This special issue of *Communication & Medicine* is dedicated to the theme of teamwork and team talk in healthcare delivery. It is a corrective to the research tradition which predominantly focuses on doctor–patient talk as the orientation here shifts to healthcare teams’ *talk about* patients – ‘the ways in which patients are constructed and reconstructed as objects of a medical discourse that is enacted away from the patients themselves’ (Atkinson 1995: ix). In similar vein, according to Anspach:

> Rarely do doctors directly reveal their assumptions about patients when talking to them; it is in the talking and writing to other doctors about patients that cultural assumptions, beliefs and values are displayed more directly. (Anspach 1988: 358)

Parallel to many institutional settings inclusive of social welfare, healthcare is organised around teamwork. The underlying assumption is that most patients’ needs are complex and thus lie beyond the expertise of any individual healthcare practitioner. In such circumstances, what Mayo and Woolley (2016) refer to as ‘collective intelligence’ becomes a necessity; teamwork is targeted at consolidating distributed cognition/expertise. Hutchins characterises ‘distributed cognition’ as ‘cognitive accomplishments [that] can be joint accomplishments, not attributable to any individual’ (Hutchins 1993: 35).

Teamwork on a collective footing is increasingly being seen as the default mode for healthcare delivery, especially concerning decisions in the management of the chronically ill and/or hospitalised patients. The concept does not just imply a team of professionals working interactively in physical proximity; it also refers to how decisions about patients are made in routine activities such as case conferences, ward rounds and clinical handovers. In some occasions patients or carers may be co-present but will most likely have minimal participation rights.

The overriding goal of team-based intervention in healthcare is to contain morbidity and reduce mortality, while also optimising patient safety. Evidence suggests that medical errors contribute significantly towards mortality and failures in teamwork routinely underpin medical errors. In a chain-like fashion, poor modes of communication and inadequate levels of collaboration result in teamwork failures, which, in turn, lead to adverse events. So, better collaboration and open communication constitute the kernel of effective teamwork, ensuring minimisation of medical errors.

One way of characterising teamwork is to liken it to a team sport such as rugby, football or hockey. Individual competencies count but do not guarantee smooth teamwork or successful outcomes. Given that teamwork is now a core component of medical education, having been incorporated into the standards of the Accreditation Council for Graduate Medical Education, Lingard poses the question: ‘How do we approach competence in relation to teams?’
Srikant Sarangi

(Lingard 2012: 43). She articulates the scenario as follows (Lingard 2012: 44):

1. Competent individuals can come together to form an incompetent team.
2. Individuals who perform competently in one team may not in another team.
3. One incompetent member functionally impairs some teams, but not others.

These observations lead her to propose the notion of ‘collective competence’ in the context of medical education, suggesting that ‘we might turn our attention to assessing not only what individual team members know but their awareness of what others know, their skill in the tacit and explicit forming of shared expectations, and their use of strategies to maximize coordination’ (Lingard 2012: 59). She concludes:

Such models of team cognition reflect the key notion of ‘coupling’, the idea that parts of a system are not discrete, but rather that their connectedness is such that a change or weakness in one part of the system affects other parts and the performance of the whole.

(Lingard 2012: 60)

Another useful metaphor to describe the discursive organisation of teamwork is ‘knot’; in coining the term ‘knotworking’, Engeström implies ‘a movement of tying, untying and retying together seemingly separate threads of activity’ (Engeström 2000: 972). In this sense, collaborative work is both dynamic and systemic and, by extension, teamwork is more than the sum of the parts.

Studies of teamwork in health and social care (e.g. Leathard 1994; Payne 2000; Mayo and Woolley 2016) draw upon models of teamwork in business and management settings (e.g. Belbin 1981, 1993; Parker 1990). Among the many attributes of teamwork the following are singled out for focal attention: mutual respect, trust, shared expectations, division of role/function, and agreed goals. Successful teams are built upon and sustained through a mutual calibration of role-responsibilities – which goes beyond individual competencies. A lack of appreciation of division of expert labour can compromise communication as much as poor communication can affect the network of role-responsibilities.

Decision making in multiprofessional teams is a distinctive research trajectory compared to the framework of shared decision making (Charles et al. 1997; Frosch and Kaplan 1999; Makoul and Clayman 2006; Edwards and Elwyn 2009; Coulter 2011). Shared decision making is about patient engagement and participation as a way of attesting the value of patient autonomy while moving away from paternalistic modes of healthcare delivery. According to Coulter (2011: 1):

Instead of treating patients as passive recipients of care, they must be viewed as partners in the business of healing, players in the promotion of health, managers of healthcare resources, and experts on their own circumstances, needs, preferences and capabilities.

