Structure and meaning in multidisciplinary teamwork

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Abstract

The purpose of this study was to examine the relationship between structure and meaning in multidisciplinary long-term care teams. In-depth semi-structured interviews were conducted with 26 staff working on five multidisciplinary teams in the same long-term care facility in Metropolitan Toronto. Staff in different structural locations have differing meanings of work and teamwork. Direct caregiving nursing staff have simple role-sets, minimal involvement in team decision-making and ritualistic orientations towards their work and teamwork. Multidisciplinary professionals have complex role-sets, greater involvement in team decision-making and organic orientations towards their work and teamwork. Supervisory nurses are in a contradictory structural location and shared aspects of both orientations to teamwork. The lack of shared meanings results in alienation from work and teamwork for staff in lower structural positions which, in turn, has considerable implications for team functioning.

Keywords: multidisciplinary teams, long-term care, teamwork, meaning

Introduction

The concept of the team approach is pervasive throughout health care and health care literature, particularly among health professionals working with older people (Clarke 1991, Ryan 1996). The value of teamwork is taken for granted by health care professionals, despite the lack of a systematic analysis of its effectiveness (Nagi 1975, Schmitt et al. 1988, Hogan 1990). The gerontological health care literature contains a preponderance of rhetorical, ‘how-to’ literature about teamwork with very little research and theory about health care teams. In order better to understand the phenomenon of
health care teamwork and its importance to health care professionals who work with older people, a study of the structure and meaning of multidisciplinary long-term care teams was conducted using multiple methods including social network analysis and in-depth interviews. The social network methodology and analysis have been presented elsewhere (Cott 1997). The purpose of this paper is to present a qualitative analysis of the meanings of teamwork held by staff in different structural positions and to analyse how structure and meaning are produced and reproduced through staff interactions.

Of the few studies that have been done about teamwork, most have focused on some aspect of team process such as communication or decision-making (Halstead et al. 1985, Hopkins-Rintala et al. 1986, Sands 1990, Heinemann et al. 1994, McClelland and Sands 1993, Opie 1997), power (Fried 1989, Fiorelli 1988, Drinka and Ray 1987) or conflict within teams (Sands et al. 1990). These studies invariably analysed team rounds, a (usually) weekly meeting at which team members exchanged information and made patient-related decisions. Few addressed how team members interacted outside these meetings.

Despite the widespread acceptance of the value of teamwork by health care professionals and the pervasiveness of the ideology of teamwork in health care, little work has been done systematically to examine the pattern of relationships and shared meanings that develop amongst staff in multidisciplinary teams as they go about their work. Some authors have addressed the meaning of teamwork but not specifically as it relates to the pattern of relationships in the team (Temkin-Greener 1983, Campbell-Heider and Pollock 1987) or not from the perspective of the staff (Evers 1982).

As the study progressed, it became apparent that although all the staff members valued teamwork, staff in different structural positions held different perceptions of meanings of teamwork because they were engaged in different kinds of teamwork. The structure of the team is essentially alienating for staff in lower structural positions with the result that they do not share the same meanings of teamwork as staff in higher structural positions. These differing meanings of teamwork have considerable implications for the way that the team functions.

**Theoretical perspective**

The perceptions or meanings that staff members attach to teamwork are explained by linking them to the structure of the team using a combination of symbolic interactionist and social network perspectives. The meaning of teamwork refers to the interpretations or perceptions of individual team members as to the effect of being part of a team for themselves personally and for their work. The structure of the team refers to the patterns of
relationships amongst team members that underlie the organisation of the team.

A symbolic interactionist perspective is concerned with the subjective understandings or meanings that human beings attach to various situations or symbols. According to the symbolic interactionist perspective, these meanings are developed through social interaction and individuals’ definitions of their situation. Blumer, considered the founder of symbolic interactionism, explained the way that symbolic interactionists view meaning as follows:

Symbolic interactionism . . . does not regard meaning as emanating from the intrinsic makeup of the thing, nor does it see meaning as arising through psychological elements between people. The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define the thing for the person; thus, symbolic interactionism sees meanings as social products formed through activities of people interacting (1969: 5).

In this study, the meanings that staff members attach to teamwork arise through social interaction.

Structure can be conceptualised in a number of ways. In this study, symbolic interactionist and social network conceptualisations of structure are used in combination. Following the social network perspective, the structure of the team is conceptualised as a network of different kinds of relationships or ties among team members as they go about their work. Following the negotiated order perspective within symbolic interactionism (Strauss et al. 1963), these patterns of relationships are conceptualised as the outcome of ongoing negotiation and bargaining between actors from different professions as they come together to carry out their various purposes. The structure of health care teams is negotiated through a series of conflicts and compromises between the team members as they attempt to establish a basis for their concerted action (Lazega 1992).

The difficulty with the negotiated order perspective is that it fails to account for differences in status, authority and power amongst group members in terms of structural constraints that may limit their ability to influence the structure. In order to address this limitation, Coser’s (1991) expanded concept of role-set is used to link position in the structure of social relationships to power, influence and alienation. Role-set refers to all of the different roles that are associated with any single status (Merton 1968, Blau 1991). According to Coser, a simple role-set is ‘one in which most role partners do not differ much among themselves in status’ while a complex role-set is ‘one in which at least several role partners are differently located in the social structure and subject to change’ (1991: 21). In this study, staff have varying complexities of role-sets related to their structural position that produce differing meanings of teamwork that further perpetuate their position in the structure.
The finding that the social structure in hospitals is alienating for some staff is not new. Both Pearlin (1962) and Coser (1963) linked alienation of nursing staff to their position in the social structure of the hospital. Alienation was greatest among staff with routinised, mechanical conceptions of their work (Coser 1963) and in situations with rigid and impersonal authority structures (Pearlin 1962). Health care work has evolved since these studies were conducted to incorporate more multidisciplinary teamwork. This should have resulted in less alienation of staff caused by a flattening of the hierarchy in health care and changing roles of non-medical staff. The question remains: to what extent has this happened?

