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Cultivating Interdisciplinary Shared Wisdom Through a Structured Case Conference

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Abstract

Background: The interdisciplinary practice of specialty palliative care teams faces complex challenges without clear guidance, especially around collaboration, clinical care, and teaching. Case-based group discussions on communication challenges in clinical care may promote interdisciplinary teams' professional growth and psychological wellbeing.

Objectives: To develop and understand the impact of a structured, case-based, facilitated discussion of communication challenges on the function and wellbeing of an interdisciplinary specialty palliative care team.

Methods: Our palliative care section created an interprofessional case-based conference focused on close examination of communication challenges modeled on "Morning Report", called "Wisdom Wednesday" (WW). Initial components included the clinical background and setting, planned communication strategy, and retelling of the clinical encounter in question. We included discussion of differential diagnoses for communication challenges encountered, and strategies for how to explore the underlying contributing factors and how to find success moving forward. Over time more structure has been developed to guide facilitation and allow for a more diverse facilitation group.

Results: Results from a focus group of 23 palliative care clinicians found that the WW conference facilitated team connection, served as a resource for clinicians facing clinical challenges, and celebrated interprofessional perspectives. A subset of participants expressed a need for additional support to feel confident presenting.

Conclusions: Embedding a weekly facilitated case discussion in the usual practice fostered a virtuous cycle of individual growth and team connectedness among interdisciplinary palliative care providers. Similar conferences could be implemented in other medical teams to teach practical wisdom and reduce burnout.

Keywords

interprofessional team, case conference, communication, interprofessional education

Introduction

Interdisciplinary care is a core component and distinguishing feature of specialty palliative care. Consensus-based clinical practice guidelines offer direction on the composition of the interdisciplinary team (IDT),[1] and there is some evidence for best practices within interdisciplinary healthcare teams.[2] However, there is little available guidance on how to practically operationalize interdisciplinary care and communication in the palliative care setting.[1] Barriers to interdisciplinary collaboration can include insufficient time for exchange and collaboration, as well as professional, gender, and cultural hierarchies.[3] Additionally, overemphasizing biomedical information over psychosocial information and role confusion among team members can be challenging.[3] Beyond the challenges of interdisciplinary practice, palliative care teams encounter a wide variety of clinical scenarios requiring advanced communication skills, often without clear or standard pathways forward.[4] Furthermore, many interdisciplinary palliative care teams are also charged with teaching specialty palliative care, a task that requires nuanced communication

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and other skills honed over years of practice.[5] The result is that palliative care IDTs are managing many tasks and challenges without clear guidance about how to do so. In our specialty palliative care team, we developed a structured, case-based conference initially conceived as a venue to discuss challenging clinical communication, with the goal of mitigating challenges in clinical practice.

Case-based discussion has long been a mainstay of medical education.[6] One notable example is Morning Report, a ubiquitous part of internal medicine training.[7] Although the exact format of Morning Report varies, it commonly includes discussion of specific cases with the goal of transmitting medical knowledge and improving clinical care.[7,8] Clinical supervision, part of the training of mental health practitioners, is another model of learning clinical skills and has shown effects in bridging gaps between knowledge and real-world practice, promoting providers' self-awareness, and decreasing burnout.[9–12] Our case-based conference represents a hybrid of Morning Report and clinical supervision, and ultimately serves as an operationalization and reinforcement of the key specialty palliative care competencies. In this manuscript we describe the structure and implementation of our conference format and impact on our clinical practice.

Methods

Background

In 2016, representatives from medicine, social work, and nursing in the Section of Palliative Care piloted a standing conference with a primary goal of facilitating in-depth discussion of cases involving communication challenges in support of learning how and when to apply communication skills. Secondary goals included creating a team culture of continuous learning and growth, modeling vulnerability and curiosity, and increasing access to interprofessional perspectives. The 30-minute weekly conference came to be known as "Wisdom Wednesday", and was incorporated into the standing one-hour daily IDT meeting, which is protected time for all team members.