Despite the persistence of various models of shared decision making, it is still unclear how decisions are arrived at in a shared way. In a discourse-analytic study of primary care consultations, ‘doctor’s use of “partnership talk” was found to minimize resistance and worked to invite consensus rather than involvement’ (Robertson et al. 2011: 74).

There is a scarcity of studies devoted to decision making in teams at a discourse-analytic level, although there exists a healthy body of research on interactional organisation of meetings talk where decision making is not at stake. A small number of studies in the domains of health and social care (e.g. Mehan 1983; Atkinson 1995; Sarangi 1998; Housley 2002; Hall et al. 2006) have oriented to decision making as an analytical focus (for an overview, see Halvorsen 2010). In his analysis of decision making in special needs team meetings, Mehan (1983) foregrounds not only the ‘role of language’ but also ‘the language of role’ (e.g. speaker-format relations in terms of presentation and elicitation of information) in constraining participation and precipitating different decisional outcomes.

Let us turn to the role of team talk (or, for that matter, team text, although none of the contributions here deals with team text) in the performance of teamwork. Team talk and team
text (re)produce knowledge at a collegial level, with strategic acts of persuasion as regards diagnoses and clinical management. With reference to the sports analogy, team talk conjures up coaching talk that transpires during the half-time in a football or rugby match or in other sporting events. Team talk in such settings is usually instructive, evaluative and charged with passion and aggression, including foul language.

As a threshold, talk as information exchange is basic to teamwork, especially when teamwork is accomplished in the physical absence of colleagues, often mediated by computers. When information does not travel from one person or unit to another, teamwork breaks down, thus putting the patient in discomfort and possibly in an adverse situation. Many of the complaints made by patients and carers about their hospital appointments and stays concern how the patient was left unattended and uncared for because of relevant information not being communicated properly.

Consider the brief examples below – taken from written complaints addressed to a hospital management in Denmark⁴ – which point to gaps in information exchange among the hospital team:

On arrival at Hospital A no one knows he is coming and there is no booking for a CT-scan. [C6]

Even though I told her [the receptionist] about the conversation with the doctor she said she could not see anything on the screen [...] Whether the cold rejection without checking with the doctor if he had forgotten to write it into the computer just shows what kind of treatment ordinary people are subjected to. [C5]

Saturday he is told that he will be taken down to the X-ray during the day. He asks several times when this will be, but they can give no answer. Sunday morning nothing has happened and he asks again, but cannot get an answer [...] [at the X-ray unit] they let him know that they have been expecting him since yesterday??? [C2]

Team talk goes beyond the informative function to bind a team together in order to undertake complex tasks such as addressing diagnostic uncertainties and deciding on optimal treatment regimen and care pathways. Quantitatively, more team talk, however, does not amount to better outcomes, but team talk lacking qualitivity can compromise outcomes.

Talk in a teamwork setting functions differently. A comment made by one team member may be interpreted as an instruction for prospective action to be undertaken by another team member. Even silence may function in a similar way. Somehow the division of labour at the interactional level must be distributed and coordinated along the lines of role-responsibilities. Consider a team in action in the operating theatre. The surgeon and the scrub nurse know their tasks and in most cases these are clearly delineated and mutually understood. Who talks when and to whom has to resemble the conduct of an orchestra. Minimal talk contribution to the teamwork can thus retain its value, despite appearing insignificant. A team discussion, or even a dyadic interaction, will not be productive if no one adopts an active listener role, signalled through backchannelling cues, minimal responses or simply mutual gaze and posture orientations. This suggests that team talk needs to be kept analytically distinctive from teamwork and the former should be seen both as a resource for efficient performance of teamwork as well as a topic meriting focal attention.

The contributors to this special issue select particular sites of teamwork and team talk in the healthcare setting and adopt different analytical frameworks to explore specific talk-work configurations.

