How and why emotions matter in interprofessional healthcare

Ann Dadich*
School of Business,
Western Sydney University,
Locked Bag 1797,
Penrith NSW 2751 Australia
Email: A.Dadich@westernsydney.edu.au
*Corresponding author

Rebecca E. Olson
School of Social Science,
University of Queensland,
Australia
Email: R.Olson@uq.edu.eu

Abstract: Institutional theory draws attention to organisational rules-of-thumb that guide individual action and legitimacy – this includes the use of emotion. Within medicine, emotion is largely underemphasised. The introduction of interprofessional practice (IPP) poses an under-explored potential challenge to these rules-of-thumb. Drawing on Foucault, this article examines: 1) the emotional discourse in tweets from member-based organisations for healthcare practitioners; 2) themes in interviews and a focus group with practitioners-in-training. While the tweets largely illustrated the illegitimacy of emotion within healthcare, the practitioners-in-training indicated the importance of emotions and emotion work to teamwork. These findings suggest a 'cultural clash' and demonstrate that emotions matter in IPP.

Keywords: emotion; interprofessional; healthcare; knowledge translation; twitter; social media.


Biographical notes: Ann Dadich is a Senior Lecturer within the Western Sydney University, School of Business. She is also a registered psychologist and a full-member of the Australian Psychological Society. Prior to her academic career, she worked with different populations in the community, including young people and prisoners. These experiences continue to inform her approach to conducting research that is both empirical and respectful. Since entering academia, she has accumulated considerable research experience in health services management, with a particular focus on knowledge translation. This is demonstrated by her publishing record, which includes over 120 refereed publications; the research grants she has secured; and the awards she has received to date.
Rebecca E. Olson was awarded a PhD in Sociology from the Australian National University. Her research focuses on advancing sociological understandings of interprofessional education and practice, public health, cancer and end-of-life care and the role of emotions and affect in these contexts and research processes. She is currently a Senior Lecturer in Sociology at the University of Queensland, Brisbane, Australia and Associate Editor of the Journal of Sociology. Her recent book publication, ‘Towards a sociology of cancer caregiving: time to feel’ (Ashgate, 2015), offers a sociological study of the temporal and emotional dimensions of informal cancer caregiving.

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1 Introduction

Interprofessional practice (IPP) represents a form of organisational change to be achieved through a revised interprofessional education (IPE) curriculum (Olson, 2015), where students of diverse health professions learn ‘from, with and about each other to improve collaboration and the quality of care’ [Freeth et al., (2005), p.15]. It has been introduced to address demands for more holistic and cost-effective care in an increasingly specialised medical system (McCallin, 2001). Rather than working within silos, IPP is designed for a ‘patient-centred, team-based approach to health care delivery that synergistically maximises the strengths and skills of each contributing health professional’ [Hoffman et al., (2009), p.e75] for safer and more cost-effective patient outcomes (Aiken and McColl, 2009).

Empirical approaches to studying this form of organisational change have been largely atheoretical and interventionist, emphasising attitudinal change (Olson and Bialocerkowski, 2014). Emotions have curiously been marginalised within this and the broader medical education literature (Artino, 2013). Emotions however, play an important role in healthcare practice and interprofessional teamwork. Emotional labour – or managing one’s own and patients’ emotions (Hochschild, 2003) – is a widely acknowledged feature of nursing (James, 1992); accordingly, recognition of emotion work in other health professions is growing (Williams, 2012; McNaughton and Zubairi, 2014).

Emotional intelligence (EI) – those ‘abilities to recognise and regulate emotions in ourselves and in others’ [Goleman, (2001), p.14] – has received recent attention in the context of healthcare (Karimi et al., 2015; Johnson, 2015). Some depict EI as a skill closely aligned with core competencies in medicine (Satterfield and Hughes, 2007; Arora et al., 2010), while others are hesitant about the current focus on EI as it is unclear if it is an ability or a trait. Furthermore, it has been accused of having an inward focus, directing attention away from the social contexts in which certain emotions are deemed (in)appropriate (McNaughton and Zubairi, 2014).

Despite the seeming interest in the role of emotions in healthcare, research suggests that much terrain remains unexplored. For instance, Helmich et al. (2012) examined medical students’ reflections on their first workplace learning experiences and found that
while participants’ narratives were emotionally-charged, emotions were viewed as irrelevant – something to be overcome. In a follow up study, Dornan et al. (2015) found emotions to be directly associated with junior clerks’ identity development. Both studies concluded that further research is required to explore intersections across emotions, social contexts, power and professional identity development, and to improve the legitimacy of students’ and professionals’ emotions within medicine.

This small but growing body of research clearly implicates the importance of emotion to interprofessional healthcare practice, training, and socialisation. However, the scope is largely limited to viewing emotions as experienced individually or shared with patients. Despite studies indicating the importance of a positive, respectful, and an emotionally supportive work environment for effective IPP (McCallin and Bamford, 2007; Amundson, 2005), few have examined the emotional aspects of interprofessional teamwork, the emotional context in which these teams operate, or the role of emotion within the organisational change process that is IPP.

Drawing on institutional theory (Eisenhardt, 1988) and Foucault (1972), this article examines the organisational rules-of-thumb and discourses that implicitly inform emotional aspects of IPP practices. This is achieved through an analysis of:

1. tweets issued by three cancer care professional organisations
2. the reflections of eight healthcare practitioners-in-training following an interprofessional teaching activity.