To understand the different meanings that staff might attach to teamwork, it is important to understand the ideology of teamwork. There is considerable rhetoric around health care teamwork (Evers 1982) as exemplified by definitions of teams and teamwork such as the following definition of teams modified from Drinka and Ray: 'Multiple health disciplines with diverse knowledge and skills who share an integrated set of goals and who utilise interdependent collaboration that involves communication, sharing of knowledge and coordination of services to provide services to patients and their caregiving systems' (1987: 44).

Definitions of teamwork are more difficult to find. Brill defines teamwork as 'that work which is done by a group of people who possess individual expertise, who are responsible for making individual decisions, who hold a common purpose and who meet together to communicate, share and consolidate knowledge from which plans are made, future decisions are influenced and actions determined' (1976: 10).

These definitions of teams and teamwork underline some of the basic assumptions of multidisciplinary teams. Although not explicitly stated, most literature on health care teams subscribes to three basic assumptions: (1) that team members have a shared understanding of roles, norms and values within the team; (2) that the team functions in an egalitarian, cooperative, interdependent manner; and (3) that the combined effects of shared, cooperative decision-making are of greater benefit to the patient than the individual effects of the disciplines on their own. A review of the literature suggests that, in many cases, aspects of the first two assumptions such as shared understanding of roles, power and egalitarian decision-making are not confirmed by the research (Fried 1989, Fiorelli 1988, Ducanis and Golin 1979); however, when these conditions are present to a greater degree, there is some evidence to support the third assumption (Feiger and Schmitt 1979).

In her case studies of multidisciplinary teamwork in geriatric wards, Evers (1982) identified issues concerning the meaning of teamwork, but focused on the patients' perspectives. However, she notes that the multidisciplinary professionals on geriatric wards subscribed to the ideology of
collaborative, egalitarian teamwork although there were tensions regarding work roles. She concludes that, from the perspective of the patient, care of the geriatric patient usually does not coincide with the rhetoric of teamwork as expounded in the professional literature.

There is literature to suggest that staff will have different perceptions of teamwork depending on their professional affiliation. Each member of the team comes to that team with a different set of values about teamwork based on their professional socialisation and personal experiences and beliefs (Qualls and Czirr 1988, Sims 1979). For example, although physicians and nurses advocate the use of teamwork, they do so for different reasons. Physicians tend to see nurses as helpers and extenders of their role (Temkin-Greener 1985) and encourage a form of teamwork in which nurses are subordinate (Campbell-Heider and Pollack 1987). In contrast, nurses view teamwork as providing access to direct patient care and as a means to gain status (Temkin-Greener 1983) and seek a form of teamwork that encourages mutual collegiality with physicians (Campbell-Heider and Pollack 1987). However, no research has been done to explore how these differing meanings of teamwork are renegotiated or perpetuated as staff interact with each other on a daily basis.

In summary, a review of the literature identifies a number of gaps in understanding of the way that health care teams function, particularly in terms of the meanings about teamwork held by staff members and the implications of these meanings for team function. The goals of the study are therefore; (1) to identify the meaning of work and teamwork for individuals in different structural positions within multidisciplinary long-term care teams; and (2) to interpret the implications of staff meanings of teamwork for team function in this context.

Method

In-depth, semi-structured interviews were used. A set of questions was developed that guided the interview, but the sequencing and phrasing of the questions varied as the interview progressed. As much as possible, questions were non-directive, other than specifying the topic area, and prompts were used only to ask for clarification or expansion of points that respondents made.

The study was conducted on five wards in a highly specialised, multi-level care facility concentrating on the needs of older persons in Metropolitan Toronto. The facility is highly regarded by the professional and lay communities and, at the time of the study, had just received the maximum accreditation award of the Canadian Council for Health Facilities Accreditation.

Selection of the teams to be studied was made by the Nursing Department. Two of the teams were in a Home for the Aged, two were chronic care teams and one a palliative care team in Chronic Care. The
teams were similar in size but varied in terms of professionalisation. For example, the Home for the Aged teams consisted of more Registered Practical Nurses (RPNs) and Health Care Aides (HCAs) than Registered Nurses (RNs) or non-nursing Health Care Professionals (HCPs) than the Chronic and Palliative Care Teams.

Sampling for the in-depth interviews was guided by a protocol approved by the Centre’s ethics committee. Key respondents were identified, based on their staffing category and shift worked. Potential respondents were identified from each unit to ensure representation of all staff categories and shifts. Staff members identified to be interviewed were contacted initially by two social work representatives so as to ensure that staff members were not contacted by their own supervisor or someone from their own department.

Twenty-six out of 30 staff who were contacted were interviewed including all levels of nursing staff, such as RNs, RPNs and HCAs, and other professionals from departments, including medicine, social work, physical therapy (PT), occupational therapy (OT), speech language pathology, dietary and recreational therapy. All the respondents had worked at this institution for at least two years. Of the four staff who were not interviewed, two refused to participate, one went on extended sick leave and one was unable to arrange time for the interviews.

All the interviews were conducted at a time and place convenient to respondents and lasted approximately one hour. All of the interviews were audiotaped. At the end of each interview, field notes were recorded as to overall impressions and key issues that had arisen during the interview. Transcription of interviews occurred concurrently with the data collection. After editing, data were categorised and coded utilising Ethnograph (Seidel et al. 1988), a qualitative data management system. Each interview was numbered by line by the Ethnograph software package, which allowed each interview to be categorised and coded. These segments were subsequently retrieved in order to explore commonalities and differences.

Analysis followed a general symbolic interactionist perspective (Mead 1934, Blumer 1969) using the constant comparative method originally described by Glaser and Strauss (1967) and explicated by Strauss and Corbin (1990). All the data sets were reviewed, broken down into discrete parts, and subsequently compared for similarities and differences. All 26 data sets were read and coded, based on concepts, categories, ideas and issues that emerged from the data. Next, the data were put back together in new ways, by making connections between categories and concepts. Finally, all the core categories were systematically related to other categories. During this stage, all the data sets were reviewed to validate the core concepts.

