



Accomplishing professional jurisdiction in intensive care: An ethnographic study of three units



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ABSTRACT

This paper reports an ethnographic study examining health professional jurisdictions within three intensive care units (ICUs) in order to draw out the social processes through which ICU clinicians organised and delivered life-saving care to critically ill patients. Data collection consisted of 240 h observation of actual practice and 27 interviews with health professionals. The research was conducted against a backdrop of international political and public pressure for national healthcare systems to deliver safe, quality and efficient healthcare. As in many Western health systems, for the English Department of Health the key to containing these challenges was a reconfiguration of responsibilities for clinicians in order to break down professional boundaries and encourage greater interprofessional working under the guise of workforce modernisation. In this paper, through the analysis of health professional interaction, we examine the properties and conditions under which professional jurisdiction was negotiated and accomplished in day-to-day ICU practice. We discuss how staff seniority influenced the nature of professional interaction and how jurisdictional boundaries were reproduced and reconfigured under conditions of routine and urgent work. Consequently, we question theorisation that treats individual professions as homogenous groups and overlooks fluctuation in the flow and intensity of work; and conclude that in ICU, urgency and seniority have a part to play in shaping jurisdictional boundaries at the level of day-to-day practice.

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1. Introduction

Despite policy reports, recommendations and research on improving the delivery of safe and quality healthcare (Department of Health (2009), Department of Health, 2014; Vincent et al., 2001, 2009; Hogan et al., 2012), public enquiries into hospitals over the past decade have demonstrated that progress is variable (e.g. Kennedy, 2001; Francis, 2013; Keogh, 2013). Key policy reports from the Institute of Medicine (IoM) in the USA, the Canadian Patient Safety Institute (CPSI) and the Department of Health (DH) in the UK argued that interprofessional collaboration and coordination of health professional work is essential in driving up the quality of care (Institute of Medicine, 1999; Institute of Medicine, 2001; Department of Health, 2000a; Department of Health, 2008; CPSI, 2011).

Within the social sciences, interprofessional working is viewed as problematic due to the implications for reconfiguration of professional boundaries, which professions can resist (Martin et al., 2009; Finn et al., 2010; Powell and Davies, 2012). Martin et al. (2009), drawing from Abbott (1988), argue that professions tend to defend their jurisdictions fiercely, and respond to incursions by reasserting the legitimacy of existing boundaries, although there are also instances where it is more beneficial for professions to also shed tasks deemed to be less prestigious. They note, however, that the majority of literature on the health professions concentrates on potential rather than actual shifts in professional boundaries, echoing calls for more detailed case studies of micro-level processes in the context of specific challenges to the professional division of labour. In this paper, we respond to this call by reporting an ethnographic study that examined health professional work in ICUs in the context of Department of Health (2000b; 2005) policies for the modernisation of the ICU workforce.

Our data suggest that official positions in the ICU hierarchy, those of doctors and nurses specifically, did not determine the decision-making process in the way much of the literature had

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assumed. In ICU, nurses did not always follow medical instruction; there were also situations in which doctors acceded to what nurses suggested for patient care. We discuss how staff seniority – referring both to rank as well as the combination of experience and expertise – influenced the nature of professional interaction and how jurisdictional boundaries were reproduced and reconfigured under conditions of routine and urgent work. Consequently, we conclude that in ICU, urgency and seniority have a part to play in shaping jurisdictional boundaries at the level of day-to-day practice.

Next, we situate our research within the policy context of health workforce modernisation and research of ICU nurses and doctors at work. The theoretical position of the paper follows, as does the method of the current study. We then examine our findings presenting field note extracts and interview quotes to illustrate our points. Finally, we critically discuss our findings in relation to existing research and theory on the division of labour.

2. Background—the policy context of workforce modernisation

A way through which patient safety and quality of care concerns are addressed in many Western health systems is workforce modernisation. Modernisation is used to describe a number of health-policy initiatives calling for changes to the provision of public services in welfare states from the late 1990s onwards (Green et al., 2011). Among other drivers, such as external audit, professional performance indicators, introduction of market principles and user empowerment, modernisation calls for changes to the governance style towards interprofessional working (Waring and Currie, 2009).