Specifically, this article considers how emotions – as ‘movements in space, in between individuals, groups, and things’ [Lindqvist, (2013), p.230] – shape institutions and the emotional subject positions available to individuals. Findings reveal a ‘cultural clash’ [Monrouxe and Rees, (2012), p.671], where practitioners-in-training depict emotional labour as central to interprofessional teamwork, while the culture within healthcare constrains the acknowledgement of emotions and emotion work. In the sections that follow, the theoretical perspectives adopted in this study are discussed before elucidating the methods and findings.

1.1 Institutional theory

As institutional theory has proven to be particularly helpful in clarifying how organisations change and conform within a dynamic social web, it was purposefully chosen as a useful framework for this study. Institutional theory awards primacy to the institution – its rules, requirements, customs, and conventions; that is, its ‘rules of thumb’ [Eisenhardt, (1988), p.489]. These standardisations and assumptions are beneficial for two key reasons. First, they foster efficiencies – stock-standard practices enable individuals to rely on experience when attending to mundane or low-priority matters, and direct their energies to novel or high-priority issues (Cyert and March, 1963). Second (and perhaps more importantly), they offer legitimacy. Rules, requirements, customs, and conventions help organisations to operate, orchestrate, and evaluate (Hinings and Greenwood, 1988; Scott and Meyer, 1983). These activities can suggest responsible management (Meyer and Rowan, 1977) and thus shape the beliefs and values of those within the organisation as well as those external to it.

Despite these seeming benefits, organisational ‘rules of thumb’ can also represent a constraint. In the absence of a systemic overhaul, change can be difficult to introduce and
sustain (Clark, 1972). Individuals who are tightly wedded to or embedded within their social context are largely said to be resistant to change (Zucker, 1987). Although personal agency can help to transform embeddedness into an opportunity for change, albeit incrementally (Reay et al., 2006; Weber and Glynn, 2006), such change still requires negotiation with prevailing organisational norms. Thus, scholarship on institutional work examines, ‘how actors are continually engaged in the partial re-enactment of routines and practices that may ultimately lead to field dynamism, but may also result in strengthening of existing institutional arrangements’ [Currie et al., (2012), p.939].

1.2 Discourse

To understand the impetus for rules-of-thumb related to emotion in healthcare organisations, this study also draws on Foucault’s (1972) concept of discourse. Discourses are ‘particular understandings’ informed by powerful paradigms that reflect a historical-cultural context (Bacchi, 2005) and allow certain social practices and subject positions (Garrity, 2010). These understandings constrain interpretations of the self and the world, foregrounding some aspects while backgrounding others. In short, discourses establish what is and is not possible for subjects within an organisational setting.

Emotions can be important consequences of discourses; there are also discourses on emotions. In a Foucauldian review of medical education textbooks, McNaughton (2013) found three emotion discourses. Dominating was writing that conceptualised emotion as a universal physiological phenomenon – that is, something to get used to or to overcome. This emotion discourse reflects a Cartesian view of mind and body, reason and emotion as separate, with the latter being suspect. Also identified were texts depicting emotion as a form of labour or skill, reflecting Hochschild’s (2003) conceptualisation of emotions as inter/intrapersonal work. In the minority was scholarship that ‘directs our attention to emotion’s function in social exchanges and its role as a social, political and cultural mediator’ [McNaughton, (2013), p.71].

Building on McNaughton’s (2013) example, discourse was used as a sensitising concept in this study to thematically explore:

1. the emotional discourses in tweets from member-based organisations for healthcare practitioners
2. themes in interviews and a focus group with practitioners-in-training.

This helped to draw attention to the relationships between emotion, power, status, knowledge, and practice.

2 Method

2.1 Twitter analysis

2.1.1 Professional bodies

A recognition of emotion is said to be most important in emotionally-charged settings (Cherry et al., 2014) – cancer care represents one such setting, ‘where bad news, declining health, and death are commonplace’ [Cashavelly et al., (2008), p.536]. Given the emotional nature and collaborative models within cancer care, three Australian
professional, member-based organisations were identified for this study – namely, the Cancer Nurses Society of Australia (CNSA), the Clinical Oncology Society of Australia (COSA), and the Medical Oncology Group of Australia (MOGA). Each is summarised in turn.

Founded in 1998, CNSA (2014) aims to ‘promote excellence in cancer care through the professional contribution of Cancer Nurses’. This is pursued through professional development initiatives, the publication of a journal and newsletter, as well as affiliations with relevant bodies, like the International Society of Nurses in Cancer Care. Membership is open to registered and enrolled nurses, allied health professionals, and nursing students who have an interest in cancer care and control.

Established as the Clinical Oncological Society of Australia in 1971 (COSA, 2014d), COSA is a national peak body with over 1,000 members, including ‘doctors, nurses, scientists and allied health professionals’ [COSA, (2014c), para.1], involved in cancer care. Towards its aim of ‘develop[ing] and maintain[ing] high-quality clinical care of cancer patients in Australia’, the organisation pursues four key activities – namely,

1. professional development
2. professional network development
3. Australian cancer care policy advocacy
4. the facilitation and publication of information on research pertaining to cancer care.

According to COSA (2014e, para.1), ‘The culmination of these activities occurs at the Annual Scientific Meeting (ASM)’.

