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ORIGINAL ARTICLE

Interprofessional collaboration and family member involvement in intensive care units: emerging themes from a multi-sited ethnography

Scott Reeves[1], Sarah E. McMillan[2], Natasha Kachan[2], Elise Paradis[3], Myles Leslie[4] and Simon Kitto[2,5]

[1]*Centre for Health and Social Care Research, Kingston University & St George's, University of London, Kingston upon Thames, UK,* [2]*Office of Continuing Professional Development, Faculty of Medicine, University of Toronto, Toronto, Ontario, Canada,* [3]*Wilson Centre and Postgraduate Medical Education, Department of Anesthesia, University of Toronto, Toronto, Ontario, Canada,* [4]*Armstrong Institute for Patient Safety and Quality, Johns Hopkins University, Baltimore, MA, USA, and* [5]*Department of Surgery, University of Toronto, Toronto, Ontario, Canada*

Abstract

This article presents emerging findings from the first year of a two-year study, which employed ethnographic methods to explore the culture of interprofessional collaboration (IPC) and family member involvement in eight North American intensive care units (ICUs). The study utilized a comparative ethnographic approach – gathering observation, interview and documentary data relating to the behaviors and attitudes of healthcare providers and family members across several sites. In total, 504 hours of ICU-based observational data were gathered over a 12-month period in four ICUs based in two US cities. In addition, 56 semi-structured interviews were undertaken with a range of ICU staff (e.g. nurses, doctors and pharmacists) and family members. Documentary data (e.g. clinical guidelines and unit policies) were also collected to help develop an insight into how the different sites engaged organizationally with IPC and family member involvement. Directed content analysis enabled the identification and categorization of major themes within the data. An interprofessional conceptual framework was utilized to help frame the coding for the analysis. The preliminary findings presented in this paper illuminate a number of issues related to the nature of IPC and family member involvement within an ICU context. These findings are discussed in relation to the wider interprofessional and health services literature.

Keywords

Critical care, ethnography, family member involvement, interprofessional collaboration, qualitative research

History

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Introduction

The need for effective interprofessional collaboration (IPC) to reduce duplication of effort, restrict clinical error, improve safety and enhance the quality of patient care is now widely acknowledged (e.g. Farrell, Schmitt, & Heinemann, 2001; Frenk et al., 2010; Gregson, Cartlidge, & Bond, 1991; Onyett, 2003; Schmitt, 2001; Shaw, 1970). Policy makers regularly call for effective IPC as a key mechanism for tackling poor service delivery, reducing errors and contributing to service modernization (The National Academies of Practice, 2013; World Health Organization, 2010). Involving patients and family members in care continues to be a growing area of research and practice as more family members are expressing the desire to participate and be recognized as constituents of the patient care team (Garrouste-Orgeas et al., 2010). Indeed, research suggests that gains in patient care can be realized where staff regularly interact to negotiate and agree upon their work (Zwarenstein, Goldman, & Reeves, 2009) and family members are supported (Davidson et al., 2007).

Effective IPC is crucial within the clinical area of intensive care, given the severity of cases and the quick and often unpredictable changes in patients' conditions (Reeves et al., 2013). However, it has been found that a range of professional, organizational and culture factors can impede efforts to ensure care is responsive, timely and effectively delivered to patients. The role of family members in these attempts are also unclear. Efforts to enhance IPC often encounter difficulties, such as a limited understanding of how to work together, poor leadership of teams, the effects of professional socialization, status differentials between practitioners and the impact of organisational change (Bosk, Dixon-Woods, Goeschel, & Pronovost, 2009; Pronovost, 2011).

While there continues to be an increase in the number of studies focused on IPC, our understanding is limited as much of this work continues to rely on survey and/or interview data. As a result, these empirical accounts only provide perception-based descriptions of IPC processes, which are often limited by poor memory recall or responses affected by social desirability (e.g. an unwillingness to acknowledge collaboration difficulties). A similar case can be made for investigating family member involvement in the intensive care unit (ICU). Family members are a routine presence in the ICU, yet their day-to-day interactions with the interprofessional care team have not been explored. Ethnographic studies that gather observational data overcome these limitations as they record IPC processes and family member involvement in real-time. Such accounts are revealing, indicating a very complex negotiated activity affected by a range of different socio-cultural factors (e.g. Baker, Egan-Lee, Martimianakis, & Reeves, 2011; Chatalalsingh & Reeves, 2014; Cohn, 2010).