Conference Structure

The structure of the meeting was modeled on an internal medicine-style Morning Report case conference, long a mainstay in healthcare education.[8] The idea of identifying a differential diagnosis in communication challenges leverages a diagnostic pathway familiar to medical training to explore the "why" behind those challenges. Cases are usually current and extemporaneously presented by any clinical member of the interdisciplinary team (IDT). Common topics of discussion include patient-family conflicts, complex emotions and disruptive behaviors, questions of decisional capacity, or counseling around substance use disorder. One case is discussed per week, and at times team members may present several times on the same patient as the case evolves. If there are multiple team members seeking feedback in a given week, the facilitator negotiates to seek consensus on who will present, usually based on urgency of need. Presenters are most often physician and nurse practitioner faculty, and interprofessional fellows, although social workers and nurses can and do present cases and frequently join the primary presenter in sharing information about the challenging case. In 2019, the team collaboratively produced a standardized format for the conference based on the structure that had developed iteratively. All members of the interprofessional team had the opportunity to contribute to and revise the written materials.

Conference Facilitation

Initially, one experienced faculty member served as facilitator, joined in subsequent years by additional physician team members in a rotation. In 2024, all members of the interprofessional team were invited to join the facilitator group; two social workers accepted the invitation. The training of new facilitators has evolved from initially quite informal, to a more structured process beginning with scribing for experienced facilitators followed by dedicated debriefing, and then progressing to a new facilitator leading the meeting with an experienced facilitator scribing for them followed by a dedicated debriefing after the meeting. Facilitators rotate informally based on availability and do not know ahead of time who may seek to present a case. All facilitators are experienced palliative care clinicians with specific training in communication.

The co-produced facilitation guide includes prompts for presenters to identify their challenge and needs, and to describe the patient and relevant clinical information. Prompts for the facilitators include exploring the presenter's plan and rationale prior to the clinical encounter, description of the encounter itself, and solicitation of clarifying questions, differential diagnoses for the challenge, and identification of new ideas/strategies from the group (Table 1). The facilitation guide may be adapted "on the fly" to meet the needs of the presenter; for example if a presenter is anticipating a challenging encounter that has not yet occurred, the facilitator may omit exploration of a specific clinical encounter.

Facilitators (or a volunteer scribe) take notes in the facilitation guide, and these notes are then disseminated to team members and stored centrally for team access. We transitioned from in-person to virtual sessions via WebEx in 2020 in response to COVID-19 and the conference has remained virtual to support increased participation across care settings. In 2022, the team expanded the scope of the conference to include not only communication challenges but also cases involving ethical dilemmas.

Outcomes

The conference was rapidly and successfully integrated into routine team practice and has now been held weekly for nine

Table 1. Co-developed Structure of WW

Prompts for presenters	
1. What was I challenged by in this encounter?	a. Something the patient or team said or did b. Something I felt c. Other
2. What do I need from the facilitator/ group?	a. Give me space to vent, then help me understand why I was triggered b. Help me debrief the encounter to understand why it went the way it did c. Give me new ideas to try the next time I have an encounter like this d. Bless my plan e. Other
3. Which part of the encounter best illustrates my challenge?	
Facilitation guide	
1. Succinct description of the challenge and presenter's need	
2. ID the patient	Demographics, relevant medical and psychosocial background
3. Describe the interaction	a. Who were the players? b. Going into the encounter, what were your thoughts/hypotheses/planned approaches? c. What happened? i. Things you said, things they said ii. Strategies you tried and the outcome d. (if relevant) How did you feel?
4. Pause	a. Group support b. Clarifying questions
5. Differential diagnosis	Identify the 'pain spot/learning spot' (encounter data), lead group brainstorm
6. New ideas/strategies (if desired by the presenter)	
Goals of wisdom wednesday	
Diversity of perspectives	Maximize time for discussion incorporating broad perspectives from the entire IDT
Team connectedness	Know one another (and ourselves) better, encourage and praise growth, validate struggles
Learning and growth	Identify new strategies & different perspectives, name skills/approaches; encourage us to articulate what we need (while understanding that this may take space/time)
Spirit of curiosity	Non-judgmental, explore/deeply understand before problem-solving

years. Attendance averages 20-30 participants a week; in addition to members of the palliative care team, palliative care fellows and all rotating learners (typically composed of 3-6 residents and medical students per week) attend. It has become commonplace for observers from outside of our team to join the conference to learn about palliative care practice and team culture.