**Findings**

The findings will be presented as follows: the main theme underlying meanings of teamwork for all staff will be defined; next, the meaning of
teamwork for staff in three different structural positions will be examined; and finally, the implications of these differing meanings for team function will be discussed. Except for nursing, there are insufficient numbers of respondents in other professional categories to allow identification of professional affiliation to a particular unit. Therefore, in order to maintain confidentiality, respondents are referred to either as a Health Care Professional (HCP) or by their level of nursing preparation.

The main theme: getting the work done
The main theme underlying all the respondents' comments about teamwork was how being part of the team helped them to do their job, usually in the context of sharing knowledge and information or work tasks. Sharing work tasks with other team members helped alleviate the difficulty of working with multi-problem frail institutionalised elders. For example, one respondent said:

Because by teamwork . . . it’s much easier for everybody . . . if you work together it’s much, much easier. RN 4

‘Getting the work done’ was the main underlying theme common to all respondents and was an important foundation for whether staff valued teamwork. Also, whomever staff defined as helping to ‘get the work done’ was defined as being part of the team. Depending on their structural position, staff differed on how they defined the team and their perceptions of the meaning of teamwork.

The structure of the teams
It is largely supposed, in the literature, that the ‘team’ is the multidisciplinary group of professional health care providers working together for the well-being of the patients. In this study, the team was defined very broadly to include all health care providers on a particular unit who provided direct care to patients. As the interviews progressed, it became increasingly clear that there were two sub-groups within the larger team. The differentiation between ‘nursing’ and the ‘multidisciplinary team’ was commonly made by all respondents.

These two sub-groups were quite different in their structure (Cott 1997). The multidisciplinary sub-group consisted mainly of non-nursing professionals such as physicians, therapists and social workers. It was non-hierarchical. These health care professionals had no supervisory capacity over each other, and proceeded with their work tasks autonomously and independently. They met regularly for team meetings which were only attended by other multidisciplinary professionals and supervisory nurses (Head Nurses and Team Leaders). The direct caregiving nursing staff, which included mainly RPNs and HCAs, rarely, if ever, attended multidisciplinary rounds. The multidisciplinary professionals interacted
mainly with each other and the supervisory nurses. They had little contact with the direct caregiving nursing staff, particularly those nursing staff working the evening or night shift.

The nursing sub-group consisted of RNs, RPNs and HCAs on the day, evening, and night shifts. In contrast to the multiprofessional sub-group, it was very hierarchical, as described by one of the RNs:

... usually the chain of command is the head nurse to the day registered staff. The day registered staff and the Head Nurse pass it on to their aides. The day nurses pass it on to the afternoon registered staff who pass it on to their aides and the evening registered staff pass it on to the night registered staff who pass it on to the night aides. RN 19

The direct caregiving nurses (mainly RPNs and HCAs) had the majority of their interactions with other nursing staff on their shift and the supervisory nurses (mainly RNs).

This common team structure reflects social class distinctions within society (Navarro 1976) with higher educated, higher status professions assuming responsibility and control of the team and lower educated, lower status, workers carrying out tasks delegated to them from above. It represents the ‘we decide, you carry it out’ division of labour in health care (Cott 1997) in which one group of professionals decides on a course of action that another group of health workers is expected to carry out.

As the analysis progressed, it became increasingly clear that the team to which respondents were referring differed depending on their structural position. When staff were referring to the ‘team’ they were referring to those staff who helped them to get their work done. However, the nature of the work that staff in different structural positions were trying to ‘get done’ differed, and influenced the type of teamwork in which they were involved, resulting in differing perceptions of the team and teamwork.

The way that staff talk about their work will reflect alienation from work (Hughes 1971, Coser 1963). Central to the notion of alienation is the importance of work to individuals’ experience of self and to their sense of ‘who they are’ (Hughes 1971: 339). The way that staff in different structural positions talked about their work reflected differing levels of attachment to their work. The perceptions of work and teamwork of staff in three different structural positions were subsequently compared and contrasted using Coser’s (1963) differentiation between organic and ritualistic conceptions of work. Staff with an organic conception are concerned with the human implications of their work and talk about a more inclusive ‘role’. Staff whose conception of their work is more ritualistic are more concerned with the concrete aspects of what they do such as the mechanics and routines involved in performing tasks. These conceptualisations of work were also applied to teamwork.
Direct caregiving nursing staff
Invariably, when the direct caregiving nursing staff defined the team, it included the other nursing staff on their shift and specifically those nursing staff with whom they were paired. They included the supervisory nurses in their definition of the team, especially if they worked the same shift. As it was these particular nursing staff who helped them to get their work done, it was their teamwork with these other nursing staff that was important to them.

The work that these nursing staff did was very immediate, concrete and task-oriented, with the result that their work orientations were ritualistic. When they talked about their work, they focused on the completion of basic care needs. For example, one aide commented:

Oh, routinely, we come in, get them [the patients] up, get them dressed, bathe them, feed them. Sometimes we just go in and chit chat . . . and then we go back. It's like a routine, we go back and we put them back or you help them to attend programs or something along that line. HCA 2

A few of the direct caregiving nursing staff were more engaged in their work and concerned about their relationships with the patients. Another HCA said: 'This is a work of caring, sharing . . . sharing and caring' (HCA 20). However, for the most part, these staff were concerned mainly with the physical, task-oriented aspects of their work. They did not have regular patients to whom they were assigned and they were rotated every few weeks to work with a different group of patients. As one of them commented:

So find out what they [patient and family] want and then just try to maintain it, you’re only doing it for a week, then you switch sides again, so I’m not worried. HCA 9

These nursing staff were responsible for bathing, feeding and dressing a group of patients today. They were not responsible for what happened to those patients tomorrow or next week. They had a narrow view of what they did, and they stuck to it. As one said, ‘I just work according to the [Health Care Aide] course, what they teach me to do’ (HCA 27). Clarke (1978) also found that nurses’ definitions of work revolved around completion of physical tasks. In her study, attending to the social or emotional needs of the patients was regarded less as work than completing tasks such as dressing or bathing.

