

Chapter 7

Qualitative analysis of the Delphi surveys

Introduction

In this chapter the analysis of qualitative data collected through theoretical sampling is presented. Theoretical sampling occurs when additional data is collected in a specific manner for the purposes of adding to the existing codes, categories and core category. This process also identifies the properties of and links between the categories and the core category in order to advance the theory (Glaser 1978; Glaser & Strauss 1967).

The theoretical sampling in this study included data from the literature together with the qualitative and quantitative data from the two Delphi questionnaires. The literature was examined in order to ascertain if there was any new information that would add to the codes and categories that had emerged from the focus group interviews.

Selective coding was undertaken on the qualitative data obtained from the literature and the Delphi survey questionnaires. The quantitative data from the two Delphi surveys, which was also part of the theoretical sampling process, was analysed and reported in the previous chapter. Selective coding is the next step in the cycle of constant comparative analysis. It follows on after the open coding has produced codes, preliminary categories and categories that appear to reflect the essence of the data, i.e. data from the focus group interviews.

Selective coding is more analytical than open coding and uses conceptual and theoretical codes that are the essential components of the developing theory (Glaser & Strauss 1967). Selective coding moves the categories from being simple to more complex. At each stage of analysis there is more integration and refining of the codes and categories, which account for variations in the behavioural patterns of study participants.

Selective coding of the data obtained through theoretical sampling is also used to further identify the properties of and links between the categories and the core category, which are essential to theory development (Glaser 1978). Theoretical sampling is completed when the codes, subcategories, categories and core

category are saturated and have been integrated into the developing theory (Glaser 1978).

Literature as a source of data and its use in this study

A comprehensive review of the literature was undertaken to ascertain if there was data that would add to the six categories that had emerged. The second review was not confined to the contemporary literature due to the limited availability of research articles on transplant coordinators and their practice. To expand the search parameters, it was necessary to include empirical research and anecdotal articles written prior to 1993 and up to and including 2005 in the review.

The categories that emerged following the analysis of the focus group interviews were:

1. WORK DEMANDS AND CONDITIONS
2. KNOWLEDGE AND EXPERIENCE
3. CHARACTERISTICS OF THE ROLE
4. RELATIONSHIPS
5. EXPECTATIONS AND OUTCOMES
6. POOR REGARD FOR COORDINATORS AND THEIR ROLE.

Also of interest was the possibility that other researchers may have identified themes or categories pertaining to transplant coordinators and/or their practice that had not emerged from the focus group data. If this was the case they would also be included in the developing theory.

New themes or categories

The first category to emerge from the constant comparative analysis of the focus group data was **WORK DEMANDS AND CONDITIONS**. There were a number of relevant research articles available, some of which are discussed in Chapter Two, pertaining to the category. Anecdotal and historical literature suggests that transplant coordinators have considerable work demands and are often required to cope with challenging conditions.

Several authors/researchers discussed the issue of burnout within the transplant coordinator fraternity (Gimbel, Strosberg & Lehrman 2001; Mandefield, Wellington & Morgan 2001; Shafer, Van Buren & Andrews 1999; Taylor et al. 1998; Kennedy & Jones 1997; Wight & Cohen 1997). Mandefield, Wellington

Burnout

and Morgan (2001) discussed the need to develop a job and stress management course. The aim of this was to prevent burnout by recognising the many stresses of the role and offering coordinators strategies to assist them in addressing the demands of their profession.

This article evoked a positive response in the form of a letter to the editor of the *Journal of Transplant Coordination* from Duckworth (1997). The authors were commended for acknowledging employees who may be exposed to uncommon stresses and for taking positive steps to address the issues. This letter indicated there was a lack of recognition within organ donation and transplantation circles of the stressors and work demands and the subsequent limited resources available for addressing these issues.

Uncommon stresses

Research conducted by Gimbel, Strosberg and Lehrman (2001) highlights the demands and conditions they believe donor coordinators have to deal with on a regular basis:

The work environment of the OPO can best be described as fast paced, emotionally stressful, psychologically demanding, and arguably, extremely rewarding. Employees are frequently unable to separate their employment from their family life, because work responsibilities are not contained within normal business hours (Gimbel, Strosberg & Lehrman 2001, p. 250).

Others, who describe the transplant coordinators' role as multifaceted, share similar views, stating that the demands of the job necessitate advanced clinical skills and significant management abilities (Paris, Smith, Carlson, Aussi, Bak, Emmett, Kwan, Pennington, Lancaster & Paris 1998). Herbertt (1990) believes the role of the transplant coordinator is both emotionally and physically demanding. Other work demands and stresses reported in the literature included; on call commitments, long hours, irregular hours, sleep deprivation, difficulties interacting with medical staff, a lack of personal and family time, lack of acknowledgement, excessive workloads, poor quality 'off call' time and insufficient resources (Taylor et al. 1998; Elick 1997; Kennedy & Jones 1997; Smithers 1995; Haid et al. 1993).

Multifaceted role

In their article, Kennedy and Jones (1997) assert that procurement coordinators are exposed to and experience intense emotions and that their reactions to these emotions can negatively affect their health, wellbeing, work and home environments. This may lead to low staff morale and burnout resulting in increased staff attrition rates. Clarke (2002), a donor coordinator from Western

Australia, informs that although the role is extremely rewarding it is also very challenging both physically and psychologically.

The literature from the USA reflects a business-like approach to organ donation. *Organ donation as a business*

This is evident in the following statement:

Historically, the OPOs [sic] employees were involved in procurement in order to "help" people. However, in this age of cost containment and health care reform, the business aspects can no longer be ignored (Tham Hoffman 1996, p. 23).

This view is strongly supported by Shafer, Kappel and Heinrichs (1997). They believe that although organ donation and OPOs developed from a cottage industry in the early 1970s, it is now important that growing business principles be applied to their management. These organisations, like others, should have personnel such as a chief executive officer (CEO), an accountant, legal support, a human resource manager and staff who have skills in data management. These authors infer that OPOs need more than organ procurement coordinators and basic secretarial support to function in an efficient and productive manner. Shafer, Kappel and Heinrichs (1997) also state that adequate and appropriate staffing of OPOs may be the single most significant factor in maintaining and increasing organ donation rates.

In contrast, Doncliff (2000) suggests that business principles clash with the clinical culture of medicine, particularly nursing. As the large majority of transplant coordinators are nurses, it could be inferred that business principles also clash with transplant coordination. In the current economic climate with an increasing quest for efficiency and productivity, objective, measurable and quantifiable patient outcomes are the most valued by the business fraternity (Doncliff 2000). He believes that these business principles are inadequate when applied to the work of nursing, which he says, takes place within the parameters of the nurse-patient relationship. Doncliff (2000) believes the requirement for nurses to document every component of their practice, unlike other health professionals such as doctors, physiotherapists, psychologists and social workers who, he asserts, are given more professional freedom, is tantamount to preventing them from taking control of their own practice.

Doncliff (2000) argues that there are many aspects of the nursing role that are not open to reduction as is required in the business world. The physical care of patients is somewhat quantifiable. However characteristics and attributes that are difficult to articulate, document and measure include intangible aspects such

as the invisible labour and emotional work involved in patient care. The following coordinator scenarios support this: How does a nurse or transplant coordinator quantify and adequately document the intimate relationship between health professional and client? How does the coordinator quantify the support they give to a donor family, for example, listening to the life stories the family share about the deceased? How do they demonstrate 'the extra mile' they travel in order to help alleviate some of the families' suffering? A phone call at 3 am to say the retrieval operation is over, being there for a family during a viewing, holding the potential recipient's hand, a gentle touch or smile to reassure them prior to their surgery. These qualities and characteristics are the essence of nursing and transplant coordination. They are fundamental and inseparable to their practice. To ignore them is to disregard these professionals and the significant contributions they make.

*Invisible labour
& emotional
work*

The category **KNOWLEDGE AND EXPERIENCE** was represented in a number of ways in the literature. There was significant documentation about the demographic profiles of these health professionals suggesting that they are multi-skilled (Vincent, Repper & Peters 2002; Roels & Kranenburg 1996; McBride 1995; Shafer 1994; Jureidini 1993). This was supported by the fact that many of these health professionals have worked as both a donor and recipient coordinator – dual roles (Elick 1997). The diversity of the role is partly described by Herbertt (1990). She reflects this notion of multi-skilling in stating that transplant coordinators play a pivotal role in organ procurement. They are required to gain consent from donor families, support donor families, contact the designated officer of the hospital and the coroner, organise blood tests and tissue typing, and liaise with ICU staff, theatre staff, interstate coordinators, surgical teams and pilots. They coordinate all who have a role to play in the process of organ recovery.

Multi skilled

Shafer (1994) refers to recipient coordinators as health professionals who are responsible for coordinating a multidisciplinary team of physicians, nurses, social workers and other hospital personnel to guarantee a successful transplantation outcome for the patient in the short and longer term. Other duties performed by this group include monitoring post-transplantation patients for signs and symptoms of infections, rejection and the recurrence of disease (Elick 1997).

*Recipient
coordinators*

The other aspect of this category discussed regularly in the literature was the background of transplant coordinators. Although the majority of professionals are from a nursing background, others come from medical, psychology, scientific,

*Backgrounds
of the
coordinators*

health administration or social work backgrounds and an array of other professional and educational perspectives (Elick 1997; Roels & Kranenburg 1996; Jureidini 1993).

Transplant coordinator education and training was discussed superficially throughout the literature. Whilst there are a number of short courses conducted for transplant coordinators – some in conjunction with local universities, there appears to be very few specific university courses that provide transplant coordinator qualifications. This has implications in terms of the role being recognised as a profession (O'Neill 1994). Short courses offered include the Spanish Advanced International Training Course (Manyalich, Cabrer, Valero & Matesanz 1993), the ETCO courses in Europe (Kranenburg & Roels 1997; Roels & Kranenburg 1996), NATCO and the American Board of Transplant Coordinators (ABTC) who conduct certified courses and promote credentialing for transplant coordinators (Shafer 1994), and the recent International Course for Organ Donor and Transplant Recipient Coordinators conducted by ATCA and the South Australian Organ Donation Agency (SAODA) in Australia.

Education and training

Courses for coordinators

O'Neill (1994) believes that to be recognised as a profession, those involved need to monopolise a certain body of knowledge that is of some value to others. This he states is achieved by having control over the tertiary education of those admitted into the profession. It also means having control over the curriculum, providing lecturers from within the field, having the course accredited and having influence on the dissemination of the said body of knowledge (O'Neill 1994). The fact that transplant coordinators come from many and varied backgrounds, generally have no specific tertiary qualifications and poorly defined roles, together with a number of other factors cited by O'Neill (1994), limit their opportunities to professionalise their discipline.

The category **CHARACTERISTICS OF THE ROLE** that was discovered during analysis of the focus groups contains a number of intangible codes that are difficult to quantify. Several authors discussed job satisfaction and the intrinsic rewards that are a valued component of the transplant coordinators' practice. Examples of the comments made in the literature in relation to this code included:

Job satisfaction

The role is satisfying, challenging and rewarding (Maddison 1998, p. 24).

I like many things about my job, which is why I stay. I like the patient contact and the fact that the patients are like family to us. I like my staff and I like being inventive and flexible with the systems in place, to create

a pleasant work environment for all. I like the autonomy in my work ... (Debi Dumas-Hicks interviewed in Kaan 1999, p. 21).

The job can be highly rewarding ... (Clarke 2002, p. 7).

Another characteristic that was mentioned in the literature on several occasions and is highlighted in the following example is responsibility (Elick 1997; Roggen 1995). This reference also makes the point that coordinators are a vital component of the organ donation and transplantation network: *Responsibility*

The most important person in the program is the transplant coordinator, since he/she is responsible for the identification of potential donors, and thus the gatekeeper to organ donation (Gabel 1994, p. 479).

It is noted that the above statement refers to Spanish transplant coordinators – the majority of whom are medical practitioners. Cited in the literature also is the belief that the role of the transplant coordinator is unique. Other characteristics that emerged and were confirmed in the literature were accountability, challenges, autonomy and advocacy (Clarke 2002; Shafer, Van Buren & Andrews 1999; Shafer et al. 1998b; Shafer et al. 1998a): *Unique role*

The donor coordinator's role is unique and can be difficult to define (Clarke 2002, p. 7).

... and constantly refined their unique, diverse specialty (Elick 1997, p. 330).

One characteristic, which was discovered in the literature but only implied in the current research, was leadership. Shafer, Van Buren and Andrews (1999) discuss the importance of leadership in OPOs. They believe that in order to deliver excellence rather than mediocrity all OPOs need to have leaders who believe in their staff, are enthusiastic about the aims and philosophies of the organisation and are committed to excellence (Shafer, Van Buren & Andrews 1999). *Leadership*

The category **RELATIONSHIPS** that emerged as the potential core category from the constant comparative analysis of the data was frequently referred to in the literature. The significance of relationships in the field is summarised by Fox and Swazey (1992):

The donor who offers a part of his [sic] body for transplantation is making an inestimably precious gift. The acutely ill patient who receives the organ accepts a priceless gift. The giving and receiving of a gift of enormous value, we believe, is the most significant meaning of human organ transplantation. This extraordinary gift exchange, moreover, is not a private transaction between the donor and the recipient. Rather, it takes place within a complex network of personal relationships that

extends to the families, the physicians, and all the members of the medical team who are involved in the operation. Within the network of these relations, a complex exchange occurs through which considerably more than the organ is transferred (Fox & Swazey 1992, p. 30).

This evaluation of the effects the organ donation and transplantation process has on relationships agrees with the thoughts of Starzl (1992) discussed in Chapter One and his belief that no-one stays the same once they have been involved in this area. Interestingly, none of these authors mentioned transplant coordinators in the included passages of text - the only individuals who remain with the donor and in the case of transplantation, the recipient for the entire process. This omission may reflect the invisible labour and emotional work that coordinators contribute to the field. Although it is a fundamental component of their role, it may be unrecognised or undervalued by other professionals including those involved in organ donation and transplantation.

*Invisible labour
& emotional
work*

Holtkamp (2002) recognises this aspect of the transplant coordinators' practice, which is only mentioned occasionally in the literature. She highlights the importance of caring for the carers who provide the ongoing emotional support to others:

*Caring for the
carers*

The emotional cost of caring for donors and donor families must be recognized by those with positional power to address such issues. Caring for the caregiver is as much about reverence for life as is caring for the recipient, the donor and the donor's family (Holtkamp 2002, p. 189).

Stockdale and Warelow (2000) support this notion stating that a health system of value does not require its carers to be self-sacrificing but should advocate appropriate care for oneself. They also point out the paradox of simultaneously - caring for patients/clients, working within the confines of the institution that employs them with its accompanying ethical obligations and work ethos, whilst attempting to adequately care for oneself. Their observations epitomize the difficulties experienced by most individuals involved in a 'caring' role.

Elick (1997, p. 329) also makes the point that in the early years transplant coordinators formed working relationships that 'knew no boundaries'. Implicit in this statement is the level of cooperation, teamwork and commitment shown by coordinators to put the needs of the patients and their families first and themselves, a 'poor' second.

There were very few references made in the literature to the category **EXPECTATIONS AND OUTCOMES**. One comment made by Shafer (1994)

referred to the integral role the clinical coordinator has in ensuring successful outcomes for transplant patients.

Transplant coordinators also mentioned recipient outcomes in the literature.

Examples of these comments are shown below:

... to play a small part in improving the quality of life of someone is reward in itself (Maddison 1998, p. 24).

It is also very rewarding when the outcome is a new quality of life for the recipients and their families (Herbertt 1989, p. 6).

The successes are easy to celebrate. The failures are very challenging, both professionally and at times personally, it hurts and as a transplant unit we grieve (Chester 2002, p. 9).

Such statements confirm that successful recipient transplant outcomes are an important component of the transplant coordinators' role.

There was also some discussion in the literature on donor family and recipient contact. O'Neill (2000) warns of the pitfalls of facilitating face-to-face contact between these parties. He asserts that the driving force for this type of contact appears to be initiated by donor families and organ donation agencies, whilst anecdotal evidence suggests that the recipient population rarely initiate this type of contact. O'Neill (2000) offers no references for these statements.

*Donor family &
recipient
contact*

Other authors argued that face-to-face contact between donor families and recipients is already a reality, occurring with or without the knowledge of health professionals in the field. They believe it is time to establish guidelines and national policies for all parties concerned to establish some uniformity and consistency should donor families and recipients choose to meet (Corr, Coolican, Nile & Noedel 1994).

The final category, which emerged from the analysis of the transplant coordinator focus group data, was **POOR REGARD FOR COORDINATORS AND THEIR ROLE**. There appears to be limited confirmation of this category in the current literature. Reasons for this may include: coordinators who are reluctant to discuss such difficult and serious issues; coordinators who are prepared to maintain the status quo; limited opportunities to discuss their own issues and feelings; fear that they may be disciplined for speaking out; or the fact that this type of behaviour may not have been problematic in the past.

There is documented anecdotal evidence to suggest that transplant coordinators were and continue to be valued. Paris et al. (1998) proclaim that in the early

*Coordinator
value*

literature they reviewed, there was considerable value placed on the transplant coordinator's role. Personally, this is a fair assessment. Certainly, Elick (1997, p. 330) confirms the point in her work when she says that transplant coordinators' voices were heard. A more recent author reiterates this sentiment when he refers to 'the excellent work of donor and transplant coordinators over recent years' (Forbes 2000, p.5).