Akin to CNSA, MOGA is a discipline-specific organisation, representing medical oncologists in Australia. It was established as the Medical Oncology Group of Australia in 1979 – a recognised group within COSA. As a peak body, MOGA ‘works closely with Government, health organisations, affiliated international associations and societies, industry and learned colleges to improve and develop the profession of medical oncology and the management of cancer both nationally and globally’ [MOGA, (2009b), para.1]. Towards this aim, MOGA (2009a, para.3–5), ‘Support[s] members in professional practice… Maintain[s] and improve[s] standards of clinical practice in medical oncology… Promote[s] and foster[s] cancer research… [and] Enhance[s] the public and professional profile of MOGA and Australian medical oncologists’.

2.1.2 Analysis

A retrospective study was conducted of the Twitter accounts maintained by CNSA, COSA, and MOGA over 21 months (November 29, 2012 to August 29, 2014). This was aided by the social media data aggregator, Twitonomy (Enriquez-Gibson, 2014). Twitonomy is an internet-based, analytics program that enables Twitter accounts and the tweets issued from them to be examined over time. It collates account information (e.g., date the account was registered, number of followers, etc.); delves into and extracts accessible archival tweets; computes detailed statistics on account traffic, connections, and trends; and presents visual depictions of results.

After sourcing official Twitter handles for each organisation, two steps were completed to create three comparable samples for analysis. First, the period of study was established. This was determined by the latest date that one of the organisations – CNSA
— joined Twitter (see Table 1). Second, three samples of tweets, which were issued within this timeframe, were created for analysis. Sample size was determined by the account that issued the fewest tweets — COSA. As CNSA and MOGA had issued a greater number of tweets (963 and 331, respectively), a random selection of 193 tweets was extracted from their accounts for analysis. As such, the total sample of tweets analysed is 579.

Table 1  
<table>
<thead>
<tr>
<th></th>
<th>CNSA</th>
<th>COSA</th>
<th>MOGA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joined Twitter</td>
<td>29/11/12</td>
<td>05/11/11</td>
<td>30/08/11</td>
</tr>
<tr>
<td>Analytics1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tweets</td>
<td>1,058</td>
<td>350</td>
<td>698</td>
</tr>
<tr>
<td>Following</td>
<td>802</td>
<td>514</td>
<td>217</td>
</tr>
<tr>
<td>Followers</td>
<td>574</td>
<td>752</td>
<td>506</td>
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<td>1.23</td>
<td>2.14</td>
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<tr>
<td>Analysed tweets</td>
<td>1,057</td>
<td>350</td>
<td>697</td>
</tr>
<tr>
<td>Analysed from</td>
<td>29/11/12</td>
<td>07/11/11</td>
<td>30/08/11</td>
</tr>
<tr>
<td>Analysed to</td>
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<td>24/02/15</td>
<td>24/02/15</td>
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<tr>
<td>Tweets per day</td>
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<td>0.29</td>
<td>0.55</td>
</tr>
<tr>
<td>Retweets</td>
<td>572</td>
<td>120</td>
<td>157</td>
</tr>
<tr>
<td>% of tweets being retweets</td>
<td>54.12</td>
<td>34.29</td>
<td>22.53</td>
</tr>
<tr>
<td>User mentions</td>
<td>140</td>
<td>120</td>
<td>134</td>
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<tr>
<td>Mentions per tweet</td>
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<tr>
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<td>14</td>
<td>17</td>
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<tr>
<td>% of tweets being replies</td>
<td>1.51</td>
<td>4.00</td>
<td>2.44</td>
</tr>
</tbody>
</table>

Study period2
|            |          |          |          |
| Tweets issued | 963     | 193      | 331      |
| Tweets analysed | 193     | 193      | 193      |
| Retweets in sample (%) | 56      | 42       | 28       |

Notes: 1As at February 24, 2015; 2November 29, 2012 to August 29, 2014 (21 months)

Guided by a Foucauldian framework, the analysis focused on power and legitimacy, and how discourses are used by and through subjects. However, given the importance of, and the need to balance this with a consideration of ‘that which is positive, flourishing and life-giving’ [Cameron and Caza, (2004), p.731; Cameron et al., (2003)], the Foucauldian framework was complemented by critical appreciative inquiry (CAI; Oliver, 2005). The analysis was also guided by the push to incorporate more than text — but bodies, emotions, and affect – into research following the affective turn within the humanities and social sciences (Poynton and Lee, 2011; Cromby, 2012a; Cromby, 2012b). Accordingly, the analysis was thematic, but directed by affective CAI (ACAI) to foreground emotions, researcher affect, instances of flourishing, and power inequities (Dadich and Olson, 2014).

This approach to analysing the three datasets involved four stages. First, each sample was reviewed to identify elements and concepts, akin to first-level coding (Schreiber and Noerager Stern, 2001). Second, reflections were noted — in accordance with CAI and
literature on the affective turn – and guided by several questions (see Table 2). Questions were not intended to be prescriptive – but rather, they were a reference point, sharpening the interpretative process and positive critique. Third, elements and concepts were distilled into constructed themes, akin to axial coding (Charmaz, 2006). Fourth, reflections were revisited to add to, and clarify those noted during the second stage.

Table 2  Research questions

1 What roles do both structure and agency play in achieving positive social change?
2 Who determines what positive change should look like and how that process unfolds?
3 What surprised us? Why?
4 What promotes human flourishing?
5 What demonstrates inclusivity?
6 What demonstrates emancipation?
7 What influences shape emancipation or emancipatory aspirations?
8 Which emotions are explicit in this material?
9 Which emotions are implicit in this material?
10 How is emotion embodied or materialised?
11 What evidence is there of the productive aspects of affect? For instance:
   a How does emotion affect the self?
   b How does emotion affect others?
   c How does engaging with this material make us feel – why?
12 What evidence is there of an affective economy?
13 How are flow, intensity and contagion demonstrated?
14 What evidence is there of identity-talk?

