Interdisciplinary Health Care Teamwork in the Clinic Backstage

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ABSTRACT  A long-term ethnography of an interdisciplinary geriatric oncology team at a regional cancer center revealed the existence and importance of backstage communication that occurred outside of team meetings to the enactment of teamwork. Seven inductively derived categories describe the communication involved in backstage teamwork in the clinic: informal impression and information sharing; checking clinic progress; relationship building; space management; training students; handling interruptions; and formal reporting. The centrality of backstage communication to caring for patients is explored, and a view of embedded teamwork is proposed, extending upon the bona fide group construct. The study provides a valuable complement to controlled studies of group decision-making through its focus on dynamic communication outside of meetings among dyads and triads of team members in a web-like organization and extends bona fide group theory.

KEY WORDS: Interdisciplinary communication, teamwork, backstage communication, health communication, geriatric team, health care organization, bona fide group

Contemporary health care organizations increasingly rely on interdisciplinary teams for comprehensive diagnosis and treatment of patients (Cott, 1998), particularly in the field of geriatrics (Wieland, Kramer, Waite, & Rubenstein, 1996). By far, the majority of studies of health care teams have sought to establish a correlation between team intervention and measurable patient outcomes. Interdisciplinary teams improve overall care for patients (Cooke, 1997; McHugh et al., 1996) and correlate with specific outcomes such as: decreased length of hospital stay (Wieland et al., 1996); better coordination of patient care (McHugh et al., 1996); fewer nursing home admissions following hospitalization (Zimmer, Groth-Junker, & McClusker, 1985); and decreased mortality one year after discharge (Langhorne, Williams, Gilchrist, & Howie, 1993). Teams improve training of students in medicine and allied health disciplines, as well as enable veteran staff to learn from each other (Abramson & Mizrahi, 1996; Edwards & Smith, 1998) and promote job satisfaction for team members (Gage, 1998;
Resnick, 1997). Despite evidence of positive effects of teams on patient outcomes and employee satisfaction, we know relatively little about how health care teams communicate in daily practice (Opie, 2000). Critics of team research argue that despite correlations between use of teams and favorable outcomes, the effectiveness of team communication is often in doubt:

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 efforts of shared, cooperative decision-making are of greater benefit to the patient than the individual effects of the disciplines on their own. (Cott, 1998, p. 851)

Research often fails to support the first two assumptions, and the third is unlikely to come true without the others in place. Much team research is “anecdotal, exhortatory and prescriptive...there is an absence of research describing and analyzing teams in action” (Opie, 1997, p. 260).

This study uses ethnographic methods to examine a bona fide team in order to understand more fully how teamwork is enacted through communication. Bona fide groups occur naturally in organizations and are “characterized by stable yet permeable boundaries and interdependence with context” (Putnam & Stohl, 1990, p. 248). I focus on dynamic teamwork in the clinic backstage, those regions off-limits to patients (Goffman, 1959).

**Health Care Teams**

Health care teams have fostered and formalized collaboration among members of different disciplines, particularly in the field of geriatrics (Lichtenstein, Alexander, Jinnett, & Ullman, 1997). Increased specialization contributes to the need for collaboration among experts from different specialties (Cooley, 1994; Satin, 1994). Geriatric teams are designed to meet the needs of elderly patients through comprehensive assessment and intervention (McCormick, Inui, & Roter, 1996). Assessment and coordination of services are especially important for older patients because this population is more likely than others to experience complex interactions of medical, psychosocial, and material circumstances (Siegel, 1994; Stahelski & Tsukuda, 1990).

Composition, organization, and functioning of teams vary widely among institutions, specialties, and services provided. Scholars of teamwork use differing terminology but generally represent teamwork as existing along a continuum of collaboration. Representing one end of the continuum, Jones (1997) defines multidisciplinary collaboration as “a multimethod, channel type process of communication that can be verbal, written, two-way, or multiway involving health care providers, patients, and families in planning, problem solving, and coordinating for common patient goals” (p. 11). Members of multidisciplinary teams work toward common goals but function largely independently, relying on formal channels (e.g., memoranda, meetings) to keep others informed of assessments and actions (Satin, 1994). Moving along the continuum toward interdependency, Wieland et al. (1996) define interdisciplinary teams as working interdependently in the same setting, interacting both formally and informally to achieve a significant degree of coordination and integration of services and
assessments. Some role shifting and evolution may occur over time (Schmitt, Farrell, & Heinemann, 1988). In some cases, interdisciplinary teams evolve into transdisciplinary teams, in which “members have developed sufficient trust and mutual confidence to engage in teaching and learning across disciplinary boundaries” and comfortably sharing their “turf” as they work toward common goals (Wieland et al., 1996, p. 656). At their best, teams are synergistic, enabling high quality patient care and a high level of job satisfaction (Pike, 1991).

Effective communication is crucial to teamwork but often lacking (Abramson & Mizrahi, 1994; Gage, 1998). Negotiation of overlapping roles and tasks may be difficult because of territorial behavior; each team member must sacrifice some autonomy for the group to function (Sands, 1993). Role confusion, overlapping responsibilities, and other disciplinary factors can inhibit teamwork (Berteotti & Seibold, 1994; Sands, Stafford, & McClelland, 1990); successful negotiation of boundaries is a hallmark of well functioning teams (Sands, 1993). Additionally, the ideology of teamwork often is not accompanied by egalitarianism. Despite recent changes in medical organizations, physicians remain firmly ensconced as team leaders and administrators, with the majority of the high ranking physicians being (white) men and the vast majority of the lower status professions (e.g., nurses and social workers) being women (including women of color) (Cowen, 1992; Wear, 1997). The power disparity can cause a great deal of resentment and impede successful collaboration (Lichtenstein et al., 1997). Perceptions of teamwork effectiveness vary significantly between prestigious highly paid positions of physician and administrator and relatively low ranking positions, such as nurses (Cott, 1998; Griffiths, 1998).

**Backstage of Health Care**

Much teamwork among health care professionals takes place in the backstage of the health care system. Goffman (1959, p. 112) defines the backstage region as a place, relative to a given performance, where the impression fostered by the performance is knowingly contradicted . . . It is here that the capacity of a performance to express something beyond itself may be painstakingly fabricated . . . illusion and impressions are openly constructed. Here stage props and items of personal front can be stored in a kind of compact collapsing of whole repertoires.

Atkinson (1995) points out health care researchers have focused the vast majority of research and theorizing of the medical practice on the frontstage of medical care—physician-patient interaction. The predominance of this focus has led to certain limiting tendencies in research. One is the relative lack of problematizing of discourse among health care practitioners that occurs away from patients. Second is a largely unreflected upon preference for bounded communication episodes. Physician—patient interactions are generally very brief, take place in a single, private location, and are easily recorded and transcribed (Atkinson, 1995). Such manageable episodes influence scholars to think of medical interactions as spatially and temporally bound.

