



Enacting ‘team’ and ‘teamwork’: Using Goffman’s theory of impression management to illuminate interprofessional practice on hospital wards

Simon Lewin^a, Scott Reeves^{b,c,d,*}

^a Norwegian Knowledge Centre for the Health Services, Norway

^b Li Ka Shing Knowledge Institute of St Michael’s Hospital, Canada

^c Wilson Centre, University Health Network, Canada

^d University of Toronto, Canada

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ABSTRACT

Interprofessional teamwork is widely advocated in health and social care policies. However, the theoretical literature is rarely employed to help understand the nature of collaborative relations in action or to critique normative discourses of teamworking. This paper draws upon Goffman’s (1963) theory of impression management, modified by Sinclair (1997), to explore how professionals ‘present’ themselves when interacting on hospital wards and also how they employ front stage and backstage settings in their collaborative work. The study was undertaken in the general medicine directorate of a large NHS teaching hospital in England. An ethnographic approach was used, including interviews with 49 different health and social care staff and participant observation of ward-based work. These observations focused on both verbal and non-verbal interprofessional interactions. Thematic analysis of the data was undertaken. The study findings suggest that doctor–nurse relationships were characterised by ‘parallel working’, with limited information sharing or effective joint working. Interprofessional working was based less on planned, ‘front stage’ activities, such as wards rounds, than on ad hoc backstage opportunistic strategies. These backstage interactions, including corridor conversations, allowed the appearance of collaborative ‘teamwork’ to be maintained as a form of impression management. These interactions also helped to overcome the limitations of planned front stage work. Our data also highlight the shifting ‘ownership’ of space by different professional groups and the ways in which front and backstage activities are structured by physical space. We argue that the use of Sinclair’s model helps to illuminate the nature of collaborative interprofessional relations within an acute care setting. In such settings, the notion of teamwork, as a form of regular interaction and with a shared team identity, appears to have little relevance. This suggests that interventions to change interprofessional practice need to include a focus on ad hoc as well as planned forms of communication.

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Introduction

Health care is increasingly characterised by the diversity of professional and non-professional providers involved in its delivery and organisation, with each group having its own scope of practice and functions, and its own position within the biomedicine hierarchy. How to co-ordinate the activities of these different providers is the focus of much policy literature (e.g., Department of Health, 2007; Health Canada, 2009). As a result, notions of health care ‘teams’ and ‘teamworking’ are invoked widely within discourses of

health care modernisation and improvement (e.g., McDonald, 2004). Inpatient hospital care is no exception to this. Within this domain, interprofessional teamwork is regarded as essential to tackling poor service delivery, to improving patient safety and to increasing patient satisfaction with care (e.g., Haynes et al., 2009; Kvarnström, 2008). Although the evidence remains weak, it has also been suggested that gains in patient care, including improvements in quality and reductions in patient length of stay, can be realised where interprofessional team members are well co-ordinated (e.g., Schmitt, 2001; Zwarenstein, Goldman, & Reeves, 2009). Further, better teamworking is seen as a mechanism for addressing deficiencies in health professionals’ communication with patients – often a major source of patient dissatisfaction with care (e.g., Beckman, Markakis, Suchman, & Frankel, 1994; Wofford et al., 2004).

* Corresponding author. Li Ka Shing Knowledge Institute of St Michael’s Hospital, 30 Bond Street, Toronto, Canada. Tel.: +1 416 340 4172.

E-mail address: scott.reeves@utoronto.ca (S. Reeves).

These (normative) discourses of ‘teams’ and ‘teamwork’ are rarely examined or critiqued in relation to the day-to-day organisation and maintenance of interprofessional practice in health care settings (Reeves, Lewin, Espin, & Zwarenstein, 2010). Teamwork clearly faces a number of challenges, including professional socialisation and hierarchies; heavy clinical workloads; poor understanding among providers of how to work collaboratively; and the effects of organisational change, including the rapid turnover of both ward and management staff. Within acute hospital care, these issues are further complicated by the wide range of professionals who may be involved in patient care at any one time (Cortvriend, 2004; Reeves & Lewin, 2004; Roald & Edgren, 2001). These factors suggest not only that teamworking may be difficult to establish and sustain within health care, but also that the notions of ‘team’ and ‘teamworking’, and how they vary across different settings and different configurations of health care providers, need to be unpacked and explored.