Correspondence: Professor Scott Reeves, Kingston University & St George's, University of London, UK. E-mail: S.Reeves@sgul.kingston.ac.uk

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This article presents emerging findings from the first year of a two-year study, which employed ethnographic methods to explore the culture of collaboration and family member involvement in eight North American ICUs (this paper focuses on four sites). This work extends previous ethnographic studies of teamwork that have been undertaken at a single site, and have also excluded patients and families (Reeves, Lewin, Espin, & Zwarenstein, 2010; Paradis et al., 2014). This study employs a comparative ethnographic approach: the systematic observation, documentation and analysis of the behaviors and attitudes from several groups or cultures across several sites (Rohner, 1977). It aims to build on work by Reeves et al. (2010) to investigate the factors that impact IPC and family member involvement in care delivery processes.

Methods

An ethnographic approach was adopted to generate a rich understanding of the nature of IPC and family member involvement in an ICU context. Located within anthropological traditions, ethnography has a focus on understanding the social processes – behaviours, perceptions, actions – and cultures that occur within teams, organizations and communities (Hammersley & Atkinson, 1995; Reeves, Peller, Goldman & Kitto, 2013). A key aim of ethnographic studies is to document culture in the form of perspectives and practices to elicit an in-depth understanding of the social world (Reeves, Kuper & Hodges, 2008).

Through the use of an ethnographic approach, this study specifically aimed to explore the team-based cultures of eight ICUs based in the United States and Canada over a two-year period. This article reports on emerging findings from the first year of data collection from four ICUs located in US teaching hospitals. To generate comparative data from differing contexts, two of the ICUs were academically oriented units, with a greater focus on teaching, while the other two were more general community-based in nature. Two PhD researchers trained in ethnographic techniques conducted observations, interviews and document collection at each site. Each researcher spent 10–12 hours per week observing in two ICUs over the course of one year, establishing a consistent presence over time and allowing them to build trust and rapport with study participants.

This study employed a conceptual framework to help sensitize data collection and analysis (Reeves et al., 2010). This framework highlights the complexity of team-based care, and is based on four core elements: relational factors (those linked to how relational issues such as power, hierarchy and leadership influence relationships); processual factors (those focused on processes of collaboration such as time, space and task complexity); organizational factors (those focused on understanding the impact of local institutional structures and management processes); and contextual factors (the broader cultural, political, social, economic issues that frame IPC). See Figure 1 for an illustration of these four elements.

Data collection

Observational data were collected by the use of a marginal ethnographer approach (Reeves et al., 2013) at four ICU sites. Staff, patients and family members at each site were verbally consented by the ethnographers for observations. Ethnographers obtained written consent for formal interviews. In addition, the use of short informal conversations with informants (staff and family members) allowed the study to explore emergent issues within their context. In total, 504 hours of observational data were collected over a 12-month period. Fifty-six semi-structured interviews were undertaken to further explore, in depth, emergent issues from the observations and informal conversations. These interviews were conducted with a range of ICU professionals (e.g. nurses, doctors, pharmacists and social workers) and family members. In addition, documents (e.g. clinical guidelines and unit policies) were gathered to help develop an insight into how the different sites engaged organizationally with IPC.