The direct caregiving staff were involved in teamwork that involved helping each other complete work tasks. For them the team consisted of those nursing staff who were on duty together and who provided assistance and support for one another in the fulfilment of their tasks of providing for the basic care needs of the patients. As one RPN said:

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You get them [patients] washed and dressed and then you get somebody to help you with a transfer or a lift. If I’m on medication that day, somebody else has to feed them, so then you have to ask them, ‘Did they eat everything, and what did they eat?’ You have to put them back to bed after lunch too. RPN 32

The lack of engagement of these direct caregiving staff in their work was also reflected in the way they talked about teamwork. For the most part, they did not talk about how teamwork improved the quality of the work done, only how it made it easier. A few who were more engaged in their work did talk about how being part of a team improved the work. However, even these more engaged nurses were only talking about nursing. They did not feel engaged with the multidisciplinary professionals, nor did they consider themselves part of a larger multiprofessional team. They talked about nursing as ‘we’, but referred to the multidisciplinary professionals as ‘they’.

Most of the direct caregiving nursing staff were quite ambivalent when they talked about the multidisciplinary team. As one said, ‘So, I guess having a [multidisciplinary] team does work sometimes’ (RPN 32). These nurses saw the multidisciplinary professionals as separate from themselves and not essential to helping them complete their work tasks. The direct caregiving staff’s ambivalence about the multidisciplinary professionals reflected the low levels of interaction between the two groups. Coser (1991) also found that low frequency of interaction among health professionals was associated with weakness of interpersonal sentiments resulting in little motivation to work collaboratively with one another.

The only time the direct caregiving nursing staff mentioned the multidisciplinary professionals was if they had a particular problem that they thought the multidisciplinary professionals could help them with. For example, one of the RPN’s said:

... because from the little that I do utilise or see [the multidisciplinary professionals], I find that they do a lot of following up ... so I think there is some good in it [having a multidisciplinary team]. RPN 2

These nursing staff had a ritualistic notion about teamwork just as they had a ritualistic notion about their work. The structure of the team placed little onus on them for decision-making. They rarely attended multidisciplinary team rounds, nor were they expected to be part of team decision-making. These limited expectations were incorporated into their attitudes towards their work and teamwork.

Since the direct caregiving nurses were not engaged in the larger team they did not incorporate being a member of the team into their social identity. They saw that they had a role on the team (although they never used that terminology), but only in the sense of passing information up the
hierarchy and carrying out decisions that were passed down. As one RPN described it, ‘Nurses do what everyone tells them’ (RPN 2). For the most part, they accepted their limited role as typified by this RPN’s description of her role in communicating with families:

You see, when it comes to important matters about the patient’s condition, like they told us when we take the [Registered Practical Nurse] course, that it isn’t up to us to discuss those things with the families. So you better leave those things with the team leader or the head nurse or doctor. RPN 8

This willingness to pass the responsibility for tasks to other staff reflected the direct caregiving nursing staff’s alienation from work and their ritualistic understanding of teamwork. In this case, teamwork helped them to get their work done by shifting responsibility to other team members.

Some of the direct caregiving nursing staff who were more engaged in their work expressed resentment at their lack of involvement in decision-making. One commented:

I never go when they have the family meetings... What’s so good is the whole team’s there, except the nurse. They won’t accept me, the primary person, I’m not there, but the team leader’s there and she basically knows everybody so this way she’s able to answer the questions or their concerns. RPN 9

These staff were engaged in their work but they were alienated from teamwork by the team structure that limited their participation. Although they expressed some anger about this restriction, they accepted their status and made no attempt to change it. Instead, they rationalised their non-participation. As the RPN above continued:

Oh, I don’t want to be there, do you know what I mean? I don’t, it’s time consuming, it’s boring, I have other things to do. Just because I happen to be in this meeting doesn’t mean that my work stops. Do you know what I mean? I don’t have time. RPN 9

Coser argues that the ‘plurality of social roles is synonymous with role segmentation, and it is the relative lack of opportunity for role segmentation that produces alienation in large sectors of the population in an otherwise segmented social structure’ (1991: 21). Individuals in simple role-sets have fewer linkages to other members of the organisation who differ from them in terms of professional affiliation. Instead, most of their interaction is with others who are much like themselves and, therefore, mutual expectations are shared and predictable. As a result, they are not provided opportunities for role articulation and are not challenged to be creative or reflective.
Coser further argues that ‘on the lower rungs, especially in organizations, people frequently operate on a level of simplified relationships (i.e. only restricted role-sets). Such restriction is alienating because it does not offer individuals sufficient opportunity for exercising their judgment in regard to their own behaviour and that of others’ (1991: 35). Further, complexity of role-sets is associated with differential access to social resources. The opportunity to form ties with a variety of others is not distributed equally in the social structure, with social economic status and occupational level being important considerations.

The direct caregiving nursing staff’s position in the social structure of the team is perpetuated by their lack of access to the social resources necessary to give them power and control. They have the least formal education of all of the team members and they have very simple role-sets with limited opportunities to interact with and learn from others who are unlike themselves. Their exclusion from team decision-making limits their opportunities to develop problem-solving vis-à-vis their work and others. The structure of the team reinforces the status differentials between these direct caregiving nursing staff and the other team members.

The task oriented nature of their work contributes to their ritualistic view of their work which, in turn, translates into a ritualistic view of teamwork. These ritualistic conceptions of their work and teamwork are symptomatic of their alienation from work. ‘It is not only that at the lower end of the hierarchy people have little power by definition, to this must be added the alienation that comes from restricted role-sets’ (Coser 1991: 47).

These staff participate in teamwork that involves helping other nursing staff complete work tasks but, just as they do not incorporate their work into their social identity, they do not incorporate being a member of a team into their social identity. However, in as much as they perceive that being part of the nursing team helps them to get their work done, they value teamwork.

