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Sharing atrocity stories in hospice: A study of niceness message strategies in interdisciplinary team meetings

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Abstract

The telling of atrocity stories offers therapeutic benefits to healthcare providers. Transcripts of hospice interdisciplinary team (IDT) meetings were used to analyze strategies for telling atrocity stories in the performance of symbiotic niceness through criticism. Symbiotic niceness draws upon niceness messages to establish reciprocal niceness by others in order to facilitate emotional labor. In IDT meetings the two predominant strategy types used were indirect and direct criticism. Nurses and medical directors engaged in niceness message strategies mostly about patients and other healthcare professionals. The study concludes that hospice IDT meetings are a venue for team members to communicate symbiotic niceness through emotional labor.

Keywords

team meetings; atrocity stories; hospice; interdisciplinary team

The study of stories in health care settings reveals the dynamic nature of the relationships, roles, and emotions associated with interactions in health care environments (1). One type of story that has garnered increasing attention is the atrocity story. Li (2005) defined an atrocity story as a story that recounts the insensitive behavior of a doctor. Early research on atrocity stories has been limited to the perspective of the patient or nurse and stories that have related solely to how physicians have treated a patient (2–4). Little research has investigated interactions where healthcare professionals share atrocity stories with colleagues (3, 5, 6). This paper expands the concept of atrocity stories to include storytelling about negative

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experiences with patients, caregivers, and other healthcare professionals and investigates the strategies used to share these stories.

The sharing of atrocity stories among healthcare professionals can be therapeutic (3, 5, 6). Atrocity stories are commonly used as a means of creating meaning during times of uncertainty and anxiety (4). In end-of-life care, these stories function as a way of constructing identity (3, 5, 6), and sharing atrocity stories in team meetings helps build a reputation in managing patient pain as well as communicates compassion (3, 5, 6). Hospice social workers tell stories as a way of demonstrating that they can handle difficult cases and are thus worthy team members (7). Team members tell stories to solicit feedback from colleagues and evaluate their own interactions with patients/families (7). However, atrocity stories can also be used to develop notions of blame among interdisciplinary team members, especially given that threats to patient safety or medical error may result in adverse outcomes for the health care team member (8). Team conflict often arises due to misunderstandings and personality conflicts, both of which are exacerbated by the sharing of atrocity stories.

It has been theorized that sharing atrocity stories serves as an emotional labor strategy in nurses' performance of 'symbiotic niceness' (3). In the facilitation of emotional labor, the work involved in dealing with other people's feelings, Li (2005) purports that nurses' construct 'symbiotic niceness' through doing criticism. Symbiotic niceness is defined as niceness by nurses that simultaneously requires and develops niceness from other nurses and patients. Thus, the sharing of atrocity stories facilitates the managing of emotions as well as functions to manage social interactions and goals (9). The goal of this study is to identify niceness message strategies used to tell atrocity stories in a hospice interdisciplinary team meeting (IDT) setting.

In hospice, IDT meetings are held to facilitate and foster interdisciplinary collaboration among all IDT members in order to develop and implement holistic plans of care. Given the interdisciplinary nature of hospice and the targeted goal of collaboration, IDT meetings are a venue for communicating symbiotic niceness and are considered a safe place to share atrocity stories (5). Within IDT the specific strategies used to share atrocity stories can be a way of expressing empathy and as a way of constructing a competent and compassionate identity (5). Moreover, the unique collection of interdisciplinary team members at one point in time presents a significant opportunity to review symbiotic niceness strategies from multiple professional perspectives. Specifically, we question: (1) What types of strategies are used by IDT members to tell atrocity stories in hospice IDT meetings? (2) Who are the atrocity stories about?