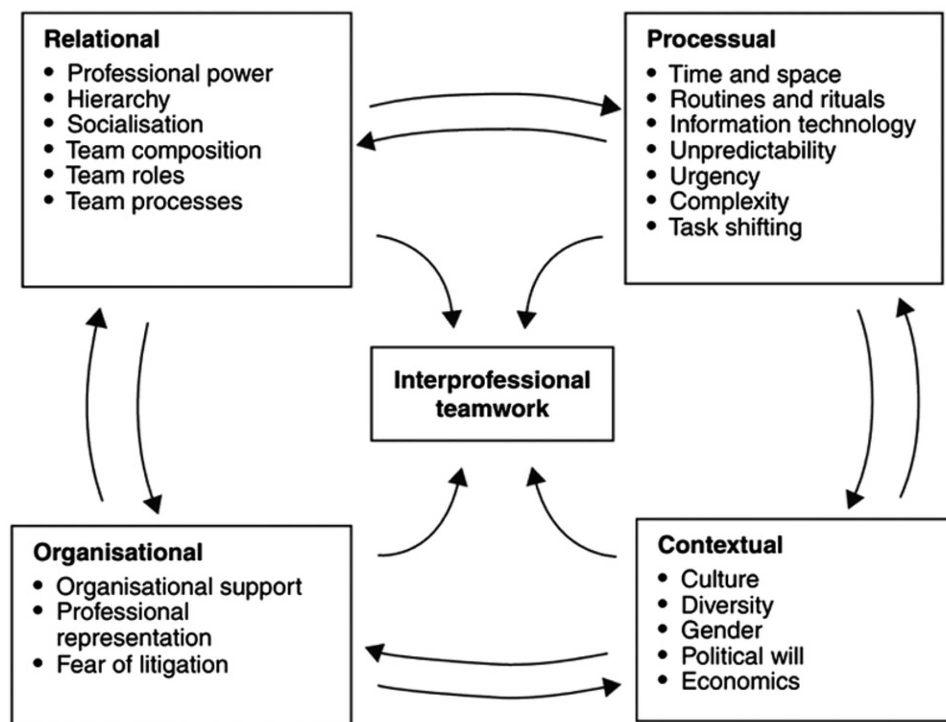

Figure 1. Reeves et al. (2010) Conceptual Framework for Interprofessional Teamwork.

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Table I. Interprofessional collaboration and family involvement in the ICU.

Domains	Interprofessional collaboration	Family involvement
Relational	Short serendipitous interactions between doctors	Positive ICU experience for family members facilitated by trusting relationship with providers
	Largely profession specific tasks for nurses and doctors, interacting only when clinical query arises	Family member as advocate/translator for patient, other family members
	Teamwork viewed as profession specific rather than interprofessional	Family members often engaged in conversation about patient care
	Traditional medical hierarchy dominates interprofessional collaboration	Continuity of communication between providers and between teams at times fractured; family member ''filter'' of information between staff
Processual	IT encourages parallel work practices; less face to face collaboration	Little involvement of family members in formal uniprofessional rounds
	Formal rounds largely undertaken on separate professional basis, particularly in non-medical rounds	IT facilitates improved patient care, but limits face to face interaction with providers
	Profession specific spaces in the ICU encourage siloed professional activities	Physical ICU space affects family member involvement
	Highly collaborative work amongst professions occurs during periods of crisis	
Organizational	ICUs as busy clinical environments	Family member admittance to ICU enforced unevenly and affects family member involvement
Contextual	Factors such as the broader social, political and economic landscape in which the institution is located, and their impact team on collaboration in the ICU	Language and cultural differences shape the way in which family members are able to engage in care decision-making in the ICU

Data analysis

Ethnographic fieldnotes and interview transcripts were coded using NVivo 10 software in an iterative analytic process. Directed content analysis (Hsieh & Shannon, 2005) enabled the identification and categorization of major themes within the data. As noted above, Reeves et al. (2010) conceptual framework for interprofessional teamwork was utilized as a coding scheme for the analysis – see Figure 1. Analyzing IPC amongst care providers was intuitive with this framework. Interviews and observations of patient and family involvement in the ICU were coded with the four domains of this framework in mind, but also utilized sensitizing concepts, such as the family environment of care and mutual understandings between families and providers from literature on patient and family involvement in critical care (Davidson et al., 2007; Söderström, Saveman & Benzein, 2006).

Quality and ethics

The quality of the data was enhanced in a number of ways, including combining observational interview and documentary data to provide rich insights of collaboration and adopting an iterative approach to data collection and analysis. Through this process, researchers were able to be reflexive about their practice and ensure qualitative rigour (Kitto, Chesters & Grbich, 2008). In addition, the study employed a longitudinal dimension to the collection of data, which has allowed the study to generate a rich, detailed description of each ICU's culture, helped to reduce reactivity (as clinical staff, patients and family members became accustomed to the ethnographers' presence over time) and limited the impact of seasonal variations in work processes.

