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Territories of knowledge, professional identities and patients' participation in specialized visits with a team of practitioners

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ABSTRACT

Objective: In specialized healthcare visits with a team of practitioners, the examination phase is a collaborative work where multiple professional competences are indexed and activated, contributing to a complex ecology of knowledge. The doctors' need to consult their colleagues might take over and collide with patients' understanding and willingness to participate. We describe the practices through which practitioners accomplish teamwork and how these impact on patients' participation.
Methods: Using conversation analysis we investigate 30 video-recorded visits where patients with an injured upper limb meet a team of practitioners in an Italian centre for prosthesis construction and application.
Results: Analysis shows the collaborative practices and division of labour through which practitioners activate their territories of knowledge in the service of the joint activity of evaluating the patient limbs' conditions. Whereas professionals orient to their different competences, patients keep their body available for inspection, monitor the ongoing activity, draw assumptions about their own conditions and tentatively claim their epistemic rights.
Conclusions: Doctors' orientation to teamwork involves the enactment of tacit communicative practices and the use of technical language, which might prevent or mislead patients' participation.
Practice implications: Doctors should employ communicative practices to ensure patients' understanding and participation in the unfolding examination activities.

1. Introduction

Compared to one-on-one primary care visits, specialized consultations with a team of professionals may be an unusual experience for patients. To date, however, these consultations have been studied little [1,2]. This paper investigates the interactions during such encounters, where a team of healthcare professionals visits patients in an Italian centre specialized in the construction and application of artificial limbs. Building on previous research on teamwork in healthcare settings [3–7], we investigate the collaborative practices enacted by doctors while examining patients' limbs, and how the interactions among the professionals impact patients' understanding and participation. Compared to one-on-one medical encounters, in this context, the doctor's side [8] includes various professional specializations to which different and specific *territories of knowledge* [9–12] correspond. Hence, the peculiar participation framework makes these visits particularly suitable for being investigated as a complex *ecology of knowledge* [13]. In this prespective, we look at the visits as localized organization of healthcare work in the service of knowledge management [14,15], given that the team members have a mission to ensure and enhance the complex ecology of knowledge which is needed in order to assure a weighted, shared decision about the prosthesis to be applied.

The teamwork is then based on the interaction among the different professional competences involved which, despite the simultaneous experience of the patient's body that the practitioners have during the encounter, determine an epistemic inequality [11] in terms of *knowing/experiencing differently* rather than knowing more or less because of having different access to the same object.

The analysis focuses on assessment and question-answer sequences carried out during the physical examination phase [16–18], when the professionals observe and evaluate the patient's limb, to reach a common decision about the prosthesis to be prescribed. During this phase, through multimodal practices of speaking, seeing, looking at and touching the patients' limbs, the participants co-construct the relevant *epistemic ecology* [19–21] for

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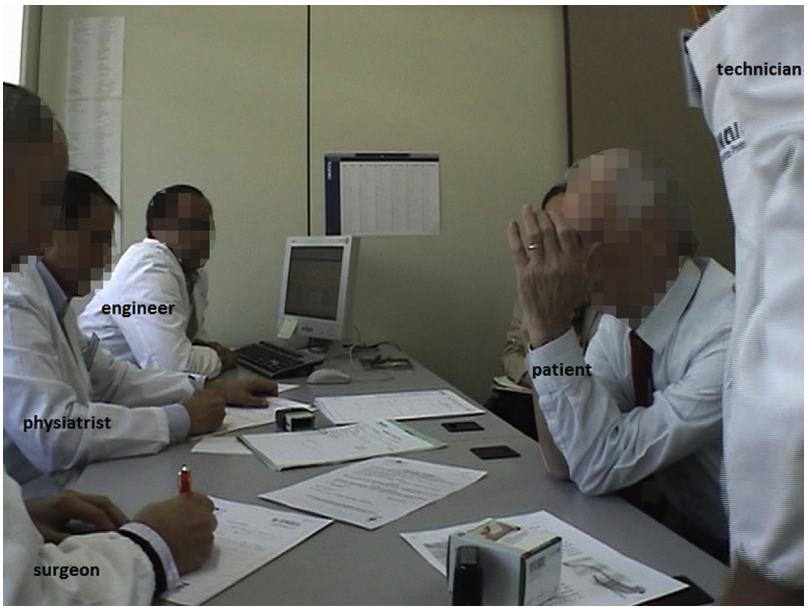

