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Who is on the medical team?: Shifting the boundaries of belonging on the ICU

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ABSTRACT

Medical teamwork promises to improve communication and collaboration in the healthcare industry, yet critics argue teamwork is little more than a new managerial discourse to obscure traditional workplace hierarchies. Based on 300 h of participant-observation and 35 interviews with staff of a medical intensive care unit at an academic medical center, this article argues that teamwork is neither a panacea for coordinating complex care nor is it simply a discourse to control workers; rather, it is an ongoing social activity characterized by boundary-work, negotiation, and resistance over the terms of membership. This study identifies three processual and temporal phases of families' participation in medical teams: (1) Constructing Teamwork, (2) Deflection and Resistance, and (3) Reintegration. Staff leveraged ambiguities in the meaning of teamwork to manage patients' family members' participation on the ICU Team. Family involvement changed in patterned ways that reflected the power staff had to define the team and the character of teamwork. Families participated on the team at admission, but their involvement narrowed considerably as staff implemented diagnostic and treatment plans. When staff determined a patient was appropriate for palliation, families were reintegrated back into a leading role on the team as surrogate decision-makers. This study advances current understandings of medical teamwork, staff-family interactions, and it highlights the value of qualitative methods in social-science research about medicine.
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Since the Institute of Medicine's landmark report, *Too Err is Human* (Kohn et al., 2000), which stated that medical mistakes caused up to 98,000 preventable deaths and one million nonfatal injuries annually in the United States, a range of institutional stakeholders, regulatory agencies, and health policy scholars have sought to recast medical care as a team-based endeavor. Medical teamwork promises to improve patient safety, promote staff commitment to work, and enhance communication both among providers as well as between providers and families (Gawande, 2011a; Greiner and Knebel, 2003; Institute of Medicine, 2001; The Joint Commission, 2012). As benign as these calls for teamwork might seem, they have also generated skepticism. Teamwork, according to its critics, is little more than a new managerial discourse in which traditional forms of hierarchy are disguised and repackaged in more palatable terms (Barker, 1993; Finn et al., 2010; Sewell, 1998; Vallas, 2003). Meanwhile, recent scholarship has shown that the work of complex medical care differs substantially from conventional understandings of medical teamwork (Alexanian et al., 2015), casting doubt on teamwork as an achievable goal.

This article examines a specific instance of calls for teamwork, in particular the call to include patients' families' as members of medical teams performing complex care in hospitals. Medicine is carving out a role for families as surrogates for patients who participate in "shared decision-making" with providers about treatment options, when patients are unable to express preferences (Azoulay et al., 2014; Davidson et al., 2007). Based on 300 h of participant-observation over 18 months in a medical intensive care unit and 35 interviews with its staff, this article shows teamwork is neither a panacea for coordinating complex care nor is it simply a discourse to control workers; rather, it is an ongoing social activity characterized by boundary-work, negotiation, and resistance over the terms of membership. Family involvement on the team widened and narrowed in patterned ways that expressed the power of staff to define the team and the character of its teamwork. The integration of families into the "ICU team" was strongest just after the patients' admission to the unit and on occasions when staff sought families' consent for the transition to palliation. It was weakest in the middle stages of care, as staff implemented diagnostic and treatment plans. Staff leveraged ambiguities in the teamwork concept, maintaining that family members were team members yet deflecting and resisting families when their

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involvement intruded upon staff medical and technical expertise.

1. Working together, but as a team?

Medical teamwork is of substantial and growing interest to clinicians, social scientists, policy makers and regulatory agencies as a critical component of patient safety. For example, the lead federal agency that implements recommendations set forth by the Institute of Medicine, the Agency for Healthcare Research and Quality (AHRQ), has designed a teamwork system called TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety), with ready-to-use materials, assessment tools, a training curriculum, and training centers at eight major medical schools (http://teamstepps.ahrq.gov). The Joint Commission, which accredits and certifies health services organizations in the United States, recently urged health care organizations to "establish a proactive, systematic, organization wide approach to developing team-based care" (2012:51) In addition to these agencies, influential public intellectuals have touted teamwork, such as when Atul Gawande, a surgeon who writes about health care, advised the graduating class of Harvard Medical School to think of themselves as members of a "pit crew" instead of as "cowboys" (2011a). The extensive range of voices that have drawn the link between teamwork and patient safety continue to influence the organization of medical care.