Empirical work on health care teams clearly reflects this preference for bounded, convenient chunks of communication in its focus on formal meetings. For example, Opie’s (2000) otherwise excellent study of health care teams in New Zealand centered on team meetings and excluded joint work between team
members that occurred outside of meetings, positing that such work was only relevant to teamwork to the degree to which it was discussed within team meetings. Researchers’ focus on meetings as the site of teamwork also reflects a privileging of formal, public (masculine) discourse over informal, more private (feminine) forms of discourse (Meyers & Brashers, 1994). Meetings have agendas, leaders, systems of turn-taking, and other norms associated with public communication, fitting naturally within researchers’ existing schemas for teamwork. Such beliefs and preconceptions reflect a white, middle-class, male bias in communication research (Wyatt, 2002). Moreover, studies of meetings have traditionally focused on decision-making as the crucial task of groups (Barge & Keyton, 1994). Topics such as cooperation, socialization, and connection have been marginalized, socially constructing current conceptualizations of how communication operates in small groups (and teams) that are inherently gender-laden (Meyers & Brashers, 1994).

My extensive interaction with one geriatric team suggests that backstage communication in the clinic is crucial to accomplishing teams’ patient care goals. Using a bona fide group perspective, I sought to uncover ways in which team members engaged in teamwork outside of meetings, addressing the following research question: What are the communication processes among team members in the clinic backstage?

Method

Setting and Participants

This study of communication in the clinic backstage is part of a larger ethnographic study of communication within an interdisciplinary geriatric oncology team at a regional cancer center in the southeastern US (Ellingson, 1998). The clinic team included two oncologists (one of whom was the team’s director; only one oncologist was in the clinic at a time), a nurse practitioner, a clinical pharmacist, a registered dietitian, two registered nurses (each assigned to one of the oncologists), and a licensed clinical social worker. During the study, the disciplines represented on the team remained constant, but personnel changed: the nurse practitioner, dietitian, and social worker each resigned and was replaced by a candidate already working within the cancer center in another capacity. The introduction of a known member made the transition into the team relatively smooth; only brief explanations at team meetings functioned as overt attempts to socialize new members. Team members worked in clinic space that they shared with health care providers in separate diagnostic areas unrelated to the geriatric program. Clinic nursing assistants escorted patients to rooms and recorded their vital signs for all programs, including the geriatric team.

All new patients over the age of seventy were seen by the geriatric team on their first visit to the cancer center for a comprehensive geriatric assessment. Virtually all patients were accompanied to their visit by one or more companions (e.g., spouses, adult children) who also participated in the interactions (Ellingson, 2002). The visit structure was as follows. After recording of vital signs by a clinic nursing assistant (not considered to be part of the team), a registered nurse conducted an orientation to the comprehensive geriatric assessment. Then, in order of team member availability, the nurse practitioner took a medical history
and conducted a physical exam; the dietitian screened for malnutrition, dehydration, eating difficulties, and use of nutritional supplements; the social worker screened for depression and cognitive deficits and discussed psychosocial well-being of patients; and the pharmacist screened for polypharmacy and potential drug interactions. At a given time, three patients occupied examination rooms, and team members cycled through the rooms, communicating with each other in the hallways and desk area. The dietitian, social worker, and pharmacist then reported their findings and interventions to the nurse practitioner, who in turn reported the results of her history taking and exam, along with selected aspects of others’ findings, to an oncologist. An oncologist, accompanied by the nurse practitioner, saw each patient and made treatment recommendations. Finally, a registered nurse discharged patients, providing prescriptions and instructions. The process typically took two to three hours. I documented this process through ethnographic field notes, transcripts, and interviews.

Data Collection

Ethnographic field notes. I assumed the participant-as-observer position in my fieldwork (Lindlof, 1995), spending three to five hours, one day per week in the new patient clinic and one hour per week in team meetings of the interdisciplinary geriatric oncology team. Clinic observation was conducted weekly from September 1997 through December 1999. With permission, I observed interactions among patients, companions, and team members; helped with minor tasks (e.g., getting patient a glass of water); relayed messages from one team member to another; offered information if requested by a team member (e.g., explained which team member was with a patient); participated in team members’ discussions about patients (e.g. listening to their opinions and offering my own opinions of patients’ or companions’ affect); engaged team members in discussions about their personal lives and careers; and talked with patients and their companions, particularly when there was a long wait before they saw the oncologist. In the clinic, I kept a notebook or a palm top computer at the desk area, in which I wrote brief notes. Immediately after observing, I typed extensive fieldnotes, producing more than 300 pages of text.

Transcripts. To supplement the field notes, I completed and transcribed nine sets of audio-recordings of initial patient visits from May through July 1999. I selected initial patient visits because initial visits were the only time that patients interacted with the entire team, and hence the primary time in which team members communicated in the backstage as they completed the comprehensive geriatric assessment of patients. The recordings enabled me to discern how backstage communication among team members both resulted from and contributed to communication between team members and patients. Following an Institutional Review Board approved protocol, I approached patients in the waiting room and invited them to participate. I was present during the interactions in order to monitor equipment. Except for a few times when directly addressed by patients or companions, I did not participate in the audio-taped interactions. Each set of recordings included interactions between a patient, his or her companion(s), and each of the team members in turn, for a total of seven interactions per patient (patients saw the registered nurse both upon arrival and
upon discharge, and had one interaction each with the oncologist, dietitian, nurse practitioner, pharmacist, and social worker). The interactions were transcribed using transcription guidelines developed specifically for medical discourse (Waitzkin, 1990).

**Interviews.** As a feminist researcher conscious of the power disparity between researcher and researched (e.g., Reinharz, 1992), I wanted the team to have an opportunity to provide feedback on my preliminary findings. I asked team members to participate in interviews; six of the current team members consented (all the clinic staff except the pharmacist with whom I was unable to schedule a meeting). I also interviewed the nurse practitioner who is no longer with the team but who was my primary informant for the first year of observation, a founding member of the team who continued to substitute occasionally for the current nurse practitioner. Semi-structured interviews (average length = 60 minutes) elicited team members’ perceptions of backstage communication and feedback on my findings (see interview schedule in the Appendix).

**Data Analysis**

Charmaz (2000) revised Glaser and Strauss’ (1967) classic method of grounded theory, moving it from a positivist to a social constructivist framework. Charmaz explains that researchers can “form a revised, more open-ended practice of grounded theory that stresses its emergent, constructivist elements” and eschews positivist claims of objectivity (p. 510). I followed the steps of traditional grounded theory research outlined by Strauss and Corbin (1990) and Charmaz (2000): coding data, developing inductive categories, revising the categories, writing memos to explore preliminary ideas, continually comparing parts of the data to other parts and to literature, collecting more data, fitting it into categories, and noting where it did not fit and revising the categories (theoretical sampling). To develop categories of communicative processes, I compared interactions in the fieldnotes and transcripts, noting similarities and differences in content and structure of interactions among team members as they communicated in the clinic backstage. I developed preliminary categories based on similarities I observed across interactions and continually refined the typology as I reread notes and transcripts, using constant comparative analysis (Charmaz, 2000). I further explored categories and subcategories of communication processes by explicating relationships among the processes and their context, conditions, and consequences in the communication I observed (paradigm model).

