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What Patients and Families Don't Hear: Backstage Communication in Hospice Interdisciplinary Team Meetings

ELAINE M. WITTENBERG-LYLES,

University of North Texas, Denton, Texas, USA

GINNIFER CIE' GEE,

University of Texas, San Antonio, Texas, USA

DEBRA PARKER OLIVER, and

University of Missouri, Columbia, Missouri, USA

GEORGE DEMIRIS

University of Washington, Seattle, Washington, USA

Abstract

Backstage communication has been shown to play a vital role in a bona fide group's teamwork. Hospice interdisciplinary teams are considered bona fide groups, and hospice interdisciplinary team meetings constitute backstage communication because they occur away from patients and families. Video recordings of interdisciplinary team meetings were systematically coded for backstage communication messages and the extent to which different interdisciplinary team members participated in backstage communication was explored. Results revealed that predominant backstage communication messages included offering of impressions and formal reporting. The sharing of backstage messages in interdisciplinary team meetings enable hospice staff to manage emotions in the safety of the backstage as well as prepare for frontstage professionalism.

Keywords

Bona fide groups; hospice; backstage communication

INTRODUCTION

Hospice services are based on an interdisciplinary team model that advocates a holistic approach to pain management of the terminal patient (Saunders, 1978). In hospice, the interdisciplinary team generally consists of a medical director, nurse, social worker, and chaplain, with the patient and family as the central figures of the team. Working together, the interdisciplinary team is responsible for the biomedical, psychological, social, and spiritual health care of terminal patients (Wittenberg-Lyles & Oliver, 2007). The interdisciplinary team works interdependently in the same setting, interacting both formally and informally to reach coordination and integration of services to treat patients (Ellingson, 2003).

Federal guidelines require hospice agencies to provide interdisciplinary teams to oversee patient care (Tax Equity and Fiscal Responsibility Act, 1982). A common practice among hospice agencies is to hold interdisciplinary team meetings that are aimed at facilitating and

fostering collaborative communication, a necessary component to the delivery of holistic end-of-life care. However, recent research has illustrated that not all hospice agencies are meeting government regulations, with deviation occurring in variation of the number and type of disciplines represented in the meetings (Wittenberg-Lyles, Oliver, Demir, & Courtney, 2007). Instead, it was found that meetings are being used for other purposes such as discussing policy, quality improvement, and staff meetings. It has also been suggested that the use of employee time impacts interdisciplinary collaboration. Thus, effective holistic collaboration does not always take place in interdisciplinary team meetings. Because this is the overall goal of the interdisciplinary team and interdisciplinary team meetings, further investigation is warranted.

Previous studies have investigated communication in relation to health care teams and hospice. According to Zimmerman (1994), communication in interdisciplinary teams affects not only basic team functioning, but also the administration of healthcare. In other words, aspects of the communicative process are important not only for general meetings and accomplishing meeting tasks, but also for the end result. In addition, interpersonal relationships do play a role in group processes and, if ineffective, issues could arise in the health care delivery process (Zimmerman, 1994). Zimmerman and Applegate (1992) investigated person-centered comforting communication in hospice interdisciplinary team meetings. Data revealed that hospice members would use comforting strategies toward an emotionally distressed team member (Zimmerman & Applegate, 1992). It was suggested that communication satisfaction resulted from comforting communication and thus increased perceived satisfaction in the evaluation of the team's success in accomplishing its tasks. These findings further suggest that interpersonal collaboration is impacted by group communication.