2.2 Interview and focus group analysis

Given the importance of undergraduate experiences to interprofessional socialisation (Bell et al., 2009), practitioners-in-training were consulted in 2013 to examine the relationship between training and interprofessional socialisation. At time of data collection, participants were studying to become nurses, physiotherapists, podiatrists, practitioners of traditional Chinese medicine (TCM), and psychologists. Following clearance from the relevant ethics committee, four participants were interviewed and five participated in a focus group (n = 8; one interviewee was also a focus group participant). The purpose of interviews and the focus group was to discuss: student perceptions of IPE and practice; and what it means to be a ‘good’ healthcare practitioner.

2.2.1 Analysis

Audio-recordings of the interviews and the focus group were transcribed verbatim. Similar to the aforesaid analysis of tweets, the analysis of the transcripts involved four stages – namely:

1 first-level coding
2 ACAI, guided by several questions (see Table 2)
3 axial coding
4 reflection and clarification.

3 Results

3.1 Twitter analysis

The following section presents relevant findings from an analysis of tweets issued by the three organisations. For comparative value, organisations are presented consecutively, with examples of tweets provided to substantiate findings.

3.1.1 Cancer Nurses Society of Australia

Tweets from the CNSA Twitter account revealed few, if any explicit references to IPP. Those within the randomly selected sample did not openly engage with interprofessional collaboration – for instance, they did not highlight the associated benefits, speak of appropriate care models, engage with other professions, or describe (even if briefly) how nursing might be combined with the care provided by other professions. Notwithstanding three generic mentions of ‘health professionals’, the only clear references to other, non-nursing professions were those of researchers and their empirical breakthroughs – and these tweets seem to position researchers as experts at the vanguard of a cancer cure:

RT @chemosabe: God I love listening to A/Prof Jane Turner present.
Small victory against aggressive #cancer
RT @SteveMcKiernan: So proud of you RT @NurseMcKiernan: So much
great cancer nursing research happening in Australia…

As the ‘link between cancer nurses in Australia… and other health professionals… [which] openly seek[s] opportunitie[sic] to… build partnerships’ [CNSA, (2014), para.1–6], it is curious that CNSA did not explicitly espouse IPP. This might be partly because it issued the greatest proportion of retweets (56%), relative to COSA and MOGA (42% and 28%, respectively). Tweets issued by the CNSA Twitter account largely paid homage to its own, reinforcing the great, if not unique role of cancer nurses in both the prevention of, and recovery from cancer:

RT @ONAcom: RT @onlive: Symptom management and monitoring by
oncology nurses is critical
RT @whittaker_k: @AnneBooms #cnsa2013 great presentation showing the
broad skills required and massive workload of ONP [Oncology Nurse
Practitioner] in regional/rural…

The Importance of Oncology Nurses in Lung Cancer Care

The suggested position of nurses was fortified by tweets that served to unite the profession. Followers were advised of nursing resources and invited to share expertise. They were also protected via advice to be mindful of vested interests:

#CNSA2014 Pre-Congress Workshop 1: eviQ Education Antineoplastic Drug
Administration Course (ADAC) – Facilitation Skills Training Workshop
The communiqués to, and about the nursing profession were peppered with positivity. At times, the tweets were hopeful, reminding followers of promising research results. These tweets suggested that a cancer-diagnosis was not necessarily reason for despair, as emerging research provided glimpses of optimism:

- Hope for new way to beat #cancer
- Cancer clue gives hope for older mothers
- Ovarian #cancer: US trial boosts hope of early detection

At other times, the tweets exuded warmth. They were attempts to affectively engage with, and include followers into the fold. When juxtaposed with tweets on ‘treatment… breakthrough[s]’, which might read more like a media headline, these tweets might help to anthropomorphise the organisation, reminding followers of its human qualities:

- @Hospira_Inc are a major supporter for the #CNSA2013 16th Winter Congress in Brisbane. We look forward to seeing you next week.
- RT @chemosabe: “@Cecilia: At #cnsa2013. The #welcometocountry of course made me cry. Heart warming.” #deadly @Straddyboy
- RT @britainsnurses: @CNSA_ORG thank you so much for the international follow :)

### 3.1.2 Clinical Oncology Society of Australia

Following an analysis of tweets from the COSA Twitter account, two key findings are apparent. First, relative to CNSA, COSA appeared to issue more tweets that recognised the importance of IPP. The brief communiqués reminded followers that patient journeys are unique. As such, cancer care requires an approach that draws on skills and expertise from different, yet complementary areas. Sometimes, these reminders were direct, while at other times, they were implied:

- RT @hollyfellowes: Theme this morning: complexity of cancer care. Good reminder that no one size fits all…
- COSA’s vision is quality multidisciplinary #cancer #care for all…
- Why do some cancer patients receiving chemotherapy choose to take complementary and alternative medicines? http://t.co/nF9nKatVob
- RT @drcbsteer: #COSAASM Interesting multidisciplinary discussion on pancreaticobiliary cancer treatment options. More than just gemcitabin…
- RT @ResearchMedia: Sandro Porceddu, President of @COSAoncology, highlights the role of #collaboration for improving outcomes in #cancer

Perhaps the most explicit recognition of IPP were mentions of the COSA Cancer Care Coordination Conference – a biennial event that brings together ‘health professionals with an interest in cancer care coordination’ [COSA, (2014b), para.1] to promote and support multidisciplinary care (among other objectives, COSA, 2014a). However, most (if not all) conference-related tweets within the sample were advertisements to lure delegates, rather than windows into the conversations that occurred at the event:
Despite this missed opportunity, given the multidisciplinary member-base of COSA, it may come as little surprise to read more tweets on IPP, relative to those issued by CNSA. After all, its multidisciplinary members are likely to recognise benefit in membership if they feel engaged, albeit in the Twitosphere.