The multidisciplinary professionals
The multidisciplinary professionals consisted of a variety of therapeutic, social work and medical staff. They could be subdivided into two groups, the core and peripheral professionals, depending on the centrality of their work and their involvement in team decision-making. The core professionals were those professionals assigned to each unit, who typically were involved with most of the patients or residents on that unit, and who attended team rounds. The peripheral professionals were less involved in the day-to-day running of the unit and functioned more in a consultative capacity, only seeing those patients or residents referred to them. They might or might not attend team rounds. In the Home for the Aged teams, the core professionals were the physician, social worker and recreation therapists whereas the peripheral professionals included the speech-language pathologist, dietitian, OTs and PTs. In the Chronic and Palliative Care

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teams, the OTs and PTs were also part of the core team, but not the dietitian or speech-language pathologist.

Interestingly, the physicians did not emerge as a distinct group in either the social network analysis (Cott 1997) nor the in-depth interviews. There may be a number of reasons for this finding. The physicians' role in long-term care is very different from that in acute care where the focus is on the medical and surgical treatment of disease. By definition the patients in long-term care, although chronically ill, are medically stable, otherwise they would not be in this type of care facility. The focus was therefore not on the medical treatment of their underlying disease, but rather, on the management of their social and physical needs over the long term. Even on the palliative care unit, the emphasis was not on medical cure, but on pain management and the social psychological issues of dying. The major focus of the team on a daily basis was related more to nursing, therapy and social work rather than medical intervention. In the majority of these cases, the physician left many of these day-to-day decisions to the rest of the multiprofessionals within whose expertise they fell. Further, the physicians were usually only on the unit one or two times a week for a few hours. Since the focus of this study was on the pattern of relationships that develop amongst team members as they go about their day-to-day work, it is not surprising that the physicians were rarely mentioned by respondents. The relationships that emerged as important to the day-to-day work of staff were the relationships between the various categories of nursing and the therapeutic and social work staff. The focus of the discussion and analysis is therefore on these relationships.

In contrast to the direct caregiving nursing staff, the core and peripheral multidisciplinary professionals were very broad and inclusive in their approach to their work and teamwork. Instead of talking about the tasks that they performed or the work that they did, they usually talked about their role. Further, they had considerable control over their work. A s one noted, ' . . . and I was always able to do . . . what I’ve done and there’s no one breathing down your neck to say “Well, why aren’t you doing this, and . . . why don’t you try that?” ' (HCP 22). They got considerable personal satisfaction from their work and viewed their work as part of their social identity. A s the same therapist commented, ‘I think it’s either a field for you or it’s not. It’s not a job’ (HCP 22).

When discussing the team, the multidisciplinary professionals differentiated between themselves and nursing, but they tended not to differentiate between the direct caregiving nursing staff and supervisory nurses, usually referring to nursing as a whole. Like the direct caregiving nursing staff, whoever helped to get the work done was the criterion for who the multidisciplinary professionals defined as part of the team. However, they defined the team quite broadly because, due to the nature of their work, they needed the input and cooperation of many others. They had complex role-sets. They were linked to individuals who were different from themselves in that they belonged to different professional groups, and, in the case of the
Peripheral professionals, might work with a number of different teams. The had more extensive responsibilities vis-à-vis the organisation, plus complex work tasks that required more integration and planning and therefore input from a variety of other health professionals. In addition, they needed nursing to fulfil their work requirements. For example, if the dietitian had the responsibility of ensuring that a patient was adequately nourished, she needed the skills and cooperation of others to do her work. She might need a complete medical workup to plan the appropriate diet, she might need assistance from speech-language pathology, OT and PT to assess swallowing difficulties, and she would need the nursing staff to ensure that the patient takes in the food that was provided. She defined the team extensively to include all the multidisciplinary professionals and the nursing staff because she needed all these staff to help her to get her work done.

The core multidisciplinary professionals felt very much a part of the team. Even the physicians who had little interaction with the others on a day-to-day basis felt part of a team because they attended and usually chaired team rounds. This sense of belonging was an important aspect of teamwork for the core professionals and was incorporated into their social identity. One said, ‘It’s just easier being part of a team, you’re not alone. . . .’ (HCP 15). These multidisciplinary professionals had an organic conceptualisation of teamwork. For example, one said:

I think that being part of the team enables me to share my expertise and knowledge with them and the knowledge and expertise of the other disciplines, especially nursing, medicine and recreation. That certainly makes it easier and more effective when you’re dealing with impaired residents and the family. HCP 23

The peripheral professionals had similar values about the importance of teamwork to the core professionals because they had had similar professionalisation to teamwork, worked autonomously and had similarly complex role-sets. As one commented about being part of a team, ‘. . . and a sense of belonging, your part of the job is just as important as somebody else’s’ (HCP 11). However, their perceptions differed, depending on whether they were included in the team meetings and team decision-making. Those that were included felt engaged in teamwork with the other multidisciplinary professionals. They felt part of the team and were satisfied with being involved in decision-making when appropriate. As one said:

I don’t think we have to be (part of the decision-making) unless there’s something that’s just come through from a family member that we think is important for the team to know. HCP 11

The structure of the team that excluded the direct caregiving nurses, despite their importance to the work of the team, included these peripheral professionals whose work is comparatively incidental.
In contrast, some of the peripheral professionals were not included in team meetings and did not feel part of the multiprofessional team. They described how they were still struggling to be accepted by the team and to gain cooperation for their ideas. As one said:

... how you introduce those new ideas to the unit, the vehicle has to be the team. How it's presented, it's really important that the individual have a good rapport with the team. HCP 5

For these peripheral professionals, issues of support and cooperation took on very different connotations because they had difficulty getting them both from the core professionals and the nursing staff. They were not alienated from their work, but they were not engaged in the team because they were excluded by the structure of the team. However, unlike the direct caregiving nursing staff, these peripheral professionals were not accepting their exclusion, but described how they were actively working towards being part of the team. In the case of the recreation therapists in the Home for the Aged, they had been successful. One of the recreation therapists described how they achieved team membership:

When I first started working here, there were a lot of meetings that didn't involve recreation and after a year, I kind of recognized this, and I used to just sort of crash a meeting, because if they were interviewing a new resident for the floor, and they were telling them about daily events, and recreation is such an important part of their life in the home, then why wouldn't I be there? So one by one, the recreationists on all the floors started crashing into meetings and now it's just expected. We expect it of ourselves. HCP 22

The difference in the responses of the peripheral professionals and the direct caregiving nurses to their exclusion from the team reflects the peripheral professionals' lack of alienation from their work and their differential access to social resources. They shared similar values with the core professionals about teamwork and valued participation in the team. They were also well educated and confident of their abilities and potential role on the team. Further, they had complex role-sets that gave them the opportunity to interact with others who were unlike themselves, and that linked them as a group to a variety of resources within the organisation. They had been able to maximise on these resources to achieve positions of power within the team.