At the same time, I was aware of the constructed nature of knowledge and the influence of my own positionality on my findings, as Charmaz recommends. Reflexive consideration of my own role in data gathering and analysis enhances “theoretical sensitivity,” or “an awareness of the subtleties of meaning of data” (Strauss & Corbin, 1990, p. 41). Specifically, my sensitivity to the complex meanings of fieldnotes and transcripts was influenced by my familiarity with literature on team communication and communication theories, lengthy interaction with my data, and my own experiences as a cancer patient. After determining a preliminary typology, I obtained team members’ feedback in interviews, which informed the final results (Reinharz, 1992). Through careful data gathering and documentation, systematic analysis, reflexive consideration of my own
positionality, and inclusion of participants in generating results, I met Fitch’s (1994) criteria for rigor and validity in qualitative research.

Results

In the following section, I explore backstage categories of communication individually for ease of discussion. However, the communication categories are interdependent and often overlap or occur simultaneously, rather than discretely. The following seven inductively derived categories describe the communication involved in daily backstage communication among team members: informal impression and information sharing, checking clinic progress, relationship building, space management, training students, handling interruptions, and formal reporting (see Table 1). Due to space constraints, I have selected an excerpt of the data to serve as an extended example. I will refer to line numbers periodically in the results. All names are pseudonyms.

Data Excerpt

2. “Hi! Thinks—i went on a shopping spree last weekend.” She opened her white
3. lab coat further and tossed her long brown hair over her shoulder so Susan could get a
good look. “I bought two of these dresses in different flowered prints, both long but with
5. short sleeves, very comfortable,” said Ashley.
6. Susan nodded but then shook her head, her brow furrowed with concern. “Have
7. you seen Mr. Walker yet?” she asked abruptly.
Informal Impression and Information Sharing

Informal impression and information sharing involved discussion of patients, patients’ companions, and related topics. This process includes five subprocesses: request for information/clarification, request for opinion, offering of information, offering of impressions, and request for reinforcement of a message. The line between fact and impression is somewhat slippery. Impressions used more emotion and description to accompany information and judgments, whereas information involved more precise, observable facts.

Request for information/clarification. Team members requested a specific piece of information that was missing, in doubt, or a source of confusion. Thus, in the excerpt on line 22, the dietitian requested a piece of information—the timing of the medication—that she needed before speaking with the patient. An unfortunate prompt for this process was when team members discovered that patients or their companions had provided contradictory or inconsistent information; they then questioned each other to resolve disparities. For example, the pharmacist said to the dietitian about a diabetic patient, “I recommended that this man see his primary care physician in regard to testing and controlling his blood sugar. He said he didn’t test it regularly.” The dietitian replied, “He told me that his blood sugar was well controlled, and he tested it twice a day.” Then the pharmacist asked, “Did he say he was taking insulin?” Through questioning each other about the information the patient supplied, the team members determined how best to address the problem.

Request for opinion. Team members solicited opinions on issues such as affect, depression, and patients’ relationships with companions both to obtain confirmation of their own uncertain impressions and to initiate discussions
about patients whose perceived problems could be addressed by one or more team members’ expertise. For example, the social worker collaborated when a patient did not screen at a clinical level of depression, but she sensed distress intuitively. By asking others, “Do you think she is depressed?” she effectively conducted her psychosocial assessment. Another way to request an opinion was to offer an opinion (discussed below) in a clearly questioning tone, inviting discussion. For example, after seeing a patient, the pharmacist said to the nurse, “This patient seemed frightened of her husband?”

**Offering of information.** Specific pieces of information about a patient or a companion were offered to other team members when team members perceived that such information would provide practical assistance to facilitate another team member’s communication with a patient. In the excerpt above (lines 10–11, 16–17), the pharmacist tells the dietitian that a patient’s blood thinner medication levels were unstable and that this was due in part to his diet, an issue the dietitian would be discussing with him. Mentioning that a patient was hard of hearing enabled the team member to be prepared to speak loudly and enunciate carefully. Also, explaining patients’ and companions’ relationships avoided possible embarrassment. For example, a team member once explained that a male patient was accompanied by his sister, since others assumed that she was his wife. In one unusual case, two friends accompanied a woman patient. One was a much younger man, for whom she used to work and with whom she now shared a house. He helped to care for her, but was not related to her, nor were they romantically involved. The man’s cousin accompanied them—a woman who spent considerable time with both the patient and her friend and caregiver. Clarifying the relationships among the patient and her companion(s) enabled team members to better understand the patient’s social support network. Similarly, researchers of a team of medical and educational specialists who provide early interventions to children with disabilities found that passing along pieces of day-to-day information informally helped team members to effectively accomplish their work (Hinojosa et al., 2001).

**Offering of impressions.** Team members offered each other positive or negative impressions, with or without facts to support their judgments. For example, opinions were offered of how patients were sweet, pleasant, sad, angry, uncooperative, or dominated by a companion. In the excerpt, the pharmacist described the patient as “stubborn” (line 18). Offering negative impressions could perform a steam-venting function as much as a collaborative one. Two team members reported in interviews that they expressed frustration over an encounter as much for catharsis as for a desire to facilitate a team member’s subsequent interaction. Venting is an important strategy for coping with stress in health care settings (Laine-Timmerman, 1999). On one occasion, an overbearing husband insisted on answering questions directed to the patient, his wife. The dietitian, social worker, and I expressed to each other how angry we felt at the husband’s behavior. We did this to warn others of what they would encounter, but it was just as important to have our feelings validated by others and relieve
some stress through articulating our anger. Expressing emotions in the backstage (away from patients) assisted team members in controlling their emotional display while in the clinic frontstage, thus preventing team members from disrupting the team’s performance of calm professionalism (Goffman, 1959).

Request for reinforcement of message. This process involved asking a team member to repeat information already mentioned to a patient. Each team member was empowered to do interventions: the pharmacist made recommendations on the timing of drugs, and the social worker advised counseling, for example. In order to encourage patients to act on recommendations, team members asked each other to provide reinforcement, as in the interaction in the above excerpt (line 18) where the pharmacist asked the social worker to repeat her recommendation on the timing of the blood thinner medication. Another example was when patients had difficulty sleeping—due to chronic insomnia, anxiety, pain, or medications—the nurse practitioner or social worker recommended a sleeping aid. If they encountered resistance from patients who perceived sleeping aids as addictive and stigmatizing, the nurse practitioner asked the oncologist to reinforce to patients that sleeping pills are safe and effective when used properly. Team members reported that they believed that repetition increased likelihood that the patients would follow recommendations: “Sometimes it helps when they hear it twice,” the pharmacist stated.