However, upon further exploration, evidence in the literature suggests there are elements of poor treatment and undervaluing of these health professionals as disclosed in the following statements. Transplant coordinators may not be the only ones who are exposed to or experience such difficulties in the work place:

Exit interviews and employee surveys frequently cite lack of recognition as a primary source of job dissatisfaction (Haid et al. 1993, p. 18).

One transplant coordinator described the indoctrination process, and subsequent independence as "trial by fire" (Gimbel, Strosberg & Lehrman 2001, p. 252).

In many instances, there is no "life line" or other support mechanisms for the coordinator ... (Gimbel, Strosberg & Lehrman 2001, p. 252).

... often working horrendous hours with little food or emotional support ... (Gimbel, Strosberg & Lehrman 2001, p. 253).

Taylor et al. (1998) cite a lack of appreciation by medical professionals as another reason why transplant coordinators wish to leave their employment. This is supported in the current study.

In summary there is a paucity of literature on recipient coordinators with most of the available research and anecdotal literature focusing on organ donor coordinators, organ donation and/or procurement organisations. There is also considerable overlap between the categories, which suggests that they are closely linked or interlinked. The only new code, which was discovered in the second review of the literature, was leadership and even then there was limited information available on this aspect of the transplant coordinators' role. This code became part of the category – **CHARACTERISTICS OF THE ROLE**. Whilst a number of the codes and categories that emerged from the focus group data are represented in the literature, it is a superficial representation.

Analysis of the first Delphi survey questionnaire

At this stage of the constant comparative analysis, stage 1 – **coding the data and comparing events within and between categories**, was beginning to

merge with stage 2 – **integrating categories with their properties** and stage 3 – **delimiting the theory** (Glaser & Strauss 1967). Analysis is not a linear process as it is necessary to revisit stages in the search for codes, categories, the core category, properties of and links between categories that are required to develop the emerging theory. Thus there are no clear delineated markers to identify when one phase of analysis ends and another begins. There may be ambiguity as to which stage of the process the research is at but this dissipates as the theory emerges from the data.

As the statements for the first Delphi survey were informed by the data obtained from the focus group interviews it was anticipated that the new data would assist in the identification of the category properties and the links between the categories and the core category. The analysis of the first Delphi survey is discussed below. Included in the discussion are examples of the data from the first round of the Delphi survey used to develop and expand the codes and categories.

The bold print in the diagrams indicates that information from the first Delphi survey was used to expand the code. Non-bold print indicates that no new information was added to the code from the survey and new codes are identified in the diagrams with an asterisk.

In relation to the presentation of quantitative data, Glaser and Strauss (1967, p. 203) caution against using the usual style of presentation commonly associated with quantitative data. They believe that it should not be used to generate theory; but suggest that the ‘analyst must take some liberties both in presenting tables and in making statements about them’. They also recommend that:

... for generating theory not all data must be presented and stated in exact detail. Since the possibilities are great, each analyst must decide on various liberties according to his [sic] particular directions of effort (Glaser & Strauss 1967, p. 203).

For the purposes of this thesis the quantitative data analysis has been presented separately and was reported in Chapter Six. However, where appropriate this information will be used to assist in the illustration and/or expansion of the codes, categories and theory development.

WORK DEMANDS AND CONDITIONS

As it suggests, the category **WORK DEMANDS AND CONDITIONS** describes the work demands experienced by the transplant coordinators and the conditions

that they believe impact on their practice. There were five new codes that emerged from the analysis of the first Delphi survey questionnaire that were added to this category as shown in Figure 7.1.

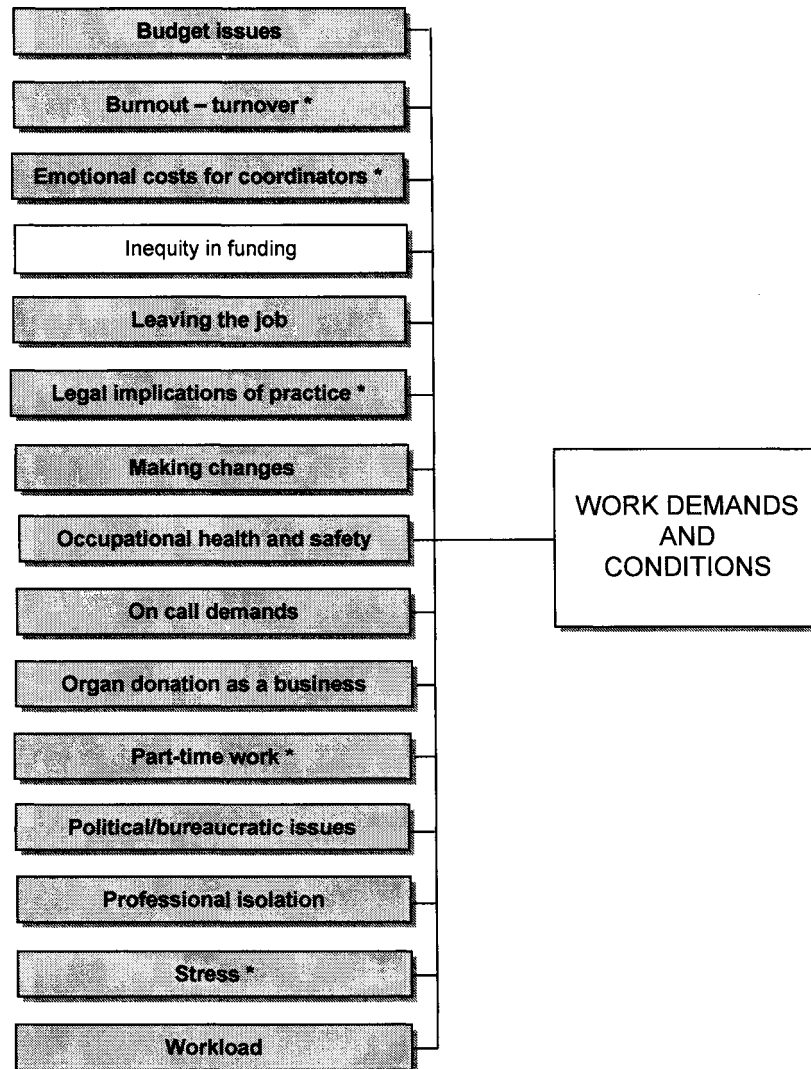


Figure 7.1: Category - Work demands and conditions

Budget issues

A number of comments were made by the participants, which were placed into the code *budget issues*. Below are two examples:

Training a coordinator is costly in terms of time and money and one would think there would be greater concern within the agencies about this difficulty (DS1, p. 113, L. 18-20).

Coordinators for the most part are not even paid on a professional salary scale but an administrative scale. Given that coordinators are required to have; a good knowledge of medical matters, counselling skills, they are

required to perfuse organs in theatre, do undergraduate and postgraduate education at universities, be involved in research, community education ... I find it personally insulting not to be either treated as a professional nor to be paid as one (DS1, p. 114, L. 21-26).

Burnout – turnover

There is some overlap between the new code *burnout – turnover* that emerged following the analysis of the first Delphi survey and *leaving the job*. In a number of cases examples from the data could have been placed in either code. The following comments are examples:

I loved my job but the burnout rate is high and I am a victim (DS1, p. 117, L. 2).

The rate of 'burnout' of coordinators is high due to the long hours of work, stress and underpay (DS1, p. 122, L. 10-11).

Emotional costs for coordinators

This was another code that emerged following the analysis of data from the Delphi survey. Several comments indicated that there are significant emotional costs to the coordinators:

There is resentment of the personal cost the job takes from us, we give so much to bereaved strangers, care for health professionals, consistently answer to politicians, work long hours - with interrupted breaks - no one really understands the effects of this job until you hit a point you can not do it anymore! No one really thanks us! (DS1, p. 110, L. 3-7).

Overall I enjoy my recipient coordination role but I definitely enjoy having a break from it (annual leave) and handing over to someone else to experience the role in my absence. On my return the relieving person usually comments on the diversity of the role and how they hadn't truly had an idea of how demanding and taxing the role can be both physically and emotionally (DS1, p. 120, L. 26-31).

Leaving the job

Most of the data coded in *leaving the job* relates to the coordinators' excessive *workload* and the personal costs many experience in the role, especially ones that lead to a high burnout rate. This is highlighted below:

Cumulative effect of working in the environment usually goes unrecognised by a) the individual and b) the agency. End result is eminently predictable – high turn over rate (DS1, p. 109, L. 28-29).

Increasingly [there is a] high turnover of staff in transplant coordination. In past years ie from the beginning of transplantation until the advent of the new agencies donor coordinators remained fairly stable through out Australia. They tended to remain in the job for years. Since the advent of the agencies there has been a huge turnover of staff. Most of the old

hands have gone and new staff are lucky if they stay eighteen months. I think this is an issue of great concern (DS1, p. 113, L. 13-18).

Legal implications of practice

Below are two participants' comments included in this new code that emerged from analysis of the Delphi survey data:

On call – responsibility, taking calls from patients, assessing patients' clinical status over the phone. What if advice is 'wrong' and the patient suffers [the] consequences, where does [the] transplant coordinator stand legally. No backup (DS1, p. 112, L. 5-7).

The legalities surrounding our role regarding tissue donation etc should not be taken lightly and we should be supported by education (DS1, p. 120, L. 16-17).

Making changes

There was only one example relating to the code *making changes* that emerged from the analysis:

It is difficult for those who have been in the role with all the new changes and new staff and it is the older [more experienced] donor coordinators that have the largest responsibility (DS1, p. 109, L. 34-35).

Occupational health and safety

Statement 7: There are occupational health and safety issues in my role.

There was a specific statement included in the first Delphi survey relating to this code. Of the participants 76.5% agreed with statement 7. Examples of the comments made include:

Extensive working hours and the ability to perform and make sound judgements is compromised by long working hours. Coordinators can be martyrs and believe that they are the only ones who can care for donor families (DS1, p. 25, L. 3-5).

Working for extended length[s] of time without [a] break. Having to run clinics after having not slept (DS1, p. 25, L. 11-12).

Most comments related to the dangers of working excessively long hours, which the participants said impaired their judgement and made driving a vehicle hazardous. Other areas of concern were lifting heavy eskies, dealing with infectious patients (recipients) and the dangers inherent in emergency transportation.

On call demands

There were a number of examples that emerged in the Delphi survey relating to the *on call demands* placed on transplant coordinators. In the example given the coordinator makes the point that not only do the *on call demands* have a significant impact on coordinators and their families but she also believes the level of remuneration for on call commitments is unsatisfactory:

On call allowances for coordinators is paltry ranging from seven dollars to ten dollars per weeknight and seventeen to twenty dollars on weekends. Given the very real impact that this has on donor coordinators and their families it is a ridiculous sum (DS1, p. 113, L. 34-35; p. 114, L. 1).

A number of examples reflected these sentiments with coordinators commenting on how poorly paid on call is and the impact it has on both them and their family lives.

Organ donation as a business

Statement 21: The management of organ donation and transplantation has moved from being an altruistic endeavour to one that is managed/dictated by bureaucracy.

Statement 21 addressed this code in the Delphi survey. Of the participants 45.1% agreed with the statement, 32.3% were unsure and 20.6% disagreed. Two participants did not answer. Examples of the comments made about this statement included:

Possibly true. Bureaucracy is purely 'value for money' and 'numbers' driven. Altruism is not quantitative and all the many nuances involved in everyone doing their very best for donor families is essentially invisible (DS1, p. 78, L. 12-14).

In my experience – the change has been for the better ie [the] establishment of state agencies (DS1, p. 81, L. 21-22).

Part-time work

Part-time work was a new code that emerged during the analysis of the first Delphi survey questionnaire and below are two examples of relevant data:

I currently work two part-time jobs, which adds quite a lot of juggling and strain. Both positions are as a donor coordinator, one as a state coordinator and the other as an area coordinator. Although the positions overlap I feel that both employers have benefited with my additional experience and insight (DS1, p. 117, L. 19-22).

The employment of coordinators on a part-time basis caused all kinds of difficulties. ... part-time coordinators are often expected to work on call or do other duties when they are not employed by the agency. In other

words they are expected to do at least three quarters of a workload for half time pay (DS1, p. 114, L. 34-35; p. 115, L.1-3).

Political-bureaucratic issues

Statement 21: The management of organ donation and transplantation has moved from being an altruistic endeavour to one that is managed/dictated by bureaucracy.

This code was also addressed in the Delphi survey by statement **21** shown above. Comments were diverse ranging from relatively positive to those that strongly opposed the perceived or actual increase in political-bureaucratic control as is evident in the second example given below:

Management of resources is an open invitation to bureaucracy. However, resources do need to be managed effectively for the best, for the greater number (DS1, p. 78, L. 22-23).

This is one of the worst things to happen in recent times and it has made no difference to organ donation rates. The whole thing has become top heavy with people pushing their own barrows, making careers pushing paper around desks, spending huge quantities of government money with no discernable outcomes (DS1, p. 79, L. 21-24).

Professional isolation

Statement 5: I experience professional isolation.

This code was addressed in the survey by statement **5**. Of the participants in the research 57.8% indicated they felt professionally isolated, 10.8% were unsure and 31.4% indicated they did not feel professionally isolated. Comments included:

Sometimes very isolated except when attending conferences (DS1, p. 17, L. 13).

I worked in isolation – received modest support from one of two senior medical staff when required (DS1, p. 7, L. 18-19).

Several participants said that although they worked alone professional isolation was not problematic for them. A number of respondents also stated that they had good working relationships with other colleagues and networked with interstate coordinators via the telephone or email, which alleviated their feelings of professional isolation.

Stress

There were a number of comments that were included under the newly emerged code of *stress*. Many of these comments related to the psychological *stress*

experienced by this group of health professionals rather than *stress* of a physical nature:

This job attracts very dominant assertive 'A' type personalities – working with these people daily becomes very stressful and difficult at times (DS1, p. 117, L. 10-11).

To do this job requires the transplant coordinator to move from comforting donor families one moment to professional high-powered technical interaction the next and back again a moment later. Emotions run high, time frames are short [and] expectations are extraordinary. You walk a tight rope every step of the way. You need to be everything to everybody (DS1, p. 112, L. 18-22).

Workload

Statement 4: My work responsibilities encroach on my private life.

This code was addressed in the survey by statement 4. Almost 80% of the respondents agreed with this statement. A significant number of the participants' comments centred on how on call responsibilities impact on their private lives as is reflected in these two examples:

Absolutely dominate it [my private life]. The amount of 'on call' is ridiculous (DS1, p. 13, L. 27).

On call requirements impact heavily on private life (DS1, p. 14, L. 11).

There would appear to be considerable overlap between the codes *on call demands* and *workload*. For another coordinator, even though the workload was considerable, she saw the position as providing a degree of flexibility to do other things as is demonstrated in the following response:

Yes but that variation in life is a part that I like. It works both ways to give me the freedom I need to fit in my study (Uni Course) (DS1, p. 15, L. 21-22).

KNOWLEDGE AND EXPERIENCE

This category incorporates key concepts relating to the transplant coordinators' *knowledge and experience*. It includes the coordinators' *education* needs, *use of skills*, *standardisation*, *career structure* and participants' thoughts regarding the requirement of a nursing background to adequately perform the role. One new sub-code *career structure* emerged in this category following the analysis of the first Delphi survey as shown in Figure 7.2.

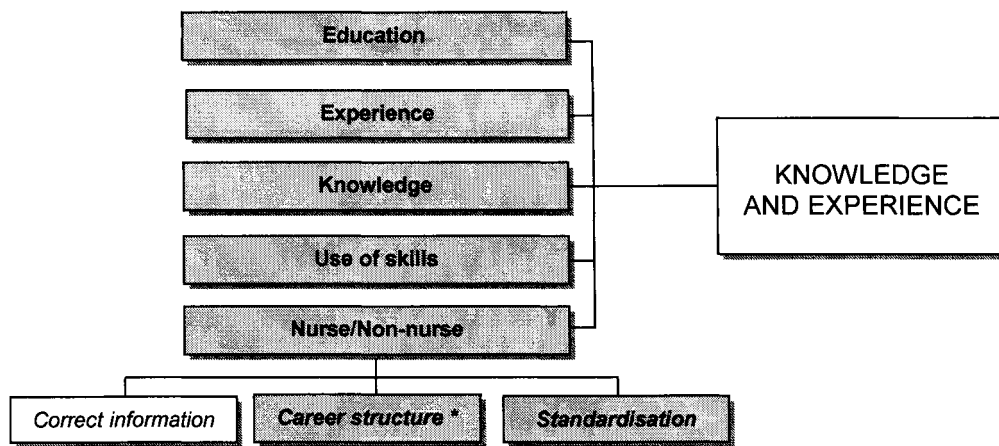


Figure 7.2: Category - Knowledge and experience

Education

Items coded under *education* included statements relating to the transplant coordinators' *education* needs and those relating to educating others about organ donation and transplantation:

Unable to gain any formal qualifications to support my role due to virtually nothing [being] available (DS1, p. 109, L. 25-26).

I find many people have no idea [about] what organ donation entails. Their understanding of who can donate organs is very diverse. I think education and awareness of organ donation issues is essential if we are going to have an impact on creating a more positive attitude toward organ donation (DS1, p. 111, L. 28-31).

There was also some discussion regarding the need for formal tertiary qualifications in the field and that the training for transplant coordinators should be more comprehensive:

Need for formalised tertiary education in organ donation (DS1, p. 118, L. 9).

