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Frames of Reference: Applying Sociology in Interdisciplinary Medical Settings

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Abstract

Unforeseen obstacles and inefficiencies may arise when medical organizations seek to implement protocols that rely upon cooperation and coordination by clinical practitioners from multiple disciplines, departments, and professional orientations. In this reflection, we discuss some ways in which sociological concepts may be useful in forestalling and mitigating such obstacles and inefficiencies in clinical settings. Echoing recent decisions by professional organizations like the American Medical Association, we use the concept of "framing" to suggest how interdisciplinary medical protocols and policy formulations may benefit greatly from sociological lessons and demonstrate some ways by which the incorporation of sociological insights can facilitate greater communication between varied disciplines and departments seeking shared outcomes. In conclusion, we provide some concrete ways by which interdisciplinary medical programs may benefit from sociological concepts and practices.

Keywords

sociology in medical settings, interdisciplinary clinical protocols, health care organization and communication, evaluation research, applied medical sociology, public health, cancer screening

In the process of an evaluation study (see Cragun et al. 2014) exploring barriers and facilitators for adoption and implementation of endometrial (ET) and colorectal (CT) tumor screening for Lynch syndrome (LS) in a wide variety of hospitals, we began to notice a pattern wherein genetic counselors involved in ET and CT implementation experienced communication breakdowns with other members of implementation teams (i.e., doctors, cancer specialists, pathologists, and other care providers). The qualitative phase of the study used interviews with 13 genetic counselors, two pathologists, and one administrator at 13 hospitals located across the United States to ascertain barriers and facilitators to the implementation of screening procedures. Specifically, we found that genetic counselors, cancer specialists, pathologists, and administrators all approached the screening program with different goals and priorities in mind (i.e., genetic counselors focused on follow-up and patient care whereas pathologists focused initially on lab activity, though through eventual lines of communication, they later recognized the importance of getting the results to counselors for follow-up) and that these different "frames of reference" or "process concerns"

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(Nowakowski et al. 2015) limited the effectiveness of implementation by stalling efforts to diagnose and communicate with patients.

In fact, our evaluation revealed that one of the primary barriers to successful screening programs arose in relation to inefficiencies and obstacles related to interdisciplinary communication. As a result of what we learned during the evaluation, we sought to outline some ways by which medical practitioners, often trained in disparate fields with markedly different perspectives, could learn to communicate better. Although applied researchers have long noted the importance of communication and the need for shared "points of view" in communication between different disciplinary and organizational fields (Morgan 2007; Tannen 1993), our evaluation revealed that such lessons have not made their way into concrete practice in some interdisciplinary medical settings. Following social movement scholars exploring communication and perspective within and between organizations (see Fominaya 2010 for a review), we thus seek to offer practical strategies such actors may use to continue efforts at better implementation and communication across varied "points of view" (see also Polletta and Jasper 2001). In this way, our findings add to ongoing calls for greater interprofessional collaboration and education (see Bridges et al. 2011; Yeager 2005 for reviews) by suggesting some sociologically informed strategies that could facilitate better interprofessional communication within concrete health care settings.

In this reflection, we thus suggest some ways existing sociological concepts related to "framing" (Benford and Snow 2000; Goffman 1974; for updates and reviews on this concept in a wide variety of organizational settings, see Fominaya 2010) could facilitate better interdisciplinary communication within clinical settings and propose some concrete steps medical practitioners could take to put these insights into action. To this end, we use insights we gained via the interviews conducted primarily with genetic counselors. Specifically, these practitioners wrestled with medical departments focused on results (without much contact with patients), treatment (without much contact with lab work), and administration (without much contact with patients or lab work). As such, they relied on these "partners" to obtain the information necessary for providing useful counseling to patients managing administrative (i.e., costs and paperwork), treatment-related (i.e., protocols and interventions), and lab-related (i.e., results and collections) interactions as part of their overall experience with tumor screening for hereditary cancer risk.

