Three Images of Interdisciplinary Team Meetings

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Teams are an essential aspect of health care today, especially in rehabilitation or chronic illness where the course of care is frequently long, complex, and unpredictable. The coordinative function of teams and their interdisciplinary aspects are thought to improve patient care because team members bring their unique professional skills together to address patient problems. This coordination is enacted through the team meeting, which typically results in an integrated care plan. This professional image of team meetings is explicit and addresses the description and provision of care as objective (mer rational activities. In contrast, the constructed and ritualistic images of health care team meetings are implicit and concern the less objective and rational aspects of planning care. The constructed image pertains to the definitional activity of team members as they try to understand patient troubles and achieve consensus. This process involves the individual clinical reasoning of team members and the collective reasoning of the group. The ritualistic image is that aspect of team meetings in which the team affirms and reaffirms its collective identity. Drawing from field research of geropsychiatric team meetings, this article defines and explicates these images, focusing on the constructed and ritualistic aspects of team meetings and the influence of these images on group function.

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The American Occupational Therapy Association/American Occupational Therapy Foundation Clinical Reasoning Study examined the clinical reasoning of occupational therapists (Mattingly & Gillette, 1991). It addressed the narrative reasoning that occurs in the patient-therapist relationship (Fleming, 1991a, 1991b; Mattingly, 1991a, 1991b). Narrative reasoning is not unique to occupational therapists. It also occurs in other patient-practitioner interactions (Brody, 1987; Charmaz, 1991; Coles, 1989; Gubrium, 1991). Narrative reasoning involves the development of understanding about a patient through the patient’s illness experience and the alteration in his or her life as a consequence of this illness. Narrative reasoning enables practitioners and patients to come to a mutual understanding of the patient’s illness experience and of how treatment should be planned to gain the desired outcome (Mattingly, 1991b). In many settings, this understanding is achieved by individual health care practitioners and their patients. Typically, this understanding is translated into an interdisciplinary plan of care during a team meeting.

Team meetings are organized to foster communication among team members and to coordinate patient care (Buckholdt & Gubrium, 1979). This formal aspect of team communication supplements the informal interaction that occurs between health care professionals during the working day. Beyond their communication with each other, team members interact with patients and often with the patients’ families. These multiple forms of communication set up a series of frames or keys in which a single event, typically a patient-practitioner interaction, is abstracted and interpreted (Goffman, 1974). The experienced event is reinterpreted every time it is discussed in a different setting. This interpretation of the event may vary from one key to another according to the audience and the situation. The frame or framework within which the rekeying occurs identifies and defines the situation so that the people involved know how to shape their behavior (Goffman, 1974).

For patient-practitioner interactions, the individual primary frameworks include those interactions that occur between patient and practitioner and between practitioner and family members. This interaction is rekeyed every time it is expressed to someone else or documented in the medical record, forming additional frameworks or abstractions of the event.

The team meeting is the secondary framework in which individual staff members report their interaction with the patient and the patient’s family. In the team meeting, practitioners bring together and negotiate their individual understandings of the patient to develop a unified plan of care. In this process they also articulate their roles and responsibilities to each other. Using Goffman’s conceptualization, staff members rekey the interactions from the individual primary frameworks in the team meetings. Although the patient remains, at least figura-
tively, the center of concern, the image of this patient is filtered through the interpretations of team members, the influence of the environment, and the interaction process that occurs in the team meeting.

The tertiary framework is the care plan. This plan is an abstraction of the team meeting. Therefore, each transformation or rekeying is a further abstraction of the original patient-practitioner interaction that started the chain of keys. From a phenomenological perspective, health care should account for the patient’s illness experience (Kestenbaum, 1982; Kleinman, 1988). These various levels of abstraction from the patient’s lived experience to the team, make the process of entering the reality of the patient’s world especially important and difficult.

This article examines three images of health care team meetings. These images are the professional, the constructive, and the ritualistic. The professional image is explicit and addresses the description and provision of care as rational and objective activities (Buckholdt & Gubrium, 1979). The constructive image relates to the definitional aspects of the team as members try to understand the patients in their care (Buckholdt & Gubrium). Finally, the ritualistic image is that aspect of team meetings in which the team affirms and reaffirms its collective identity. I define and explicate these images, focusing especially on the constructed and ritualistic aspects of team meetings.

Method

This study involved participant observation of team meetings on a 12-bed acute geropsychiatric unit in a community hospital in New England. I observed seven team meetings over 4 weeks. Each meeting was audiotaped and the tapes were transcribed to provide a verbatim account of the meetings. Besides attending the team meetings, I interviewed the medical director, unit director, and occupational therapist about their perceptions of the team meetings. The unit director was the primary contact on the unit.