The second finding is limited demonstrations of emotion. Relative to tweets issued by CNSA, those from the COSA Twitter account did not appear to exude similar warmth. Notwithstanding the gratitude extended to individual followers and the congratulatory wishes to award recipients, tweets did not emphasise, ‘the phenomena denoted by the terms affect, emotion and feeling’ [Cromby, (2012a), p.146]. Consider for instance, the tweets that were didactic or non-reciprocal, rather than interactive. Although COSA issued the highest proportion of replies (4.00%) relative to CNSA and MOGA (1.51% and 2.44%, respectively; see Table 1), replies represented a minor proportion of its tweets. As such, these examples suggest Twitter was largely used for one-way traffic – to advise, inform, or instruct, rather than (emotionally) engage followers ‘within social practice’:

RT @nickbrookMD: Enjoyed following #COSAASM today… great work from the twittercrew. Catch up tomorrow in #prostatecancer session

We hope you’re having a great day! Don’t forget you can access everything you need from our ‘app’ – http://t.co/8eLNcziBqx #COSAASM

Thank you for making COSA’s 40th ASM such a success! We hope you’ve enjoyed it… See you all next year #COSAASM

This is not to suggest the tweets were aloof or detached. As the aforesaid examples indicate, the tweets issued by COSA were positive and affable. However, seldom did they explicitly encourage an affective exchange.

3.1.3 Medical Oncology Group of Australia

Of the randomly selected tweets issued by MOGA, there were few (if any) explicit references to IPP. There were no mentions of practitioners who were not part of the fold, and the tweets were bereft of explicit endorsements of collaborative care. Given the recognised importance of multidisciplinary care (Cancer Australia, 2014) and the organisational aim, ‘to improve and develop…the management of cancer both nationally and globally’ [MOGA, (2009b), para.1], this represents a curious absence.

The absence of references to IPP is juxtaposed with tweets (albeit a small few) that bolster the identity of medical oncologists. The brief communiqués remind followers of the role assumed by this profession and the worth of this role:

RT @kevinannjordan: Importance of Cardio-Oncology for cancer patients RT @ClevelandClinic http://t.co/6iYchDuBiJ-

RT @whereisdaz: “We are scientists. We take our time. Bear with us, while we think” - Slow Science Manifesto http://t.co/MohlbMPGad via…
As retweets, it might be argued that MOGA did not craft these statements and as such, is not responsible for the viewpoints. However, as the official MOGA Twitter account, they provide a glimpse into the stances the organisation does (and does not) support.

The identity of medical oncologists receives further reinforcement from a large proportion of tweets that clearly communicate that medical oncology matters. In addition to profile-raising tweets – like those that promote MOGA events – these include funding and training opportunities to advance: expertise in medical oncology; alliances between MOGA and similar international bodies; as well as emerging medical oncology research:

Abstract submission for the #MOGAASM2013 closes on 26th April http://t.co/zyh8E5vcAE Please Retweet

RT @ASCO: 32yo male presents w/ headache & nasal obstruction for 4week duration. Diagnosis? Test your knowledge @ http://t.co/djArse…

New Biomarker May Predict Which Breast Precancers Will Progress #cancer #breastcancer http://t.co/g5WIxO6YX9

Brain tumour cells killed by anti-nausea drug http://t.co/Wrn5pt8E7u

Collectively, these tweets speak to a medical oncology audience, and potentially disengage others who are not part of the fold.

Mentions of research (sensu lato) were arguably most prominent within the sample of tweets. Although this might be expected (given the MOGA remit), it is surprising that communiqués were often editorialised, conveyed like a media-headline, rather than the title of a refereed academic publication. This is affirmed by correspondence patently sourced from the media:

Sweet way to go? Drip-feed soft drink the road to fat http://t.co/14A4umAF via @smh

Alcohol causes 1,400 cancer deaths a year | The Advertiser http://t.co/SEJdI7DrXQ

Young workers lead cancer risk – The West Australian http://t.co/kedTXWBY via @thewest_com_au

Perhaps partly due to the editorial nature of these tweets, mentions of research occasionally tampered with follower affect. At times, emotive language was used to create a sense of: injustice; combat; exigency; and/or hope:

Cancer survivors denied access to travel insurance http://t.co/FyU9AK61HE via @theage [italics added]

Breast cancer drug combo may fight pancreatic cancer http://t.co/LkYm4ugS [italics added]

Radiation fears prompts new guidelines – baby monitors should be placed 1 metre away from cots http://t.co/5XTHaRb5ht [italics added]

RT @IMBatUQ: How surgery could soon become deadly, and how experts want to combat it: http://t.co/x7Jk739YTf #superbugs #antibiotics [italics added]

Ovarian implant success! Australian first procedure and IVF result in pregnancy after chemo treatment http://t.co/8M6Xbjhx via @smh [italics added]
The preponderance of these headline-type tweets overshadow opportunities to engage and interact with followers. Although relaying information is important, it represents only part of the many solutions to enhance cancer care.