As part of routine program evaluation we conducted a focus-group style session with a convenience sample of our interprofessional palliative care team during our standing weekly session. Twenty-three members of our IDT participated in the focus group in April 2022. Participants included clinician and non-clinician members of our specialty palliative care program, including physicians (n = 8), advanced practice nurses (n = 2), nurses (n = 4), social workers (n = 2), a pharmacist, and scientists and research professionals (n = 2). We also included trainees who were participating as rotating learners (n = 1) or members of our interprofessional palliative care fellowship (n = 3). Discussion prompts focused on exploring IDT members' experiences and perceptions of "Wisdom Wednesday" (WW) including their idea of the purpose of the conference, motivations for attending, and opportunities for improvement. The prompts were: 1) The purpose of WW is…; 2) I attend WW because I value…; 3) I present cases at WW because (or I don't present at WW because)...; 4) I think WW could be improved by…This work was conducted as part of routine QI and not reviewed by the IRB.

We used a Practical Thematic Analysis approach for analysis of the transcript of the focus group session.[13] The researchers first independently coded a transcript of the focus group line-by-line inductively, developed a shared codebook with a subset of the data, then coded the remainder of the data. Each researcher produced at least one summative analytic memo capturing their overall impressions of the dataset, and developed candidate descriptive themes. AMC and CHS independently presented candidate themes to a group of palliative care professionals and researchers in a Thematic Analysis Session. The group collaborated to develop a shared thematic model. Methods and results are described in compliance with the Consolidated Criteria for Reporting Qualitative Research checklist.[14] (Appendix 1)

Overarching Themes. We co-constructed five themes through our analysis, all of which suggest that "Wisdom Wednesday" has been successful at meeting our intended goals. We found these themes are interconnected and build on each other, creating a cycle (Table 2, Figure 1).

1. ***WW is a place where clinicians can ask for help with communication challenges.*** On the most practical level, participants characterized Wisdom Wednesday as a practice that facilitated improvement of both individual and group clinical skills. Most respondents referred to the challenges of providing clinical care to complex patients with serious illnesses and described the benefit of having a venue to seek help and support. This benefit was associated with presenting both cases of past care ("what can I do next time?") and ongoing cases ("what could I try now?"). In addition to seeking help or advice on current or past challenges, respondents also identified a goal of sharing cases to allow others to learn from them, reinforcing the idea that this skills-based learning is multi-directional.
2. ***WW nurtures clinician growth.*** One of the original goals of Wisdom Wednesday was to facilitate ongoing learning in the area of complex communication, from junior trainees to senior faculty. Many participants endorsed this goal, reflecting that they have personally gained from both sharing their own challenges and participating in the discussion of cases presented by others. Responses describing personal growth also often referred to the sense of safety that allows for participants to be vulnerable.
3. ***WW enables the creation of shared wisdom*** The safe space in which to seek and give support, informed by interprofessional perspectives and in which personal growth is enabled, creates a common wisdom that informs the practice of the team as a whole. The sense that the team itself grows and develops was described in many responses. Further, respondents shared a sense that a strong team, empowered by the shared wisdom developed in the conference, enabled them to do their jobs better. In this way, the creation of that "solid foundation" resulting from the creation of shared wisdom further reinforces the sense of community engendered by the shared experience of Wisdom Wednesday.
4. ***Through WW, the community invites vulnerability, offers support, and fosters connection.*** The role of the community in both fostering and being further fostered by others through the conference was the most salient theme. We learned that within the conference, the palliative team members invite vulnerability from those who present cases, those who facilitate cases, and those who participate. Many