Our understanding of the nature of teams and teamworking is, however, limited in two important ways. Firstly, empirical research has tended to focus on providers’ verbal accounts of these practices. Secondly, these studies rarely draw on theory to explore the ways in which teamwork between health professionals is organised. As a result we know little about how teamwork is negotiated and enacted between different professional groups in different clinical contexts; or which theories might meaningfully illuminate such issues. This paper draws upon Goffman’s (1963) theory of impression management, modified by Sinclair (1997), to explore how professions ‘present’ themselves when working together on hospital wards and also how they use front and backstage spaces in their interprofessional work.

Impression management

Goffman (1963) developed his theory of impression management from anthropological fieldwork exploring the nature of social interaction within a small rural community in the Shetland Isles. Goffman’s data indicated that communication between individuals took the form of linguistic (verbal) and non-linguistic (body language) gestures employed when individuals present their selves to others. In general, Goffman found that individuals over-communicate gestures that reinforce their desired self and under-communicate gestures that detract from their desired self. Impressions of self are therefore managed actively by individuals during their social interactions – a process termed ‘impression management’. For Goffman, the presentation process was regarded as a ‘performance’, which was undertaken in two distinct areas. Firstly, public “front region performances” (p. 109), and, secondly, private “back region performances” (p. 114). Through his observations at a Shetland Hotel, Goffman provides a helpful example of how performance in these two regions operated. He found that in the backstage region, the hotel owners and workers displayed the sort of egalitarianism which was in the local ‘crofter’ culture, which did not tally with the impression they presented in front of the hotel’s guests, which was more formal and hierarchical in nature.

Goffman argued that front region performances were formal and restrained in nature. In contrast, back region performances were more informal, allowing the individual to “relax [...] and step out of [their front region] character” (p. 115). Importantly, Goffman viewed backstage regions as key locations where individuals could prepare for their front stage performances. The activities that took place in private settings were seen as crucial in supporting the activities that occurred in public settings. Each region, then, has different “rules” of behaviour that shape the ways in which individuals present themselves. Joseph (1990, p. 316) provides a useful summary of this work: “There is a back ‘region’ where the show is

prepared and we rehearse our parts; and a ‘front region’ where the performance is presented to an audience”.

Goffman’s work has resonated widely across the social sciences. For example, the theory of impression management has been drawn on extensively to explain ‘performances’ within health care. Research on medical (e.g., Becker, Geer, Hughes, & Strauss, 1961; Broadhead, 1983) and nursing (Melia, 1987) students, for example, has indicated the significance of front and backstage performances – the latter being employed to help enhance the former – in their respective socialisation processes as they progress towards becoming qualified practitioners. Ellingson (2005) has also drawn upon Goffman’s work to understand the nature of backstage informal interprofessional communication within an oncology setting for older adults. Employing an ethnographic approach, Ellingson found that backstage communication played a central role in progressing patient care. In backstage areas, professionals experienced fewer interruptions and could speak more candidly about patient care issues than in front stage locations of the clinic. This study also indicated that there was a certain degree of fluidity between backstage and front stage areas within the clinic. For example, Ellingson’s observations revealed that the opening of a meeting room door revealed a backstage communication space to the scrutiny of patients seated in the corridor. The notion of fluidity between front and backstage areas resonates with Hindmarsh and Pilnick’s (2002) study of interprofessional collaboration within an anesthesia context. Based on their observations, Hindmarsh and Pilnick go on to argue that professionals often “constitute backstages for their work while remaining in the same ecological domain as their audience, the patient. The possibilities that the patient is drowsy, prone, and has a restricted peripheral vision at different moments provide colleagues with opportunities to produce a backstage in which to coordinate work” (p. 159).

In the context of medical student socialisation, Sinclair (1997) expanded Goffman’s original notion of front and backstage to incorporate ‘official’ and ‘unofficial’ front and backstage regions, as well as offstage work (see Fig. 1). Within the parameters of a medical school, Sinclair saw official front stage activities as including medical lectures and ward rounds, while official backstage activities consisted of the students’ personal library work. In contrast, unofficial front stage activities were made up of team games such as rugby and football, and unofficial backstage activities were focused on the students’ social time, spent largely at the university bar. Connected, but lying outside of these four areas was the offstage – outside the medical school, the “lay world” (Sinclair 1997, p16).

In this paper we draw upon Sinclair’s version of Goffman’s front/backstage model to illuminate the nature of interprofessional relations within an acute hospital setting. In doing so, we argue that health care professional interactions in this setting may be based less on formal, ‘front stage’ activities than on informal, opportunistic strategies. These allow the appearance of a collaborative

	OFFICIAL	UNOFFICIAL	OFFSTAGE
FRONT STAGE	Lectures, exams	Sports teams	Lay world
BACK STAGE	Libraries	Students’ bar	

Fig. 1. Sinclair’s modified front/backstage model.

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