Training needs to be comprehensive. Case studies, management of patients, scenarios and problem solving (DS1, p. 118, L. 33-34).

All of the participants in the study had some form of hospital and/or tertiary qualification, which were not transplant coordination specific. However, almost 67% declared they had no specific qualification in the organ donation and transplantation field. Those that had transplant coordination qualifications ranged from completion of the Australasian Donor Awareness Programme for Transplantation (ADAPT) Course, short transplantation courses, for example the International Course for Organ Donor and Transplant Recipient Coordinators

conducted in Adelaide, South Australia or alternatively units of study in relation to the topic of transplantation. These subjects were offered within the curriculum of a tertiary nursing degree.

Experience

Statement 13: I think 'on the job' experience is important in this job.

The code *experience* was addressed in the survey by statement 13. The statistical analysis showed that 98.0% agreed with this statement. This is also reflected in the following examples:

Can't learn this job in a classroom. No two donors [and] their families are the same. Coordinators need to 'think on their feet' and be aware of the domino effect their decisions have on transplant units, donor hospitals and families (DS1, p. 45, L. 2-4).

Can only learn by doing it (DS1, p. 45, L.9).

Absolutely I believe my vast case experience, greater than three hundred cases, made me a more caring and knowledgeable donor transplant coordinator (DS1, p. 46, L. 20-21).

Knowledge

Statement 12: A high level of organ donation and transplantation knowledge is required in my position.

Statement 12 in the Delphi survey addressed the code *knowledge*. Analysis of the quantitative data showed that a high level of *knowledge* in the field was thought to be a vital component in relation to the transplant coordinators' practice. Of the participants 97% agreed with this statement. Analysis of the qualitative data also confirmed this result with most respondents indicating that a high level of *knowledge* as well as *experience* in the area were important:

'On the job' training is not enough. This needs to be backed up with formal training. There is a large degree of knowledge required as we are seen as the 'experts'. This knowledge is in regard to process issues, legal, ethical, [and] grief [issues] (DS1, p. 41, L. 29-31).

As a recipient coordinator you need to be very knowledgeable regarding transplantation issues so you can educate and inform patients on all aspects of the transplant process (DS1, p. 42, L. 3-4).

Use of skills

Statement 14: My position enables me to use many skills.

This code was addressed in the Delphi survey by statement **14**. In response to this statement participants were unequivocal in their agreement as is shown in the quantitative data and the qualitative responses shown below:

The role is very diverse and requires numerous skills (DS1, p. 49, L. 32).

Job allows the development of a wide variety of skills, which is challenging but rewarding (DS1, p. 49, L. 1-2).

I have increased skills as a direct result of my job (DS1, p. 50, L. 16).

Nurse – non-nurse

The code *nurse – non-nurse* was discussed extensively in the recipient coordinator focus group (see Chapter Five). Participants in the focus group felt that coordinators needed to have a nursing or medical background in order to perform the role. In contrast the donor coordinator focus group participants were less concerned with this issue - perhaps because they had non-nurse colleagues who they believed performed adequately.

Statement 15: The coordinator role is one that can be done by non-nursing health professionals.

Given the differing opinions that were put forward in each of the focus groups regarding this issue, statement **15** was included in the first Delphi survey to see if consensus could be reached. The statistical analysis indicated that 24.5% of the participants agreed with this statement, 23.5% were unsure and 52.0% disagreed with the statement. Examples of the comments made in the survey that indicated agreement included:

Nursing training can only partially prepare a person to be a coordinator. It does not mean that the person has interpersonal skills, organisational and stress management skills. I believe that being labelled, as a 'nurse' is one of the reasons that the profession has lacked suitable acknowledgement. In the hospital hierarchy a functioning coordinator needs to be working at the same level as medicos, nurses, technicians, surgeons and other health colleagues and not be 'just a nurse' (DS1, p. 53, L. 5-10).

Yes but you need some very good medical knowledge to do it well. For example I see no reason at all why medical scientists couldn't do it. In fact some of the longest serving and very good coordinators have shown they can do this job, with no nursing background. I think nurses think that they should be the only ones to do it but that's 'discrimination' as far as I am concerned. In fact I would argue that this job requires such a range of skills and expertise that in some cases nurses are likely to be less

suitable than some other professions (DS1, p. 52, L. 32-35; p. 53, L. 1-3).

Comments from respondents that indicated disagreement or uncertainty about the statement included the following examples:

This position requires specialist knowledge in transplantation. Monitoring tests, frontline patient assessment are only two examples of many that support this position as a highly skilled nurse based role (DS1, p. 51, L. 27-29).

Doing the job is one thing, how effectively it is executed is another. There are clear benefits to having a nursing background especially when discussing, pathology results and [the] use of medications (DS1, p. 51, L. 23-25).

It does help to have a basic understanding of medical terms, to understand the patients' history and tests. Although this can be learnt over time. I have found ICU experience very helpful (DS1, p. 52, L. 1-3).

Non-nursing health professionals are a minority group in this area of health care. As there were only five non-nurses represented in the study cohort, results and comments should be viewed with caution, as there is a bias toward the views of the nurses represented in the study.

Career structure

Career structure was a new sub-code of the code *nurse - non-nurse* that emerged following the analysis of the first Delphi survey questionnaire. An example of the data included in this sub-code is shown below:

Many new young transplant coordinators feel that there is nowhere to go from here. There is no career path or structure attached to transplant coordination. Little wonder that new young coordinators are giving it away so quickly (DS1, p. 114, L. 27-29; p. 114, L. 33).

Standardisation

Statement 16: The roles of transplant coordinators throughout Australia and New Zealand need to be standardised.

The second sub-code relating to the code *nurse - non-nurse* was *standardisation*. This code was addressed in the Delphi survey by statement 16. There was a mixed response to this statement with 47.1% believing there should be standardisation of the roles, 31.4% were unsure and 18.6% did not believe standardisation was necessary and/or possible. The statistical results were also supported by the participants' comments:

Disagree from a professional practice point of view. From [an] industrial point of view agree (DS1, p. 56, L. 18).

Standardisation of the roles would help towards professional recognition of transplant coordinators (DS1, p. 58, L. 29-30).

This would be difficult to achieve with so many units operating differently (DS1, p. 59, L. 16).

Credentialing is a way for this to happen (DS1, p. 59, L. 18).

Depends on definition of standardisation – maybe credentialing is better (DS1, p. 60, L. 32).

CHARACTERISTICS OF THE ROLE

This category addresses a number of aspects of the profession, most of which may attract transplant coordinators to the role. These include *autonomy*, *challenges*, *credibility*, close connections with people which was referred to as *intimacy of the job*, *job satisfaction*, *power*, *respect*, *responsibility* and the actual or perceived *uniqueness* of the role. Two new codes emerged in this category. The first was *ambivalence*, which emerged following the analysis of the first Delphi survey. The second was *leadership*, which emerged following the second review of the literature. Figure 7.3 provides a diagrammatic overview of this category.

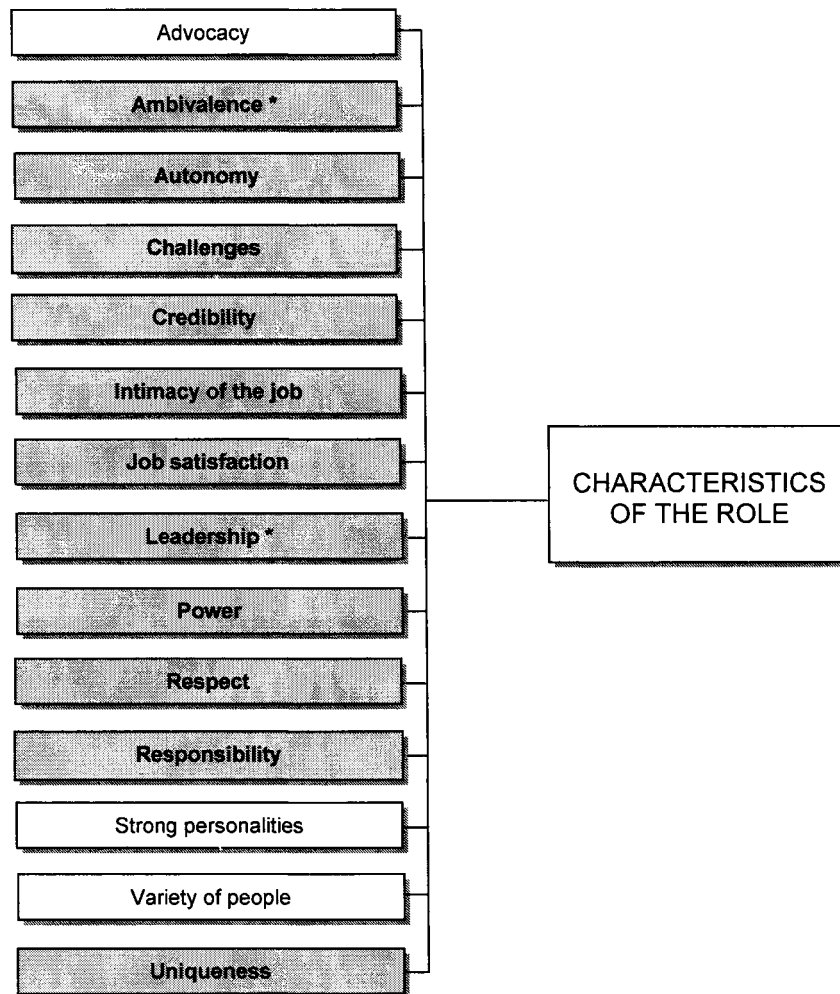


Figure 7.3: Category - Characteristics of the role

Ambivalence

Ambivalence was a new code that emerged following the analysis of the first Delphi survey questionnaire data. The statements included in this code indicated a level of *ambivalence* in relation to the role and its effects on the transplant coordinators themselves:

This is a totally schizophrenic job. Its highs and lows are extraordinary (DS1, p. 112, L. 18).

Transplant coordinators are undervalued, underpaid and at times treated quite badly by a system, which doesn't respect the role and couldn't care less. Yet we still do the job and a part of us will be bonded to it forever. Love it or hate it, whatever else it is, this job is not boring (DS1, p. 113, L. 9-12).

Autonomy

Statement 9: In my position there is considerable autonomy.

Autonomy was promoted by most of the participants as a positive characteristic of the transplant coordinators' role. Statement 9 in the Delphi survey addressed this code. Just over 90% of the participants agreed with the statement:

Considerable autonomy when hospital based. Increased accountability when moved to a centralised agency (DS1, p. 32, L. 34-35).

My role requires exceptional amounts of autonomy (DS1, p. 33, L. 5).

Autonomy and responsibility go hand in hand. Have seen these poorly managed by some coordinators possibly as a result of [the] level of autonomy (too much) and lack of accountability (DS1, p. 32, L. 12-14).

I am well supported within our unit and given extreme autonomy, which I enjoy and need. It would be hard to leave this position, which in some way explains the longevity apart from the satisfaction of obtaining a good outcome (DS1, p. 119, L. 7-9).

Challenges

The code *challenges* was expanded following the analysis of the survey data.

Examples of relevant comments included:

Job is very rewarding and challenging, doing something new each day and using new skills and knowledge makes this job wonderful (DS1, p. 117, L. 11-13).

The role is challenging yet exciting and depressing (DS1, p. 120, L.22).

Credibility

Only one comment from a participant could be included in this code:

A good knowledge base and skills will gain you professional respect (DS1, p. 120, L. 11-12).

Intimacy of the job

The *intimacy of the job* code was expanded by including the following comment from one of the research participants:

At other times you are filled with joy, a sense of achievement and a wonderful sense of spiritual fulfilment. You have to be a particular kind of person to do this job well – someone who is truly able to walk in another's shoes and who is passionate about the role (DS1, p. 113, L. 5-8).

Job satisfaction

Statement 8: My job is satisfying and rewarding.

Many transplant coordinators expressed their love of the role and the work they do. Statement 8 addressed the issue of *job satisfaction* in the Delphi survey. Over 90% of the participants agreed with this statement, 7.8% were unsure with the rest indicating they disagreed with it. Examples of the participants' comments included:

Thoroughly love it despite the 'roller coaster' rides. Love the autonomy and respect from other health professionals (DS1, p. 29, L. 26-27).

Without a doubt, despite the personal price I paid, the most challenging, fulfilling [and] emotional position in a forty-year career (DS1, p. 29, L. 33-35).

One of the most satisfying roles in my nursing career (DS1, p. 30, L. 25).

Working on the recipient side you always get reminded of the reason why we do transplants (DS1, p. 30, L. 29-30).

Leadership

This new code emerged from the second literature review which was conducted as part of the study. Some examples taken from the literature include:

... leadership in OPOs are similar to those in other industries: belief in people, teamwork, passion and enthusiasm for one's mission, risk taking, integrity, vision and commitment to excellence (Shafer, Kappel & Heinrichs 1997, p. 30).

... selected leaders who desired to excel and who could inspire their staff to excel (Shafer, Van Buren & Andrews 1999, p. 44).

Lumby (2005, p. 13) makes several points in relation to leadership. She argues that the debate surrounding it is unchanged over the years, with most seeing leaders as individuals who stand out, have power and a number of followers. This she sees as an outdated concept, which encourages the 'non-leaders' to acquiesce and take on a victim-type mentality whereby they wait for someone to rescue or lead them. She uses the analogy of superman or the knight in shining armour coming to an individual's rescue to articulate her point. She states that this view of leadership is a limiting factor in the health care system.

Lumby (2005) sees leaders as being individuals who think outside the square, engage in dialogue rather than a monologue, take responsibility for their actions, work within their own realm, are inclusive of others, use their imaginations, move out of their own comfort zones and get on with the job at hand. She believes true

*Leadership
qualities*

leaders are not individuals placed at the top of a hierarchical system but are those with the characteristics outlined above who are willing and able to take action to improve their own and others' circumstances. This concept is demonstrated in the following extract from her article:

... leadership is about the ability to live with ambiguity and a lack of empirical data, with flexibility, changed structures and uncertain futures. It is about relying not only on the ability to reason but also on our imaginations (Lumby 2005, p. 13).

Transplant coordinators conform with this view of leadership articulated by Lumby (2005) as their roles require them to take on considerable responsibilities, think outside the square, engage in frequent dialogue with health care professionals and be creative in regard to problem-solving. Examples from the research data referring to the skills coordinators believe are required in their practice which also support the code *leadership* include:

Skills required – good clear communication, particularly under stress, empathy, good organiser, being able to predict and work towards a decision and yet be flexible enough to change as well. Good sense of humour, approachable, intelligent and a 'bit bossy' people look to the coordinator for leadership and direction during a donor (DS1, p. 48, L. 25-29).

Clinical problem solving, communication, negotiation, leadership, team building, project management [and] business planning (DS1, p. 48, L. 2-3).

Power

Statement 10: I have power in my position.

This code was addressed in the Delphi survey by statement **10**. Of the participants 54.9% believed they had power in their position, 19.6% were unsure and 24.5% felt that this was not the case. One participant did not respond. The term power can mean many different things to people and this was demonstrated in the participants' responses:

Depends on the interpretation of 'power'. If interpreted as 'influence' then that's possibly true (DS1, p. 33, L. 23-24).

At the hospital level as I am the only one with the knowledge and that leads to power (DS1, p. 34, L. 19).

Power to make a change, power to make autonomous decisions in my own arena (DS1, p. 36, L. 26).

I believe that most problems occur when the team approach breaks down due to the power issue. Sometimes coordinators feel that they carry more power than others. Not true. We are all working together toward a

common goal therefore power should not be a factor (DS1, p. 111, L. 5-8).

Respect

Statement 11: I am shown respect in my position.

Both positive and negative aspects of the code *respect* were raised in the data. The majority of the transplant coordinators reported that they are respected whilst others felt that this was not the case. This code was addressed in the survey by statement 11. Of the participants 81.4% were in agreement with the statement, 11.8% were unsure and 6.8% disagreed believing they were not shown respect:

I think I have respect in the community and from donor families but not from anyone else i.e. doctors, other hospital personnel or people in the system. Far from it – I'm seen as expendable (DS1, p. 38, L. 4-5).

Varied. People either 'love or hate' you. Nurses, doctors, even donor families (DS1, p. 38, L. 15).

I am respected by patients, parents, and colleagues but not necessarily by nursing administrators (DS1, p. 39, L. 19-20).

Responsibility

Statement 4: My work responsibilities encroach on my private life.

The data reflects that there are a number of responsibilities in the role that impact on the coordinators' private lives - the main one being on call responsibilities. Statement 4 addresses this code in the questionnaire. Statistical analysis showed that almost 80% of participants agreed with this statement:

I often take work home with me because there are not enough hours allocated to the work involved in this position (DS1, p. 12, L. 32-33).

Being on call does limit your social life especially on days off (DS1, p. 13, L. 3).

In retrospect I resent the intrusion of this role on my personal life. I feel it contributed to my marriage breakdown (DS1, p. 14, L. 13-14).

Particularly with the on call component and after hours responsibilities ie education in [the] evenings and [at the] weekends (DS1, p. 15, L. 5-6).

Uniqueness

Reference was made in the Delphi survey responses to the uniqueness of the role and the environment. Examples include:

The role is so different from everyone else's and there are so few coordinators (DS1, p. 18, L. 14).

Unique unit and role in hospital environment, not much contact with other professionals in similar roles (DS1, p. 18, L. 9-10).

Unique environment (DS1, p. 11, L. 28).