Transcriptions of the team meetings and field notes from the interviews and conversations with team members provided the data for the study. During my observations, I noticed patterned activity that reminded me of ritualistic behavior. Using a grounded theory approach (Glaser & Strauss, 1967), I developed this theme and identified the professional and constructive images previously described by Buckholdt and Gubrium (1979). I reviewed these themes with the team in a process that Lincoln and Guba (1985) called member checking, which enabled staff members to confirm the trustworthiness of the findings. The team was initially surprised by the delineation of the constructive and ritualistic images. On reflection they agreed that these images occur in the meetings regularly. The medical director said that the findings of the study created a hologram or a three-dimensional image of the meeting process. He drew a parallel between the findings and the team meetings themselves because they are designed to create a multifaceted image of the patient.

Two people administered the observed unit: the medical director, a psychiatrist, and the unit director, a nurse. In addition, a social worker and an occupational therapist were assigned exclusively to the unit. This care group attended every team meeting. Two dieticians provided consultation; one was always present at the team meetings. Unit nurses attended the team meeting when patients they worked with were being discussed. The team met twice a week; these meetings were the only times they met as a group, although because the unit was small they could interact informally every day.

This article uses a single vignette from one team meeting to illustrate the efforts of the team to construct a collective narrative of their patients. I selected this vignette because it illustrated most dramatically the three images described in this article. Other team discussions also contained these images, but usually they were not as explicit.

Sarah, Depression, and Electroconvulsive Therapy Clothing

Everyone gathered in the team room talking among themselves to catch up on the events of the day. Sarah was the first patient. This was the first time the team had discussed her. Without any formal announcement, the unit director began this portion of the meeting in a voice that I called her reporting register: "OK, Sarah, alteration in mental status." People stopped their conversations and attended to the meeting. The occupational therapist responded with observations of Sarah’s negative attitude. The psychiatrist chimed in, “Yes, expressions of hopelessness, helplessness, feeling overwhelmed, very passively suicidal.” He described her attitude as very negative and inadequate, noting that she often said, “I can’t do this because I don’t have any clothes.” After the psychiatrist said this, others added examples. The occupational therapist said, “[Sarah says] ‘I can’t do this activity,’ but she does it. She can’t get dressed but she is.” The dietician added that she complained about lack of appetite but ate her food. The discussion continued in this vein with staff members adding examples to form a perplexing picture. Sarah could do most things required of her although she persisted in her claims of total inability to perform. Finally the psychiatrist said, “All right, I’m trying to think of anything else . . . she is status post multiple fractures following a jumping incident 8 years ago.” This statement began the story of Sarah’s previous suicide attempt and her assertion that she is more depressed now than she was then. A nurse reported that Sarah said she could not even commit suicide, that all she did was break her heels. The psychiatrist piped up, “I can’t do it.” The nurse said,
“That's what she said. I had to bite my lip to keep from laughing.” The group dissolved in laughter at this picture of a woman who felt so immobilized and inadequate that she could not even succeed in committing suicide.

The discussion diverged to the term *inadequate personality*, which seemed to fit the team’s picture of Sarah. However, this is no longer an official psychiatric diagnosis so they could not use it. The laughter died away as the team members discussed Sarah's personality and suicide risk. The mood became somber. In contrast to the frequent exchange of ideas at the discussion's beginning, there were few interjections. People spoke more slowly and quietly. They discussed the idea of electroconvulsive therapy (ECT) because Sarah had had a successful course 8 years ago and did not need treatment until this hospitalization. The psychiatrist said that Sarah agreed that ECT would be good and was not afraid of it. The occupational therapist asked whether she was cooperating with the idea of ECT. The psychiatrist replied that Sarah said she could not have ECT because she did not have the right clothing. The occupational therapist responded, “What a stupid question.” The psychiatrist said, “You asked.” There was much cross-talk and laughter. The group became animated again. The unit director added that when she asked Sarah to sign the permission for ECT, Sarah said that she did not have the right clothing so could not sign. “Stupid me, I didn’t understand how the form and the clothes went together. I didn’t see the connection.” People continued to laugh. The psychiatrist turned to the occupational therapist and said, “Can you design something bold, some ECT clothing?” There was more laughter and cross-talk. Someone suggested doing something with paddles. Another said something with lightning bolts. More cross-talk and laughter followed.