Method

Participants

Participants in this study included members of two hospice interdisciplinary teams, comprised primarily of nurses, chaplains, social workers, and medical directors. On occasion other members attend the meetings, including volunteer coordinators, medical students, bereavement coordinators, the executive director of the hospice and home health aides. The two teams consisted of a total of 43 hospice interdisciplinary team members, 36 females and seven males. There were 17 nurses, three social workers, three chaplains, two medical directors, and 18 other members such as volunteer coordinators and medical students.

Procedure

Following consent from team members for a larger intervention study funded by the National Cancer Institute (RA-CA-05-013), hospice team meetings were videotaped.

Findings from the parent study are detailed elsewhere (10). The parent study explored the use of videophones to include hospice caregivers and patients in hospice interdisciplinary team meetings. In the first phase, regular hospice team meetings were video-recorded and caregiver and patient outcomes were assessed. In phase two caregivers and their patients participated "virtually" in team meetings using videophones.

The setting for the study was a small office room with a video camera set up in the corner. A graduate research assistant (GRA) videotaped case discussions only for patients who consented to be in the larger study. Thus, team meetings were not videotaped in their entirety. The GRA provided a seating chart of the participants, identified only by their profession. The study was approved by the Institutional Review Board at the supporting university as well as the hospice research review board. A total of 43 patient case discussions comprised the data set and these video-recordings were transcribed, producing 40 single-spaced pages of data.

Several analyses of the team meeting videotapes from phase one and two of the parent study have been completed. To summarize, team meetings represent a "backstage setting" for staff to prepare communication with patients and family members (11). Meetings are led primarily by nurses (12), where interpersonal communication and information flow are not always efficient (13), and there is sometimes a struggle for control rather than collaboration (14). Finally, pain issues make up more than a third of the team discussions (15).

Coding/Data Analysis

For the purposes of this study, Li's (2005) definition of an atrocity story was expanded to include the retelling of a negative experience with physicians, as well as negative experiences with caregivers, patients or other individuals involved in the hospice setting. Atrocity stories were coded using the analytic strategy categories used by Li (2005) and consisted of inverted comma criticism, direct criticism, and indirect criticism. Inverted comma criticism is characterized by stories that provide direct quotes and direct criticism involves the storyteller's feelings about the situation. Lastly, indirect criticism consists of paraphrasing another person. In addition to coding the type of symbiotic niceness used to tell the atrocity story, each storyteller was coded based on their profession (nurse, medical director, social worker, chaplain, other) as well as who the story was about (patient, caregiver, other health care professional).

Atrocity stories told by hospice team members were analyzed utilizing a constant comparative analysis (16). Seventeen non-data case discussions from the hospice team were used to establish intercoder reliability. Two one-hour training sessions were held to discuss differences in the coding process and agreement was reached about these differences. Two coders, a graduate student in health communication and a health communication researcher, independently coded the data. Intercoder reliability was .78.

Results

This study investigated symbiotic niceness message strategies used by hospice IDT members to tell atrocity stories during IDT meetings. Overall, 25 message strategies were identified from the data set, with strategies ranging from 0–5 per patient case discussion. Results for research question one reveal use of the three types of niceness message strategies in hospice IDT meetings. Indirect criticism (56%) was the most commonly used strategy. For example, a nurse indirectly criticized a patient's pain regimen by reporting the following:

> "I keep seeing the pill box that's full and she gives me these excuses, and I know she's… I don't wanna call her a liar, but she's a (inaudible) I guess is the correct way [to say it]…. You know the pill box has all the pills in it from the week or the two weeks before and she tells me she forgets to take her medicine."

Direct criticism (36%) was the second most prevalent strategy used and was characterized by the storyteller's feelings of the situation, as in this example of a nurse's report:

> "Anyway, you weren't the only one that got it. She was really irritable yesterday. And she hadn't had any of her medications, and she doesn't want to take them. She's reluctant to take pain medicines and other medicines due to possible side effects. And no BM [bowel movement] for a week. She had reinforced teaching on medication administration. Husband was present. I don't really know she only, she has (medication) and will not take it. She chooses not to take it, so I guess pain is controlled to an acceptable level."

