Exclusion of Residents From Surgery-Intensive Care Team Communication: A Qualitative Study

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OBJECTIVE: Communication competency is an important aspect of postgraduate training and patient care delivery in all specialties and clinical domains. This study explored staff surgeon and intensivist perceptions of and experiences with residents' communication with a view toward fostering high quality interspecialty team communication in the surgical intensive care unit.

DESIGN: A qualitative study using semistructured interviews. Data were analyzed iteratively and inductively as per standard qualitative thematic approach.

SETTING: University of Toronto, Toronto, Canada.

PARTICIPANTS: A total of 15 staff surgeons and intensivists who collaborate in patient care in the surgical intensive care unit.

RESULTS: The phenomenon of "resident bypass" emerged, resulting from staff surgeon and intensivist perceptions that residents threaten the quality of interspecialty team communication. Clear patterns and preferences for resident exclusion from this communication were present. A total of 5 interrelated drivers of resident bypass were discovered: lack of trust, lack of specialized knowledge, poor system design, need for timely communication, and residents' inadequate contribution to decision-making. Surgical and intensive care staff were dissatisfied with the structure of residents' roles in interspecialty team communication. Concerns about communication gaps, patient care continuity, and patient safety were expressed.

CONCLUSIONS: Surgical and intensive care staff exclude residents from interspecialty team communication for the benefit of patient safety and care continuity, but this limits opportunities for residents to develop communication skill and competence. Efforts are needed to effectively integrate surgery and intensive care residents in interspecialty attending-resident communication in ways that are meaningful for both patient care and postgraduate training. The implications for medical education are discussed. (J Surg Ed 73:639-647. © 2016 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

KEY WORDS: communication, surgery, intensive care, teamwork

COMPETENCIES: Interpersonal and Communication Skills, Professionalism, Patient Care

INTRODUCTION

Team communication is fundamental to the delivery of safe patient care in academic health science centers.[1] Improving provider communication skills is now emphasized in all disciplines and at all levels of the medical and interdisciplinary team.[2] Participating in teamwork and acquiring proficiency in related nontechnical skills, such as communication and collaboration, have thus become important components of postgraduate training programs.[3,4] A growing body of literature has examined optimal methods to teach and assess these competencies in simulated and real clinical environments.[5-8]

Improving communication among postgraduate trainees has largely focused on the quality of patient handover[9-11]

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and on communication in highly structured environments, such as in the operating theater[12] or during acute resuscitation.[3,13] Beyond their roles in intrateam communication, however, residents are involved in communications across medical teams on a regular basis (i.e., interspecialty team communication). This latter role is a critical one required for the safe provision of care, particularly in the tertiary hospital environment where multiple specialists are involved in a patient's care.[14] In spite of its importance, not much is known about attending staff or other health care provider perceptions of trainees' communication and collaboration skills in the interspecialty context, and there is no understanding of how the presence of postgraduate trainees effects on the communication practices of the health care providers around them.

In the academic surgical intensive care unit (ICU), surgery and intensive care residents are the frontline for interspecialty team communication about critically ill surgical patients who are jointly managed. Surgical and intensive care teams—comprised respectively of junior and senior trainees and an attending staff—communicate with one another about these patients daily, sometimes more frequently, and often urgently. In both surgery and intensive care, current research on resident roles and the effect of resident involvement in interspecialty team communication is limited, though challenges with intrateam communication have been identified in surgery and intensive care, respectively.[15-19] Previous studies have also reported conflict between surgeons and intensivists related to postoperative goals of care[20] and differing interspecialty team communication practices[21-23] which may involve residents as team members. Although important, these previous studies have not specifically considered the role of residents in interspecialty resident-attending communication in the academic context.

CONCEPTUAL FRAMEWORK

To conceptualize residents' participation in interspecialty team communication, we have drawn on the abundant literature examining teams and teamwork in health care. In particular, we take direction from analytic explorations of health care teams that illustrate the context-specific and dynamic character of hospital teamwork in such settings as the operating room and the ICU.[2] Manser describes teams in these settings as ad hoc, with team membership changing regularly, and involving providers who are oftentimes working from within different professional worldviews.[2] Ethnographic research of interprofessional health care teams working in situ has also problematized overly reductionist notions of interprofessional "teams" and the "teamwork" that is undertaken therein.[24-26] This literature suggests that, in relation to interprofessional health care teams, improvement efforts targeting enhanced team communication must account for the contextual features that make teamwork meaningful to these providers in these specific settings. In our study, the clinical teaching teams that are described are a type of ad hoc team, as they are variably comprised of junior and senior trainees with varying levels of knowledge and experience, and attending staff, all of whom rotate on and off their respective clinical services, and who are expected to coordinate and collaborate in patient care with other similarly comprised ad hoc teams. This conceptualization of the ad hoc clinical teaching team and its significance for interspecialty team communication builds on ongoing efforts to better represent, understand, and cope with the complexity and chaos of everyday teamwork that is of current attention in medicine and medical education.[27,28]

To identify enablers and barriers to optimal interspecialty team communication and collaboration, we explored staff surgeon and intensivist perceptions of and experiences with the role of residents in interspecialty team communication concerning surgical ICU patients.

METHODS

We conducted a qualitative study informed by the constructivist paradigm,[29] to produce a qualitative description of interspecialty surgery and ICU team communication.[30] The study was designed as a preliminary investigation into the organizational and cultural processes that influence team-to-team communication when caring for surgical patients in the ICU.[23] As a descriptive thematic approach[30] we sought to explore and understand what constitutes good interspecialty team communication from the viewpoints of surgeons and intensivists. Details of the methods are described elsewhere.[23] Staff were recruited from the Departments of Surgery and Critical Care Medicine at the University of Toronto, representing the same residency programs in 4 academic health sciences centers. All hospitals have intensivist-led ICUs within which surgical services typically round on surgical patients daily. Residents rotate on each of the ICU and surgical services with varying frequency, typically spending between 1 and 3 months on a given service. Participants provide clinical supervision and patient care in trauma, neurosurgical or medical-surgical ICUs. This study was approved by the Research Ethics Board of each participating hospital.

Participants

A purposive sampling strategy was used with criterion and snowball sampling techniques.[31] Participants in each of the 4 participating institutions were approached. Participants were selected for recruitment by meeting specific eligibility criteria that we determined would meet the research objective. We selected participants who were in administrative positions in their departments, who were late career, early career, middle