The NHS Modernisation Programme in the UK was an example of these kinds of policy changes (Hyde et al., 2005), through which health professional work was reframed around concepts such as teamwork and multi-disciplinarity (Lewin and Reeves, 2011; Martin et al., 2009). The case of intensive care was indicative of such workforce changes where policy called for the modernisation of the ICU workforce through role extension and expansion for nurses; for example, through the creation of nurse consultant posts (Department of Health, 2000b; Department of Health, 2005). Consequently, ICU nurses gained legitimacy to extend their influence on medical decision-making blurring the boundary with medicine; although actual changes to the division of labour were confined to ad-hoc, local arrangements rather than legal agreements (Green et al., 2011).

This is an example of state intervention that has the potential to compromise certain professionals' jurisdictional claims over distinct areas of practice while at the same time creating new opportunities for aspiring professional groups, such as ICU nurses. Commentators agree that while much has been written about this topic, less attention has been paid to the consequences of such policy reforms for the nature of professional boundaries and relationships between healthcare professionals (Nugus et al., 2010; Kirkpatrick et al., 2011; Kroezen et al., 2014). Kroezen et al.'s (2014) analysis of jurisdictional control over prescribing in The Netherlands is a notable exception, although their focus on one jurisdiction that transcends all clinical specialisms limits the transferability of lessons learned to the rather distinct setting of intensive care.

3. Literature review—Modernisation in the context of intensive care

Within the context of intensive care, little research has considered the effects of modernisation policy on health professional

work and its division of labour. In an interview based study with 45 intensive care staff in England examining their perceptions of the ICU modernisation programme, Green et al. (2011) identified that staff reported modernisation had led to better functioning teams. Nurses in particular spoke of more collaborative team-working between them and ICU doctors following the modernisation policy. Based on these findings, it would appear that in ICU the shift in professional jurisdictions brought about by the modernisation agenda did not lead to attempts from professionals to defend their boundaries; rather modernisation appeared to be a mutually beneficial professionalising strategy (Green et al., 2011).

Green et al.'s findings may be explained, in part, by the unusual context of the ICU specialism compared with other hospital areas. In particular, ICU is a relatively recent specialism that continues to evolve rapidly. The complex nature of ICU patient conditions and reliance on one-to-one nurse-to-patient ratios means the ICU has been inherently multidisciplinary. However, this explanation glosses over the ways in which professional role changes and redistribution of responsibilities are actually managed by ICU professionals in day-to-day practice and does not illuminate the conditions and processes through which professional jurisdiction is accomplished in the ICU setting. Clinicians and policy makers' ability to learn from the ICU to inform future decision-making is hindered in this and other clinical settings as a result.

At an international level, Paradis et al. (2014) undertook a comprehensive literature review of 23 ethnographic studies in ICU, out of which 11 addressed aspects of the nurse-doctor boundary. They found little evidence of collaborative working as most studies reported conflict, and concluded that nurses and doctors in ICU have unique professional approaches to healthcare work that are not always compatible (Paradis et al., 2014). Further examination of these studies reveals key challenges and contradictory findings, discussed next.

In an ethnographic study of three British ICUs Coombs (2004) identified that despite good working relationships, with respect to decision-making nurses perceived doctors to be domineering; they reported difficulties in having their contributions accepted, considered or validated by doctors and thus felt excluded from the decision-making process. Similarly, ethnographic work consisting of observations and interviews with staff in an Australian ICU argued that doctors tended to use nurses only to supplement information and provide extra details about patient assessments (Manias and Street, 2001), which led nurses to report difficulty in participating in ward rounds and care discussions. More recently, ethnographic work in four North American ICUs (Reeves et al., 2015) confirmed that typical hierarchical relations continued to prevail between doctors and nurses. Interactions between them were brief and serendipitous in nature, with medicine dominating decision-making.

In contrast, in an ethnographic study of three British ICUs involving observations and interviews with doctors and nurses, Carmel (2003, 2006) argued for a professional allegiance towards a common ICU project through which collaboration was fostered and boundary tensions avoided. Carmel (2006) argued that the physical and organisational separation of the ICU from the rest of the hospital served to reify the ICU team, as doctors and nurses worked closely to respond to clinical challenges. Carmel's study was undertaken at a time when modernising the ICU workforce was a key policy priority in England, which may partly explain his findings. The extent to which Carmel's findings are enduring or contained in that time period remains unclear.

Alexanian et al. (2015) reported from an ethnography of two North American ICUs that staff talked about there being a broad and inclusive notion of a health professional team, partly supporting Carmel's conclusion. However, in contrast with Carmel, what was

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