The team members began to discuss the legal issues of Sarah's admission, her living situation, and her long estrangement from family members. The hostility disappeared completely because this estrangement was so great that Sarah had requested orders to prevent contact between the family members and the hospital. They talked about her return to the group home where she had been living before her hospitalization. The social worker asked mischievously whether Sarah had the right clothes to go back to the group home. No one picked up on this attempt to lighten the mood. The subdued discussion continued, returning eventually to the subject of ECT. Everyone seemed to think that this was the treatment of choice because of its previous success, her history of poor response to antidepressants, and her apparent willingness to have it again. However, the sticking point was still her unwillingness to sign the permission form. Team members talked at length about this dilemma. They tried to be sure that fear of the treatment was not the source of her refusal, that her refusal came instead from her overwhelming inability to recognize that she could initiate action. The nursing director agreed to take the form to her again. The team closed the conversation with discharge criteria that included getting the patient mobilized enough so that she could return to the group home. The mood was somber. Everyone seemed caught up in private thoughts about Sarah and her situation.

**Discussion**

Care planning is a way to identify patient problems, develop solutions to these problems, and coordinate and structure patient care (Buckholdt & Gubrium, 1979; Gubrium, 1980). Team meetings or conferences organize patient care. An assumption inherent in writing these team care plans is that the plans and their subsequent implementation will make a difference to the patient. In other words, the planning process will rationalize and make more predictable what is essentially an unpredictable and irrational course of illness (Gubrium, 1991; Strauss, Fagerhaugh, Suzek, & Wiener, 1985). This view is consistent with the positivist view of medicine in which decisions are made and carried out in a logical, rational, and orderly manner (Mattingly, 1991b). This description matches the professional image of the team, that part of the team's actions that deals explicitly with members' unique professional roles and responsibilities (Buckholdt & Gubrium, 1979).

The team discussion about obtaining the patient's permission, labeling her behavior, and planning treatment occurred in the professional image. This image is explicit and may be the only aspect of the team meetings to which the team attends.

In the constructive image, staff members debate to identify the troubles experienced by patients and to negotiate the meaning of these troubles (Buckholdt & Gubrium, 1979). Buckholdt and Gubrium asserted that, unlike the professional image, the constructive image is generally tacit. Team members are not aware of the creative process in which they form a unified picture from the diversity of their individual perspectives. This constructive image relates to the sociology of scientific knowledge (Bloor, 1976; Woolgar, 1980), clinical reasoning in occupational therapy (Mattingly, 1991b), and uncertainty in medical practice (Paget, 1988; Strauss et al., 1985). It recognizes the possibility of multiple realities because each person experiences the world from his or her own perspective (Berger & Luckmann, 1967; Schutz, 1967).

This constructionist approach challenges the rationalist view that patient problems are objective and exist separately from the interpretive actions of the team. It is in this image that team members sort out conflicting data to arrive at a common definition of the patient's problems. Thus, team meetings make sense of conflicting and ambiguous data. This sense-making activity takes place in the background. Team members ignore it, just as Bloor reported in his observations of scientists in the laboratory (1976). The team members functioned in the
constructive image when they discussed Sarah's living situation and family relationships. This discussion reflected their attempts to understand Sarah's perspective and respect it. Unlike the discussion of ECT in which the team members felt compelled to ask for Sarah's permission another time, there was no discussion of asking her to initiate contact with her family. Her definition of the situation prevailed. In contrast, their discussion of Sarah's assertions of inability to do things when she could do them was constructed as problematic. Her agreement to have ECT coupled with her perplexing refusal to sign the permission form was also viewed as a problem by the team. Therefore, both problems were deemed appropriate for intervention. Their subsequent diagnosis and plans to gain her permission to use ECT were performed in the professional image, the explicit purpose of the team meeting. Thus the team shifted from its constructive activities to its professional activities of describing and providing care (Buckholdt & Gubrium, 1979).

Finally, I believe team meetings have a ritualistic image. Like the constructive image, the ritualistic image is generally implicit and thus part of the background experience of team members. Goffman (1967) viewed human interaction as a process that involves a complex network of rituals. Persons incorporate and internalize these rituals or rules of conduct into their actions, providing the interaction structure that holds society together. Shared meaning characterizes ritual action (Douglas, 1966; Durkheim, 1915/1965). Custom and tradition transmit this meaning. The outcome of these actions is a sense of group cohesion (Douglas). Usually, the rituals that occur in human interaction are an unrecognized aspect of communication. They are the routine through which interaction flows. Moore and Myerhoff (1977) argued that this ritualistic aspect, although overlooked or bracketed, must be examined along with the less patterned, more variable aspects of human communication. It is in the ritualistic image that the team defines itself as a group, appreciates its strengths and professional expertise, and identifies the difference between those who believe in their work and those who do not.

Group solidarity, according to Durkheim, is confirmed through rituals that bring persons in the group together to reaffirm their collective identity (1915/1965). The moral support formed by the group in rituals attaches the person to the group. Reunions, assemblies, and meetings reaffirm collective ideas. Douglas (1966), following Durkheim, contended that rituals provide a frame or focusing mechanism that marks off and controls experience. Thus, group interaction provides a ritualistic mechanism for the group to reinforce its solidarity and sense of collectivity.