The core and peripheral professionals were engaged in teamwork that involved problem-solving and decision-making with other multidisciplinary professionals and the supervisory nurses. For the core professionals and, increasingly, the peripheral professionals, the structure of the team reflects the ideology of collaborative teamwork in that they work with others in a...
non-hierarchical manner, attending team meetings and participating in
team decision-making. Even those peripheral professionals who were
excluded from team decision-making shared similar values about teamwork
and were actively trying to enhance their position within the team. All the
multidisciplinary professionals therefore have an organic conception of
their work and of teamwork.

The supervisory nurses
The supervisory nurses were in an interesting structural position in that
they were the link between the direct caregiving nursing staff and the multi-
disciplinary professionals. They were the conduit through which informa-
tion was passed between the two other groups. This intermediary position
was reflected in their orientation to their work and to teamwork.

The supervisory nurses had a more inclusive view of their work than did
the direct caregiving nursing staff and, when talking about their work,
referred to their role. A s one of them commented,

My role is everything [she laughs]. A s a caregiver, as a person who
delegates, as an advocate for patients – an advocate for nurses as well.
RN 1

Despite this broader vision of their work, in comparison to the multidisci-
plinary professionals, the majority of the supervisory nurses were ritualistic
when they talked about their work. They tended to be quite concrete and
talked more about what they did, rather than why they did it, or the human
implications of what they did. Like the multidisciplinary professionals, they
defined the team as including both nursing staff and multidisciplinary pro-
fessionals, although they also clearly differentiated between the two.

Unlike the direct caregiving nursing staff, the supervisory nurses defined
the team broadly because, like the multidisciplinary professionals, they
needed the wider team to help them to get their work done. They had more
complex role-sets than the direct caregiving nurses in that they interacted
with the multidisciplinary professionals as well as the nursing staff. Their
work was more complex, requiring more input and information to be com-
pleted. A s the RN quoted above continued:

And I use all of the team members . . . I make sure I do . . . so I don’t see
a negative thing with the team members, it’s all positive because I get the
help that I need. RN 1

These supervisory nurses saw themselves as somewhat apart from both the
direct caregiving nursing staff and the multidisciplinary professionals. They
referred both to the direct caregiving nursing staff and the multidisciplinary
professionals as ‘they’, although they used ‘we’ when referring to nursing
overall. This terminology reflects their paradoxical structural position in
the team. On the one hand, they were at the top of the nursing hierarchy; on the other hand, they were interacting with the less hierarchical multidisciplinary professionals. They were engaged in two different kinds of teamwork, depending upon with whom they were interacting.

This separation of the supervisory nurses from both the direct caregiving nursing staff and the multidisciplinary professionals reflects their linking position in the structure of the team. It is similar to contradictory class locations within a mode of production in which professionals are simultaneously in two different classes (Parkin 1979, Wright et al. 1982). The supervisory nurses shared some characteristics with the multidisciplinary professionals and direct caregiving nursing staff but they were not distinctly part of either group. They were in a contradictory structural location which was reflected in the way that they talked about teamwork.

When talking about teamwork with the multidisciplinary professionals, the supervisory nurses reflected some of the ideology about collaborative teamwork and how being part of a team improved the way that they did their work:

... and sometimes you're right and sometimes you're not right, so you try to work together the best way because who is going to benefit in the long run? It's the patient who you are working for – it's not for you. RN 12

However, when they were talking about teamwork with the direct caregiving nurses, they usually referred to how it helped to get the work done, with little reference to improving the quality of the work.

Unlike the direct caregiving nursing staff, the supervisory nurses were not alienated from the larger multiprofessional team by the structure of the team. They were included in team decision-making and had a more organic conceptualisation of their relationship to the team.

You know, in this kind of work, in this kind of profession, you need support. And when you feel ... that your colleagues support you, you feel good about it. RN 4

Because of their linking position in the teams, the supervisory nurses, and in particular the Head Nurses, are key to determining how the teams function. According to the structural perspective, persons occupying linking positions should have the most power in the team because they control the flow of information between the other members of the structure (Rogers and Kincaid 1981). They are key not only because of their potential power and influence, but because the quality of their interpersonal and communication skills can greatly influence team functioning. As one of the multidisciplinary professionals recalled:

... particularly the Head Nurses I think are key to all this process. I've had head nurses who really don't like that kind of communication and
also are very turf-oriented, you know, ‘This is nursing and no, there’s no point in discussing it with the whole team because it’s a nursing sort of thing.’ HCP 17

The Head Nurses’ power extended to control over who was included in the team. One of the peripheral professionals struggling for acceptance in the team commented:

I think if you talk to the other professional staff you’ll find that they say that the Head Nurse is key to whether or not you’re accepted. If you get along with the Head Nurse you’re okay, if you don’t you won’t be included [in the team]. HCP 30

The contradictory structural location of the supervisory nurses reflects the historical development of the nursing profession in Canada and its struggles to achieve and maintain professional status. Simultaneous to nursing achieving heightened professional status through registered status around the time of the Second World War was the introduction of other categories of nursing staff (Brown 1982). To maintain their professional status, RNs used teamwork in two ways: a collegial model to enhance their professional partnerships with medicine; and a group nursing model to maintain control over lower status nurses.