In summary, informal information and impression sharing helped to break down barriers by fostering connections and overlap among disciplinary roles and tasks, moving closer to Opie’s (1997) ideal of transdisciplinary teamwork. At the same time, this process helped facilitate the frontstage performance (comprehensive geriatric assessment) given by team members to patients and their companions by assisting team members in anticipating and resolving problems through backstage discussion away from the audience’s hearing (Goffman, 1959).

Checking Clinic Progress

Checking progress involved asking team members which patients had been seen, and by whom. With so many team and nonteam staff moving through the clinic, it was difficult to keep track of team members’ locations. Team members accomplished such tracking through brief questioning (e.g., “Have you seen Mr. Walker yet?”; excerpt lines 6–7). Checking progress was not one team member’s job; everyone took part. Angry patients or patient companions also prompted checking, as in the case of a patient and her husband who, after waiting over two and a half hours, threatened to leave if the physician did not appear soon. The nurse practitioner checked to make sure that all of the other team members had seen the patient before placating the couple. The long process of assessment exhausted very ill patients, particularly those who had been undergoing chemotherapy or who were in advanced stages of disease. In such cases, team members requested that the nurse practitioner report on and have the oncologist see a particular patient before the others in order to hasten the fatigued patient’s departure. A final motivation for checking progress was that nonphysician team members had competing time commitments and needed to attend to other responsibilities related to other departments or teams.
Checking clinic progress assisted team members in estimating and minimizing the amount of time before they could move on to other tasks. Although not complex, it was vital to keeping the clinic flowing smoothly. Team members valued efficiency not only for making their work easier but also as a kindness to patients.

Relationship Building

Professional and collegial relationships rather than close friendships characterized the team, although team members’ relationships varied significantly, including their relationships with me. Team members had time between patients to communicate about issues unrelated to patients. The nurse practitioner and oncologists typically had less free time than others because the oncologists saw established patients in between the new patients being seen by the entire team, and the nurse practitioner had a lengthier set of tasks and more formal reporting than the other team members. Relationship building also occurred outside of the clinic backstage, as team members encountered each other in other cancer center locations during the course of their work and also in some social situations outside of work. Team members’ non-task-related communication reflected two primary categories: life talk and cancer center troubles talk.

Life talk included discussing such outside interests as families, vacations, house buying, and clothing. While topics of discussion varied over time and changes in team membership, some topics recurred. Team members who had children discussed their progress in school, sports, and other activities, and shared pictures too. The pharmacist led a children’s choir and related humorous stories about choir rehearsal. When the social worker returned from a family emergency leave, team members offered sympathy and support. The pharmacist’s and dietitian’s discussion of clothes is another example (excerpt lines 1–5). Such talk reflects Goffman’s (1959) concept of familiarity, where team members in a frontstage performance assume a level of informality with each other in the backstage that arises from their successful cooperation and may be inconsistent with the frontstage performance, in this case the role of health care professional.

The other primary category of relationship building was cancer center “troubles talk” (Tannen, 1990), which included mild to vehement complaining about scheduling, limited resources, overbooking of patients, overcrowding in the backstage area, and the behavior of clinic staff. One source of annoyance that prompted troubles talk was the scheduling of new patients when one of the oncologists was assigned to conduct rounds for inpatients in the main hospital-building. All cancer center physicians were required to take turns fulfilling this function, even though it interfered with their clinics. The stress level on oncologists’ rounding days was noticeably higher, as indicated by more rushing, less relationship building talk, and impatient tones when handling interruptions. Mild griping, rolling one’s eyes, and expressing fatigue and frustration were typical at these times. Team members repeatedly offered and received affirmation of the difficulty of their circumstances from each other, performing a verbal ritual of griping (Katriel, 1990). For example, “We’re really hectic in here today,” the nurse practitioner said to one of the oncologists as she hurried to
gather materials to report a patient’s case. “I know, it’s crazy, don’t worry,” replied the oncologist. Both the team oncologists made an effort to thank the rest of the team for their hard work and patience on days with rushed schedules, which other team members reported appreciating. Both life talk and troubles talk fostered a sense of connection among team members (Tannen, 1990). Such talk enhanced collegial relations, judging by the initiation of talk among team members.

**Space Management**

Team members shared limited space and resources with each other and with other health care providers whose practice was assigned to the clinic. A significant number of people (one approximately every five minutes) also passed through the clinic on the way to the break room, restroom, or photocopiers, and technicians were frequently paged to the clinic to attend to patients (e.g., conduct an EKG). The number of people in the small space made it virtually impossible to move around without bumping into others or moving into others’ intimate space. Carts of patient charts and equipment also took up room. The noise level became problematic at times as phones rang, the photocopier and printer hummed, and multiple conversations occurred.

Space management involved extensive verbal and nonverbal negotiation. Nonverbal communication included claiming of desk or counter space with charts or other objects, use of facial expressions (e.g., welcoming smile or exasperated frown), pushing past someone, moving (or refusing to move) one’s body to allow another to pass, and vacating when a person of higher status approached a space (e.g., chair) or resource (e.g., phone) (nonphysicians made way for oncologists; administrative assistants vacated space for all other staff). The position of the door between the backstage area and the hallway of examination rooms (frontstage) was a hotly contested issue when certain people were in the clinic. Rather than openly discussing the issue, the door would be repeatedly opened and closed by the staff members according to their preference. It was not unusual for the door to be opened and closed four times in an hour, demonstrating how borders are disputed and negotiated (Goffman, 1959). This is particularly prevalent in service professions, where some team members prefer that the audience not be able to view the backstage, and others prefer ease of movement between the two regions. Verbal negotiation of space included asking how long someone would be using a computer; requesting a seat or space; (oncologists) ordering others to be quiet, move to another area, or reposition the door; and asking to be allowed to pass, as in the excerpt (lines 12–14) where team members verbally consented and moved their bodies to accommodate the technician.

**Training Students**

Another of the team’s communication processes involved training students in medicine, social work, nurse practitioner, and pharmacy. Students shadowed team members initially, and some then conducted interviews with patients. The
team member who was functioning as a mentor for a given period of time (ranging from a day to a month) introduced her student to the other team members to initiate relationships. Training students took time and effort, although competent students in pharmacy, social work, dietary, and nurse practitioner also took part of their mentor’s workload, interviewing one out of every three patients in place of the mentor. Team members met with their assigned students before and after interactions with patients and helped with needed interventions. For example, when a social work student found that a patient needed a referral for community services, the student informed the social worker, who questioned the patient and her companion further and then made the arrangements herself. Social work, dietary, and pharmacy students reported relevant information directly to the nurse practitioner (e.g., drug interaction risk), with their disciplinary mentor observing the report and offering assistance only if necessary. The nurse practitioner students reported on their patients first to the nurse practitioner and then, with her approval, reported to the oncologist. Medical students shadowed oncologists but did not perform any tasks or communicate with patients.