3.2 Interview and focus group analysis

This section presents findings following an ACAI of the interviews and focus group with practitioners-in-training. Constructed themes relate to the shared values and skills necessary to facilitate interprofessional collaboration, participant comfort in hierarchies, and the importance of emotion to IPP. Each is addressed in turn.

3.2.1 The good health professional

Deliberating on what it means to be a ‘good’ healthcare practitioner, participants noted the importance of: ‘a good knowledge base’; technical and ‘interpersonal skills’ (4th year psychologist-in-training, female, age 22); as well as ‘care’. A physiotherapist-in-training, for example, described ‘the will to help people’ as the first prerequisite to becoming a good healthcare practitioner (2nd year, male, age 20). Similarly, a psychologist-in-training asserted caring as a given:

people who do psychology, I would hope have a natural[ly] caring nature (4th year, female, age 22).

In performing care, emotional labour was implicated most explicitly by nurses-in-training. A ‘good’ nurse was said to ‘show... enthusiasm and always [treat others] with [a] warm heart’ (2nd year, female, age 23).

Holism, treating ‘deeply and holistically’ (2nd year TCM practitioner-in-training, female, age 45), also featured in descriptions of being a ‘good’ healthcare practitioner:

to be a good nurse it takes a lot of things… morals… compassion… scientific knowledge… Giving the holistic care and taking care of the whole human being and the family, not just targeting the disease (3rd year nurse-in-training, male, age 28).

IPP was depicted – directly or indirectly – as important to achieving holistic care. A physiotherapist-in-training, for example, remarked that physiotherapists should ‘liaise with everyone that’s involved with patient care’ (3rd year, female, age 25). However, according to a TCM practitioner-in-training, IPP was challenging for TCM practitioners as it requires training in a different paradigm marked by Western biomedical approaches, taxonomies, and treatments. For this reason, she argued that TCM practitioners-in-training should learn about:

Western culture and Western medicine and science and this way we can cooperate with the other medical practitioner (2nd year, female, age 45).

Disciplinary variations were apparent. Emotional labour featured more prominently among the nurses-in-training, while others emphasised evidence-based practices, ethics, and communication:

keep your practices up-to-date (2nd year physiotherapist-in-training, male, age 20).

do no harm (4th year podiatrist-in-training, female, age 27).
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The way you communicate with others, not just your clients but other psychologists and professionals (4th year psychologist-in-training, female, age 22).

Due to the limited sample, it is unclear whether these variations reflect personal or professional variations. Overall however, there was consensus on holistic care being synonymous with good practice.

3.2.1 Hierarchies

Reference to hierarchies and structural inequalities emerged from the focus group. These acknowledgements were not cast unfavourably – this was demonstrated in two key ways. First, disciplinary differences in care and practice underpinning structural inequalities were seen as the basis for one’s own professional contribution to care. Second, the dominance of medicine was viewed (perhaps surprisingly) with relief. Participants were thankful that medicine played the role of referee and final decision-maker within multidisciplinary and/or interprofessional teams. These two demonstrations are addressed in turn.

The nurses-in-training were quite vocal in acknowledging the hierarchy permeating interprofessional interactions. However, rather than a source of resentment, they depicted the hierarchy as the basis for their own professional practice:

Some people… kind of dominant – they say, ‘Hey, I’m in medicine… so I should lead… that’s it, you can’t change it’… that’s a challenge (3rd year, male, age 28).

it’s [a] must because… a doctor [demonstrates] the high degree… [while] the nurse, they concentrate on some care… This doctor maybe concentrate on the treatment’ (2nd year, female, age 23).

As a nurse you’re supposed to not know everything. You’re supposed to not do the doctor’s job (3rd year, male, age 28).

Critiques of medicine provided a space for other professions to contribute to patient care. For instance, when reflecting on her experience within a team-based interprofessional teaching activity, a psychologist-in-training recalled ‘conflict’ with a medical student:

When treating a problem, it’s not just as simple as medicating somebody… Luckily it didn’t amount to anything, but there was a doctor saying, ‘Give medication’ and it’s just not as clear as that and that’s something I strongly feel against…. from the psychological perspective (4th year, female, age 22).

Critiquing the neuro-chemical approach within medicine cleared the ground for psychology’s contribution.

When reflecting on clinical placements, other participants also recounted the dominance of medicine. Akin to the nurses-in-training, this was not reason for resentment – but rather, it offered relief, spurring efficient multidisciplinary care. For instance, cognisant that particular specialties, ‘have more of a say’, a physiotherapist-in-training appreciated this dynamic because it bounded the interprofessional exchange:

medicine obviously… have a very exulted position, but I think that’s necessary as well because… they tend to be holistic [in] what they look at. So while a lot of us look at different parts, in the end it’s often the doctors’ decision about what kind of care [is delivered] (3rd year, female, age 25).
Others viewed medicine’s ‘right’ to make decisions as helpful. Given each team member was respected and validated, the hierarchy prevented conflict within the interprofessional team:

it’s accepted that the doctor is in that position and they do have that right to make certain decisions that we don’t. So I don’t think there was any clash in terms of, ‘I don’t agree with you’ or ‘I think we should do this’. Everyone kind of knew where they sat (4th year podiatrist-in-training, female, age 27).