RELATIONSHIPS – THE PROFESSIONAL TEAM

The RELATIONSHIPS category has two subcategories, the first concerning relationships involving the professional team, the second about relationships involving the client. The subcategory – the professional team – focuses on communication, support and the relationships transplant coordinators have with their colleagues. There was one new code, *networking* added to this category following the analysis of the Delphi survey questionnaire as shown in Figure 7.4.

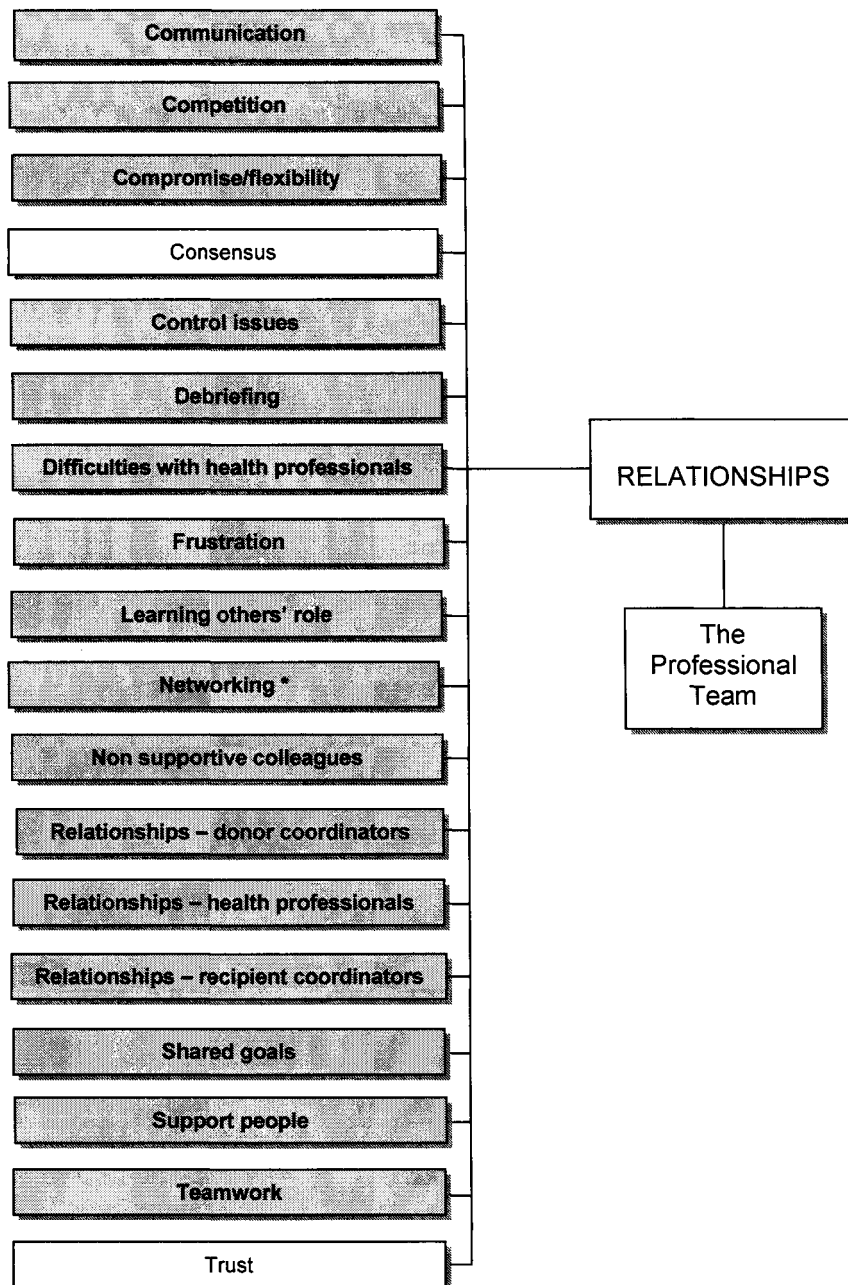


Figure 7.4: Category - Relationships and subcategory - the professional team

Communication

There were a number of comments made by the participants in relation to *communication* and its importance, examples of which are shown below:

Coordination relies on good communication/contact with other health professionals (DS1, p. 8, L. 26).

Important to have good lines of communication between colleagues to facilitate discussion of clinical cases or concerns (DS1, p. 2, L. 1-2).

... communication about each other's roles would help to improve professional respect and working relationships (DS1, p. 95, L. 26-27).

Competition

Statement 20: There is an element of competitiveness between coordinators.

This code was addressed by statement 20. Statistical analysis showed there was some uncertainty about this statement with 39.2% in agreement, 36.3% disagreeing and 24.5% unsure. Qualitative responses to this statement also reflected a lack of consensus amongst the study participants:

I don't think this is a negative aspect though. If treated positively it assists us as a collective group to develop and progress organ donation and the process to a new and improved level/service (DS1, p. 75, L. 19-21).

I have not witnessed competitiveness between recipient coordinators or the donor coordinators that I am involved with (DS1, p. 76, L. 34-35).

I don't think so, I certainly have not experienced it (DS1, p. 76, L. 20).

Shafer, Kappel and Heinrichs (1997, p. 30) describe competition as a highly desirable feature in the OPO environment whereby the desire to be the best is an integral component of a successful organisation and positive leadership. They remark that the Olympic Games are an example of what can be achieved with competition, where seemingly unbreakable records are broken time and again when competitors are challenged. Subsequently, impossible odds can be overcome and records broken if there is healthy competition and a willingness to strive for excellence. They also suggest that the concept of a competitive edge should be the subject of further research. *Competition*

Compromise/flexibility

Following analysis of Delphi survey one there were a few comments made that were placed into the *compromise/flexibility* code. An example is shown below:

Greater flexibility of movement between states for coordinators would give coordinators a broader view of the whole system, provide variety for them and a really wonderful way of helping agencies to train new coordinators (DS1, p. 115, L. 33-35).

Control issues

There was one comment, about difficulties that may ensue when donor coordinators do not negotiate theatre times with the recipient coordinators. This contributed to the expansion of this code:

... the donor coordinators set theatre times ... sometimes these times are difficult to meet eg. not enough time to contact people and get them to the hospital ... the push now is to do dual liver transplants from one donor. Therefore times are extremely important but as yet we have failed to do them due to the donor theatre times. The time required to organise three teams, two recipients [and] one donor has not yet been available as the donor theatre time is too soon (DS1, p. 116, L. 27-34).

Debriefing

Statement 1: Debriefing is important to me.

This code was addressed in the Delphi survey by statement 1. Of the participants over 80% agreed. Examples of the qualitative responses are provided:

Formal debriefing is not always required; however, there is a need to have 'someone to talk to' (DS1, p. 1, L. 14-15).

Very important either formally or informally (DS1, p. 4, L. 23).

Debriefing has never been offered to me. I do not think it is necessary (DS1, p. 1, L. 31).

Difficulties with health professionals

Statement 23: Relationships with intensivists/transplant surgeons and physicians can be difficult at times.

Following the analysis of the first Delphi survey the code *difficulties with doctors and nurses* was changed to *difficulties with health professionals*. This code was then partially addressed by statement 23. Of the participants 72.5% agreed with this statement:

Often transplanters/physicians have unreal expectations because of a lack of understanding of the donation process (DS1, p. 87, L. 16-17).

Has improved enormously (DS1, p. 87, L. 14).

I have never had relationship problems with any of the above. I believe we are all working together towards the best outcomes for those concerned with the transplant program (DS1, p. 87, L. 27-29).

This is probably the most difficult part as they all have differing views relevant to their interests and often don't agree and the coordinator is often the one stuck in the middle (DS1, p. 89, L. 19-20).

Frustration

Statement 17: There are aspects of my role that can be frustrating.

The majority of participants (97.0%) agreed with statement 17. These sentiments were also echoed in the participants' comments as shown below:

The dependence on ICU's staff to identify and refer donors (and [they] want to control the process which they have very limited experience in) is frustrating (DS1, p. 62, L. 24-25).

Non-compliance of patients post-transplant would be the most frustrating thing that I have experienced (DS1, p. 63. L. 1-2).

Learning others' role

Statement 25: Recipient and donor coordinators do not have a good understanding of each other's role.

Statement 25 addressed the code *learning others' role* in the first Delphi survey. No consensus was reached about this statement, as was evident following statistical analysis with 39.2% agreeing with the statement, 42.2% disagreeing and 18.6% unsure. Participants' qualitative responses also confirmed the wide-ranging views in this area:

No idea in most cases. The roles are completely different. One transplant coordinator has a focus on the donor, the donor family and the donor hospital. For them the recipient and the organs are important but not the main focus. The other has a focus on the recipient and the quality of the organ. Each has a demanding role but very little understanding of the others' job (DS1, p. 96, L. 16-20).

I believe recipient and donor coordinators have a good understanding of each other's roles and support each other as necessary (DS1, p. 95, L. 18-20).

Improving all the time with ongoing communication (DS1, p. 98, L. 26).

Networking

Statement 3: Networking with my colleagues is an essential component of my role.

Networking was a new code that emerged following the analysis of the Delphi survey data. This code was addressed in part by statement 3. Of the participants 95.1% indicated agreement with this statement, 2.9% were unsure and 2.0% disagreed. Qualitative responses to this statement included the following:

It is important for transplant coordinators to network with their colleagues. Professional associations such as the Australasian Transplant Coordinators' Association (ATCA) and the Transplant Nurses' Association (TNA) are excellent mediums for networking (DS1, p. 111, L. 1-3).

Networking is an integral part of the position both within the hospital and community (DS1, p. 9, L. 10).

I agree that it is important to network with other coordinators and this is often done at conferences. Funding support to attend conferences is often difficult to obtain, particularly for nurses in my hospital (DS1, p. 10, L. 8-10).

You can't do this job if there is no rapport. It is easier to get jobs done if you know people's likes and dislikes (DS1, p. 10, L. 12-13).

Non-supportive colleagues

Comments that further developed the code *non-supportive colleagues* are shown below. This code and the following code *relationships – donor coordinators* are strongly linked with some overlap as can be seen in the data extracts:

... constant struggle/conflict with fellow coordinators (DS1, p. 117, L. 8-9).

Lack of understanding from colleagues on the importance of donor family support/follow-up (DS1, p. 117, L. 16-17).

Relationships – donor coordinators

Statement 19: I experience difficulties with other coordinators.

This code and the code – *relationships with recipient coordinators* – were both addressed by statement 19. Just over 50% of participants disagreed with this statement while 37.2% agreed. The following responses are examples:

Have a good relationship with donor coordinators ... (DS1, p. 69, L. 16).

This is only due to trying to fit in with everyone and their needs. People are generally very pleasant during these difficult times (DS1, p. 72, L. 2-3).

Yes but we all have competing priorities at the time (DS1, p. 72, L. 29).

Sometimes, most are fantastic – a few are difficult (DS1, p. 73, L. 29).

Relationships – health professionals

Statement 23: Relationships with intensivists/transplant surgeons and physicians can be difficult at times.

This code was addressed in part by statement 23. Of the participants 72.5% were in agreement with this statement, 6.9% were unsure and 20.6% disagreed. Qualitative responses to this statement included the following:

Arguments over the identification and ongoing support of potential donors particularly if 'marginal' can be stressful especially when the unit is busy and bed space is at a premium (DS1, p. 90, L. 30-32).

All highly trained and intelligent professionals can be occasionally difficult to deal with and that is why transplant coordinators must have exemplary communication and people management skills (DS1, p. 90, L. 12-14).

I have never had a problem with any of the above. They are most obliging (DS1, p. 90, L. 8).

Relationships – recipient coordinators

Participants' qualitative comments that contributed to the expansion of this code included:

Mostly lack of communication [is a difficulty when dealing with other coordinators] (DS1, p. 70, L. 25).

Recently have felt that coordinators are working well together nationally – more as a team (DS1, p. 71, L. 16-17).

Shared goals

Statement 26: Donor and recipient coordinators have shared goals.

Almost 70% of the participants were in agreement with statement 26. Examples of comments in regard to this statement include:

In terms of offering an ethical and professional service (DS1, p. 99 L. 1).

Positive outcomes for both donor family and recipient (DS1, p. 99, L. 21).

The roles are entirely different with different goals. Donor coordinators are advocates for donor families and recipient coordinators are advocates for recipients. The donor family and recipients have different needs (DS1, p. 100, L. 29-31).

The ultimate goal of both donor and recipient coordinators is to give the donor organs the best possible outcome (DS1, p. 102, L. 3-4).

Support people

Statement 2: There are support people in my job.

This code was addressed by statement 2. Of the participants 73.5% were in agreement, 19.6% disagreed and 5.9% were unsure and one person did not respond to the statement:

The only true support is from colleagues in the same position (DS1, p. 5, L. 6).

I am fortunate enough to have a close working relationship with my colleagues. Our network also has access to regular supervision with a clinical psychologist both in a group and on an individual basis (DS1, p. 6, L. 5-7).

... yes there are support people in my job though often not where expected. I think some people who have performed roles for long periods of time forget what it is like to learn this very specialised role and how emotional it may be at times (DS1, p. 6, L. 13-15).

Teamwork

Statement 24: The teamwork between the transplant coordinators is excellent.

Of the participants 75.5% were in agreement with statement 24. Those who disagreed with the statement accounted for 11.8% and 12.7% were unsure. Examples of the respondents' comments in relation to the code teamwork included:

Disagree – clashing of priorities (DS1, p. 88, L. 32).

Teamwork is the essence of transplantation (DS1, p. 91, L. 27).

There is excellent teamwork between my colleagues who are recipient coordinators but this does not always extend to donor coordinators (DS1, p. 91, L. 17-18).

In my experience I disagree. I feel that each transplant team is out to look after themselves and their recipients with little or no regard for the donor and donor family / coordinators (DS1, p. 93, L. 14-16).

RELATIONSHIPS –THE CLIENT

The second subcategory relates to relationships involving the client. The codes in this subcategory focus on the care of donor families and relationships with donor families, recipients and recipient families. The final code addresses the activities or actions the coordinators engage in to go *'the extra mile'* for their client group. No new codes emerged in this category after analysis of the first round of the Delphi survey questionnaires as shown in Figure 7.5.

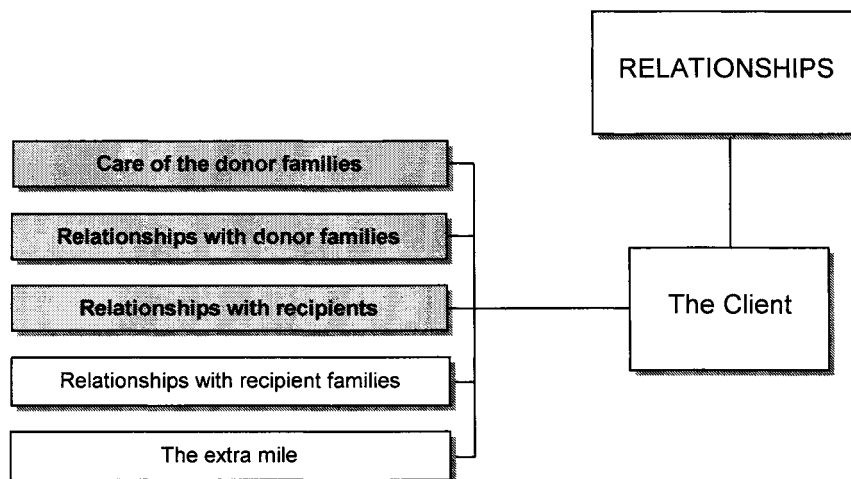


Figure 7.5: Category - Relationships and subcategory - the client

Care of the donor families

The research participants made a number of comments relating to the code *care of the donor families*. One example relates to a transplant coordinator's concern about the time it takes for the organ donation process to occur:

The length of time required for the donation process from the time of death and receiving family consent to the actual time of retrieval [is problematic] (DS1, p. 118, L. 3-4).

Other issues raised relating to the donor family include:

Family dynamic – accepting patient diagnosis ... death – possibility of donation [can be difficult for families] (DS1, p. 118, L. 5-6).

The availability of suitable surroundings for the friends and family of the donor patients can be problematic (DS1, p. 118, L. 15).

Relationships with donor families

There were a number of comments regarding the coordinators' *relationships with donor families* but one participant encapsulates very succinctly what the donor families mean to her:

I love this job. I feel so privileged to work with donor families who represent to me such a beautiful side to human nature that it is almost a spiritual experience to be with them. It is they who uplift my spirit. It is they who make it all worthwhile (DS1, p. 112, L. 32-35).

Relationships with recipients

An example of the transplant coordinators' comments concerning their relationships with recipients is shown below:

Personalities of patients can impact upon you – how you relate to the patient, how easy it is to form a connection with them, difficult personalities can sometimes make it hard work to take a person through the assessment process (DS1, p. 116, L. 15-17).

EXPECTATIONS AND OUTCOMES

This category appears to have a focus on donor families, recipients and their expectations and desired outcomes in relation to organ donation and transplantation. It also includes the transplant coordinators' expectations and desired outcomes as they relate to their client groups. There were four new codes added to this category – *poor regard for donor and donor families*, *negativity towards organ donation and transplantation*, *public perceptions of organ donation and transplantation* and *who should get a transplant* – following

the constant comparative analysis of the first Delphi survey questionnaire as shown in Figure 7.6.