The nurse begins her report with direct criticism about the patient's mood ("you weren't the only one who got it"), agreeing with the prior team member's report that the patient was angry and irritable.

The least used strategy was inverted comma criticism (8%) which includes direct quotes in the criticism. For example, a nurse described her experiences with a patient and caregiver in which she quoted the caregiver:

> "He'll come in there yelling (Patient's Name), screaming it. 'Yeah, what do you want?', 'What do I do with these batteries?' Well can you not ask (Patient's Name) that when I leave? I mean very inappropriate. You know and (Patient's Name) is a very sweet laid back girl, she really is. You know just constant, the other day I was back there talking, and one day she, she wanted to show me something, and she was showing me something, she is talking to me. He yells, '(Patient's Name), will you get me a beer?' Just very inappropriate."

Results for research question two found that these strategies were employed to share criticism about patients (48%), other healthcare professionals (32%), and caregivers (20%).

Finally, cross-tabulations were computed to examine use of each of the three message strategies among interdisciplinary team members. Since some of the cells had fewer than five cases, Cramer's V was used to test the significance of these results (Cramer's $V = .30$; $p < .001$). As Table 1 illustrates, nurses and medical directors mainly engaged in indirect and direct criticism message strategies. Social workers, chaplains and other IDT attendees did not engage in any of the message strategies.

Discussion

This investigation explored the niceness message strategies used to tell atrocity stories in hospice IDT meetings. Findings suggest that there are two predominant strategy types used to share atrocity stories among hospice IDT staff, and that IDT members differ in their use of strategy types. The most common message strategy used was indirect criticism (56%) which is characterized by paraphrasing another person and/or situation. Nurses most often engaged in this strategy. Nurses are the primary reporters in IDT meetings (17) and thus assume an aspect of leadership within the group's communication. These findings suggest that this approach minimizes potential for emotional reaction by allowing the nurse to remain focused on discussing the patient's plan of care. According to Li and Arber (2006), shifts in talk from atrocity stories to plan of care reporting safeguards professional integrity wherein nurses can be critical but still be professional (9). Thus, the nurse is able to establish a professional organizational identity, and at the same time the report of the patient's case

within the IDT meeting facilitates release of emotional labor. Thus, symbiotic niceness is communicated mainly to facilitate the nurse's emotional labor rather than to draw niceness from other IDT members.

Medical directors in this study sample also engaged in indirect criticism. Given that the majority of medical directors work only a few hours per month (18), they often do not have established relationships with patients/family members. Instead, they rely on the medical chart for pertinent information. Since the medical chart is commonly shared among the team, physician team members paraphrase stories to elaborate on details that do not have a place within the chart. By doing this, they can share exchanges with non-hospice physicians and healthcare staff and establish symbiotic niceness by demonstrating commitment to the team and team goals.

Interestingly, the second most common approach was direct criticism which includes the storyteller's feelings about the situation. The medical directors predominantly engaged in this strategy. Findings suggest that the hierarchical structure of the medical director within the organization and the team meeting setting may influence this approach. Medical directors are informally in charge of the IDT meeting, and have been historically recognized as the leader of the healthcare team. This backdrop situates the medical director as perhaps more inclined to be direct with their criticism. However, nurses also engaged in direct criticism. Taken together, these findings suggest that this approach may take advantage of informal channels of communication related to the setting of the IDT meeting as discussions typically take place backstage, away from patients and families (11, 19).

Although atrocity story talk contradicts professional expectations of healthcare professionals as sympathetic and caring (9), indirect and direct criticism occurs because IDT members feel safe about sharing in the meeting (5) and as a result IDT meetings become a safe harbor for the expression of emotional labor and the sharing of atrocity stories. During routine care, team members engage in patient/family interactions individually. Team meetings provide a special context for developing trust and sharing patient/family information. For example, team members commonly turn to chaplains for help with difficult family/patient cases and for spiritual care (20). Hospice interdisciplinary team members of different disciplines have high spiritual beliefs and report spiritual integration into the work that they do (21). This study suggests that team meetings are one site for spiritual integration and thus the performance of symbiotic niceness.