Recent research on communication in hospice interdisciplinary team meetings has been grounded in naturalistic inquiry (Arber, 2007; Li & Arber, 2006; Wittenberg-Lyles, 2005; Wittenberg-Lyles & Oliver, 2007). Due to the lack of research in the communicative practices of psychological, social, and spiritual collaboration, studies have explored how patient's psychosocial information is addressed in interdisciplinary team meetings (Arber, 2007; Wittenberg-Lyles, 2005). Ethnographic observation has been used to understand the whole communicative phenomenon and to better grasp a complete picture of the patient's situation (Wittenberg-Lyles, 2005). Early research in this area has indicated that psychosocial information sharing creates a dialectical tension for the team (Wittenberg-Lyles, 2005). The study also indicated that the sharing of biomedical information is a normative social practice of the team whereas psychosocial sharing is not (Wittenberg-Lyles, 2005). Consequently, communication in hospice interdisciplinary team meetings is distorted by the emphasis on medical information sharing (Wittenberg-Lyles, 2005). In many cases, clinical or medical information is most often shared in hospice interdisciplinary team meetings due to the fact that a doctor or nurse leads the meeting rather than a social worker or chaplain (DeFord, 2003). Thus, the focus of communication within the team is influenced by the leader's area of expertise. Additional research on collaboration in interdisciplinary team meetings suggests that this is due to the team meeting environment that involves the structure of the meeting as imposed by organizational practices (Wittenberg-Lyles & Oliver, 2007). The purpose of this study is to further understand communication processes in interdisciplinary team meetings by taking into consideration the discipline-specific roles of interdisciplinary team group members. A bona fide group perspective is used to guide the investigation.

Theoretical Background

The bona fide group perspective has been used to study groups in naturalistic settings (Kramer, 2005; Lammers & Krikorian, 1997; Putnam & Stohl, 1990). Bona fide groups have "stable yet permeable boundaries" characterized by interdependence with context (Putnam & Stohl,

1990). Group membership establishes the group's boundaries; however, group membership as a boundary is problematic because membership is not static (Lammers & Krikorian, 1997). Rather, group boundaries are influenced by overlapping group memberships wherein group members are members of more than one group. These multiple memberships can create role conflict or divided loyalties, but alternatively they can provide support, strength, and security (Lammers & Krikorian, 1997).

Within hospice, attendance at interdisciplinary team meetings vary, making group membership boundaries permeable as well as creating multiple group boundaries (Wittenberg-Lyles et al., 2007). In the interdisciplinary team meeting, group members are members of two groups: (1) the interdisciplinary team and (2) a representative of their own specific discipline. Group members in the interdisciplinary team share group membership with other group members with similar training and background. For example, it is not uncommon for a hospice interdisciplinary team meeting to involve participation from several nurses, social workers, and chaplains. In this manner, each group member shares discipline-specific membership as well as group membership. Hospice teams carry multiple group affiliations in that they are members of various groups (nurses, doctors, chaplains, and social workers) and simultaneously a member of the hospice team.

Additionally, bona fide group members experience fluctuation in membership. Lammers and Krikorian (1997) noted in their study of surgical teams that bona fide group members can exchange roles. Hospice interdisciplinary team members experience this type of role fluidity. Information sharing by nurses in interdisciplinary team meetings stems from their role as either case manager or on-call nurse (Wittenberg-Lyles & Oliver, 2007). Although each team member has a defined area of responsibility and services to the patient and family, it is not uncommon for team members to be called on to deliver services outside of their area of expertise. Role blurring occurs in hospice because similar services are provided between professions (Reese & Sontag, 2001). For example, chaplains provide patient and family support but are often called on by family members to interpret medical information. Thus, team members work in their own areas as well as in other group member's areas of expertise as required and needed by patients and families.

Finally, tight/loose coupling is another element to the bona fide group perspective. Coupling refers to the linkages between group members at various levels or between their orientations and behaviors (Lammers & Krikorian, 1997). Loosely coupled groups perform their tasks independently and coupling can be related to the environment in which the group operates. From an organizational perspective, hospice interdisciplinary team meetings are tightly coupled because they primarily occur *at* the hospice agency's office setting at a specific day and time of the week. However, hospice interdisciplinary team meetings are loosely coupled because they occur separate from patients and families. Contrary to the idea that patients and families are a part of the interdisciplinary team process, recent research concludes that patients and families are rarely included in this process (Parker Oliver, Porock, Demiris, & Courtney, 2005; Wittenberg-Lyles et al., 2007). Rather, much of the interdisciplinary team process takes place backstage, away from patients and families (Ellingson, 2003).