Team members trained students in their disciplines as they carried out tasks, and socialized students into teamwork as they interacted in the backstage. In addition to reporting to the nurse practitioner (or in the case of nurse practitioner students, to the oncologist) students engaged in informal information and impression sharing and relationship building with team members (and me) as we worked and waited in the clinic backstage. In Goffman’s (1959) terms, students experienced both the frontstage performance of providing comprehensive geriatric assessments and the backstage where that performance was dropped in favor of familiarity; they were treated as people in the know and functioned as part of the team.

At the same time, students marked their outsider status by deferring to team members’ higher status, as evidenced by students’ respectful tones, waiting to be acknowledged rather than interrupting an interaction between team members, and actively listening to and carefully following instructions given by their mentors. For example, “I’m ready whenever you are,” a nurse practitioner student said to the nurse practitioner, indicating she had prepared her report and that she would wait for a time that was convenient for her mentor. However, students were treated as trustworthy sources of information and opinions; team members requested information and opinions of students and took seriously information and impressions offered by students, often acting upon them. For example, a student nurse practitioner offered to the dietitian information regarding a patient’s hearing loss; the dietitian responded to the information by speaking loudly and slowly to the patient. Likewise, when a nurse practitioner student reported a patient’s medical history to an oncologist, her report was accepted as the basis for treatment recommendations. Communicating in the backstage with members of other disciplines is valuable because students learn about differences in disciplinary socialization and terminology. Teamwork is increasingly important in health care as managed care decreases reliance on physicians and promotes the roles of other health disciplines to cut costs (Cooley, 1994). Teams are particularly effective at training health care students (Edwards & Smith, 1998). Having engaged in interdisciplinary collaboration
during training, students were better prepared to begin (or advance) their careers.

Handling Interruptions

As in any other workplace, outside concerns intruded. Tangentially related and unrelated tasks were fairly minor interruptions of team members’ work. I distinguish between interruptions, and talk about outside concerns within the team, which I consider part of relationship building. Interruptions were either patient-care related, or personal and family concerns. Such interruptions were unavoidable, and while they could delay patient care or interrupt teamwork, they were handled efficiently. Patient-care related activities included calls or pages from team members’ departments concerning patients who were not part of the geriatric program but who were under their care in other capacities. Team members, except for the director and nurse practitioner, had only part of their time designated for the team. The rest of the time, they worked with their home department or other teams. Thus, for example, while seeing geriatric patients, the social worker received calls that related to discharge planning for patients she served as a member of the psychosocial oncology department. Handling interruptions from other departments and teams overlapped with checking clinic progress; team members checked with others to see when they could finish their current tasks and attend to the other work. Another patient-care related task that interrupted the oncologists and registered nurses was answering telephone calls from community physicians consulting about established patients’ care plans. Established patients also called the registered nurses frequently, who discussed symptoms and requested recommendations from the physicians to address patients’ concerns (e.g., nausea).

Personal and family concerns also interrupted team members. Calls from childcare providers about team members’ sick children and pages by spouses exemplify family concerns. Nonurgent personal messages were left on team members’ voicemail to be picked up at their convenience. Team members did not voice resentment of interruptions caused by other team members’ personal issues, and I did not observe signs of tension between team members when one was handling an interruption. Both oncologists (the highest status team members) reported being sympathetic to the need for parents to balance work with their children’s needs and expressed their understanding to team members. For example, once when the nurse practitioner received a page and had to leave the clinic to collect her sick baby at a day care center, an oncologist smiled and said kindly to her, “Go! Go! It can’t be helped. We’ll be fine.”

Formal Reporting

The final process I identified is the formal reporting of patient information. Team members accomplished such reporting both in writing and through oral communication, and it was both the first and the last aspect of patient care. Written reporting involved reading patient charts and team-specific paperwork
completed by patients and either writing or dictating a clinic note after the patient was seen. Oral reporting of information existed in conjunction with the informal system of information sharing.

**Formal written reporting.** As in all health care settings, record keeping was an essential component of patient care. Preparation for a patient interview involved looking through the chart and, if available, the information provided by the patient on the paperwork sent to patients before their visit. Information from the chart was added to assessment forms (e.g., the patient’s weight was recorded on the malnutrition screening instrument). Team members attended to different types of information in the chart, with the nurse practitioner conducting the most thorough review to obtain medical history and to determine patients’ current stage of diagnosis and treatment. In the data excerpt, the dietitian was reviewing a patient’s chart to learn about his dietary habits, weight, and nutritional level when she was approached by the pharmacist (lines 8–9). She added the information supplied by the pharmacist about blood thinner medication and vitamin K intake to her paperwork (line 19).

Initial gathering of information had a profound effect on how team members constructed images of patients. According to Berg (1996), “the medical record plays an active, constitutive role in current medical work” (p. 501). Charts contain a complex but abbreviated accounting of a patient’s history. Medical records reflect a biomedical assessment of the patient that relies on claims of objective data and systematic objective evaluation; records note very little about how patients feel about their diagnosis, how they are coping, or what the illness means to them (Donnelly, 1988). The record not only represented past events (diseases and medical interventions), but actively shaped the current event by shaping the information team members had, their expectations, and even what blanks needed to be filled in (Berg, 1996). Thus interacting with written accounts affected team members’ views of patients before they met.

After seeing new patients, team members (except the oncologists and RNs) wrote or dictated a note, the second form of written formal reporting. The dietitian, social worker, and pharmacist wrote brief notes on the computer database, while the nurse practitioner dictated the note for her and the oncologist’s visit. This difference in recording medium was due in part to the large volume of information contained within the medical history which the nurse practitioner dictated, as well as her responsibility for dictating some information gathered by other team members, such as the Body Mass Index from the dietitian and the treatment plan developed by the oncologist. The selection and ordering of information determined the official accounts of “what happened,” (Berg, 1996) as in this excerpt of a note written by a social worker.