Table 2. Themes and Exemplar Quotes

Themes	Exemplar quotes
1. Through WW, the community invites vulnerability, offers support, and fosters connection	(The purpose of WW was to) *"support other community members in communication interaction challenges" (Participant 6, learner)* (WW) *"create[s] a safe space to share challenging (situations) and/or interactions that went really well" (Participant 7, nurse)* (WW) *"often makes me laugh and feel lighter" (Participant 17, physician)*
2. WW is a place where clinicians can ask for help with communication challenges	(I present at WW when) "*I have hit an intuitive roadblock and want it to be understood so I can do better next time" (Participant 20, physician)* *"I have presented when I've "gotten stuck", and colleagues have encouraged me to use the Wisdom Wednesday space to explore and gain wisdom" (Participant 15, social worker)*
3. WW celebrates interdisciplinary perspectives	(WW's purpose is) *"to both have real-time input regarding communication challenges, but also learn from other thought processes, approaches, and successes in their encounters" (Participant 18, learner)* "[it] *allows me to understand other's (sic) perspectives esp those from other disciplines [and] allows me to reflect on my own practice to make improvements." (Participant 2, nurse practitioner)*
4. WW nurtures clinician growth	(WW) "*helps me recognize my blind spots" (Participant 17, physician)* (WW) "*help(s) us in a safe space develop self awareness*" *(Participant 19, nurse practitioner)* (WW) *"Build(s) a culture of openness with struggle, support, collaboration and ever-learning" (Participant 3, physician)*
5. WW enables creation of shared wisdom	*"WW gives us a chance to debrief a challenging communication interaction as a group and pool wisdom as well as support each other in the shared challenges of our work" (Participant 13, physician)* (WW shows that the team) *is "putting in the effort each and every week to maintain a solid foundation for all the hard work they went off and did as individuals". (Participant 3, physician)*

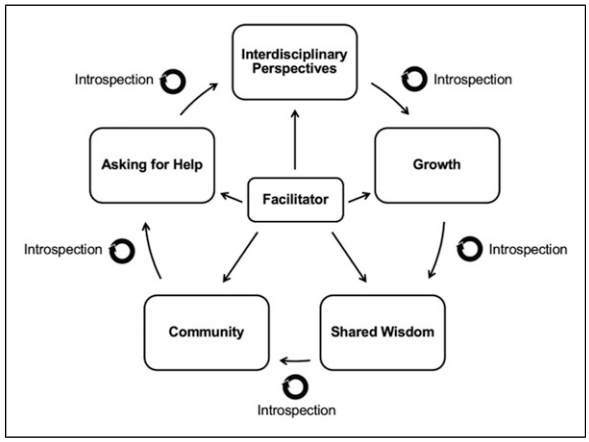

Figure 1. Virtuous cycle of team function supported by WW

respondents referred to the importance of the conference as a place to come together, share the challenges of clinical work, and to offer and receive support. Many respondents cited this as the actual purpose of Wisdom Wednesday. In addition, many respondents alluded to the value of the conference in building a sense of "*camaraderie*" and "*psychological safety*" that extended beyond the conference and into other parts of their work.

5. WW celebrates interprofessional perspectives. Repeatedly, participants emphasized the value of interprofessional insights, articulating the benefit of receiving input from team members from different disciplines, with varying training backgrounds, and life experiences, who often see challenging encounters from their unique perspectives. The conference facilitates a sense of connection with other team members by sharing common experiences and personal learning about other ways to interpret communication challenges. Additionally, by celebrating the unique positionalities of each participant, Wisdom Wednesday also enhances the team.

Secondary Themes

We identified several types of potential improvements to be made to the conference, either through further evolution in our section or for adaptation to another context. Some participants noted reticence to present because they wanted "complete" information about the case first. Others noted that although more seasoned participants and more senior faculty may be completely comfortable presenting, others, particularly trainees, may need additional support to feel psychologically safe. Most suggestions for improvement concerned opportunities for more of this type of practice. Some participants lamented the short 30-minute window and wanted more time to explore complex cases, or a formal venue to continue discussion (via email or some other platform). Others wondered if the ad-hoc approach to soliciting cases meant we were missing out on cases that might be best considered more thoroughly ahead of time. Finally, participants noted there could be an opportunity to expand Wisdom Wednesday practices across other disciplines, either in medicine or beyond.