Given that patients and families rarely attend interdisciplinary team meetings, we argue that these meetings constitute backstage communication. Backstage communication (Goffman, 1959) is defined as:

a place relative to a given performance, where the impression fosters 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. (p. 112)

Ellingson's (2003) long-term ethnographic study of an interdisciplinary geriatric oncology team concluded seven types of backstage communication processes used by the team: (1) informal impressions and information sharing; (2) checking clinic progress; (3) relationship building; (4) space management; (5) training students; (6) handling interruptions; and (7) formal reporting. The study revealed the existence and importance of backstage communication and that informal communication plays a vital role in a bona fide group's teamwork.

Although organizational meetings are not typically considered backstage communication, we argue that in the context of hospice care interdisciplinary team meetings are actually backstage communication. First, the structure of hospice care positions interdisciplinary team meetings as backstage communication. Each team member spends the day visiting patients and providing services. This is facilitated independently from the team. The interdisciplinary team meeting provides an avenue for all team members to come together and collaborate on patient care. Such collaboration involves sharing information with others and contributing to decision making. Given that each team member works interdependently from the team, the only time the entire team is together is at interdisciplinary team meetings. Thus the meetings are backstage from the rest of their care services. Second, interdisciplinary team meetings rarely include patients and families. Consequently, good communication in interdisciplinary team meetings facilitates a positive picture frontstage for patients and families. The goal of this study is to investigate the types of backstage communication processes that are facilitated through the interdisciplinary team meeting, especially given that patients and families are not represented in this aspect of the team process. Specifically, we assessed the most common types of backstage communication messages and the extent to which different interdisciplinary team members participate in backstage communication messages during interdisciplinary team meetings.

METHOD

Participants

Participants in this study ($N = 15$) were hospice interdisciplinary team members at a hospice facility in the mid-Western United States. The research team was granted permission to record team meeting discussions for patients and caregivers who had consented to participate in a larger study. Team meetings lasted approximately 1 hour and attendance at the team meetings varied from 8 to 10 participants. Participants included a medical director, nurses, social workers, home health aides, chaplains, a hospice director, and volunteer coordinator. Overall, 14 patient-caregiver cases were discussed by two different hospice interdisciplinary teams at one hospice over a 3-month period. Data collected for this study was part of a larger telemedicine intervention study and was approved by the supporting university's Institutional Review Board as well as the hospice research review board.

Patients and caregivers were solicited for recruitment in the study by a research assistant by phone following their admission to hospice. At that time, demographic information and other psychometric measurements were collected. The research assistant assured patients and caregivers that their participation was voluntary. Patients ranged in age from 44 to 91 years. Five of the eight patients were female. Half of the patients were enrolled for hospice with a primary diagnosis of cancer. Half of the patients were married, three were widowed, and one never married. Caregivers ranged in age from 48 to 83 years and all were female except one. At the time of this study, four of the eight patients had died, with an average of 55 days on hospice care. Three other patients were still alive and one patient had been transferred to a nursing home.

Procedure

Prior to the start of the hospice interdisciplinary team meeting, the research assistant would set up a video camera in the corner of the room. Recording would begin with the announcement of the patient's name given that they had previously consented to the study and end prior to the announcement of the next patient's name.

Coding Process

The research questions were investigated by repeatedly viewing the videotaped discussions and coding the data into backstage communication messages. For each taped discussion, the patient was identified by subject number only, allowing for protection of participant's confidentiality. Additionally, the research assistant conducting the videotaping provided a seating chart of the team meeting that indicated each speaker's discipline (e.g., nurse, medical director, and chaplain). The unit of analysis coded was each participant's turn in talking, with the exception of diagnostic opening statements, which included the patient's name, age, diagnosis, medical history, and primary care physician. After an initial training period, the coders came to 100% agreement on the number of turns by talking through differences. For each turn, two coders categorized the interaction using Ellingson's (2003) backstage communication processes, with the exception of three categories (space management, training students, and written reporting) because they did not apply to the context. Operational definitions and applications to hospice interdisciplinary team meetings for each process are summarized in Table 1. In addition, a message category for organizational messages was added to the typology. The raw average agreement rate was 89% and correction for chance using Cohen's kappa resulted in .81 reliability. Two coders coded 25% of the data to establish reliability and the remaining data set was coded by one coder.