PT is a 78 YO WWF S/P liver biopsy. She is at [hospital] for evaluation by [team]. Not interested in support groups or counseling. She joined a support group after her husband died but did not find it useful. “I can do better by myself.” She missed 3 of 30 on the mini mental status: She was unable to count backwards from 100. She scored perfectly on the Geriatric Depression Scale. Pt denied any stressors at this time, seemed relatively unconcerned about possible treatment. Writer briefly discussed psychosocial services available at [hospital] and gave business card to PT... Pt is well-groomed with carefully applied makeup. She emphatically answered GDS questions related to happiness.
The sense-making process of choosing details and arranging them directly affected team members’ understanding of their just-concluded interactions with patients. Because team members composed separate accounts, the record generated from the initial visit could contain consistent, somewhat variable, or contrasting views of a patient, depending upon the amount and type of communication among team members regarding the patient. Such disparities were discovered when team members shared their summaries of patients in their weekly meeting, two to three days after the interaction with the patients. If disagreements warranted follow-up with a patient, a team member was assigned to contact the patient. Otherwise, the divergent opinions were simply noted before discussion moved on to the next patient on the agenda; team members did not express a need to make the accounts consistent.

Another aspect of formal written reporting was the preparation of the treatment plan and discharge paperwork by the nurse practitioner or oncologist in conjunction with the registered nurse. Team members wrote out instructions, prescriptions, orders for tests, and other forms, which were compiled by the nurse practitioner for delivery to the patient by the registered nurse. The treatment plan was also recorded on the nurse practitioner’s dictation.

**Formal oral reporting.** Set reporting procedures determined in advance were completed routinely for each patient via structured verbal communication. The dietitian, social worker, and pharmacist reported specific pieces of information (e.g., Geriatric Depression Scale score) to the nurse practitioner after interacting with the patient, before the nurse practitioner reported to the oncologist. The nurse practitioner then reported her own findings and aspects of the others’ findings (at her discretion) to the oncologist, who then went with the nurse practitioner to see the patient. An example of a nurse practitioner dictating a case to an oncologist follows:

Mr Morton is a 71 year-old man diagnosed with multiple myeloma in 1992. Gradual onset of paralysis in his lower back and legs led to the diagnosis. Surgery was performed to remove a tumor in the vertebrae, which was then followed up with 15 radiation treatments. He had three courses of chemo that was discontinued after a liver reaction. Then he had 96 hour continuous drip of another chemo drug, then radiation for tumors in the pelvis and femur. In February of this year tumors were located in T5 and T6 and he began a series of 7 doses of chemotherapy for those. He has had severe neutropenia and low red blood cells and was hospitalized for neutropenic fevers and cardiac problems. He says his oncologist told him that the chemo wasn’t working and discontinued it, but then called him in a week later and said that blood tests show the tumors are responding. They’re here for a second opinion. These are his CAT scans.

Like most reports, this one focused on diagnostic and treatment information, but also included the patient’s perceptions and purpose for the visit.

At the conclusion of the visit, the nurse practitioner or the oncologist reported both the treatment plan and any orders for prescriptions and diagnostic tests to the registered nurse, who discussed information with patients and saw that they were discharged. This process of reporting was carried out for each patient; however, it occurred within the midst of other types of backstage communication, such as information and impression sharing. Thus, the social worker reported screening scores for a specific patient to the nurse practitioner, but also
shared her impression that “[patient] doesn’t want to continue treatment, but I think his family was uncomfortable with discussing hospice [palliative care] arrangements.” For a high functioning patient whose assessment was more a formality than an in-depth exploration, the dietitian reported to the nurse practitioner the Body Mass Index score along with her impression, “He’s fine,” accompanied by a casual tone and a dismissive wave of her hand. Thus at times the ritual of formal reporting became a forum for informal impression and information sharing.

Discussion and Implications

Theorizing and Researching Teams

Putnam and Stohl (1990, p. 260) called for research to “improve the ecological validity of our findings” by paying attention to the meaning of bona fide group processes within their specific contexts, a task for which ethnographic methods are well suited (Dollar & Merrigan, 2002). Privileging formal communication (i.e., meetings) in past studies of teamwork has led to a lack of recognition of the crucial roles that informal communication play in teamwork. The ethnographic study reported here demonstrates that the clinic backstage, not just team meetings, must be recognized as a site of teamwork (Goffman, 1959).

The bona fide group model does not adequately account for the capacity for teams to interact informally through a system that they devise or adapt to suit their constraints, communication styles, and goals. The examples of interactions offered in this article represent the creativity of a particular team that developed ways to do its work and meet its goals more effectively. Collectively, these interactions demonstrate clearly that team members conducted significant teamwork in hallways, desk areas, break rooms, and other clinic spaces not designated as meetings. The orderly presentation of these communicative processes in the results section somewhat obscures the contextualization of the processes within the busy clinic, perhaps leading readers to perceive them as much more orderly and organized than they were. Indeed, in our interview, the team’s first nurse practitioner called the backstage “controlled chaos,” emphasizing that the chaos usually worked quite well in its organic development and constant readjustment. The interactions occurred opportunistically rather than on a schedule; emerged in response to team members’ desires to improve patient care and assessment as they went about providing it, not by a preset agenda; were dyadic and triadic rather than including the entire team; and developed within the process of accomplishing comprehensive geriatric assessments in an outpatient clinic, with all the noise, crowding, and simultaneously activities of that space. The opportunities and constraints differed every clinic day, and team members responded to each day’s contingencies. A more holistic model would reflect this dynamism and multiple sites of communication in the everyday enactment of teamwork. Therefore, I propose the concept of embedded teamwork. Embedded teamwork acknowledges the discourse between dyads and triads of team members in which disciplinary (or professional) lines are blurred and redrawn; significant variation in teamwork practices occurs; team members’ beliefs and attitudes are expressed and change over time; and contextual constraints are reproduced, resisted, and negotiated through communication.
Certainly, some of this negotiation of meaning happens in meetings in which ritualistic reporting of patients’ cases occurs. However, the discourse of clinic practice as team members carry out comprehensive geriatric assessments should not be dismissed as joint work (Opie, 2000). Both stage models of teamwork developed by allied health and social services disciplines (e.g., Opie, 1997) and the bona fide group model which focuses on communication (Putnam & Stohl, 1990; see also Lammers & Krikorian, 1997) would be enhanced through incorporation of the embedded teamwork concept; I will discuss each in turn.

Stages of cross-disciplinary collaboration developed by theorists such as Opie (1997) (i.e., multidisciplinary, interdisciplinary, transdisciplinary) function as a useful heuristic for health care researchers and are widely cited by researchers in social work, medicine, nursing, pharmacy, dietary, rehabilitation, and mental health. However, such theories do not account fully for the dynamic nature of teamwork. Teams do not attain the level of interdisciplinary, for example, and consequently work in that mode. While models of interdisciplinary teamwork mention that informal communication occurs in interdisciplinary teams, there is no explication of what that would involve or how it influences the dynamism of teamwork. Realistically, there will be good and bad days for teamwork, and there will be some patients for whom teamwork will be more effective than for others. Moreover, some members of a given team will be more willing than others to blur boundaries, openly negotiate roles, and learn from each other (the team pharmacist blurred disciplinary boundaries with the dietitian much more often than with the nurse practitioner, for example). Such fluctuations can be accounted for and their influence considered more fully with attention to embedded practices. Moving beyond the formal meeting expands what counts as teamwork, and hence enables teams both to work in dyads and triads when they deem such collaboration to be beneficial for patient care and to frame such communication as teamwork.