The first paper is by Per Måseide, titled ‘Team talk and problem solving in thoracic medicine’. Måseide considers a diagnostic setting in a thoracic ward in a Norwegian hospital. It involves different medical experts where decision making or problem solving is the main goal. He approaches team talk as a basis for ‘collaborative problem solving’. It is the complexity of the patient’s presenting problem that necessitates a team-based intervention, parallel to the notions of ‘distributed cognition’ and ‘distributed expertise’. Team meetings – variously known as multiprofessional meetings or multidisciplinary
meetings – are a ritualised activity type with a focus on examination procedures, diagnostic reasoning and forms of treatment. Based on fieldwork and analysis of audio recordings, the main finding relates to the ways in which the team collaboratively solves problems, while being constrained and challenged by institutional medical standards. The analysis extends to reveal deviances as well as ‘a certain form of normative orderliness and interaction order’.

The next paper is titled ‘A collective clinical gaze: negotiating decisions in a surgical ward’, co-authored by Gro Underland and Aksel Tjora. Here the research site is the surgical ward in a Norwegian teaching hospital. As is the case with the first contribution, the thematic focus is the collaborative aspect of clinical decision making. Video-recorded data is combined with ethnographic fieldwork. The analysis is targeted at the mobilisation of different artefacts (e.g. electronic patient records, documents) to construct the patient. The finding suggests that clinical decision making relies, in part, on electronic patient records and the like for obtaining hard-core evidence. The validity of the decision made is achieved through knowledge sharing and memory work.

This is followed by ‘The management of diagnostic uncertainty and decision making in genetics case conferences’, co-authored by Olga Zayts, Srikant Sarangi and Stephanie Schnurr. The authors examine a case conference in a specialist genetics clinic. Case conferences as an activity type also have an institutional character – similar to other professional settings such as social work. Each case conference processes several patient cases, presented and closed down in a sequential manner. Based on audio-recordings of a single case conference, Zayts et al. identify three different modes of talk: pedagogic talk, diagnostic talk and decisional talk. Despite their overlapping boundaries, the co-occurrence of the different modes of talk attests to the fact that a case conference involving several professionals is multifunctional and that language/communication is key to professional socialisation – for novices to gain access to expert knowledge/experience. Thus team talk in a case conference can be targeted both at a therapeutic/clinical goal as well as an apprenticeship/educational goal – the latter evidenced in how interactional space is created within the discussion for affording socialisation.

The next contribution is co-authored by Gørl Thomassen Hammerstad, Ellen Andenæs, Stine Gundrosen and Srikant Sarangi and is titled ‘Discourse types and (re)distribution of responsibility in simulated emergency team encounters’. The simulated environment heightens the educational character of the encounter, parallel to the case conferences and also clinical handovers (see below). The videoed data concerning the ad hoc team is analysed using the activity-analysis framework, with a specific focus on ‘online commentaries’, ‘offline commentaries’ and ‘metacommentaries’ that are distributed role-relationally – and multifunctionally – to carry out the emergent clinical tasks as a team. The educational dimension remains embedded throughout the encounter.

The next two contributions focus on clinical handovers in hospital settings, which are a prototypical teamwork site where fellow professionals routinely gather together at scheduled times – usually in crowded and noisy rooms and corridors – to exchange updated information about patients. The activity has a ritual character. To borrow the phrase from Philip Strong (1979), it is like the ‘ceremonial order of the clinic’, or what Paul Atkinson (1995) characterises as the ‘liturgy of the clinic’. The handover activity is quite structured in comprising updates on admissions and discharges, bed management, eligibility criteria, nature of referrals etc. The activity also reflects how hospital work is organised along admissions and discharges and that nurses work in shifts. The way in which information is managed connects with notions of multiple roles and goals in team-based settings including sharing of information, allocation of tasks and responsibilities, accountability with regard to patient safety, professional duty of care and ethics.

Suzanne Eggins and Diana Slade’s paper is titled ‘Contrasting discourse styles and barriers to patient participation in bedside nursing handovers’. Audio-recorded data from a public hospital setting in Australia is subject to qualitative discourse analysis, with insights from systemic functional linguistics. The analytic focus is on
transition or shift work – which has to be accomplished as a team, while ensuring patient safety. It thus constitutes a challenging communicative practice, which is a little lessened because of its routine, ritual characteristics. Eggins and Slade go beyond the descriptive task by undertaking an evaluative stance towards the effectiveness of contrastive handover styles: exclusive vs inclusive and objectifying vs agentive. A key variable is the extent to which the patient is included in the handover process, as well as how clinical information is selected, organised and drawn attention to. Whether the patient is framed as an object or as an agent can have consequences. There seems to be a link between how nurses talk about patients in handover meetings and how nurses talk to patients in clinic settings – this certainly calls for further research into nursing practice from a communication perspective.