RESULTS

The number of turns coded in each of the 14 interactions ranged from 13 to 99, with a mean of 48.42 ($SD = 23.253$). Table 2 presents the frequencies of the types of backstage communication messages that took place in interdisciplinary team meetings. The first research question explored the most common types of backstage communication messages. Not surprisingly, formal reporting was the most common backstage communication message (34.5%), followed by offering impressions of patients and caregivers (16.5%) and requesting clarification of information (14.7%).

The second research question asked the degree to which different staff participated in interdisciplinary team meetings. Similar to other research (Wittenberg-Lyles, 2005), nurses did the majority of talking in interdisciplinary team meetings, accounting for 63% of all talking turns. Table 3 illustrates that nurses primarily engaged in formal reporting and offering of impressions. The medical director was the second most active speaker in the meetings, contributing formal reporting (36%) and request for clarification (31%). The chaplain had the least active communicative role, with only 5% of all talking turns, primarily offering impressions (25%) and offering information (19%).

Analysis of the 14 interactions concluded that formal reporting was the most common backstage communication message (34.5% of all talk turns) and reflects previous suggestions that this is the normative information sharing standard in interdisciplinary team meetings (Wittenberg-Lyles, 2005). Likewise, congruent with the emphasis on collaborative communication within hospice, backstage messages that request clarification and offer information reflect that collaboration is indeed occurring. Below is an example of a patient case discussion from the data that illustrates both formal reporting and offering of impressions:

Nurse: (Name) has his oxygen, which is continuously at five liters. More difficulty with mobility due to the shortness of breath, but he has his electric scooter still. He doesn't have any pain issues, and we are re-approving his certification. I admitted him.

Social Worker: Mr. (name), Mr. (name) yes I like him.

Nurse: Very nice.

Social Worker: The other day when I went to see him, a couple of days ago, he said, and it was the first time he's ever said that, he said, "You know I just want you to know I really appreciate the fact that you guys come and sit and talk with me." And that's something, you know what I mean, he really likes that one-on-one conversation with somebody.

Nurse: That's nice to hear.

Social Worker: Yeah, well, you know ... it is. It's nice to know that it makes, you're making a difference in somebody's life.

Nurse: Um hum.

Social Worker: 'Cause he doesn't really have a lot of issues, he's, he's pretty ... self-sufficient. He's got the support from his family ... they feed him, you know.... He could last for quite a while with this pulmonary fibrosis he has.

Nurse: Well good, we might have one that's on six months, not necessarily two years (small laugh).

Social Worker: Well, you know, he's different from other people with ... problems, you know, because the one's we've had, we've had before were just, you know, very manipulative and ... he's not that way at all. He's very appreciative of everything we do, so.

Nurse: It's nice for a change.

Social Worker: Nice guy. Are you, are you seeing him (to camera), Mr. (name)? Good guy.

In this interaction, the nurse begins with a formal report about the patient, including a standard update on the patient's current medical needs and difficulties as well as pain and symptom management. The social worker responds by offering an impression of the patient and the following acknowledgement by the nurse continues to elaborate on this impression. More importantly, it is the nurse's acknowledgement and agreement that allows the social worker to elaborate on her impression. However, it is interesting to note that the social worker ties her impression of the patient back to the patient's medical status (pulmonary fibrosis). Thus, she relates the offering of impression back to the formal report on the patient's medical status. The nurse's response is a general response about patient longevity with this particular diagnosis and the social worker ultimately finishes her impression of the patient and again is acknowledged by the nurse.

The organizational details of combining formal reporting and offering impressions in the conversational practices of interdisciplinary team meetings reveal that team members' impressions are a form of collaboration in meetings. Offering impressions as a prevalent category of talk facilitates the creation of identity for patients who are not present and thus are an opportunity to sustain agreement from team members. Because this study examines "talk as data" by assigning a single functional meaning to different types of talk (Ainsworth-Vaughn, 2001), collaboration can be interpreted as an outcome of talk that offers impressions. Similar

research (Li, 2004) has found that “niceness” messages used in interdisciplinary palliative care teams facilitate professionalism and promotes the goals of the group.