Moreover, embedded practices are more flexible than meetings for navigating the hierarchical medical system. Authors call for boundary blurring, role flexibility, and dynamic teamwork structures to improve health care teamwork by bridging the gaps that persist when team members socialized in different disciplines dismiss, devalue, or misunderstand each other’s discipline-specific knowledge claims (Opie, 2000; Siegel, 1994). If the rigid divisions of health care disciplines, and the hierarchy which privileges physician knowledge and power over other disciplines (e.g., Cott, 1998; Griffiths, 1998), are ever to be renegotiated, embedded teamwork through backstage communication may be a good place to start. The fluidity of backstage settings forms contexts in which disciplinary boundaries can more easily waffle, and micro-negotiations can take place without a large audience (as in a meeting). Despite considerable constraints related to the crowded and hectic environment of the backstage, backstage communication moved the team from a multidisciplinary mode (acting in parallel, keeping each other informed) toward an interdisciplinary or transdisciplinary mode where (some) professional boundaries were blurred and roles negotiated (Opie, 1997). By attending to communication within embedded teamwork practices, researchers using stage models of teamwork will be better able to determine the degree of interdependency and boundary blurring that occurs among team members.

Furthermore, acknowledging and exploring embedded teamwork extends bona
fide group theory in a useful direction for communication scholars bringing our unique perspective to bear on the study of groups and teams in a myriad of settings, including health care. Lammers and Krikorian (1997) expanded upon Putnam and Stohl’s (1990) original model of bona fide groups by articulating implicit aspects of the model via their study of surgical teams. Lammers and Krikorian argued that studies of bona fide groups must involve attention to the group in its specific institutional context because a given team task or decision “is a manifestation of much individual, small group, organizational, and institutional work that goes on prior to and after [it]” (p. 36). To continue along that path, embedded teamwork practices, those that dyads and triads of team members carry out in the backstages of medical (or other) work, involve communication among team members that is just as much a part of the team’s discourse and history as that which occurs in meetings; such embedded practices are part of the ongoingness of the team (Berger & Luckmann, 1966; Lammers & Krikorian, 1997). Attention to ongoing communication among team members outside of meetings enables recognition of the embedded nature of teamwork within a context in which team members spend the vast majority of their time not in team meetings, but in accomplishing the work which is planned, reviewed, and evaluated in team meetings. I do not doubt the centrality of meetings to the discursive accomplishment of teamwork; however, an exclusive focus on meetings suggests an artificial demarcation between team communication in meetings and communication among team members in other backstage spaces. My study of an interdisciplinary geriatric team indicates that team members do not experience these forms of communication as separate, but as co-existing in a dynamic system. Thus the permeable boundaries of bona fide teams should be considered to include communication between dyads and triads of team members whether or not that communication is ever brought into a meeting as a specific point of discussion.

Further studies of bona fide teams would be enriched by qualitative documentation of embedded teamwork communication outside of meetings. In addition to the potential of these findings for theories of teamwork, this typology of backstage teamwork also offers crucial insights into frontstage health care delivery.

Researching and Theorizing Linkages between Frontstage and Backstage

By expanding the definition of what counts as teamwork, we can envision opportunities for enhancing theory and improving practice of health care provider-patient communication. Goffman (1959) points out that all backstages are, in some sense, frontstages for other performances. An embedded teamwork approach blurs the boundary between the frontstage and backstage of health care delivery, and hence reveals both as performative. As team members repeatedly crossed over the literal doorway between frontstage and backstage, the boundary between the performance for the patient and companion audience and the performance of teamwork was continually blurred. The performances became enmeshed and the exact threshold elusive. Theorizing frontstage and backstage as separate spheres obscures the vital connections between them; Goffman’s (1959) dramaturgical theory emphasizes that the frontstage and backstage are adjacent, and both are integral to team performances. Even teams that conduct
assessments and interventions asynchronously (not in the clinic backstage at the same time) are likely to carry out joint work in dyads and triads of team members outside of meetings (Opie, 2000; Saltz, 1992). These discourses should be considered as existing in a reflexive, integrated, dynamic relationship that is not only the context for frontstage and backstage forms of communication, but produces the communication. Theories and conceptualizations of health care teamwork must inhabit a crossroads of organizational, team, health care provider-patient, and health care provider-patient-companion communication in order to offer a sufficiently complex view of the daily world of clinics. The daily negotiation of teamwork creates a world in which frontstage and backstage communication are inseparable and mutually productive. Backstage practices such as reading and writing notes, discussing patients’ affect, and sharing information and impressions influence subsequent interactions with patients. As this cycle is continually repeated, each interaction contributes to the development the climate and culture of teamwork and health care delivery.

Pragmatic Implications for Health Care Practitioners and Administrators

Because of the interrelation of backstage and frontstage communication, the backstage can be conceptualized as a site for improving patient care. Backstage communication impacted communication with patients and companions in five specific ways that may be useful to teams reflecting on backstage teamwork or considering fostering such communication. For each, I offer pragmatic suggestions to enhance patient care. Like the typology of backstage communication, these processes overlap; they are separated for ease of discussion.

First, team members developed beliefs and attitudes about patients before they met them, and backstage communication contributed to this process. Information and opinions from other team members and from documentation in charts led to preconceived ideas about patients (Donnelly, 1988). Forming at least some ideas about patients is inevitable, and in many ways it had beneficial effects. For example, it was often helpful to know in advance that the patient about to be seen was angry or fatigued; the team member could then enter the room ready to deal with the patient’s affect instead of having to react unprepared. On the other hand, advance warnings also may have caused snap judgments or discouraged team members from making up their own minds about a patient. For example, the social worker received negative information from the pharmacist about a couple before she saw them; being warned of the patient’s communication style may have helped her to negotiate her tasks more effectively, but it also provided her with an unflattering impression that shaped her views. Team members did not always accept the impressions that were shared with them, however. In interviews, two team members explained that they sometimes used warnings from others as an inspiration to try to be empathic with a patient. Health care providers should be conscious of how the information contained in charts and the information and impressions shared with them by team members has lead them to anticipate certain behaviors. Ideally, health care providers should both be prepared to manage such behaviors, and be open to the possibility of forming a different impression than the one fostered in the backstage.