Rick Iedema and Eamon Merrick’s paper is titled ‘Analysing teamwork in health care: What matters when clinicians negotiate the continuity of clinical tasks and care responsibilities?’ Beginning with the notion of ‘enactment’, the focus is on exchange of critical patient information. Based on a large dataset, the paper is devoted to a case study within an emergency department at a tertiary teaching hospital. The analysis demonstrates a reciprocal relationship between teamness and information exchange. ‘Being a team’ is central to effective information exchange; by its corollary, deficiencies in information exchange during the clinical handover would weaken the team’s clinical tasks and care responsibilities. This nuanced finding about teamness emerges through the methodological framework – video-reflexive ethnography – whereby healthcare practitioners engage with their own video footage and offer ‘lived response’ – which goes a long way towards ratifying the discourse-analytic findings. This has implications for both discourse analytic methodology and for clinical practice.

Staying within the Australian context and working in the same research programme as Eggins and Slade, the co-authored paper by John Walsh, Nayia Cominos and Jon Jureidini is titled ‘How language shapes psychiatric case formulation.’ The study context is an emergency department in the mental healthcare context. Their focus is on formulation of the patient’s illness and its evolving nature within and across meetings. It concerns talking about patients – how clinicians discursively construct and negotiate their understanding of patients’ illness. To quote the authors:

The clinicians valued the adding of collateral information; they sought the “eyes of others” expressed through the words used by their colleagues about the patients; they valued the potential to generate new knowledge about the patient as part of their professional dialogue.

The narrativisation of the patient – which is accomplished through specific linguistic realisations, i.e. lexical items, nominalisations and conjunctions – is as important as the objective signs, e.g. X-ray or CT scan. This work is a collaboration between applied linguists and healthcare practitioners.

Sara Keel and Veronika Schoeb’s paper is titled ‘Professionals’ embodied orientations towards patients in discharge-planning meetings and their impact on patient participation.’ They choose as their focus what they call interdisciplinary entry meetings as part of discharge planning in a rehabilitation centre in German-speaking Switzerland. Based on audio-visual recordings, they approach their data from the viewpoint of conversation analysis to explore the notion of embodied orientation of the professionals towards the co-present patients. They pay particular attention to patient participation in the rehabilitation process and demonstrate through their microanalysis how patient participation is compromised, or minimised, through the selection of interactional devices during the meeting encounter. Elicitations are made when no decision making is at stake, mainly to respond minimally to proposals made by the professionals. Patient participation in team meetings calls for further investigation.

Equally pressing is the need for evaluating the efficacy of team talk and teamwork. The final contribution comes from a team of researchers – Amy Gillis, Marie Morris, Nikita Bhatt and Paul F. Ridgway – and is titled ‘Pilot evaluation of a novel observational tool for collaboration and communication within multidisciplinary
team meetings (MDTs), which addresses the issue of developing an evaluative tool for assessing teamwork. It is about evaluation of collaboration in multidisciplinary teams. The observational tool was developed to fill the gap in the literature, although MDTs are a prevalent form of clinical practice and have attracted the interest of researchers as a site of study. But our knowledge remains very limited about how to assess group functioning in such meetings, even before we can claim to achieve better patient outcomes via teamwork.

With the exception of Per Måseide’s contribution, the rest of the contributions to this special issue of Communication & Medicine are outcomes of team-based work – either involving collaboration between applied linguists and discourse analysts or extending to include healthcare professionals. The conditions for successful collaboration in research and writing are not that different from the house rules underpinning teamwork in general – division of labour, distributed expertise, shared expectations, agreed goals, trust, mutual respect etc. Not all collaborations across disciplinary and professional boundaries, however, go smoothly, but such tensions within shared ‘communities of interest’ (Sarangi 2015) are no doubt healthy in affording reflections about our scholarly endeavours.

Note

1. I am grateful to Bettina Jensen for the English translation of the original Danish complaints.

Acknowledgement

This editorial was written during one of my stays (November-December 2016) as Visiting Research Professor at the University of Hong Kong. I am grateful to colleagues at the Centre for the Humanities and Medicine for allowing me the time and space to concentrate on this writing task.

References


Teamwork and team talk as distributed and coordinated action in healthcare delivery