This analysis highlights the hierarchies and structural inequalities inherent to interprofessional teamwork. Furthermore, these were found to facilitate IPP. Emotions related to one’s identity as a ‘good’ healthcare professional however, potentially hindered IPP – this is explored in the following section.

3.2.2 Emotion

Explicitly and implicitly, participants described emotions related to their university experiences and interprofessional interactions – notably, pride. Pride in their scholarly achievements and their professional capacities to provide holistic care were deemed to be important, for they enabled the participants to feel empowered and to empower others, including their patients:

I just find that after doing an assignment… it feels really fulfilling… After that assignment [on] what physiotherapy is… I just felt like this was really what I wanted to do… seeing all the things that you could do as a physiotherapist… just helping people… you could really change someone’s life… I didn’t realise how much it means to people (2nd year physiotherapist-in-training, male, age 20: emphasis added).

I thought previously that nursing is kind of a neglected profession that, okay, you just have to follow the doctor’s commands… But in this kind of program, you find out that, no, nursing has their own opinion… It does count (3rd year nurse-in-training, male, age 28).

Pride seemed to impel participant actions, particularly IPPs. Practitioners-in-training wanted to do their best for patients and experience a sense of accomplishment from helping patients:

Between the professions and in yourself also you feel like, yes, you’re giving the best care. You can provide the best care to the patient (3rd year nurse-in-training, male, age 28).

According to some participants, a limited understanding of, and appreciation for other professions could hinder their confidence in their ability to deliver ‘the best care’. They explained that taking pride in one’s work might be stymied if one is dubious or unclear of the practices of other practitioners:

I’ve got one patient. He needs something to be addressed, which is something related to feet. So just refer to podiatrist. But we don’t know what podiatrists do… [It is important to] know what they are doing… for the sake of the patient, so you know that this is the outcome the patient is going to get (3rd year nurse-in-training, male, age 28).

Improved familiarisation with other healthcare practices could then, conversely, build interprofessional trust, enable IPP, and foster feelings of pride in providing ‘the best care’, which was previously defined as ‘holistic’ care.
Interprofessional teamwork might also be facilitated by emotion work. According to the participants, this involved: managing pride – both in oneself and others; quieting disruptive emotions; liberally cooperating with others; and exercising tactful negotiation skills:

send your message across in such a generous way that it’s not hurting anyone’s ego… be very careful that you are not sounding rude… Somebody might turn up cranky, so you should know how to handle that (3rd year nurse-in-training, male, age 28).

There is a challenge if you’re developing a treatment [plan] and you don’t agree with something the other person is trying to say… you need to negotiate… (4th year psychologist-in-training, female, age 22).

These findings suggest that emotion work can both promote effective teamwork and stymie holistic care. Organisational, team, and interpersonal expectations around tact and agreement with others might undermine interprofessional processes of open negotiation.

4 Discussion

This article contributes an ACAI reading, guided by institutional theory (Eisenhardt, 1988) and Foucault’s (1972) concept of discourse, of tweets issued by three cancer care organisations, as well as interviews and a focus group with healthcare practitioners-in-training. Institutional theory encourages a consideration of social context and the extent to which an individual is linked to, and embedded within their context (Reay et al., 2006). Although embeddedness can constrain change, it can also reveal how context functions and identify viable ways to introduce and sustain change. Foucault’s concept of discourse opens imaginations to the paradigms and subject positions underpinning these constraints. This analysis offers insight into organisational cultures and the discourses within these cultures that guide IPP in one emotionally-charged area of healthcare practice. These insights are juxtaposed against definitions of ‘good’ (interprofessional) practice offered by practitioners-in-training. Findings suggest a ‘cultural clash’ [Monrouxe and Rees, (2012), 671] between an organisational context constraining the acknowledgement of emotions, and individual recognition of the centrality of emotions and emotion work to IPP. These findings are explicated in the following sections.

4.1 Twitter analysis

The organisational cultures and emotional discourses guiding the three cancer care organisations varied. The benefits of multidisciplinary approaches were heralded within the COSA tweets alone and COSA appears to be the organisation with the most multidisciplinary following. Given the commitment to IPP within cancer care, limited reference to IPP within the tweets of CNSA and MOGA peaks curiosity. Reflecting on institutional theory (Eisenhardt, 1988), this might suggest their tight weddedness to, or embeddedness within traditional institutional arrangements, which largely prize siloed professional practices – particularly that of medicos.

Emotions were unique features of CNSA tweets. For example, both sadness and joy were depicted in the ‘welcometocountry’ tweet. Emotional labour was also apparent, with several tweets broadcasting hope for a cure, suggesting an attempt to manage the
emotions of others. In contrast, beyond those MOGA tweets that were stylised to replicate news headlines and affect readers with a sense of injustice, emotions were largely absent from the tweets of COSA and MOGA. This suggests that emotions and emotion work are overt aspects of organisational cultures in nursing, but not in medical or IPP. Although this might be surprising – given the emotionally-charged setting of cancer care (Cherry et al., 2014) – this finding reflects Cartesian discourses that present the emotions of healthcare practitioners (as opposed to patients) as physiological distractions that can hinder rational decision-making and teamwork (McNaughton, 2013; McCallin and Bamford, 2007).