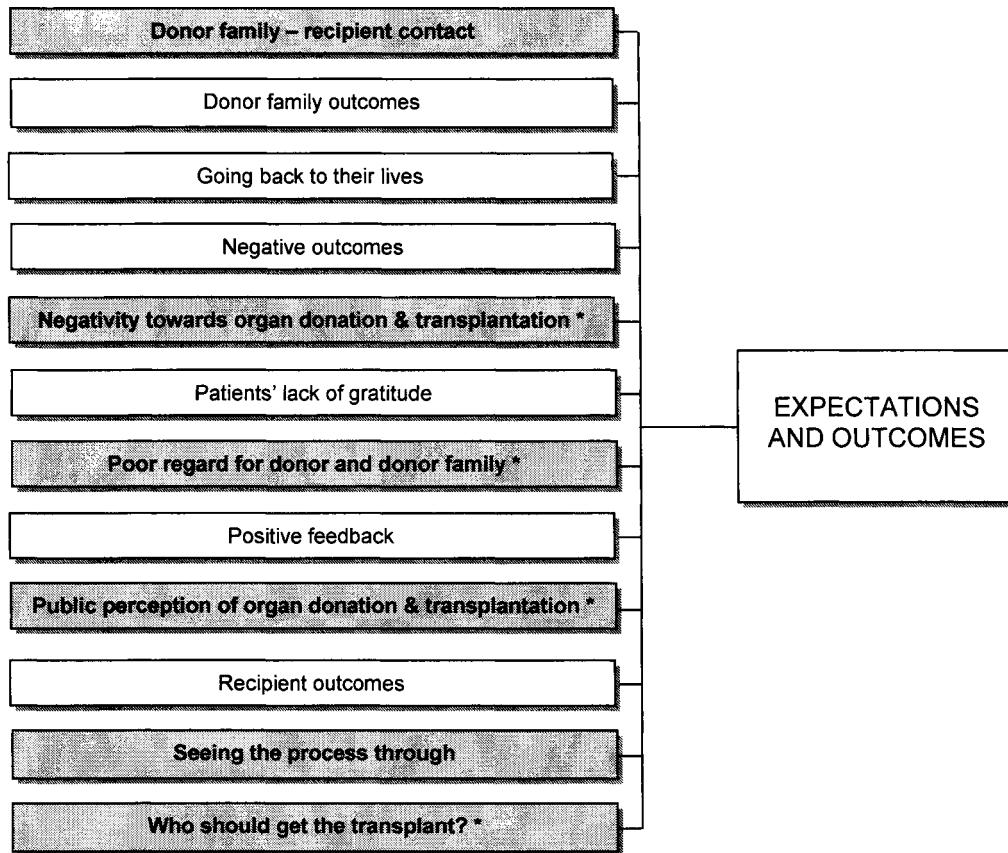


Figure 7.6: Category - Expectations and outcomes

Donor family – recipient contact

Statement 22: Donor families and recipients should be allowed unrestricted contact with each other.

There was a specific statement included in the first Delphi survey relating to this code – statement 22. Over 70% of the participants in the survey disagreed with this statement. The main reason for this appeared to be the inclusion of the word unrestricted. Examples of the comments included:

I don't think unrestricted is the right word but if they want contact and are both willing to meet I think it should be allowed more freely than it is currently (DS1, p. 86, L. 28-29).

I feel that restricted contact with counselling/supervision should be considered for selected donor/recipient families (DS1, p. 86, L. 25-26).

I am concerned about 'unrestricted' contact. Donor families and recipients should be able to meet but not 'unrestricted'. A system should be in place where, with appropriate timing and counselling, they could meet. Possibly similar to adopted children meeting real [biological]

parents. Unrestricted contact could put donor families and recipients at risk of adverse psychological events (DS1, p. 82, L. 20-24).

A psychological minefield ... (DS1, p.86. L.6).

Negativity towards organ donation and transplantation

Several comments contributed to the emergence of this new code, for example:

As time has passed and the novelty value of transplantation has worn off the degree of cooperation from many members of the health sector has decreased (DS1, p. 111, L. 33-34).

Transplantation is seen by some to be a costly exercise for little gain when there are many other areas of health that are under funded (DS1, p. 110, L. 33-34).

Poor regard for donor and donor family

Another new code which emerged from the analysis of the Delphi survey was *poor regard for donor and donor family*. One participant expressed a view that there is sometimes poor regard for the donor and their family:

I feel that transplant/procurement surgeons generally have little regard for the donor as a person, hence can be difficult to liaise with especially when coordinating logistics of procurement. They don't seem to be flexible and couldn't care less for the donor families' wishes. The recipient coordinators tend to mimic the surgeon's wishes rather than advocate what is best for the team as a whole (DS1, p. 117, L. 24-28).

Public perceptions of organ donation and transplantation

Another new code that emerged from the data was *public perceptions of organ donation and transplantation*. Several participants' responses were placed into this code, examples of which are shown:

Lack of good publicity – this is improving and increasing (DS1, p. 117, L. 33).

Loss of trust by the public in the medical profession following the disclosure of kept tissue in mortuaries without consent. This was 'normal' practice many years in the past and was discovered by [the] general public [in] 2000 – 2001 (DS1, p. 118, L. 10-12).

Seeing the process through

Statement 18: It is important to me to see the organ donation and transplantation process through from start to finish.

This code was addressed by statement 18. Of the participants 64.7% agreed with this statement, 8.8% were unsure and 26.5% disagreed. Qualitative responses from the participants included:

Splitting donors is also a cause for great concern and frustration to many coordinators because there is a sense of [a] 'lack of completion' of the job that you have started (DS1, p. 114, L. 5-7).

Initially I would have agreed however, with the process of time (increased activity) each case could take up to 24 hours. Occupational health and safety, good practice, now make it impossible and impractical for [a] donor coordinator to see a case through from start to finish (DS1, p. 68, L. 18-21).

Organ donation/transplantation is a team effort. I am happy if I carry out my role to the best of my ability (DS1, p. 65, L. 34-35).

Who should get a transplant?

The final code that emerged under this category was *who should get a transplant?* Responses from two participants contributed to this aspect of the research:

The diagnosis can affect you, e.g. alcoholic liver disease and make you question your beliefs about transplantation (DS1, p. 116, L. 18-19).

Anger expressed by nursing staff towards the coordinators when patients are transplanted that they don't feel deserve it. Anger never expressed towards the medical staff (DS1, p. 122, L. 4-6).

POOR REGARD FOR COORDINATORS AND THEIR ROLE

This category describes the negative aspects of the coordinators' role. It encompasses codes such as *bullying* and describes some coordinators' feelings of being *undervalued*. There is also a belief that coordinators are seen as *expendable* with minimal or no professional acknowledgement. Some also expressed the belief that others think they know what is best for coordinators and their practice. There were no new codes that emerged in this category as shown in Figure 7.7.

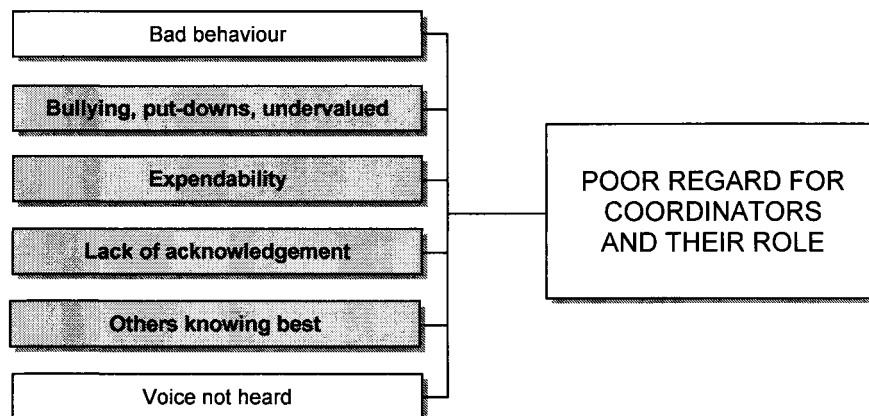


Figure 7.7: Category - Poor regard for coordinators and their role

Bullying – put-downs and undervalued

Examples of respondents' comments which expanded the code *bullying – put-downs and undervalued* are highlighted below:

Anyone who does this job for any length of time has a love/hate relationship with it. Unless you have done it there is no way to explain what's really involved. At times you feel so undervalued, so low emotionally, so exhausted, so frustrated and emotionally 'wrung out' that you want to just walk away and scream (DS1, p. 113, L. 1-4).

You spend your time looking after surgeons' emotions – doctors, nurses, parents, families – worrying about how much sleep the various surgical teams will get, worrying about recipient's health but NO ONE, NO ONE ever even asks about how you are coping! How you are travelling! (DS1, p. 112, L. 22-26).

Expendability

An example of the responses received from the participants in relation to this code included:

Coordinators are told what to do with little or no consultation. Their experience is devalued and often they are excluded from even the most basic decision-making at an agency level. At [an] interagency level decisions are often made by managers with little or no experience in organ donation (ie bureaucrats) whilst many very experienced coordinators have been passed over for management positions (DS1, p. 114, L. 16-20).

Lack of acknowledgement

Statement 6: **The monetary reward does not reflect the responsibility of my position.**

Statement 28: **There is a lack of professional acknowledgement in my job.**

This code was addressed by two statements in the Delphi survey - the first being statement 6. Of the participants 77.5% were in agreement with the statement, 8.8% were unsure and 13.7% disagreed:

The fact that coordination usually occurs after hours and [is] paid as overtime provides good money – but has personal and health costs (DS1, p. 23, L. 28-29).

Particularly when on a case I felt I earned every dollar and a lot more. On call allowance was grossly inadequate (DS1, p. 23, L. 2-3).

For the responsibility that is taken on [the] monetary reward is not even close (DS1, p. 22, L. 14).

It is totally ridiculous. Especially the 'on call' allowance, which is a pittance. Part of the problem is that the bureaucracies under which we work don't understand the role at all and have little interest in finding out about it. It is not only the monetary reward. Donor coordinators are not

only underpaid, considering the level of responsibility for the people's lives and wellbeing, they also have too few holidays. Four weeks holiday is not enough to recuperate from the emotional stress and tensions in this job, not to mention [the] physical tiredness that goes with being up all night and the irregular hours (DS1, p. 21, L. 25-31).

The second statement addressing this code was **28**. Statistical analysis of this statement indicated that 53.9% of the participants agreed, 34.3% disagreed and 11.8% were unsure.

This demonstrates that over three quarters of participants felt that financial remuneration for the role was unsatisfactory given the responsibilities of the position. Also, more than half felt there was a lack of professional recognition. Examples of the qualitative responses that contributed to this code are shown below:

When was the last time the transplant recipient thanked the donor coordinator or the recipient coordinator? There is a lack of 'thanks' in this position. Often the only people who say thanks are the people who gave the most – the donor family (DS1, p. 107, L. 5-7).

Coordinators' roles, both donor and recipient, are very much misunderstood and under acknowledged (DS1, p. 108, L. 13-14).

I am answering from an industrial/professional/organisation perspective I think transplant teams provide professional acknowledgement (DS1, p. 105, L. 34-35).

I have never been in any other job where acknowledgement has been imparted at such high levels (DS1, p. 106, L. 5-6).

Others knowing best

Statement 27: Members of the medical profession often think they know what is best for transplant coordinators.

The final code *others knowing best* was addressed in part by statement **27**. Of the participants 53.9% agreed with this statement, 28.4% were unsure and 16.7% disagreed. This suggests that more than half of the coordinators surveyed feel they have limited say in their professional development and practice:

Not only the medical profession! Managers without any medical background (DS1, p. 102, L. 32).

Sometimes they do and sometimes they don't. Eg. thanks to medical staff [the] Australasian Transplant Coordinators' Association (ATCA) membership [can thank the] Transplant Society of Australia and New Zealand (TSANZ) [for] raising [the] profile and voice of transplant coordinators (DS1, p. 104, L. 10-12).

Members, both medical and surgical, of transplant teams have a far better understanding of what is best for coordinators in stark contrast to medical and nursing hospital administrators/directors (DS1, p. 104 L. 27-29).

Would tend to disagree – have always found the role to be autonomous with supportive medical staff ... (DS1, p. 103, L. 31-32).

Yes they do – but I was absolutely sure none of them ever wanted to take on my role (DS1, p. 104, L. 34).

The first Delphi survey statistical and qualitative data confirmed the codes and categories that had emerged from the recipient coordinator and donor coordinator focus group interviews. There were several new codes that emerged from the analysis with some evidence that the category **RELATIONSHIPS** may be the core category.

Further constant comparative analysis lead to the reconfiguration of the categories and the emergence of a number of changes as shown in Figure 7.8. At this stage four categories were identified, these being KNOWLEDGE AND EXPERIENCE, THE ROLE, OUTCOMES and **RELATIONSHIPS**, which emerged as the potential core category. Examples of the participants' statements that supported this view included:

It can be highly rewarding, especially interaction with donor families who share so much of themselves with us. They are such special people thinking of others in their moments of tragedy. Sometimes I feel an almost spiritual connection with them. Viewings too can be a special experience with families. From this point of view I can hardly think of another job, which would make me feel so fulfilled (DS1, p. 28, L. 23-27).

The transplant coordinator is the focal position and medical staff often do not understand the complexity of the relationships (DS1, p. 103, L. 27-29).

In our setting we deal with a huge number of different critical care areas in a diverse range of settings. As with most things some individuals can't do enough to help and some don't care at all but feel obliged to make contact because we benchmark their performances (DS1, p. 119, L. 31-34).

Yes, but they are informal supports only – one colleague who is available all the time. Thank God for her! Without that support I'd have left long ago (DS1, p. 6, L. 9-10).

Further theoretical sampling was necessary to expand and/or saturate the categories and determine the properties of and the links between each of the categories and the potential core category. A second round of the Delphi survey was designed, piloted and distributed to the participants. These qualitative results are discussed in the next section. Included in the second Delphi survey

were restructured statements pertaining to areas of ambiguity or non-consensus highlighted in the first Delphi survey. Statements from the previous survey were included in a reconfigured format if there was no consensus, complying with the Delphi survey method discussed in Chapter Four. The areas of minimal or no consensus and/or ambiguity that were re-addressed in the second Delphi survey are listed below:

- Professional isolation
- Power
- Nurse/non-nurse coordinators
- Standardisation
- Difficulties with colleagues
- Competition between coordinators
- Organ donation/transplantation and bureaucracy
- Donor coordinators and recipient coordinators' understanding of each others' roles
- Medical officers input into the coordinators role
- Professional acknowledgement
- Donor family/recipient contact.

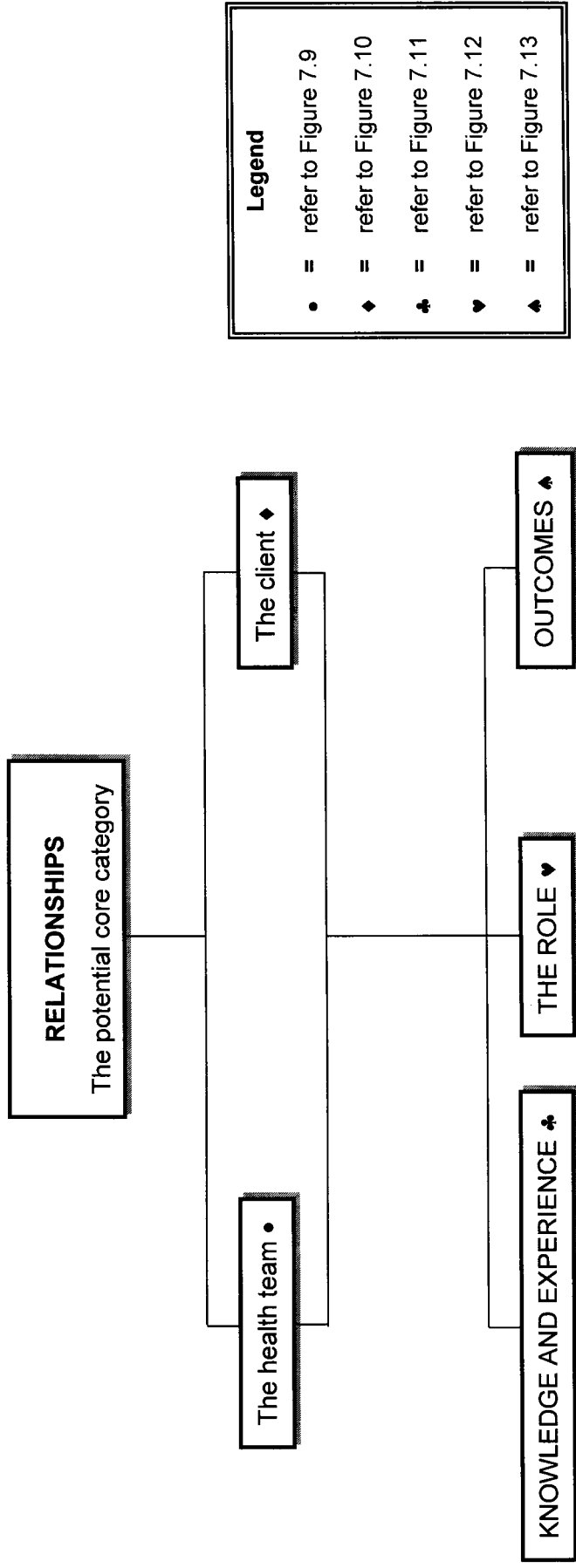


Figure 7.8: Overview of the categories and potential core category following completion of the analysis of the first Delphi survey questionnaire