Bailey (1983) discussed patterns of interaction at meetings that have a ritualistic quality. These involve particular patterns that center on getting the meeting started, the framework for the middle of the meeting, and ways of ending the meeting. For this team there were few overt cues to signal the beginning of the meeting. Typically, after everyone was present the nursing director would say, “OK, Sarah, alteration in mental status.” She said this in what I called a reporting register; it was quite different from her typical speech pattern. This change in voice tone was sufficient to get everyone’s attention. The psychiatrist periodically summarized the discussion. He, too, used a different speech pattern, in the style of dictating, to differentiate the summarization from his typical conversational speech. The entire group responded to these verbal signals, which were the only markers to show movement to the next part of the treatment plan.

This pattern of interaction in the group was consistent from meeting to meeting. The nursing director called the meeting to order by starting the first plan. Once she spoke, the group informally discussed the patient and the particular issue. This discussion was disorderly; people spoke at random, sometimes interrupting or interjecting comments. Often they would respond to what another person said. No one led this part of the discussion. At some point, the psychiatrist would summarize in his dictating voice. The nursing director wrote this dictation on the care plan form. Typically, the group did not challenge this summarization, although sometimes a staff member would interject some additional thoughts and the nursing director would alter the summary. In this way, she and the psychiatrist controlled the flow of the discussion from one topic to the next. This control, however, did not extend to the content of the discussion nor to the order in which people spoke. Stock phrases described patients. The one I heard most frequently was “hopeless, helpless, feeling overwhelmed.” These phrases described patients; however, their patterned use and rhythm lent a ritualistic tone to the discussion, just as pledging allegiance to the flag binds groups together in public gatherings in the United States. This patterned interaction and the use of stock phrases lent a predictable aspect to the meetings. The occupational therapist described the meetings as rote-like, which they were in terms of pace and interaction pattern. However, the content of the meeting in the constructive and professional images varied with discussion of different patients.

Bailey (1983) noted patterned movement between moods of reason and passion, with use of jokes, play, sarcasm, and drama as points to shift these moods. No matter how disparate the moods of team members at the beginning of the meeting, by the time they finished discussing the first patient, the mood was unified. Typically the mood remained unified throughout the meeting, shifting from humor to despair. This vignette contained dramatic mood shifts. In fact, this vignette exhibited the wildest humor and greatest despair that I heard during my observations of the group. The use of humor at the patient’s expense was out of character for the team. In my observations of the team meetings, this type of humor...
typically occurred after a long discussion about a patient in which the team members felt thwarted by their powerlessness to help the patient. One cause of this powerlessness was their inability to understand the patient’s problem. Other causes were circumstances in the family or social service agencies that worked against the best interests of the patient. I believe they used humor to cushion the frustration they felt with the situations of their patients.

Finally, in addition to helping to make sense of the patient, stories played a role in the development of group cohesiveness. The occupational therapist was the source of many of these stories because of her home visits with patients. Team members told the stories of the driving evaluation, the 50-year-old candy, and the macaroni stored with cleaning supplies in the bathroom several times during my observations. These stories united the group by repeating its collective history. Thus the patterned interaction, way of mood, and reaffirmation of shared history through storytelling combined to provide a sense of solidarity for the group.

Conclusion

The implications of making the constructive and ritualistic aspects of team meetings explicit are threefold. First, making these aspects explicit challenge the image of the team meeting as an efficient mechanism to report patient progress and the assumption that the provision of health care to human beings can be entirely rational and efficient. A tightly organized team meeting does not allow for the collective construction of the meaning of illness to the patient and the patient's family. Second, it develops an appreciation for ritual, especially humor, as a way to manage stress and to prevent burnout. Finally, teams that recognize and appreciate the constructive and ritualistic images of their discussions may use this understanding to enhance the development of meaning of illness from the patient’s perspective.

Team meetings are the focal points of communication for health care professionals. In these meetings team members bring together their disparate views of the patients they are treating. Because of their centrality to health care, these meetings are important to study. Future studies of team meetings in different settings are needed to further delineate and explicate their role and function within the organizations in which they exist. In this study, the professional, consor- tive, and ritualistic aspects of the team meetings contributed to the creation of care plans. The roles of the constructive and ritualistic aspects of these meetings were an unrecognized and unappreciated part of the process. Ritual behavior was particularly important because it gave the team the strength to deal with overwhelming patient troubles. It sustained the group members, when the group sometimes failed, in their belief that the group could make a difference.

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References

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