Despite the interest and investment in medical teamwork, considerable differences exist between the work routines observed in recent studies of complex medical care and idealized versions of teamwork often found implicit in the literature. For example, an ethnographic study of interprofessional care in two ICUs showed that although staff used teamwork rhetoric extensively, workplace practices were better characterized with other terms such as collaboration, coordination, and networking (Alexanian et al., 2015). Most intensive care work is parallel, with physicians, nurses, and others doing their own tasks, increasingly in front of computers, except for sudden bursts of urgent activity in response to crisis (Piquette et al., 2009). In those sudden bursts, teams are ad-hoc creations formed to complete a specific task (such as cardiopulmonary resuscitation), which dissolves when completed (Janss et al., 2012). Along these lines, scholars have characterized ICU teamwork as "threads of activity" that are tied and untied throughout a typical workday (Reeves et al., 2015).

Research has also found that teamwork does not necessarily enhance social integration. For example, a recent hospital ethnography showed teamwork to be more a contested ideological frame of understanding than a shared set of organizational practices (Apesoa-Varano and Varano, 2014:42). A series of articles based on evidence collected from an operating department found teamwork rhetoric reproduced the status distinctions it was meant to soften (Finn, 2008; Finn et al., 2010; Martin and Finn, 2011). Teamwork rhetoric and practices have also been shown to create the conditions for medical errors by undermining independent thinking and diffusing responsibility (Kerr, 2009). Taken together, these findings show that "teamwork" as it is conventionally understood may not adequately describe the character of work even in settings whose workers consider themselves to be members of a team.

Furthermore, the hierarchical relations that characterize hospital medicine persist within the teamwork framework and emerge in a variety of ways. For example, physicians typically rate the quality of teamwork more highly than nurses (O'Leary et al., 2010; Thomas et al., 2003). This is most likely due to the fact that physicians have more authority than nurses and what physicians interpret as teamwork nurses interpret as following orders (Makary et al., 2006). Staff in different organizational positions give different meanings and assign different values of teamwork (Cott, 1998). Occupational cultures also act as silos of information and resources that may limit the effectiveness of teamwork rhetoric and practices (Hall, 2005). The research shows workers perceive and evaluate teamwork through the lens of their position in the organizational hierarchy.

From a work and occupations perspective, social scientists also argued that teamwork is a managerial strategy to control the labor process. Teamwork, according to this view, acts as an ideological frame of reference to supervise and monitor each other according to managerial standards (Barker, 1993). Drawing from Foucault's Panoptical Control (1995) and Weber's Rationalization (1958), Barker argues that workers, "create the meanings that, in turn, structure the system of their own control (1993:412)." Sewell similarly conceptualized teamwork as an internalized set of values in workers that control the labor process without appearing to control it (1998). Teamwork discourses obscure the visibility of workplace hierarchies, but research shows they persist and are reproduced among workers who self-identify as members of a team.

This article goes a step further to show not how teamwork discourses reproduced hierarchies among staff; but rather, between staff and patients' families.

2. Medicine and families

Until the emergence of hospitals as a public institution in the decades after the Civil War, family members were caregivers for basic human experiences such as childbirth, illness, and death (Rosenberg, 1995; Rosner, 1982; Starr, 1982; Vogel, 1985). As hospitals grew throughout the 20th Century, physicians rose to a dominant position and families were progressively excluded from medicine. Now, early in the 21st Century, the relationship continues to change. Medicine is carving out a new role for families; but on different terms, no longer as hands-on caregivers but as empowered, surrogate decision-makers (Apatira et al., 2008). The American College of Critical Care Task Force, for example, advocated in its clinical practice guidelines that family members should be "active partners in multiprofessional decision-making and care" (Davidson et al., 2007: 606). The recent Institute of Medicine report, *Dying in America,* suggested end-of-life care should be "patient-centered and family-focused" (2014). Current thinking on the integration of families into intensive care suggests a "shared decision-making" model that exists along a spectrum of care between medical paternalism on one end and patient autonomy on the other (Azoulay et al., 2014; Barry and Edgman-Levitan, 2012). Scholarship suggests that including families in medical rounds, having an open visitation policy, and frequent communication with staff may foster such shared decision-making (Azoulay et al., 2001, 2014; Charles and DeMaio, 1993; Davidson et al., 2007; Marent et al., 2015). Yet recent scholarship has shown the integration of families into intensive medical care processes is inconsistent and the asymmetries between staff and families undermines effective communication (Gooding et al., 2011; Schubart et al., 2015).

Shared decision-making represents a change in practice that physicians have historically resisted. Physicians in the 20th century solidified a dominant position in medicine, leading to a paternalistic model in which they controlled the general terms of their work and the care provided (Freidson, 1970a,b; Starr, 1982). That position was challenged on a number of fronts, from the patient autonomy movement (Rothman, 2001), the corporatization and rationalization of health care (Light and Levine, 1988; Ritzer and Walczak, 1988), and the growing power of administrators, lawyers, and ethicists (Rothman, 2003). Although physicians may have less formal power in the workplace, they are still able to deflect the concerns of subordinate staff, patients, and family members in

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