DISCUSSION

This investigation explored backstage communication messages in hospice interdisciplinary team meetings. The most common type of backstage communication messages were formal reporting, offering of impressions, and requesting clarification. Taken together, these backstage messages facilitate the preparation of identity management for team members. In this manner, backstage talk influences control over future action (Ainsworth-Vaughn, 2001). Specifically, Goffman (1955) used the term *face* to describe the positive self-image of identity performance. *Facework* refers to the communicative strategies used to present, maintain, or restore performative identities in conversation (Goffman, 1955). In this study, backstage communication in hospice interdisciplinary team meetings contribute to presenting face, the performative preparation of managing face in the front stage presence of patients, families, and other healthcare professionals.

Hospice interdisciplinary team members also use backstage interdisciplinary team meetings as a site for sharing the emotional dimension of the nature of their work. Offering of impressions allows team members to express emotions backstage (away from patients and caregivers) and helps control emotions frontstage when providing health care services (Goffman, 1959/1973). For example, statements that offer impressions are similar to what Li and Arber (2006) call “emotional work.” They suggest that these types of messages manage social interaction and achieve interpersonal goals, such as presenting oneself as a thoughtful and knowledgeable individual (Li & Arber, 2006). It is argued that emotion talk is valuable in that it reveals how team members manage conflict and tension in frontstage interactions. Prior work on talk in end-of-life care teams includes Li’s (2004) ethnographic summary of atrocity stories in an interdisciplinary palliative care team. Li concluded that nurses share atrocity stories (stories about a negative event patients have with a physician) as a means to rationalize behaviors, anxiety, or a lack of understanding (Li, 2004). The sharing of these stories backstage allows team members to reflect and assess on future frontstage communication approaches, thus facilitating preparation of the performative nature of identity frontstage.

Likewise, backstage communication messages are used to prepare frontstage professionalism. Requesting clarification and offering impressions in interdisciplinary team meetings, for example, are used as forms of engaging in positive and negative facework. It is within the safety of the backstage meeting that team members reveal their impressions of patients and care-givers. These impressions, both negative and positive, are shared away from patients and family members because to not do so would be unprofessional. Team members also solicit feedback and information about how best to strategize or approach patients in the frontstage. Often, such strategizing is necessary backstage to resolve frontstage problems, such as missing medication or patient noncompliance. Consequently, it is in the backstage meeting that all team members agree to share specific frontstage messages by discussing and agreeing on a specific course of action with patients (Wittenberg-Lyles & Parker Oliver, 2007). Particularly in special cases, such as difficult caregivers, it is not uncommon for the entire team to openly discuss and agree on a course of action (Wittenberg-Lyles & Parker Oliver, 2007). The backstage discussion ensures that everyone is knowledgeable about a special case so that all team members communicate the same message to the patient and family in the frontstage (Wittenberg-Lyles & Parker Oliver, 2007).

Our study of backstage communication in hospice interdisciplinary team meetings also found that nurses dominated the meeting communication time delivering medical information through formal reporting and offering impressions. Message dominance in interdisciplinary

team meetings by nurses reveals three important findings. First, backstage communication is primarily focused on sharing biomedical information. Consequently, non-medically oriented staff such as social workers and chaplains has little to contribute to dialogue in the meeting. Similar research has noted the frustrations of social workers in nurse-dominated, medically oriented discussions (Parker Oliver & Peck, 2006). This finding reveals that priority is being given to the patient's biomedical needs over his or her social and psychological needs. In essence, a subgroup appears to form within the interdisciplinary team meeting, wherein medical-specific group members dominate. Second, non-medical discipline-specific group members may need to be more active participants. Rather than wait to be called on for comment, social workers and chaplains may need to actively engage in the discussion prior to invitation. They also may need to educate team members about the value of their information. Third, the domination of nurses in interdisciplinary team meetings suggests that perhaps nurses are taking on the role of social worker and chaplain in patient care. Nurses have the most direct contact with the patients and caregivers and are often called on to fulfill care services outside of their area of expertise. For example, a nurse explained that a patient's wife called just to talk.

Nurse: "She called crying and said 'I just need someone to talk to' ... so what could I do, I just listened."

The fluctuation of group roles, particularly when group members exchange roles, has implications for group processes, and this study suggests that it impacts backstage communication processes as well.