The structure of the team ensures the control of the division of labour in health care in terms of manual and intellectual, or dirty and clean work (Goffman 1959, Hughes 1971) by the higher status professionals (Cott 1997), and in particular, the higher status nurses. In long-term care, clean work is associated with therapeutic and decision-making work, while dirty work is associated with the basic manual tasks involved in patient or people work (Goffman 1959). The exclusion of the direct caregiving nurses from the team meetings, and therefore from team decision-making, perpetuates the supervisory nurses’ status in the team and their control over nursing-related decision-making. The supervisory nurses have effectively used the notion of teamwork in nursing to perpetuate their control over lower status nurses similar to the way that medicine has tried to use teamwork as a way of maintaining control over the other health professions. At the same time, their importance in nursing decision-making ensures their status with respect to the multidisciplinary professionals who need nursing to get their work done.

Meaning, structure and team function

Differences in meanings of teamwork for staff in different structural positions are reflected in how the team functions and perpetuate the ‘we decide, you carry it out’ division of labour within the teams. The notion of teamwork is important to maintaining this social order, but it is limited in this function by the differing meanings of teamwork held by staff.

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Team members are considered to be dependent on each other for the provision of care to complex, multi-problem institutionalised elderly individuals. At the same time, the direct social contacts that occur within teams promote social integration as well as socialisation of new team members. Interdependence, the crux of teamwork, refers to workers sharing distinctive values or interests that unite them, or to performing complementary functions that make them interdependent (Blau 1972). The process of social integration of individuals in a large collectivity involves direct social contacts in small groups. The notion of teamwork serves both functions.

These functions of teamwork are important in a professional locale in which professionals have little authority over each other and must negotiate their relationships with each other (Strauss et al. 1963). Common to all the descriptions of teamwork by the multidisciplinary professionals and the higher status nurses is the way that negotiation and compromise are key to cooperation within the team.

The organic orientation to teamwork held by the multidisciplinary professionals and, to a certain extent, by the supervisory nurses reflects the ideals of collaborative teamwork, as espoused in the literature, that are key to promoting cooperation amongst disparate groups of health professionals who are working together without clear lines of authority over each other. It is a means of social control. The rubric of teamwork provides the justification and rationale for staff cooperating with other disciplines. Because they feel that they are part of a team, the multidisciplinary professionals and supervisory nurses feel obliged to try and work things out with other disciplines instead of proceeding independently. As a supervisory nurse said:

Sometimes you agree and [sometimes you] disagree, but you have to take into consideration it’s the welfare of the patient and so you can’t be dogmatic and say this is what I think, I’m not going to change . . . We have to work together. RN 12

The ideology of collaborative teamwork works as a social control for the multidisciplinary professionals and supervisory nurses because they share aspects of an organic orientation to teamwork. The structure of the team, when they are interacting with each other, reflects the ideology of collaborative teamwork. However, interaction becomes more problematic when it involves the direct caregiving nursing staff.

The meaning of teamwork shared by the multidisciplinary professionals and supervisory nurses has little meaning for the direct caregiving nursing staff because the overall structure of the team does not reflect the ideology of teamwork – egalitarian, cooperative decision-making. The multidisciplinary professionals’ roles may be to make decisions and recommendations about care and treatment plans, but their job is not complete until these decisions or plans are implemented. Invariably, implementation of their...
patient-related recommendations involved the direct caregiving nursing staff. As one of the multidisciplinary professionals said:

And I use the nursing team to input my recommendations and that's probably the hardest part of my job – just getting my recommendation implemented. R N 30

French and Raven (1968) described five bases of social power: expert power through expertise and knowledge; legitimate power through authority and position; reward power through positive reinforcement; coercive power through adverse stimuli and punishment; and, referent power through identification and modelling. Medicine has both expert and legitimate power, however, the multidisciplinary professionals only have expert power. They have no direct, supervisory authority over the nursing staff. Making a decision and having the authority to ensure that the nursing staff carry it out is one thing – making a recommendation and having the nursing staff follow through on it is another. Because they are not part of the decision-making, the direct caregiving nursing staff may not subscribe to the multidisciplinary professionals' goals. As one nurse commented:

Because nursing is often the vehicle to get things done so how it is presented is very critical. I don't want to be told that I have to do this, this, this, especially if I don't see a need for it - we've been doing this all along, why do we have to change? R N 5

The basic assumption of the negotiated order perspective (Strauss et al. 1963) is that all occupations wish to control the conditions of their work as much as possible. Since much of the work in health care is patient-centred, much of the negotiation occurs in this context. Negotiation implies that all actors, even in the lower echelons, have power, but, what are the sources of this power? Other studies of health care workers have highlighted how occupational groups are able to control the conditions of their work by ignoring or modifying orders (Roth and Eddy 1969) and/or by controlling knowledge and information (Rosenthal et al. 1980, Roth 1963, Mechanic 1962). Usually, lower status participants use these structures when they consider the orders of higher authority to be illegitimate (Dingwall and McIntosh 1978).

Despite their subordinate position in the hierarchy, the direct caregiving nursing staff were able to exert some control over their conditions of work. Simply giving orders and expecting them to be carried out did not work for the multidisciplinary professionals because they had no authority over the nursing staff, and even if they had, the nursing staff had ways of undermining what orders they received. As one therapist commented:

... and they [the nursing staff] can really sabotage what you're doing [she laughs] if they don't understand why the specific diet's recommended. HCP 30
Even the supervisory nurses, who do have legitimate power through their supervisory authority over the direct caregiving nursing staff, found that giving direct orders was not always sufficient to gain cooperation. All of them described instances in which they had had difficulty obtaining the cooperation of the direct caregiving nursing staff.

The implications of these negotiations within the ‘we decide, you carry it out’ chain of command are fragmented patient care and problematic interactions with patients and families. Because their authority was not sufficient to ensure cooperation, the supervisory nurses had tried to use teamwork to ensure that they got the cooperation that they needed to get their work done. They were sometimes successful in their attempts to promote teamwork with the direct caregiving nursing staff because they were able to help the direct caregiving nurses with their work tasks.