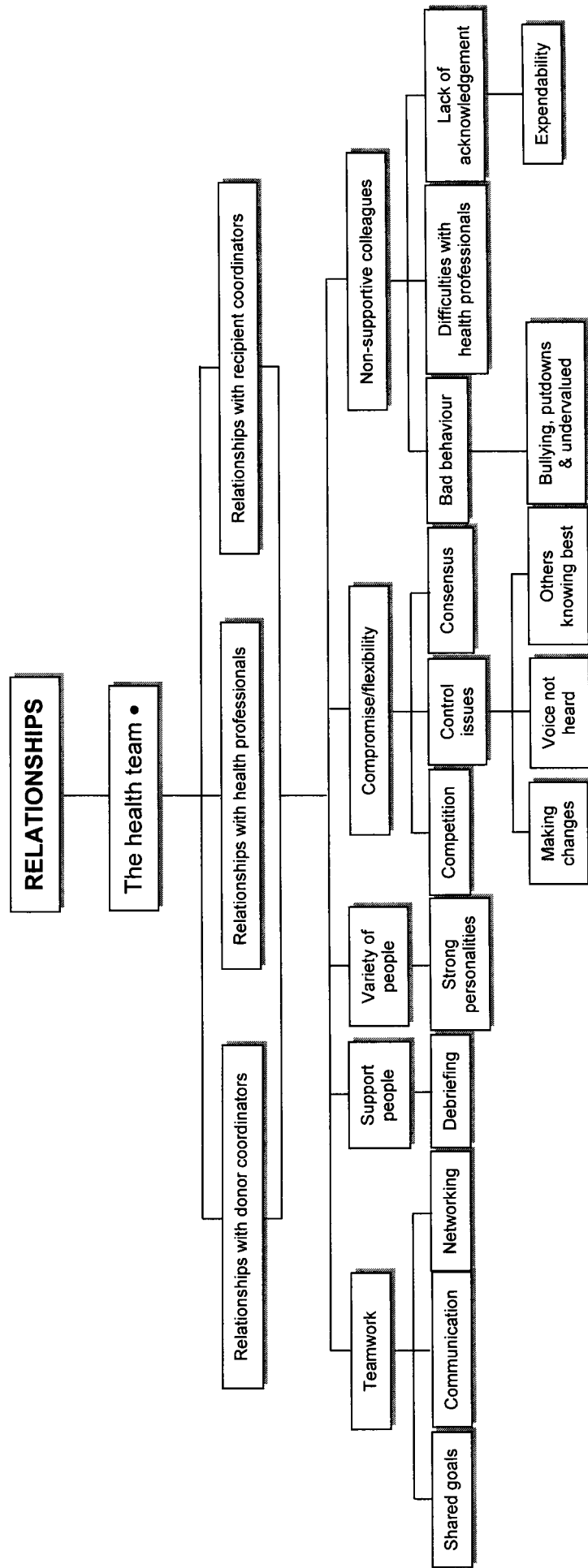


Figure 7.9: Flow chart showing the category RELATIONSHIPS with the sub category – The health team and the preliminary categories and codes

• = please refer to Figure 7.8

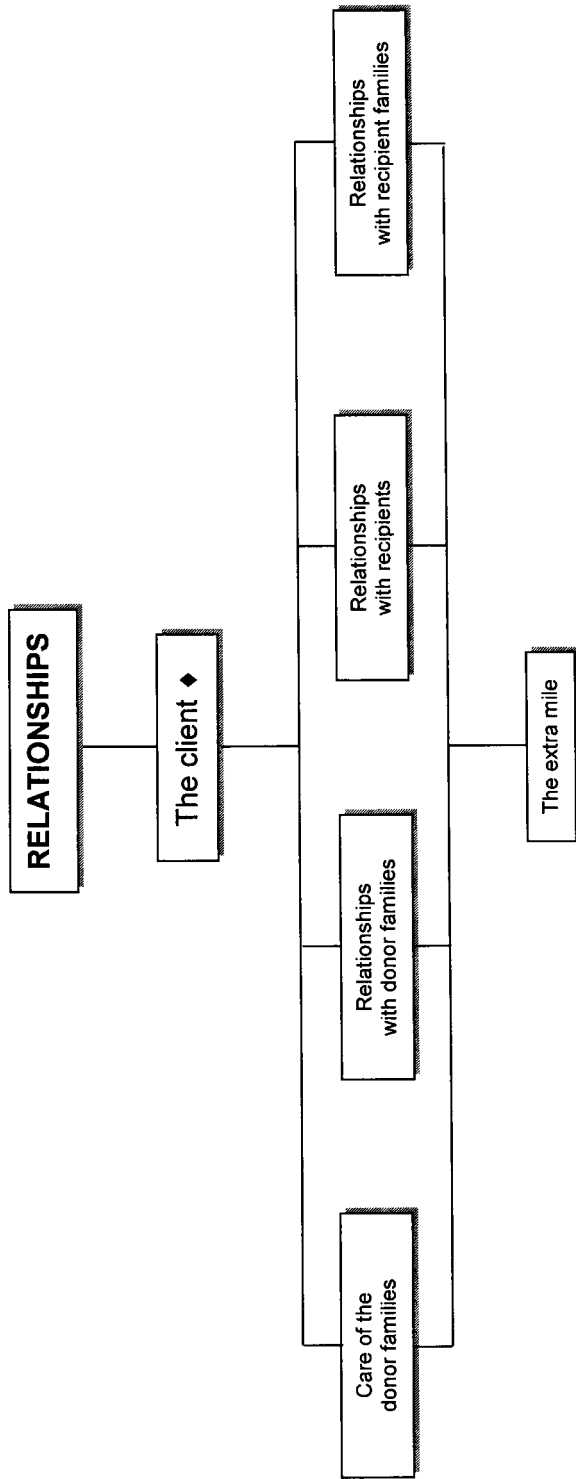


Figure 7.10: Flow chart showing the category RELATIONSHIPS with the sub category – The client and preliminary categories

♦ = please refer to Figure 7.8

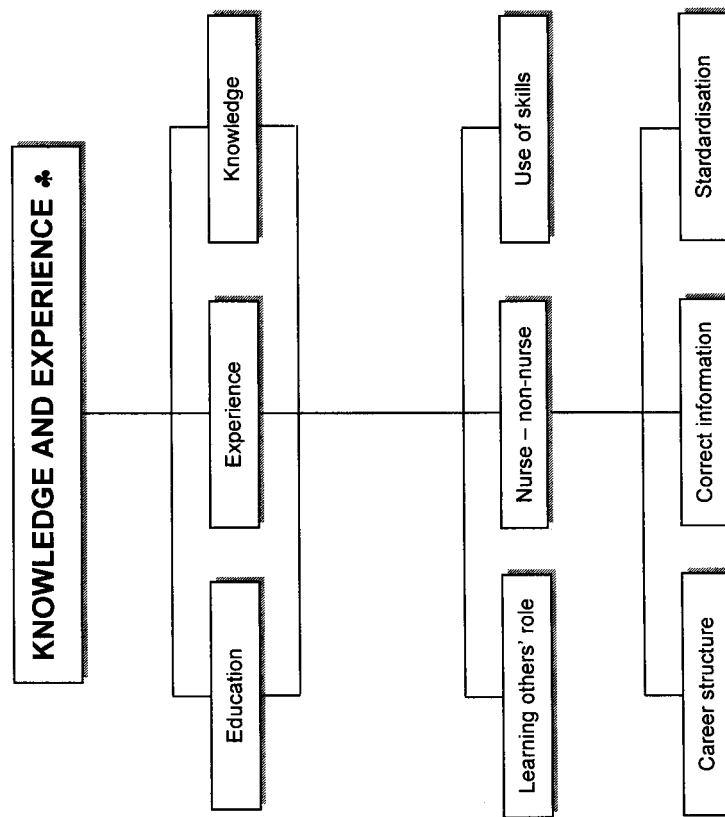


Figure 7.11: Flow chart showing the category KNOWLEDGE AND EXPERIENCE and the preliminary categories and codes

♣ = please refer to Figure 7.8

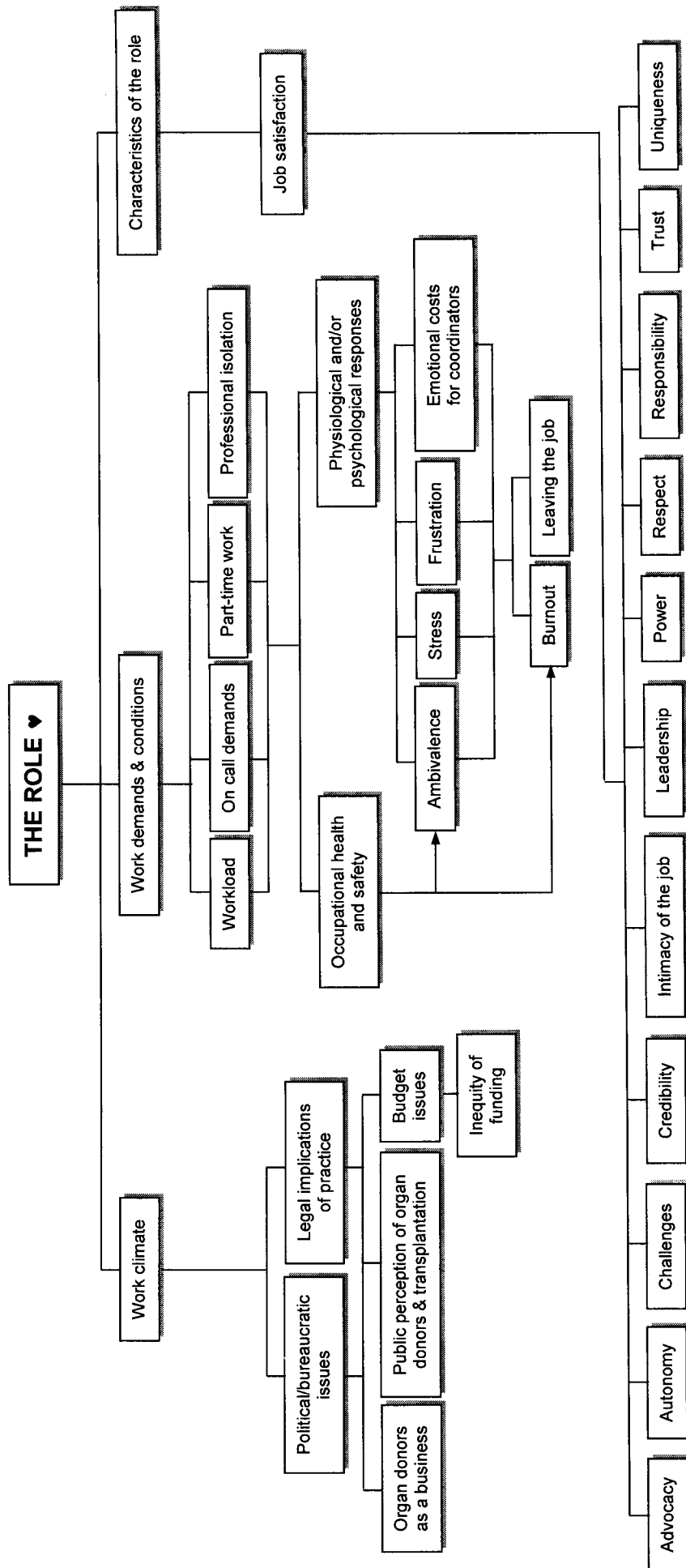


Figure 7.12: Flow chart showing the category THE ROLE and the preliminary categories and codes

♥ - please refer to Figure 7.8

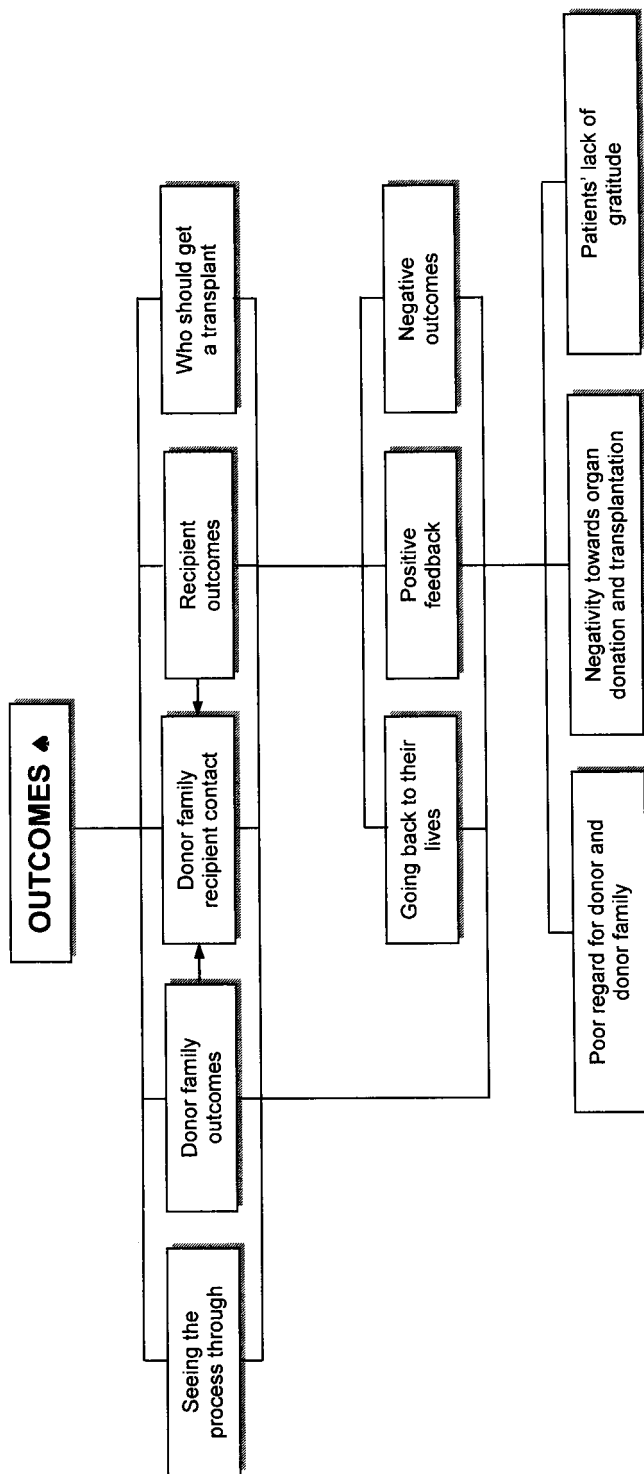


Figure 7.13: Flow chart showing the category OUTCOMES and the preliminary categories and codes

▲ = please refer to Figure 7.8

Analysis of the second Delphi survey questionnaire

In this section the codes, preliminary categories, categories and the potential core category that emerged from the analysis of the focus group interviews, literature and the first Delphi survey were added to, using selective coding of the responses in survey two. As explained, examination of the second survey began with analysis of the quantitative data, as reported in Chapter Six. This information was used to see if the results added new information to the categories and the proposed core category, confirmed information that had already emerged under the category headings or generated new categories. Constant comparative analysis of the participants' comments to each of the statements in the second survey follow and are reported here.

The analysis of the qualitative data from the second survey was undertaken using the same methods as in the first. The participants' responses to each of the statements were transcribed into the NVivo program with each of the statements grouped to facilitate easier and more accurate analysis. All the responses to each of the statements were read in turn and compared to the statistical results obtained from the quantitative data. This information was compared to the codes and categories in order to expand or confirm the current information or facilitate the emergence of new codes, preliminary categories and/or categories.

As the data from the focus group interviews, the previous Delphi survey and the literature were constantly compared with that of the second survey questionnaire it became clear that the existing codes and categories were supported by information emerging from the second survey. It was also evident that a number of the existing codes and categories were saturated. As the analysis progressed, the links between and properties of each of the categories began to emerge. These are discussed in the next chapter.

This section begins with the analysis and constant comparison of the qualitative data - commencing with data that adds richness and density to the category KNOWLEDGE AND EXPERIENCE.

Knowledge and experience

There were eight statements in the second Delphi survey relating to the category KNOWLEDGE AND EXPERIENCE.

Statement 5: The International Course for transplant coordinators held in Australia has/will help donor and recipient coordinators understand each other's roles.

Statement 14: Agency/transplant unit managers need a transplant coordination background.

Three quarters of the study cohort were in agreement with statement 5 indicating that the International Course has or would facilitate greater understanding of the roles performed by transplant coordinators. This was also reflected in participants' comments:

After attending this course I have a greater insight into all roles (DS2, p. 15, L. 1).

All should attend regardless of experience! We need to establish an ongoing commitment to staff development and learning (DS2, p. 15, L. 23-24).

Statement 14 also elaborates on the issue of understanding the coordinators' role. Again there was no consensus achieved in relation to this statement with 47% of the study cohort believing that agency/transplant unit managers need a coordination background, whilst 40.2% felt that this was unnecessary. Examples of the participants' responses include:

A medical/nursing background would be highly desirable rather than pure management (DS2, p. 48, L. 33; p. 49, L. 19).

A good manager does not necessarily need the skills of all the people they manage (DS2, p. 49, L. 28).

Statement 12: Transplant coordinators are 'generalists' not 'specialists' as they wear many different hats in their role.

Statement 26: Transplant coordination is a specialised area of practice.

Statement 12 discusses the notion of transplant coordinators being generalists, rather than specialists, who perform many activities and functions in their role. Just under a quarter of the cohort were in agreement with this statement as is reflected in their comments:

The role has many dimensions but I believe it is quite specialised (DS2, p. 40, L. 31).