Finally, the primary limitation to this study was not being able to videotape entire interdisciplinary team meetings. This perspective could have provided a more in-depth analysis of backstage communication in its truest form. Future research should explore the contributions of differing group members, with a particular focus on psychosocial information sharing. Additional work should examine how talk in interdisciplinary team meetings contributes to the identity development of patients and caregivers and whether perceptual differences impact standards of care. The comparison between team backstage talk and the formal assessment and plans of care by specific disciplines might also be valuable to compare. Do the backstage discussions represent the assessments of the individual disciplines and the formal plan of care documented in the record? What types of problems are noted in the records that do not make the discussion in the team meeting? What other forums of backstage talk may exist that serve the purpose for the non-nursing staff? More importantly, as the focus of the larger funded project attempts to explore, more research is needed to understand the impact of backstage talk in teams once the patient or family enter the discussion and it moves to the front stage.

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TABLE 1

Operational Definitions of Communicative Acts Within Hospice Interdisciplinary Team Meetings as Adapted from Ellingson's (2003) Backstage Communication Processes

Verbal Behavior	Definition	Examples ^a
Request for clarification	Questioning each other about information about the patient being discussed	"What patient are we on?" "Any drug problems?" "Is she changing?"
Request for opinion	Questions that solicit opinions on issues such as patient/caregiver affect, depression OR to confirm their own opinion OR initiate discussion about how team member's can resolve problem	"Do you think she's depressed?" "She has an abusive husband, don't you think?"
Offering of information	Information shared that would provide practical assistance to other team member's communication with patient	"Stays in bed most of the time" "She doesn't like to take medications"
Offering of impressions	Descriptive statements that share positive or negative impressions and opinions about patients/caregivers	"He's adorable"
Request for reinforcement of a message	Asking team member to repeat information already mentioned to the patient	"Maybe you could talk to her about _____"
Clinical progress	Asking team members which patients had been seen and by whom OR stating when the patient had been seen	"Have you seen him yet?" "I haven't seen him yet." "Is she mine?" "Whose is she?" "I saw him yesterday."
Life Talk—Patients	Sharing outside patient information such as life history/experiences	"He used to drive a truck that carried bombs." "He was shot."
Life Talk—Team members	Sharing outside personal information such as life experiences	"Your grandson works at that restaurant"
Troubles Talk	Complaining about scheduling, limited resources, behavior of outside clinic staff	"Too many patients, I didn't have time"
Handling interruptions	Patient-care related or personal and family concerns. Service interruptions—e.g. nurse listening to caregiver concerns, talking phone calls from caregivers for lengths of time	"She called me crying ... just said she needed someone to talk to"
Formal Reporting	Primarily diagnostic (such as patient name, age, diagnosis, medical history, primary care physician), Yes and No responses	"She has COPD and is a patient of Dr. _____."
Organizational Issues	Comments about healthcare system, such as billing, costs, insurance issues	"It is hospice policy"

^aThese examples were taken from the transcripts used in this study.

TABLE 2

Frequencies of Backstage Communicative Messages in Hospice Interdisciplinary Team Meetings

Behavior	Number of Turns	Percent
Formal reporting	234	34.5
Offering of impressions	112	16.5
Request for clarification	100	14.7
Offering of information	83	12.2
Clinical progress	50	7.4
Request for opinion	41	6.0
Life talk—team members	22	3.2
Life talk—patient	19	2.8
Organizational issues	12	1.8
Handling interruptions	2	0.3
Reinforcement of a message	2	0.3
Troubles talk	1	0.1

TABLE 3
Frequencies of Backstage Communication Messages as Related to Discipline-Specific Group Members

Backstage Communication Message	Role				
	Nurse	Medical Director	Social Worker	Chaplain	Other
Formal reporting	148 (34%)	32 (36%)	27 (43%)	9 (3%)	17 (26%)
Offering of impressions	80 (18%)	5 (5%)	6 (9%)	9 (25%)	12 (18%)
Request for clarification	48 (11%)	27 (31%)	11 (17%)	2 (5%)	12 (18%)
Offering of information	62 (14%)	3 (3%)	5 (8%)	7 (19%)	6 (9%)
Total turns ^a	429 (63%)	87 (12%)	62 (9%)	36 (5%)	64 (9%)

^aThere was a total of 678 turns overall