Discussion

We successfully implemented a relatively brief and highly interactive facilitated case-conference for teaching and learning how to apply communication skills, with additional benefits to team function and cohesiveness. In the field of palliative care, other teams have described similar case conferences in conference presentations; however these are typically explicitly intended to improve the function of the interprofessional team.[15,16] While our conference likely does have benefits for team function, the primary intent was to create opportunities to apply communication knowledge and skills. As highlighted by some of our participants, the structure and format of this case conference may be applicable beyond palliative care, particularly for teaching communication skills in other medical settings where communication may be complex and/or sensitive such as the intensive care unit. This conference structure may also help to meet undergraduate and graduate medical training requirements to include interprofessional learning.[17,18].

There are limitations to this work. Our palliative care team is well-established and well-resourced, which is not the case for many palliative care and other interprofessional teams. Palliative care is highly interprofessional in nature, and introducing a conference structure like the one described here may face challenges depending on team dynamics. We would encourage teams considering implementing a similar format to consider iterative revision to meet the needs and culture of their team.

Next steps for our team include planned study of the content of conference discussion based on the written notes kept by facilitators and team members to identify key educational strategies and opportunities, and of the experience of facilitators to understand their roles and skills needed for success. We aim to develop more structured facilitation tools to support implementation of this conference format in other medical teams and care settings. We are also currently exploring expanding this format to partner palliative care programs regionally.

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References

1. Ferrell BR, Twaddle ML, Melnick A, Meier DE. National Consensus Project Clinical Practice Guidelines for Quality Palliative Care Guidelines. *J Palliat Med*. 2018;21(12): 1684-1689.
2. Nancarrow SA, Booth A, Ariss S, Smith T, Enderby P, Roots A. Ten principles of good interdisciplinary team work. *Hum Resour Health*. 2013;11:19.
3. Youngwerth J, Twaddle M. Cultures of interdisciplinary teams: how to foster good dynamics. *J Palliat Med*. 2011;14(5):650-654.
4. Hodiamont F, Jünger S, Leidl R, Maier BO, Schildmann E, Bausewein C. Understanding complexity - the palliative care situation as a complex adaptive system. *BMC Health Serv Res*. 2019;19(1):157.
5. Kesonen P, Salminen L, Kero J, Aappola J, Haavisto E. An Integrative Review of Interprofessional Teamwork and Required Competence in Specialized Palliative Care. *Omega* . Published online April 19, 2022:302228221085468.
6. McLean SF. Case-Based Learning and its Application in Medical and Health-Care Fields: A Review of Worldwide Literature. *J Med Educ Curric Dev*. 2016;3. doi:10.4137/JMECD.S20377
7. Gross CP, Donnelly GB, Reisman AB, Sepkowitz KA, Callahan MA. Resident expectations of morning report: a multi-institutional study. *Arch Intern Med*. 1999;159(16):1910-1914.
8. McNeill M, Ali SK, Banks DE, Mansi IA. Morning report: can an established medical education tradition be validated? *J Grad Med Educ*. 2013;5(3):374-384.
9. Edmonds KP, Yeung HN, Onderdonk C, Mitchell W, Thornberry K. Clinical supervision in the palliative care team setting: a concrete approach to team wellness. *J Palliat Med*. 2015;18(3):274-277.
10. Hession N, Habenicht A. Clinical supervision in oncology: A narrative review. *Health Psychol Res*. 2020;8(1):8651.
11. Barham D, de Beer W, Clark H. The role of professional supervision for palliative care doctors in New Zealand: a quantitative survey of attitudes and experiences. *N Z Med J*. 2019; 132(1501):10-20.
12. Heaven C, Clegg J, Maguire P. Transfer of communication skills training from workshop to workplace: the impact of clinical supervision. *Patient Educ Couns*. 2006;60(3):313-325.
13. Saunders CH, Sierpe A, von Plessen C, et al. Practical thematic analysis: a guide for multidisciplinary health services research teams engaging in qualitative analysis. *BMJ*. 2023;381: e074256.
14. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349-357.
15. Meyerson RE, Chai E, Horton J. Model for Running a Palliative Care Interdisciplinary Team Case Conference (303). *J Pain Symptom Manage*. 2012;43(2):330.
16. DePiano S, Frieman A, Bender K, Gualtieri-Reed T. Practical Strategies for Building and Growing an Effective, High-Functioning Interdisciplinary Team (P12). *J Pain Symptom Manage*. 2020;59(2):397-398.
17. Interprofessional Education Requirements at US Medical Schools. AAMC. Accessed April 4, 2025. https://www.aamc.org/data-reports/curriculum-reports/data/interprofessional-education-requirements-us-medical-schools
18. Program ACGME. *Requirements for Graduate Medical Education in Internal Medicine*. Accreditation Council for Graduate Medical Education (ACGME. https://www.acgme.org/globalassets/pfassets/programrequirements/140_internalmedicine_2023.pdf (2023).