I disagree with the word 'generalists' we are no doubt specialists in our field and we are uniquely multi-skilled in a variety of areas that many people are not (DS2, p. 43, L. 25-26).

The belief that transplant coordinators are specialists in their field was further explored in statement 26. This statement was confirmed by an overwhelming affirmative response of 98%. Their thoughts include:

Transplantation is a new evolving unique form of medicine and therefore a specialised area with few understanding the complexities (DS2, p. 89, L. 3-4).

Absolutely (DS2, p. 89, L. 18).

Statement 25: A nursing qualification should be the minimum required for transplant coordinators.

Statement 27: There needs to be a specific university qualification for transplant coordinators.

There were two statements in the survey relating to the issue of qualifications for transplant coordinators. The first of these was statement 25, which proposed that a nursing qualification should be the minimum requirement. Of the participants 70.6% were in agreement but the qualitative comments were less definitive. The results and comments should also be viewed with caution as there is a significant imbalance between nurses and non-nurses in the study cohort. Examples of the comments made by the respondents included:

I believe coordinators need to be nurses (DS2, p. 86, L. 18).

Need multi-skills in the team. Nurses are not necessarily good communicators, educators, counsellors, organisers [or] computer literate (DS2, p. 86, L. 31-32).

Despite the above findings, only 33.3% felt that there needed to be a specific university qualification for coordinators as suggested in statement 27. This is an interesting finding particularly as most coordinators believed transplant coordination to be a specialised area of practice. Responses to this statement included:

While I think it would be great to have university based education programmes for coordinators I don't think it is a crucial requirement (DS2, p. 92, L. 9-10).

Would be too limiting to use in other jobs (DS2, p. 93, L. 23).

Statement 13: There is no career structure for transplant coordinators.

Statement 16: The roles of transplant coordinators throughout Australia and New Zealand need industrial standardisation.

The final two statements in this category identified that most respondents believe there is no career structure for transplant coordinators. There is, however, a desire for industrial standardisation in the field. Statement 13 highlighted that 72.6% of participants agreed that there is no career structure for coordinators as was also evident in their qualitative responses:

Limited opportunities for career advancement (DS2, p. 46, L. 23).

This role provides many opportunities as the training and skills acquired during a coordinator's tenure place the individual in a good position for other roles or even career changes (DS2, p. 46, L. 11-13).

The issue of standardisation was addressed in the previous Delphi survey and resubmitted in the second survey in a changed format to encompass the word 'industrial' as shown in statement 16. Results indicate that the majority of coordinators believe that industrial standardisation would be beneficial to their profession. However, a number of responses suggested that this might be difficult to achieve due to the different states, territories and countries:

Different states have different awards for all health workers (DS2, p. 59, L. 31).

Would help to 'uniform' working conditions - each state will always have different needs but you can still work within the same framework (DS2, p. 57, L. 9-10).

Summary of the category – knowledge and experience

Responses to statements included in the survey that addressed the category KNOWLEDGE AND EXPERIENCE suggest that generally coordinators believe that knowledge, education and experience are important aspects of their career and professional development. This is, in part, supported by the strong affirmative response to the benefits of the International Course for transplant coordinators conducted in Adelaide, which they believe facilitates an understanding of their colleagues' professional practice. There was also strong support to suggest that coordinators feel they are specialists in their field and that transplant coordination is a specialised area of practice.

This is further substantiated by the fact that the majority of coordinators believe that a nursing qualification should be the minimum requirement to practice as a transplant coordinator. However, just under a third of the study cohort felt the necessity for a specific university qualification. This may be an indication that organ donation and transplantation may not be as specialised as the coordinators perceive it to be.

The diversity in the coordinators' professional backgrounds was seen by a few as beneficial, believing those from non-nursing backgrounds make a significant contribution to the field of organ donation and transplantation. For others, however, the lack of uniformity of educational backgrounds and experience was problematic. In particular this diversity made it difficult for industrial standardisation and was not conducive to any type of career structure within the field. These were not the only impediments to standardisation and a career structure, as was highlighted in the survey responses.

The final area addressed in this category was whether or not agency or transplant unit managers should have a transplant coordination background to perform their role. There was no consensus regarding this issue and essentially the main requirements put forward for effective management were exemplary management and communication skills coupled with respect for others.

The role

As discussed earlier following the constant comparative analysis of the first questionnaire the categories were re-examined and reconfigured. This led to the categories WORK DEMANDS AND CONDITIONS and CHARACTERISTICS OF THE ROLE being combined and relabelled THE ROLE. Eleven statements addressed the category THE ROLE in the second Delphi survey.

Statement 9: The role of the transplant coordinator is unique.

Statement 1: Transplant coordinators have control over their role and how it should be performed or carried out.

Statement 4: The management of organ donation and transplantation is overly bureaucratic.

Statistical results and qualitative responses to statement 9 revealed that almost 90% of the study cohort believed that the transplant coordinators' role is unique:

The visible tangible outcomes of this work make the role unique/remarkable. Definition: - one of a kind (×), - unusual (✓), remarkable (✓) (DS2, p. 30, L. 7-8).

The transplant coordinator is the only person looking at the big picture, every other professional concentrates only on their part and thinks it is the most important, the transplant coordinator ensures everyone stays on track and brings it all together (DS2, p. 34, L. 16-18).

Statement 1 revealed that 71.6% of coordinators believe they have control over their role and how it should be performed with just over 20% believing this was not the case:

I have had the opportunity to develop up my own position. This has been done as a team and independently. I am very much in control and accountable for my position (DS2, p. 2, L. 2-3).

No more. Since the advent of agencies the role has become very bureaucratic and proscriptive with little sense of professional decision-making and satisfaction (DS2, p. 2, L. 24-25).

As was suggested in one of the above examples, 40.2% of the participants who responded to statement 4 felt that the management of organ donation and transplantation is becoming more bureaucratic. There was no consensus achieved in relation to this statement as 41.2% disagreed with this view. Examples of the two opposing perspectives include:

I believe this is exacerbated by the emotive nature and the high profile of transplantation (DS2, p. 14, L. 2).

Organ donation has historically occurred on too little bureaucracy, hence the inability to get adequate funding for programmes and promotion. It has not been seen as a State or National priority [and] tended to be dictated by transplanters. The separation between organ donation and transplantation has now occurred with the state agencies, Australians' Donate and Commonwealth committees (DS2, p.12, L. 32-33; p. 13, L. 1-3).

Statement 18: A large percentage of the transplant coordinators' work is invisible labour and therefore difficult to quantify.

Statement 10: There are strong intrinsic rewards in the transplant coordinators role.

Statement 20: I feel ambivalent about my role as a transplant coordinator.

Statement 15: Professional isolation is a concern for me.

The majority of transplant coordinators agreed with statement 18, stating that a large percentage of their work is invisible labour and difficult to quantify. This is reflected in the following examples:

Absolutely. So much is not rewarded, recognised or acknowledged (DS2, p. 64, L. 18).

I don't agree it's invisible; we can quantify the number of education/presentations, amount of promotional work, the database results etc. We just have to adequately document it (DS2, p. 64, L. 31-32).

Family support is one of those areas (DS2, p. 63, L. 29).

Statement **10** suggested that there are strong intrinsic rewards in the transplant coordinators' role. The study cohort confirmed this with 87.2% agreeing with the statement. Below are two examples - one which reflects a positive response to the statement and the other reflecting a negative comment:

The reward of a successful transplant and a second chance at life for clients was the most rewarding aspect of this role. Equally the suffering of those who passed on due to complications was very distressing (DS2, p. 35, L. 13-15).

At the present time I see no rewards – I only see dead people, grief and sadness. I get paid too little, work long hours and get no thanks (DS2, p. 37, L. 3-4).

Only 15.7% of respondents to statement **20** reported being ambivalent about their role as a transplant coordinator. Most participants appeared to be content with the work they perform which was highlighted in a number of comments:

I love my role (DS2, p. 71, L. 23).

I feel that the role is very important and needs support to function. If you felt ambivalent the on call and tiredness would destroy you (DS2, p. 72, L. 10-11).

I hate it (DS2, p. 72, L. 20).

There were equally divided opinions in response to statement **15** which addressed the issue of professional isolation. There was no consensus with those in agreement accounting for 46.1% and those who disagreed also accounting for 46.1%.

Yes! It is hard to debrief or find professional support ... (DS2, p. 54, L.12).

I get support from my peers (DS2, p. 55, L. 19).

Statement 19: The amount of 'on call' for transplant coordinators is excessive.

Statement 22: There is a high turn over of transplant coordinators due to the amount of 'on call' they are required to do.

Statement 24: Transplant coordinators often have minimal time with no 'on call' commitments.

Statement 23: I often feel fatigued in this role.

There were three statements included in the second Delphi survey relating to on call and one relating to fatigue. Statement **19** asked coordinators to consider if the on call commitments were excessive. Of the participants 62.7% felt they were, as was strongly reflected in many comments:

Major factor in my resignation (DS2, p. 67, L. 16).

Outrageous. For some almost every day of the year. For most others 2 in 3 with more when people are on holidays. It is destructive of family life and the health and wellbeing of coordinators (DS2, p. 67, L. 25-27).

The amount of call I am forced to do will ultimately force me out of my role (DS2, p. 70, L. 19).

It is part of the job and you are told when you start (DS2, p. 69, L. 7).

Statement **22** addressed the issue of increased transplant coordinator turnover due to the on call demands they are subjected to. There was a mixed response to this statement with no consensus. Of the participants 48% felt on call was responsible for staff turnover, whilst 23.5% were unsure and 27.5% disagreed with the statement. A number of qualitative responses indicated that coordinators felt the high turnover of staff may in fact be multifactorial with on call being just one component:

Multifactorial. There is attrition in all employment; this is not necessarily a bad thing (DS2, p. 77, L. 27).

On call plays a big part in the turnover rate as does bullying (DS2, p. 78, L. 7).

And the lack of supportive management. It's also about the lack of family life and ability to put space between you and the job that goes with the level of 'on call' (DS2, p. 77, L. 24-25).

The issue of on call and its impact on coordinators continued to be explored with the inclusion of statement **24** in the survey. This addressed the fact that coordinators have minimal time without on call commitments. There was also a mixed response to this statement with 58.8% agreeing and the rest either unsure or disagreeing:

I can't speak for current trends but I did not feel exploited during my time in the position (DS2, p. 82, L. 24).

I have no time off call – only when I go on annual leave and even then I have been called back for a donor on two occasions when I was on annual leave. So essentially I feel as though I am never off call unless I leave the country (DS2, p. 83, L. 31-33).

Forget having a life if you are a transplant coordinator. The bureaucrats can't seem to understand and don't even seem to want to understand -

the impact of on call, even the anticipation of being called. It's often a relief when the pager actually goes off (DS2, p. 83, L. 22-24).

The final area explored under the category THE ROLE was the issue of transplant coordinator fatigue. Statistical responses to statement **23** revealed that 70.6% of transplant coordinators often felt fatigued in their role:

At every level – extremely fatigued emotional and physical. The job impacts on my physical health and well-being. There are times when I feel very depressed and even suicidal (DS2, p. 80, L. 28-29).

No spare time, no time to think! And no longer any time to initiate new projects or keep up with reading (DS2, p. 79, L. 27-28).

Fatigue is a huge factor experienced by transplant coordinators (DS2, p. 80, L. 16).

Summary of the category - the role

In relation to this category the majority of transplant coordinators felt that the role of a coordinator is unique and that they have control over how it is performed. Yet they were undecided as to whether it had become overly bureaucratic or not. The majority of participants felt that a large amount of the coordinators' work is invisible and difficult to quantify. They also indicated that there are strong intrinsic rewards and most stated that they were not ambivalent about the role. In relation to professional isolation the group were divided.

Matters relating to on call suggest that just over 60% felt that such commitments were excessive whilst just fewer than 50% felt this was the reason for staff turnover. A number of the study cohort suggested that the reasons for staff burnout and turnover were multifactorial and on call was just one contributing factor. Almost 60% of participants felt that coordinators have minimal time with no on call commitments whilst the majority stated that they often felt fatigued in their role.

Outcomes

Following the reconfiguration of the codes and categories after the constant comparative analysis of the first Delphi survey the category OUTCOMES AND EXPECTATIONS was relabelled OUTCOMES. Four statements relating to this were included in the second questionnaire.

Statement 28: **An appropriate third party, other than organ donation agencies and transplant units, could facilitate the meetings between donor families and recipients if both parties agree.**

The issue of donor families and transplant recipients meeting was addressed in the first survey. The word 'unrestricted' was a point of contention so the statement was reformatted and included in the second survey. Of the participants 54.9% agreed with statement **28** that donor families and recipients should be allowed to meet if an appropriate third party facilitated the process. Just over 25% opposed or strongly opposed this type of meeting. Qualitative responses were mixed with a number suggesting that to go down this path was 'opening a can of worms'. Others felt it would be appropriate if a third party was involved and some felt it was long overdue. Several respondents indicated a degree of ambivalence regarding the matter:

Opens a can of worms (DS2, p. 95, L. 10).

Yes! Have been advocating this for years (DS2, p. 95, L. 25).

In reality these families are already meeting courtesy of current affair shows – I don't believe this offers either side the best support. Something structured needs to exist (DS2, p. 94, L. 24-25).

Statement 29: The selection criteria for transplant recipients needs reviewing.

The competency of the selection process for organ recipients was addressed in statement **29**. Of the participants surveyed 49.0% of participants believed that the selection criteria for transplant recipients needed reviewing whilst 28.4% felt this was unnecessary. Comments supporting the differing points of view are offered:

Our selection criteria for recipients have very recently been revised. It is a standard and satisfactory criteria (DS2, p. 97, L. 30-31).

At times I feel that inappropriate recipients have been transplanted (DS2, p. 97, L. 33).

Statement 30: The pre-mortem wishes of the deceased to donate their organs should not be overridden.

Of the participants 68.6% were in agreement with statement **30** that the pre-mortem wishes of the deceased to donate their organs should be respected. Those who disagreed had concerns regarding the relatives of the deceased:

I do believe their wishes should be followed but I don't know that causing more trauma to a grieving family who do not wish to [donate their deceased relatives organs] is worth it (DS2, p. 101, L. 30-31).

If the deceased has made a clear wish to donate such as registering with the organ donor registry then I believe the wishes should be carried out (DS2, p. 102, L. 9-10).

Statement 31: Medical staff uncomfortable with organ donation should delegate the task of approaching families to request organs for donation.

There was strong support for statement 31 with 96.0% of respondents agreeing that medical staff who are uncomfortable approaching families about organ donation should delegate the task. A number of comments suggested that some coordinators believe there should be trained requestors to approach potential donor families regarding organ donation:

I really believe there is a place for dedicated requestors (DS2, p. 106, L. 4).

This is not done (DS2, p. 106, L. 25).

Donors are missed because the medical staff did not make the request or made the wrong assumptions (DS2, p. 107, L. 1-2).

Have worked with staff that are uncomfortable/disagree with donation. Some have been loathed to broach [the] subject but have referred and been supported. Others need to be reminded the public have a right to make an informed decision and their wishes respected (DS2, p. 107, L. 7-9).

Summary of the category - outcomes

In relation to the category labelled OUTCOMES just over half of the coordinators believed an appropriate third party could facilitate meetings between donor families and recipients. However, there was also evidence of significant opposition to the concept of donor families and recipients meeting with many believing it is fraught with danger! Just fewer than 50% of the participants felt that selection criteria for recipients needed reviewing. There was also overwhelming support to suggest that medical staff who are uncomfortable with organ donation should delegate the task of requesting organs. Nearly 70% of respondents believed that the wishes of the deceased regarding organ donation should not be overridden.

Relationships

RELATIONSHIPS was another category that evolved following the constant comparative analysis of the first Delphi survey with POOR REGARD FOR COORDINATORS AND THEIR ROLE being subsumed into it. This category has two subcategories - THE HEALTH TEAM, which was previously titled the PROFESSIONAL TEAM, and THE CLIENT. The following nine statements from the second Delphi survey questionnaire contributed to the density, richness and saturation of this category.

Statement 2: There is a lack of national focus among coordinators.

Statement 3: There are times when dealing with other coordinators is difficult.

Statement 32: There is tension among transplant coordinators when marginal organs are offered to transplant units.

Statistical analysis of responses to statement 2 suggests that coordinators are divided regarding their ability to focus on national matters pertaining to their role. This, in part, may be explained by the responses to statement 3, which indicates 66.7% felt there were sometimes difficulties experienced when dealing with colleagues. This would suggest that if there is unrest amongst coordinators then national consensus would be more difficult to achieve. Examples of the qualitative responses to these statements included:

Too many people wish to reinvent the wheel instead of looking at current resources (DS2, p. 4, L. 29).

I did not always feel as though I had enough contact with the heart and lung transplant coordinators from the other states. Although when visiting Melbourne I found the team there keen to share knowledge and ideas (DS2, p. 4, L. 31-33).

Organ donor coordinator to transplant coordinator can be very difficult as they have very different agendas at the time of referral (DS2, p.10. L.3-4). Circumstances can often be difficult, but I feel that coordinators themselves are not difficult to deal with (DS2, p. 9, L. 13-14).