4.2 Interview and focus group analysis

An analysis of the interviews and focus group with practitioners-in-training revealed their commitment to holistic care, which was deemed to be a feature of ‘good’ practice. Holistic care was considered to be compassionate, evidence-based, and ethical – it acknowledges the limits of one’s own knowledge and the need for collaboration with other healthcare practitioners. Studies suggest that power inequities and boundary-work can stymie IPE and IPP (Olson and Bialocerkowski, 2014; Paradis and Whitehead, 2015; Baker et al., 2011). It is therefore surprising that the participants in this study described the hierarchy within healthcare with relief, viewing it as a necessary organisational feature of efficient and holistic care.

Emotions and emotion work were found to both facilitate and hinder IPP. The participants described pride and fulfilment in achieving successful and holistic care for patients. These rewarding emotions could be fostered by IPP teamwork – but these required practitioners to recognise the work of other healthcare practitioners. A limited understanding of other professions caused hesitation when referring patients, underscoring the importance of learning ‘about each other [during IPE] to improve collaboration and quality of care’ [Freeth et al., (2005), p.15, emphasis added].

Potentially more concerning is the finding that, while emotion work was described as central to successful teamwork, working harmoniously as a team was not always in the patient’s best interest. Managing emotions to comply with interpersonal, team, professional, and organisational expectations of being calm and cooperative could undermine holistic care, causing some voices and professions to be underrepresented within IPP. This finding suggests a need for further research into IPP as a process driven by more than individual attitudes, emotional intelligence, or even group emotional intelligence (Olson and Bialocerkowski, 2014; Amundson, 2005; Arora et al., 2010; McCallin and Bamford, 2007) – but as involving intersubjective emotions and emotion work. Extant scholarship reflects the discourses within health sciences, conceptualising emotion as an individual phenomenon (McNaughton, 2013). The application of theoretical perspectives that depict feeling and emotion as shared across individuals (Cromby, 2012a) and as phenomena shaped by socio-cultural norms (McNaughton, 2013) might help to expand inquiry in this field to inform improvements in IPP.

4.3 Cultural clash

Overall, the analysis of organisational cultures and emotional discourses guiding CNSA, COSA, and MOGA, and the reflections of practitioners-in-training reveal a ‘cultural clash’ [Monrouxe and Rees, (2012), p.671]. Monrouxe and Rees employ the term to
describe disparities in the professionalism training that medical students experience within undergraduate and clinical teaching environments. The phrase is used here to denote the chasm between:

1. the emotionally-constrained and uni-professional cultures in organisational tweets
2. the experiences of practitioners-in-training, which assert the importance of emotions and emotion work to IPP.

Although the expression of emotions was overt in CNSA tweets, the organisational cultures of COSA and MOGA were comparatively devoid of emotions. However, practitioners-in-training, especially those in nursing and psychology espoused the importance of care and emotional labour to achieve the subject position of the ‘good’ health professional. This suggests overlapping definitions of what it means to be a ‘good’ health professional, ranging from the provision of up-to-date evidence-based treatment to offering empathy and care. Furthermore, the Cartesian understanding of emotions as a distraction that dominates much of the healthcare system is precisely what makes room for other subject positions – the more care-oriented approaches in other professions. The ‘culture clash’ regarding emotions seems to reinforce professional specialisation and differences in health practices within the healthcare system hierarchy.

Moreover, there was agreement among allied health practitioners-in-training that emotions were relevant to interprofessional interactions and that emotional labour should be performed to assuage ‘egos’ and show respect across the team. This reinforces top-down decision-making and potentially undermines the more egalitarian (and holistic care) goals of IPP.

IPE is arguably a form of social and organisational change designed to reshape healthcare culture. Rather than leaving practitioners-in-training to face this conflict on their own, pioneering change unguided, it might be helpful to investigate and subsequently embed reflection on these emotional discourses and emotional labour into clinical placement and continuing education. A lack of explicit ‘recognition and support for emotion work’ risks sending the ‘powerful message’ that emotional challenges represent ‘failure’ [Williams, (2012), p.371]. Thus, following suggestions from the communication and professionalism literature, role-playing (Monrouxe et al., 2014; Bell et al., 2014) and analytic reflection (O’Flynn et al., 2014) might represent fruitful strategies worthy of future investigation.

5 Conclusions

This article juxtaposed an analysis of tweets from three cancer care organisations, with that of interviews and a focus group with practitioners-in-training. Although the tweets were carefully sampled to be representative of the chosen organisations’ tweets, the findings are limited to an Australian context and based on an analysis of a small number of organisations and participants; thus, transferability is limited. Nevertheless, the strength of this study lies in its theoretically sensitive analysis, informed by institutional theory (Eisenhardt, 1988) and Foucault’s (1972) concept of discourse, which together helped to reveal a clash in the organisational change process that is IPP. Pride and emotion work are implicated in the reflections on IPP described by the practitioners-in-training, who arguably bear the weight of this organisational change process. However,
Cartesian discourses that frame emotions as an interference to rational care, and rules-of-thumb within the medical system obscure recognition of the emotional dimensions and emotion work involved in interprofessional teamwork. Furthermore, the predominance of the Cartesian emotional discourse, and critiques of it, underpin the differing subject positions held by many practitioners-(in-training) outside of medicine, possibly serving to reinforce the hierarchy within the healthcare system. These findings suggest a need for further research into the complex interplay of individual and inter-subjective emotional experiences, within organisational cultures, and investigation of IPP as an emotionally-charged instance of organisational change.

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