Fig. 1. The setting.

the unfolding activity. This teamwork may result in the partial exclusion of the patient, and his/her perspective may be minimally solicited or valued.[1] Nonetheless, during the professionals' examination of the limb, patients monitor the interaction, draw inferences and may, to different degrees, succeed in claiming their *epistemic entitlement* [22] by volunteering information or expressing their standpoint.

Finally, we offer the analysis of a case in which the doctors succeed in involving the patient, and we suggest some practical recommendations to improve patients' understanding and make their participation more systematic in this phase of the visit. We argue that this is a crucial aspect for better preparing the prosthesis recommendation, which takes place in the prescription phase that immediately follows.

2. Data and methods

2.1. Data

The corpus consists of 50 visits (30 with patients with injured upper limbs and 20 with patients with injured lower limbs) in which the patients meet a multidisciplinary team at a centre for prosthesis construction and application. The visits were video recorded using two video cameras. For this study, we analysed the 30 visits with patients with injured upper limbs. The medical encounters we analyse are called the "First Visits" because they are the first meetings between the patient and the medical staff of the centre.

The members of the team are the orthopaedic surgeon, who evaluates the state of healing of the limb following amputation or loss by accident; the physiatrist, who understands the possibilities and limitations of the limb's mobility; and the orthopaedic technician and/or engineer, who knows the technical features of the prosthesis and is charged with evaluating what type of prosthesis best meets the patient's conditions and needs. A healthcare assistant eventually helps the patient with bandages and dressing the limb. The patient's relatives or caretakers may also be present. Filling out forms is a cross-sectional task, which may be accomplished by several members at the same time, while only one member of the team actually retrieves and enters the necessary information via computer.

Fig. 1 above shows the setting. The professionals are sitting in a row on one side of the table and face the patient.

Patients enter the centre after the loss of a limb, or part of it, primarily due to work accidents or, more rarely, a disease that necessitated amputation.

The aim of the encounter is to determine the appropriate treatment plan, which might involve prescribing a prosthesis or additional surgery to prepare its application. When a prosthesis is prescribed, the team members have to decide between a functional or an aesthetic one, according to the state of the limb and the patient's needs.

It is noteworthy that when the visit begins, the practitioners do not know the patient nor his/her medical history; they access the files (on the computer) and medical records (Rx, records about previous medical interventions, etc.) during the visit, in the presence of the patient.

The visit has four main phases [16–18]: (1) opening, (2) examination including history-taking and physical examination, (3) prosthesis prescription, and (4) closing. Because of the centre's specialization, the reason for the visit is implied; consequently, there is no complaint presentation [18] by the patient. A proper diagnosis phase is also missing, given that the doctors evaluate the patient's limb conditions among themselves during the examination phase and then proceed directly with the proposal of the prosthesis (prescription phase). Our analysis focuses on the examination phase during which the history-taking and physical examination are strongly interlaced, as opposed to primary care visits [26]. This combination is most likely due both to the presence of multiple professionals, which makes it possible to accomplish different tasks simultaneously, as well as to the visual and tactile availability of the patient's upper limbs throughout the encounter.[2] During the history-taking phase, when the doctors ask the patient questions about the reasons for amputation or the dynamics of the

[1] On the importance of patients' participation in medical care, see Street & Bradford [23]. On patient centered medicine, see Bensing [24], Bensing et al. [25].

[2] In *First visits* with injured lower limbs, the boundary between the history-taking and the physical examination phases is marked by the fact that the patient must move to the bed, and the doctors move accordingly.

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