Although the majority of participants felt there were difficulties experienced in interacting with other coordinators this was not clearly highlighted through statement 32. Statistical analysis demonstrated that less than 50% of participants indicated there was tension between coordinators when marginal organs were offered to transplant units, with the other participants disagreeing or undecided about the statement. Examples of the qualitative comments are shown below:

I don't think there is tension, but donor coordinators need to be aware that marginal organs may often be refused as transplant units have a responsibility to ensure optimal outcomes for their recipients are achieved. It would be unethical to put a medically unsuitable organ into a recipient unless there were extenuating circumstances (DS2, p. 109, L. 29-32).

Depends how they are offered. I think some units are disadvantaged because they'll take just about anything - others want Olympic athletes. Sometimes organs can be offered 'without prejudice' to other states. One can never tell if there is a really sick patient who might be grateful for anything. There probably needs to be two separate rotations that doesn't disadvantage the units that use less than optimal organs (DS2, p. 109, L. 29-32).

- Statement 6:** Other health professionals do not acknowledge the complexity of my role.
- Statement 7:** As organ donation and transplantation has become more 'run of the mill' the level of cooperation from health professionals has improved.
- Statement 8:** Other health professionals see transplant coordinators as expendable.
- Statement 11:** Medical staff through the TSANZ have enabled the transplant coordinators to have a voice by allowing ATCA members to join their professional organisation.
- Statement 17:** Doctors' attitudes can impact on the transplant coordinators' ability to undertake their role.

More than three quarters of the study cohort agreed with statement 6 indicating that the role of the coordinator is poorly understood by other health professionals:

I don't think that it is that they don't acknowledge it but maybe they don't really understand or know what is involved in my role (DS2, p. 20, L. 13-14).

No one else realises the complexity and enormity of a coordinators' role (DS2, p. 18, L. 16-17).

Not the complexity - because the role is hard to understand when you only see a small part of it for example operating theatre staff see one piece - ICU staff another. However many of these staff see the complexities associated with the particular bits of the job that they see. For example, nurses will occasionally say things like: 'It's a really hard job - how do you do it?' 'I would never do your job - it's a nightmare.' When other professionals do acknowledge the complexities and difficulties, there is, for me anyway, a sense of acknowledgement and relief. In a sense I feel validated - silly I know but there you are! (DS2, p. 18, L. 19-25).

Analysis of statement 7 demonstrated a lack of consensus about whether the cooperation between health professionals has improved as organ donation and transplantation has become more commonplace. This was reflected in general comments:

As transplanters have got older they seem more likely to want to work when it suits them and not when it suits the donor hospital, family [or] other transplant units ... (DS2, p. 21, L. 28-29).

I think people understand the process more and are now more accepting (DS2, p. 23, L. 32).

Analysis of statement **8**, which referred to other health professionals regarding transplant coordinators as expendable, demonstrated a lack of consensus between the responses. A third of participants agreed with the statement, almost 20% were unsure and the remainder disagreed. The qualitative data also mirrored the statistical results:

Some health professionals do see transplant coordinators as expendable. One newly appointed physician on meeting me commented that he had not worked with a transplant coordinator before and didn't really see a need for them (DS2, p. 24, L. 15-17).

Transplant coordinators are seen as having a vital role in both organ donation and transplantation (DS2, p. 25, L. 3-4).

Really because they don't understand the role (DS2, p. 24, L. 33).

Analysis of statement **11** indicated that just over 50% of respondents felt that the TSANZ enabled coordinators to have a 'voice' whilst 11.8% disagreed. However, the majority of the comments suggested that even for those who expressed an affirmative response to the statement they considered 'that voice' to have a limited impact:

Token gesture only – they still have control (DS2, p. 39, L. 24).

Aren't we associate members and therefore a very quiet voice? (DS2, p. 40, L. 18).

In response to statement **17** the majority of participants agreed that doctors' attitudes did influence their ability to undertake the requirements of their role. Examples of the qualitative responses indicated that this had both positive and negative consequences:

Collaboration is essential (DS2, p. 60, L. 2).

Doctors' attitudes impact on the role significantly. I believe much of this is 'attitude' and lack of insight into what the role involves (DS2, p. 60, L. 27-28).

Coordinators are working closely with senior medical staff, hence their attitudes have a huge impact on the coordinator and their role (DS2, p. 61, L. 21-22).

Statement 21: Transplant coordinators experience horizontal violence in their role.

Responses to statement **21** indicated that 50% of the study cohort felt that transplant coordinators experience horizontal violence in their role. Of the other participants 9.8% stated they were unsure about the statement whilst 39.2% felt

this was not the case. One person did not provide an answer. Comments were varied, with a number pertaining to the deliberate withholding of information, bullying and aggressive behaviour:

As a relief coordinator I have experienced inadequate handovers, important information not being passed on. Coordinator going on leave and not leaving keys to his office or locking filing cabinets (DS2, p. 73, L. 9-11).

Bullying and harassment is a daily part of my life. Ironic when you consider that my supervisor was a coordinator. Unsupportive and actively aggressive management practices have a lot to do with this (DS2, p. 74, L. 20-22).

Not in my experience (DS2, p. 75, L. 28).

Virtual relationships

At this point in the constant comparative analysis it became obvious that there were other types of relationships being described in the data. These encompassed the ambiguous relationships donor coordinators have with donors. Although logic dictates a traditional relationship with a deceased person is incomprehensible, donor coordinators are vicariously exposed to these individuals through the donor families' descriptions and shared verbalised memories:

I find the intimacy that comes when a family lets you in, [lets you] share their love and sadness for their loved one - it is a privilege (DS2, p. 37, L. 15-16).

A recipient coordinator also highlights this virtual relationship. She acknowledges donor families she will never meet and says she stays in the job in spite of the bullying she experiences because of the recipients and donor families:

This has certainly toughened me up because I am doing it for the patients and donor families therefore I deal with it! (DS2, p. 74, L. 10-11).

Another example was offered by a coordinator in relation to seeing the process through:

Yes it gives a sense of completion and I think its very important for donor families because you give a commitment to them that you'll be the person who will look after their loved one (DS1, p. 66, L. 19-21).

Two more examples that demonstrate a virtual relationship, include one from a recipient coordinator who is concerned with the loss of a young donor whom she will never see. The second is from a donor coordinator who has a strong association with a child organ donor of the same age as her child:

Dealing with young donors and the issue of loss (DS1, p. 110, L. 19).

And sometimes a case will come out of the blue and hit you right between the eyes when you are least expecting it - a child dies and it's the same age as yours - and all those hidden repressed emotions come pouring out! I remember the only time someone from another hospital sent a thank you card and small gift of appreciation to me. I just broke down and cried - it was so unexpected it took me by complete surprise and touched me in a way I wasn't prepared for. It was the fact that someone noticed; someone cared about me that was so astonishing (DS1, p. 112, L. 25-31).

Donor coordinators are in the privileged position of being part of family discussions and may develop an identity for the deceased based on the families' descriptions of them. This can inadvertently lead to a virtual relationship. This relationship is both powerful and significant to those involved, although it may not be directly expressed as such. This phenomenon emerged in the constant comparative analysis of the data.

There are also virtual relationships that donor coordinators have with unknown recipients, and that recipient coordinators have with the unknown donor and donor family. Included in this group are the relationships donor families and recipients have with each other. They too could be described as virtual relationships. Although the parties do not know each other, and for most will never meet, there is a bond that exists between donor families and recipients - a life long association. In the absence of information, donor families and recipients often develop an image, as do coordinators, of those involved in the complex process of organ donation and transplantation. This is highlighted in the first of the following quotes from donor families surveyed in the National Donor Family Studies:

It is upsetting to receive a letter, but at the same time it is wonderful. I have received a letter from one recipient and just recently I received a small plaque from him, I read it nearly every day, and I think of him with his family. It is the nicest gift I've ever been given (White 1995, p. 51).

If I hadn't heard anything I would have wondered if it was all in vain. Having contact made me proud and pleased that another person (7 in all) had survived because of my brother's donation. It was upsetting but good to know a little about the recipients and to know they were well and enjoying life. ... I felt most important was basic information about recipients shortly after donation - I think I accepted the whole situation much more when I knew (concrete evidence) that my brother had helped other people survive (White 2000, p. 21).

These relationships, although not traditional in the sense of personal interaction between the parties, can be complex emotional attachments. They could be said to be unique to the health care professionals, donor families and recipients

involved. The examples from the second Delphi survey and previously collected data, demonstrate the virtual relationships encountered or experienced by the transplant coordinators. They have been grouped together in the research to form the subcategory VIRTUAL RELATIONSHIPS. It is not because coordinators are working on behalf of an unknown person or receiving a benefit for their patients that make this situation unique - one could also put large corporations in that subcategory as they too work on behalf of their shareholders. Of significance in these relationships is the context within which they evolve and the emotional attachments, either conscious or unconscious that are formed. For many the attachments represented in the subcategory VIRTUAL RELATIONSHIPS last a lifetime:

Coordinators work to meet the needs of an unknown patient by caring for a deceased person and their family who will make this possible (DS2, p. 26, L. 14-15).

The privilege of working with families experiencing acute grief and knowing that an incredible difference is being made possible for those receiving transplants (DS2, p. 34, L. 8-9).

Knowing that [I] assisted patient and family in their wishes to donate. Knowing recipients benefited (DS2, p. 37, L. 10-11).

Summary of the category - relationships

The statements discussed above add to the richness, density and saturation of the codes and subcategories THE HEALTH TEAM, THE CLIENT and VIRTUAL RELATIONSHIPS that form the category RELATIONSHIPS. The data from the second survey adds to and makes transparent the relationships the transplant coordinators have with their colleagues, their clients and the health care professionals they work with. The new subcategory VIRTUAL RELATIONSHIPS suggests that transplant coordinators have relationships, some with deep emotional ties with individuals they have not met. Similar relationships can be identified between donor families and recipients who have not met. Responses in the second survey, both in relation to the statements and the general comments at the end, consolidated the notion that **RELATIONSHIPS** was the core category:

I found it quite difficult initially taking on a newly developed role as clinical transplant coordinator and educator. The orientation was limited and coordinators are employed with varying position descriptions in outlying hospitals so often no comparison between jobs. Some renal physicians were accepting of my position and others were not so keen. It is taking time to establish a really good rapport with all of them around my position. Although working as a member of the health team, there is a certain degree of the position that is stand-alone so to speak. This

situation has been more difficult in terms of negotiating with management regarding rewards such as on going education and wage increases etc. On occasions it has taken the support of outlying resources such as (name of organisation) and Director of Nursing ... (DS2, p. 113, L. 2-11).

Also helps build strong working relationships (DS2, p. 16, L. 12).

Because you get to deal with life and death on such different levels, but get to follow your patients and form relationships with them over such a long time (DS2, p. 34, L. 23-24).

Need strong working partnerships (DS2, p. 60, L. 25).

Summary of the second Delphi survey

Following the constant comparative analysis of the qualitative and quantitative data, one new subcategory VIRTUAL RELATIONSHIPS emerged and added information to the core category **RELATIONSHIPS**. The data from the second Delphi survey also added density and richness to the subcategories and categories that had already emerged in the research.

Comments from the data that contributed to the emergence and isolation of **RELATIONSHIPS** as being the core category also included the following:

I work within a flexible and approachable team who have allowed me to discuss my role with them and pretty much determine my own boundaries and activities (DS2, p. 1, L. 28-29).

There are always the odd few that will try to take over your role so they can have the control. However most people will have faith in your abilities to carry out your role and once referred to the appropriate party will leave you alone to do your job the way you think things should proceed (DS2, p. 3, L. 6-9).

Below is a memo written by the researcher earlier in the study which highlights the relationships thought to be emerging from the data:

There appears to be a number of relationships emerging from the data, examples of which are:

- Relationships with others – clients, colleagues and health professionals.
- Relationships with the job and characteristics of the role that appeal to the coordinators – autonomy, advocacy, intimacy of the job, uniqueness, power, responsibility and job satisfaction.
- Relationships between the coordinators work and their personal lives.
- 'Virtual relationships' between donor families and recipients, donor coordinators – vicariously with deceased donors and possibly organ recipients, recipient coordinators with unknown donor families.

- The relationships appear to be either positive and helpful or negative and harmful all in various stages of development – building relationships.
- There is also a relationship between life and death that is evident in this field of medicine.
- These relationships can also be divided into a number of other types for example:
 - Professional relationships
 - 'Virtual' relationships
 - Personal relationships
 - Organisational relationships
 - Emotional relationships
 - Interrelated relationships.

Sometimes the coordinators almost have relationships by proxy. In fact both donor and recipient coordinators do have relationships via proxy as they are both working on behalf of another person or persons (Memo 5.9.04).

A further memo was written making the analogy that the 'virtual' relationships experienced by those in the field were similar in some ways to the Unknown Soldier:

The relationships that the transplant coordinators, other health professionals involved in the field and recipients have with a donor are similar to that of the Unknown Soldier – whilst there is no physical relationship with the deceased there is an emotional attachment to the person as they have given their life so that others may live.

There is also a sense of needing to thank that person. Like the Unknown Soldier you wonder who the deceased was, what they were like and whether or not they would be satisfied with the outcome in terms of – was their sacrifice worth it! There is a mystique about the deceased and a need to honour them in some way. Just as the Unknown Soldier gave his life so that others may have their liberty, donors too make a significant difference to the lives of others (Memo 7.4.05).

The second Delphi survey confirmed the data already contained in the core category **RELATIONSHIPS** and the categories that support it, adding both richness and density to the developing theory. Figure 7.14 shows a flow chart of the core category together with the categories and subcategories that support it.

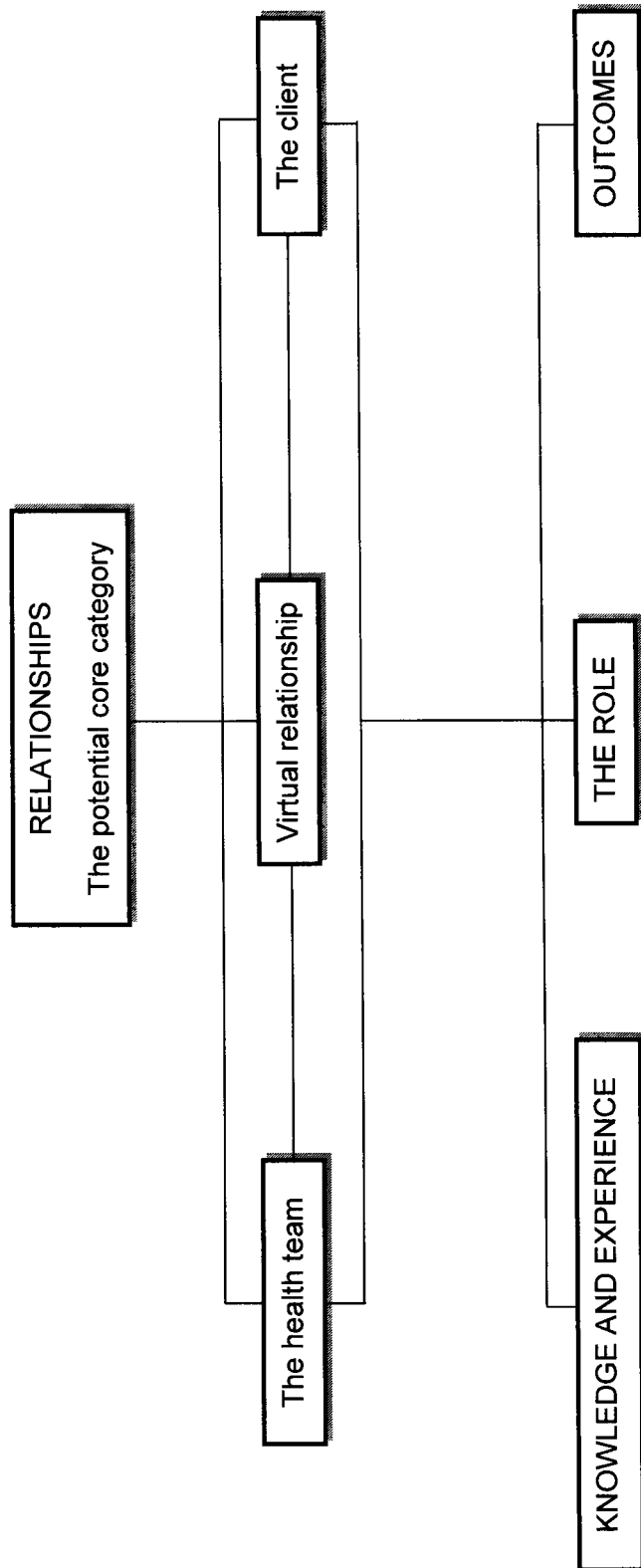


Figure 7.14: Flow chart showing the core category RELATIONSHIPS, categories and sub categories

Summary

This chapter and the previous one summarise the constant comparative analysis of the data obtained through theoretical sampling in the form of Delphi survey questionnaires and the available literature. As the study progressed the researcher moved from open coding to selective coding with the subsequent emergence of the core category **RELATIONSHIPS**.

Selective coding was carried out on the participants' responses to the statements in the second Delphi survey. Statistical analysis and qualitative example were used to add density and richness to the codes, subcategories, categories and core category that emerged from the data. The constant comparative analysis of the qualitative and quantitative data also facilitated the saturation of the categories and the core category.

The next chapter reports on stages two, three and four of the constant comparative analysis process - the integration of categories and their properties, delimiting and writing the theory. The implications of the findings and opportunities for their dissemination are also discussed. The chapter concludes with the limitations of the study and future research opportunities.