The multidisciplinary professionals also tried negotiation and compromise to gain the direct caregiving nursing staff’s cooperation as described by one therapist:

R. . . . I would maybe suggest something to the nurses at first and then just see that it wasn’t being followed through and basically I would see that it just wasn’t of any use to try and approach them in that way. I. So what do you do now? R. So now when I do demonstrate I . . . let them . . . take control like, allow them to make more of the decision. But I find that works better and then that way they do do things [she laughs]. HCP 15

There are structural limits on the direct caregiving nursing staff’s sources of power. The mechanism by which the structure of the teams reinforces the power differentials within the teams is role-set. Complexity of role-set is associated with differing degrees of alienation, different approaches to conflict management, different work orientations and differential access to social resources. Mechanic (1962) argues that the sources of power of lower status participants are access to information, persons and instrumentalities. By excluding lower status participants from access to knowledge and to persons different from themselves the structure of the teams limits the power of the direct caregiving nurses and maintains the control of the higher status professionals, particularly the supervisory nurses.

The paradox is that while the integration of the direct caregiving nursing staff is important for their cooperation, the structure of the team works against this happening by excluding the lower status staff from any formal participation or membership in the team. Because the direct caregiving nursing staff are alienated from the larger multiprofessional team and have a ritualistic understanding of teamwork, the multidisciplinary professionals have to spend much of their time trying to counteract the effects of the structure as they try to gain the cooperation of the direct caregiving nursing staff.

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Discussion and conclusions

Has the supposed flattening of the hierarchy in the health care division of labour through multidisciplinary teamwork resulted in less alienation of staff? These findings indicate that the hierarchy in health care has been flattened for a few higher status professionals but remains for the lower status workers, for whom alienation from work and teamwork remains an issue. The alienation of these workers represents an unanticipated consequence of teamwork. Anticipated and unanticipated consequences of the team’s structure are similar to Merton’s manifest and latent functions in which: manifest functions refer to ‘those objective consequences for a specified unit . . . which contribute to its adjustment or adaptation and were so intended’; and latent functions refer to ‘unintended and unrecognised consequences of the same order’ (1968: 63).

The anticipated consequence of teamwork is that the hierarchy in the health care division of labour is flattened. As it flattens, it becomes necessary to establish some means of ensuring cooperation among groups of health professionals with disparate resources and goals. The ideology of teamwork functions to promote cooperation and collaboration and prevent the lack of cooperation that could occur among disparate professionals.

The function of teamwork ideology is successful when the structure of the team echoes the ideology; however, the structure of teamwork is not always what it is purported to be in the literature. The structure of the team is both an outcome of the health division of labour and a factor in the reproduction of that division of labour. By reinforcing status differentials within the team, the structure allows certain higher status team members to maintain control over the division of labour through their complex role-sets which are associated with greater power and influence. The staff members in higher levels are able to maintain their dominant position whereas the lower level staff members have fewer resources and opportunities to change their status.

The unanticipated consequence of teamwork is that, if the structure of the team does not reflect the ideology of egalitarian, cooperative teamwork, it can promote alienation from teamwork in lower level staff who are key to the implementation of the decisions made by the higher status professionals. Just as medicine supported the notion of teamwork in order to ensure the cooperation of subordinate professions, now these professionals find themselves having to promote more collaborative teamwork for the lower status staff with whom they interact in order to accomplish their goals. However, in order to achieve the kind of teamwork that the higher status professionals profess to desire, the structure of the team would have to change to allow for more equitable or meaningful participation in decision-making for all staff, and therefore a more similar orientation to teamwork for all team members.
Do definitions of health care teamwork espoused in the literature reflect the day-to-day interactions in multidisciplinary long-term care teams? The answer is equivocal. Not all staff are included in the type of egalitarian, cooperative teamwork described in those definitions. For those who are, the ideology of teamwork for the benefit of the patient prevents the potential splintering, factioning and lack of cooperation that could occur among the disparate professionals. However, the ideology of teamwork is not always successful in this function because it is not always reflected in the structure of teamwork. The findings of this study provide further evidence that not only do team members not share understandings of roles, norms and values, they do not share similar meanings of teamwork. Although professional affiliation may provide part of the explanation for these differing meanings of teamwork, structural position, particularly when resulting from differential involvement in different types of teamwork, is an important consideration. As multidisciplinary health care teams continue to diversify, and as more layers of ‘cheaper’ subordinate staff are brought in to perform tasks traditionally performed by higher status professionals, it will be increasingly important to consider whether the structure of health care teams is appropriate and supports their supposed functions.

This study sheds a different light on multidisciplinary teamwork from the traditional notions of health care teams in which the physician is head of the team, supported by an egalitarian, cooperative group of health care professionals. Instead, the balance of power is not clear-cut. The higher status professionals, who supposedly have the most power, are limited in that power by the ability of the direct caregiving nurses to exercise control over the conditions of their work. The supervisory nurses emerge as potentially having the greatest power and influence in the teams, although this is not formally recognised in the organisation. The supposedly functional division of labour in health care in which the higher status professionals make decisions that are carried out by lesser trained workers is actually dysfunctional in that it perpetuates a structure which produces alienation in those lower level staff, resulting in potentially fragmented and less than optimal patient care.

These findings suggest a number of important questions with implications for research, policy and clinical practice. Does the structure of teamwork differ in other settings with different organisational structures? This study was conducted in a geriatric long-term care facility where arguably multidisciplinary teamwork has evolved to a greater extent than in acute care. Further, the model of nursing in this setting was a group nursing model. Would a setting in which nursing operates under a primary nursing model facilitate involvement of all nursing staff in team decision-making and facilitate more interaction between the multidisciplinary professionals and the direct caregiving staff? With the shift to programme management, many multidisciplinary professionals are now reporting directly to a nursing supervisor. How has this affected the structure and hierarchy in teams?
This study has only scratched the surface in terms of understanding all that there is to know about health care teams. However, it reinforces the findings of other studies that indicate that health care teams represent complex sociological phenomena that merit closer examination if we are better to understand multidisciplinary teamwork and maximise its effectiveness.

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