 29(8): 709-26. http://dx.doi.org/10.1097/00005650-199108000-00004

[14] Shortell SM, Zimmerman JE, Rousseau DM, Gillies RR, Wagner DP, Draper EA, et al. THE PERFORMANCE OF INTENSIVE-CARE UNITS - DOES GOOD MANAGEMENT MAKE A DIFFERENCE. Medical Care. 1994; 32(5): 508-25. http://dx.doi.org/10.1097/00005650-199405000-00009

[15] Barry TT, Brannon D, Mor V. Nurse aide empowerment strategies and staff stability: Effects on nursing home resident outcomes. Gerontologist. 2005; 45(3): 309-17.

[16] Scott-Cawiezell J, Main DS, Vojir CP, Jones K, Moore L, Nutting PA, et al. Linking nursing home working conditions to organizational performance. Health Care Manage Rev. 2005; 30(4): 372-80.

[17] Temkin-Greener H, Zheng N, Katz P, Zhao H, Mukamel DB. Measuring Work Environment and Performance in Nursing Homes. Medical Care. 2009; 47(4): 482-91.

[18] Kostiwa IM, Meeks S. The Relation between Psychological Empowerment, Service Quality, and Job Satisfaction Among Certified Nursing Assistants. Clinical Gerontologist. 2009; 32(3): 276-92. http://dx.doi.org/10.1080/07317110902895309

[19] Flynn L, Liang YL, Dickson GL, Aiken LH. Effects of Nursing Practice Environments on Quality Outcomes in Nursing Homes. J Am Geriatr Soc. 2010; 58(12): 2401-6. http://dx.doi.org/10.1111/j.1532-5415.2010.03162.x

[20] Anderson RA, Issel LM, McDaniel RR. Nursing homes as complex adaptive systems - Relationship between management practice and resident outcomes. Nurs Res. 2003; 52(1): 12-21. http://dx.doi.org/10.1097/00006199-200301000-00003

[21] Scott-Cawiezell J, Jones K, Moore L. Nursing home culture - A critical component in sustained improvement. Journal of Nursing Care Quality. 2005; 20(4): 341-8.

[22] Temkin-Greener H, Zheng NT, Cai S, Zhao H, Mukamel DB. Nursing Home Environment and Organizational Performance Association With Deficiency Citations. Medical Care. 2010; 48(4): 357-64. http://dx.doi.org/10.1097/MLR.0b013e3181ca3d70

[23] Aiken LH, Clarke SP, Sloane DM, Sochalski J, Silber JH. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. JAMA-J Am Med Assoc. 2002; 288(16): 1987-93.

[24] Clarke SP, Rockett JL, Sloane DM, Aiken LH. Organizational climate, staffing, and safety equipment as predictors of needlestick injuries and near-misses hospital nurses. Am J Infect Control. 2002; 30(4): 207-16. PMid:12032495 http://dx.doi.org/10.1067/mic.2002.123392

[25] Shortell SM, Jones RH, Rademaker AW, Gillies RR, Dranove DS, Hughes EFX, et al. Assessing the impact of total quality management and organizational culture on multiple outcomes of care for coronary artery bypass graft surgery patients. Medical Care. 2000; 38(2): 207-17. http://dx.doi.org/10.1097/00005650-200002000-00010

[26] Van Kleffens T, Van Baarsen B, Hoekman K, Van Leeuwen E. Clarifying the term 'palliative' in clinical oncology. Eur J Cancer Care (Engl). 2004; 13(3): 263-71.

[27] Stromgren AS, Groenvold M, Pedersen L, Olsen AK, Spile M, Sjogren P. Does the medical record cover the symptoms experienced by cancer patients receiving palliative care? A comparison of the record and patient self-rating. J Pain SymptomManage. 2001; 21(3): 189-96. http://dx.doi.org/10.1016/S0885-3924(01)00264-0

[28] Sepulveda C, Marlin A, Yoshida T, Ullrich A. Palliative Care: the World Health Organization's global perspective. J Pain SymptomManage. 2002; 24(2): 91-6.

[29] Kaasa S, Loge JH. Quality of life in palliative care: principles and practice. Palliat Med. 2003; 17(1): 11-20.

[30] André B, Sjøvold E, Rannestad T, Holmemo M, Ringdal G. I. Work Culture among Healthcare personnel in a Palliative Medicine Unit. Palliative & Supportive Care. 2012 Oct.; 23: 1-6. (Epub ahead of print). http://dx.doi.org/10.1017/S1478951512000818

[31] Sjøvold E. Group in Harmony end tension: The development of an Analysis of Polarization in Groups and Organizations based on the SYMLOG Method. The Norwegian institute of Technology, 1995.

[32] Sjøvold E. The SPGR manual. Oslo 2002.

[33] Sjøvold E. Systematizing Person-Group Relations (SPGR) - A Field Theory of Social. Small Group Research. 2007; 38(5). http://dx.doi.org/10.1177/1046496407304334