Appendix 1.Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist

No	Item	Guide questions/description	Reported in section #
Domain 1: Research team and reflexivity			
Personal characteristics			
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?	Method: Analysis
2.	Credentials	What were the researcher's credentials? E.g. *PhD, MD*	Method: Procedures, analysis
3.	Occupation	What was their occupation at the time of the study?	Method: Analysis
4.	Gender	Was the researcher male or female?	Method: Analysis
5.	Experience and training	What experience or training did the researcher have?	Method: Analysis
Relationship with participants			
6.	Relationship established	Was a relationship established prior to study commencement?	Method: Procedures
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. *personal goals, reasons for doing the research*	Method: Procedures
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? eg, *Bias, assumptions, reasons and interests in the research topic*	Method: Analysis
Domain 2: Study design			
Theoretical framework			
9.	Methodological orientation and theory	What methodological orientation was stated to underpin the study? e.g. *grounded theory, discourse analysis, ethnography, phenomenology, content analysis*	Method: Analysis
Participant selection			
10.	Sampling	How were participants selected? e.g. *purposive, convenience, consecutive, snowball*	Method: Participants
11.	Method of approach	How were participants approached? e.g. *face-to-face, telephone, mail, email*	Method: Procedures
12.	Sample size	How many participants were in the study?	Results: Characteristics of participants
13.	Non-participation	How many people refused to participate or dropped out? Reasons?	N/A
Setting			
14.	Setting of data collection	Where was the data collected? e.g. *home, clinic, workplace*	Method: Procedures
15.	Presence of non-participants	Was anyone else present besides the participants and researchers?	Method: Participants
16.	Description of sample	What are the important characteristics of the sample? e.g. *demographic data, date*	Results: Characteristics of participants
Data collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Method: Procedures
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Method: Procedures
20.	Field notes	Were field notes made during and/or after the interview or focus group?	Method: Procedures
21.	Duration	What was the duration of the interviews or focus group?	Method: Procedures
22.	Data saturation	Was data saturation discussed?	N/A
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Method: Analysis
Domain 3: Analysis and findings			
Data analysis			
24.	Number of data coders	How many data coders coded the data?	Method: Analysis
25.	Description of the coding tree	Did authors provide a description of the coding tree?	Figure 2
26.	Derivation of themes	Were themes identified in advance or derived from the data?	Method: Analysis
27.	Software	What software, if applicable, was used to manage the data?	N/A
28.	Participant checking	Did participants provide feedback on the findings?	Method: Analysis

(continued)

(continued)

No	Item	Guide questions/description	Reported in section #
Reporting			
29.	Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. *participant number*	Results
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	Results
31.	Clarity of major themes	Were major themes clearly presented in the findings?	Results
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Results: Secondary themes