Reflecting on Communication Breakdowns in Cancer Screening Implementation

Our evaluation study focused on the ways hospitals implemented ET and CT screening protocols to identify patients with hereditary cancer. In such cases, clinical programs are following calls by the National Comprehensive Cancer Network (NCCN) to institute routine tumor screening on all newly diagnosed patients regardless of family history. Although implementation of such programs currently rests at various levels of completion, in all such cases, interdisciplinary coordination is necessary between—at least—genetic counselors (charged with making sense of the screening and results for patients and explaining the implications of results and need for follow-up diagnostic testing), general practitioners (charged with overall care of patients), oncologists (charged with treatment protocols), surgeons (involved in resection of the tumor specimens), pathologists (who perform the tumor screening), hospital administrators (charged with overseeing the program development), and other hospital staff (who often interact with and care for patients before, during, or after screening protocols). Not surprisingly (Michalet 2013), protocols requiring collaboration across so many domains create challenges for interdisciplinary health centers.

Studies suggest that routine screening for ET and CT may pay substantial dividends in terms of patient outcomes, treatment possibilities, and prevention of additional cancers (Evaluation of Genomic Applications in Practice and Prevention (EGAPP) Working Group 2009; Tafe, Riggs,

and Tsongalis 2014). However, practitioners coming from different backgrounds, like other social beings (Blumer 1969), interpret these protocols in different ways (see also Nowakowski et al. 2015 for examples in other interdisciplinary fields). The genetic counselors, for example, focused on the patients and the need to improve follow-up with screening results while expressing frustration with doctors and administrators who were often more focused on managing or treating the cancer and concerned with financial aspects of the programs. Such frustration only arose in the midst of communication breakdowns that kept the counselors from getting necessary information about patient results. When communication processes worked effectively, counselors spoke much more positively about their experiences. However, our interviews often revealed at least three different languages operating at once in relation to these protocols and inefficiencies that emerged from different interpretations of what "mattered most" in the implementation of tumor screening protocols. As a result, we began to see many of the barriers and inefficiencies arising from differential "definitions of the situation" (Goffman 1974) held by practitioners approaching the screening programs from varied professional and academic backgrounds.

Although more commonly investigated in relation to social movements, communication, and public policy (see Fominaya 2010 for a review), "frames" are definitions of a situation shared by people in the same situational or structural context. Following Goffman (1974), frames are tacit assumptions about what exists, what happens, and what matters in a given situation (see also Morgan 2007). Within any given setting, people interpret goals, outcomes, behaviors, protocols, and needs in relation to what they believe the setting is, what happens in that setting, and what matters in that setting or in relation to stated goals (see also Schrock, Holden, and Reid 2004). As a result, the "frames" or "definitions of the situation" people carry into any medical—or other—setting will influence the ways they interpret and act upon the "work" at hand. In cases where people from multiple disciplines and backgrounds come together for a shared goal, each person may arrive at the task with shared or different frames capable of facilitating or impeding successful implementation.

In our case, the various practitioners arrived at routine screening implementation efforts with different frames. Specifically, genetic counselors sought to help patients manage the medical information they were receiving and the emotional effects of diagnosis, whereas other medical practitioners (i.e., general and oncology medical doctors) were focused on either examining labs or establishing treatments. In the former case, the counselors thus framed the situation as one of education and care, whereas the latter case involved framing the situation as one of medical intervention and analysis. Although these frames are each relevant in the overall situation faced by the patients and practitioners, they require a "shared language" or "collective focus" (Polletta and Jasper 2001) if they are to function collaboratively. In our case, however, no shared language existed between these organizational fields.

When this happens in any setting, people are likely to experience misunderstandings, advocate for incongruent practices, and miss opportunities for greater coordination and cooperation (Goffman 1974; Polletta and Jasper 2001; Schrock et al. 2004). Taking a lesson from social movements, people in such cases need to "align" their expectations with one another to accomplish efficiency and successful implementation of shared protocols (Fominaya 2010; Snow et al. 1986). To accomplish this, for example, practitioners working toward routine screening implementation could focus on what they share (i.e., the goal of increasing positive patient outcomes through screening, the necessity of funding routine screening, and the ability to care for patients following screening) when outlining policies, procedures, and protocols. In so doing, they can sidestep areas where they disagree in terms of disciplinary norms and practices by focusing their efforts on the ways their varied skill sets can be integrated for the pursuit of shared goals. Furthermore, arriving at a shared definition of "what matters" can facilitate better information sharing by alerting all parties to what information is needed for each element of protocol implementation and patient care (Morgan 2007).