Second, backstage communication often resulted in a modification of the
agenda for a team member's subsequent encounter with a patient. The most significant and consistent example of shaping an agenda was the nurse practitioner's report to the oncologist. For every patient, the nurse practitioner had to make strategic decisions on which details to present, wanting to be comprehensive, but also balancing time constraints and not wanting to give the impression that she was unable to make sound judgments concerning what data was relevant to the oncologist's decisions. Since the oncologist had no prior contact with the patient, the oncologist's view of the patient, and hence the oncologist's agenda, was influenced strongly by the nurse practitioner. Informal collaboration among team members also altered agendas. Recommendations that patients eliminate, reduce, or change dosages of vitamin and herbal supplements were messages that were reinforced frequently by multiple team members following backstage communication. Being prepared to address issues ahead of time, and being able to reinforce pieces of information or an impression, appeared to increase team member effectiveness and patients' receptiveness to messages. Health care providers should consider both formal and informal talk in the backstage as opportunities to adapt their own and each other's agendas for communicating with patients in ways that enhance case delivery.

Team members' backstage communication also provided practical facilitation of encounters. For example, being told that a patient was very hard-of-hearing encouraged team members to speak loudly and more slowly from the outset of their encounter and thus improved communication. Reading of patient records, one aspect of backstage formal reporting, also may have facilitated subsequent communication with patients. For example, the pharmacist always checked the list of over-the-counter and prescription medications before entering a patient's examination room. If the list was lengthy or included drugs that were likely to have harmful interactions, the pharmacist was prepared upon entering the room to spend more time conducting a detailed review with the patient. Diabetics are a good example of patients who often required longer visits from the pharmacist; seeing insulin on a chart facilitated her preparation. Such practical and useful information should be freely shared among health care practitioners in the backstage in order to facilitate others' communication with patients.

A final, and problematic, effect of backstage teamwork on frontstage communication concerns power. Despite its potential for improving patient care, backstage communication increases health care providers' power over patients, undermining patient autonomy. Team members strategize (often extensively) out of patients' presence about how to persuade patients to adopt or discontinue specific behaviors. The paternalism-autonomy dialectic in the health care provider-patient relationship is certainly not unique to team interventions (e.g., Waitzkin, 1984), and is always a significant problem for older patients, toward whom physicians often exhibit ageist attitudes and behavior (Beisecker, 1996; Hummert & Nussbaum, 2001). Additionally, since the team studied works in an outpatient setting, recommendations are made to patients who have time to consider options and make decisions, enhancing their autonomy. Nonetheless, the power (even if benevolent) wielded by team members is problematic because it gives team members further rhetorical advantage over patients who already face status and knowledge differences that privilege medical professionals in their interactions (Adelman, Greene, Charon, & Friedmann, 1992). The exclusion of patients and family members from many teams' meetings has been highly
criticized by some scholars of teamwork who object to the marginalization of patients’ and families’ perspectives (Opie, 1998). A similar criticism could be made of backstage teamwork that fosters repetition and modification of messages designed to move patients toward a particular decision. This ethical issue warrants attention in further research.

In addition to specific implications of backstage communication for frontstage practice, the findings presented here have an important implication for the formation, training, and management of teams in health care settings. Teams should recognize the communication among team members outside of team meetings as part of the fluid process of teamwork, rather than ignoring or discounting such communication as apart from or preliminary to the real teamwork that occurs in meetings. Recognition could include documenting dyadic or triadic interactions by briefly logging date, time, topic, and participants in a team member’s daily planner or notebook; compiled periodically, this data would support team members’ requests to administrators for (re)allocation of time for teamwork. Periodically bringing such data into meetings for discussion also would enable identification of trends in topics that necessitate frequent out-of-meeting interactions—such knowledge could lead to anticipating and preventing some problems by implementing changes to meeting agendas or procedures to address recurring issues. By recognizing such fleeting, dyadic or triadic communication among team members as impacting on team relationships and process, both team members and administrators can value and reward this professional work, and strategize on how to maximize its effectiveness.

**Limitations**

Because the typology was developed on the basis of one team’s work, the findings can not be generalized to all teamwork contexts. The elite context of a regional cancer center also limits generalizability; all but one of the team members and the vast majority of their patients were white and from middle or upper socioeconomic classes. More culturally diverse medical contexts would present constraints and opportunities largely absent in the team studied. In terms of providing a model or inspiration for future research, this study is limited by its cumbersome methodology. While ethnography of embedded teamwork yielded valuable insights, it is very time consuming, involving long term commitment to an organization. Researchers may find access to informal aspects of teamwork and backstage communication difficult to obtain (Atkinson, 1995; Opie, 2000). Moreover, informal interactions are not bounded geographically or temporally, and do not lend themselves to tape-recording, making them difficult to follow and systematically document, and requiring flexible data gathering strategies (Atkinson, 1995).

**Conclusion**

The exploration of backstage communication among members of a geriatric oncology team revealed the critical nature of teamwork outside of formal team meetings for both internal team functioning and communication with patients and companions in the frontstage of health care delivery. An embedded teamwork perspective offers important pragmatic and theoretical applications by
complexifying the current conceptualizations of teamwork. The backstage of health care delivery will move into the frontstage of health communication research as it becomes increasingly apparent that much of the work of health care teams takes place both in the absence of their consumers and outside of formally designated team meetings.

**Endnotes**

1. It is, of course, quite possible that my presence impacted the interactions. However, given the research emphasis of the cancer center, my presence was not unusual or disruptive. Staff routinely approached patients about participating in studies, and patients interacted with professionals, students, and interns from many disciplines. It bears mentioning that I walk with a pronounced limp due to reconstructive surgeries for bone cancer in my right leg, and patients and companions often asked about it. I answered all questions about my personal health history and status as a researcher but avoided discussing what I was studying, except to say that I “wanted to understand how patients and team members communicated with each other.” While I did not announce my identity as a cancer survivor to every patient, I did reveal it when asked about my limp and leg brace because I believe it would have been unethical to deceive patients and their companions about my survivor status. Patients and companions often said that they were glad that I had some idea of what they were experiencing, and that it was comforting to talk with a survivor. See Ellingson (1998) for a discussion of a cancer-survivor-as-researcher positionality.

2. My process of interpreting and analyzing data also included writing ethnographic narratives and an autoethnography of my participant observation; these narrative sense-making processes influenced my understanding of what I had witnessed, and hence affected the meanings I generated in the grounded theory analysis.

3. Systems of social power and privilege in the medical establishment exist in reflexive relationship with backstage clinical communication. Space constraints prohibited full explication of this complex relationship, which I will explore in future publications.

**References**


APPENDIX

Interview Protocol

1. Please examine this preliminary typology of backstage communication carefully. What are your initial reactions to it? Prompts:
   - What do you agree or disagree with?
   - What seems unclear to you?
   - What have I left out or what would you add?

2. How do you see these communication practices as varying among different team members?
3. How do you think these communicative practices developed?
4. Why do you think you engage in these communicative practices with team members?
5. How is communicating with team members related to your discipline?
6. How do you think your communication in the backstage areas of the clinic is related to or affected by the context of the cancer center as an organization?

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