Notably there was a lack of message strategies used by social workers, chaplains, and other IDT attendees. Prior research has noted that information sharing in IDT meetings is dominated by nurses (22) and that these members do not equally participate. Future research is needed to fully understand how IDT meetings provide an outlet for sharing emotional labor associated with hospice care, especially among attendees that have limited participation in IDT meetings. This is an especially salient issue for those disciplines who are not using the IDT meeting as a context for releasing emotional labor. It might be that these professions (social workers, chaplains, etc.) feel more comfortable sharing atrocity stories only among members of their own profession. More research is needed to examine the discipline-specific differences in telling atrocity stories.

Niceness message strategies were most commonly used to share stories about patients. This finding reflects the goal of the IDT meeting. Interestingly, nurses and medical directors also engaged in niceness strategies to share stories about other healthcare professionals. As an aspect of symbiotic niceness in the IDT meeting, this talk could function as a form of team building. Li (2004) refers to this as institutional niceness because stories are about other healthcare professionals that team members come into contact with. Li and Arber (2006)

found that references to “we” in atrocity story talk enables health care professionals to self-compliment their actions, thereby creating “niceness” in talk. Our findings suggest that the IDT meeting provides a context for creating symbiotic niceness as it enables IDT members to talk collectively about their shared experiences.

The most important limitation of this study is that the entire IDT meeting was not captured. Rather, due to privacy concerns, discussions were recorded only for patients who had consented to participate in the larger study. Moreover, the data set revealed that IDT meetings do not afford time for lengthy storytelling. Rather, storytelling in IDT meetings is truncated to fit the goals of the meeting, which is to review a certain number of patient care plans within a specified time frame. As a result, stories were shared as abbreviated experiences. Future research should explore symbiotic niceness among IDT members in different settings, outside of the IDT meeting. Additional work should examine the various opportunities and venues for IDT members to engage in such storytelling and its impact on interdisciplinary collaboration. Supervisory roles within the organization should be taken into account as findings from this study suggest that they impact IDT members’ inclination to practice symbiotic niceness.

Finally, clinical implications of this study involve the use and function of hospice interdisciplinary team meetings. Although the purpose of team meetings is to discuss, collaborate, and develop holistic patient/family care planning, meetings could also be utilized in other ways that may benefit team processes. Specifically, team-building activities and self-care activities could be used to bolster communication among disciplines and encourage symbiotic niceness. For example, music therapy sessions have improved team building among hospice interdisciplinary team members (Hilliard, 2006). Given that atrocity stories are one way of expressing the emotional labor of hospice care, team members could also benefit from self-care exercises that highlight spiritual integration. Spirituality is a common denominator among hospice professionals and is related to high job satisfaction (21), with satisfaction positively related to family perception of quality of care (23). Team meetings provide an opportunity to improve team dynamics, potentially impacting patient care.

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Table 1

Frequencies of symbiotic niceness message strategies used in hospice interdisciplinary team meetings by speaker

			Speaker	
Message strategy	***Example from the transcripts***	***N (%)***	**RN**	**MD**
Inverted comma criticism	*(Nurse quotes the doctor saying)* "it would just be better for her to just drown instead of go through the pain, this horrible pain"	2 (8%)	2	0
Indirect criticism	"I asked her how she could forget to take medicine if she's hurting…even her blood pressure, her diastolic is over a hundred"	14 (56%)	13	1
Direct criticism	"I'm not impressed with somebody collecting Medicaid and smoking and drinking all day long while I'm there working"	9 (36%)	7	2
		25 (100%)	22 (88%)	3 (12%)

Cramer's $V = .303$, $p < .001$