Practical Strategies for Solving Communication Breakdowns in Cancer Screening Implementation

As researchers who have done various types of evaluation research to date, we are aware that there is likely no catchall method for resolving communication issues that arise in relation to interdisciplinary protocols and settings. In fact, previous literature (both applied and traditional) has revealed many ways people go about attempting to resolve such dilemmas in practice (Morgan 2007). Our experience thus speaks to these prior efforts by revealing some ways in which sociological theory and research on framing—and other aspects of interaction and communication—could be used to mitigate interdisciplinary communication issues in applied settings. To this end, our experience suggests that the following concrete practices could be beneficial when interdisciplinary teams seek to establish protocols requiring collaboration and communication:

1. From the outset, interdisciplinary teams should have meetings or online forums where members from each respective discipline, department, or background explicitly state their goals for the program in question. Teams should then use these disclosures to arrive at a shared set of goals they all seek to achieve.
2. From the outset, interdisciplinary teams should collaboratively discuss and outline plans for financial and practical management of programs within *and* between departments and disciplines. In so doing, teams may establish (prior to implementation) pathways for knowledge, evidence, and strategy sharing in relation to the program as well as who will be responsible for which activities.
3. Interdisciplinary teams should consider recruiting (i.e., as a consultant or full-time team member) sociologists (or public health practitioners trained in sociology and/or sociological social psychology and communication) to oversee and manage interpersonal and organizational communications and evaluation in much the same way as some medical schools that have begun recruiting sociologists to teach ethics, diversity, and communication techniques to future doctors and medical researchers. In some cases, genetic counselors (who generally have training in communications and psychology) play this role on top of their other duties, and either bolstering their power in these areas or providing them with a supportive colleague focused on communication issues could aid their efforts.
4. Interdisciplinary teams could create positions (i.e., official or informal) wherein the stated function is to coordinate cooperation and communication throughout implementation and accomplishment of interdisciplinary programs. In this regard, a team member could assume the role of translator and manager to facilitate ongoing monitoring of communication and cooperation efforts. In fact, in some of the more successful centers, genetic counselors have been empowered to play this role. However, issues have arisen when physicians are unwilling to give up control despite not having the time to manage the operations themselves. It may thus be useful to formalize coordination and management within a position granted the time and resources to ensure that all elements are carried out throughout the process and between departments.
5. From the outset and continuing as long as the program is in place, interdisciplinary teams should set aside times and resources for regular meetings wherein team members (especially those in different areas) may voice concerns, check in on progress of the program, and establish solutions to any barriers that arise over time. Although this practice could facilitate greater involvement and more effective communication, it may be hard to accomplish in relation to how busy many medical practitioners already are with varied tasks, protocols, and programs.

6. Interdisciplinary teams could also evaluate such endeavors regularly and consistently by bringing in outside observers to ascertain what is working and what is getting missed in evolving communication standards. To this end, evaluation researchers would explore and compare communication strategies, frames of reference for different members of the team, and intervention protocols with an eye toward ongoing integration and communicative efficiency within and between interdisciplinary teams.

Although we are sure that other interventions will become necessary over time, as social, biological, and psychological health fields become more focused on team-based and interdisciplinary protocols (see also Morgan 2007 for a similar insight in relation to previous consideration of communication in varied organizational fields), our research to date suggests that these practices may be important steps to continuing the incorporation of sociological knowledge into interdisciplinary health settings in ways that maximize efficiency and break down existing barriers to care. To this end, we encourage others to look into ways sociological concepts concerning communication, interaction, and organizational process may be useful to health-related structures experiencing tremendous shifts and adjustments in coming years.

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