Access to information was negotiated with, and ethical approval granted by, the Internal Review Board at each institution.

Results

The main themes from the analysis are listed in Table I and illustrated in the following two sections. First, emerging themes, which focus on IPC, are provided. Second, data related to family member involvement in the ICU are presented. Data excerpts from the sites are labelled as ICU 1, 2, 3 and 4.

Interprofessional collaboration

In general, observations revealed that the ICUs were busy clinical environments. At any one time, a number of people, including clinical staff, patient relatives and other visitors (e.g. clinicians from outside the ICU) could be seen entering or leaving. Staff were also undertaking rounds, working on patient procedures, updating patient information on computers, dealing with telephonic and verbal enquiries as well as arranging tests for patients. The observational data provided a very similar picture across the participating ICUs regarding the nature of interprofessional interactions.

Interactions involving physicians and nurses were the most commonly observed amongst health provider exchanges. When these interactions occurred, they were generally brief and often serendipitous in nature, with both parties then returning to their respective tasks, as the following data extract indicates:

> An MD comes to talk to an RN about the patient in Room 3 . . . The RN tells him that she is getting a renal consult. The MD asks: ''Can we do anything for you?'' The RN responds: ''No, thank you.'' The encounter is short but polite. (ICU 3 Fieldnote, April 9)

For large portions of time, observations indicated that doctors and nurses worked separately on their own profession-specific tasks, only interacting with one another if they had a clinical query:

> An ENT MD [Ear, Nose and Throat Medical Specialist] is in Room 6 . . . He shouts: ''Suction?'' An RN walks in, manages the situation. ''Mrs. W, I'm going to suction you.'' The ENT doesn't introduce himself. A medical fellow is talking really

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fast, describing the case, while the ENT MD is looking through a scope. The RN continues to care for P6 as the [Fellow and ENT MD] speak. (ICU 4 Fieldnote, April 25)

The use of information technology appeared to encourage parallel work practices. For example, the use of electronic health records (EHRs) on the ICUs was found, at times, to impede interprofessional communication. It was found that nurses and physicians, in particular, were often more focused on working at the computer, usually updating the EHR, than engaging in face-to-face collaboration. The following excerpt from an attending physician speaking informally to the observer illustrates this point:

> Since the computers came in, there's no doubt communications have become a challenge. There's a whole generation of doctors who never knew anything else, so they're accustomed to spending all their time in front of a screen . . . I mean, I try to encourage them to talk to the nurses. To check in about things . . . In the old days you were up and around all the time. You were at the foot of the bed for the vital signs or the chart and you wrote up your orders right there, or maybe at the nursing station. And you could follow up . . . (ICU 3 Fieldnote, Feb. 6)

Formal activities, such as medical and nursing rounds, across the ICUs were also undertaken on a separate professional basis:

> Interviewer: So one of the things that I have noticed is when they [physicians] do their rounds, they make a circle.
> Nurse: Right, try and get around them, it's close to impossible . . . you have to fight to get in it. As a nurse, as a person at the bedside, I will walk through the whole thing. I'll say, ''Excuse me,'' and I'll kind of go in there, and I want to hear. But if you say, ''Excuse me,'' and they don't move out of the way a couple times, and I'm like, ''Excuse me,'' and then I'll touch them to encourage them to move (ICU 4 Interview, RN 1).

While there was some involvement of nurses and pharmacists on medical rounds, there was never any medical involvement in, for example, nursing patient handovers. The separateness observed between the medical and nursing activities appeared to be compounded by their spending periods of time in separate spaces (e.g. physicians' room, nurses' room) completing profession specific tasks or engaging in conversations with members from their own professional group.

In interviews, ICU staff discussed the notion of ''teamwork'', which they tended to view as a profession-specific, rather than an interprofessional, activity. Also, when asked to describe interprofessional relations, a number of staff noted how interprofessional discussions could be based on traditional hierarchical notions of collaboration where medicine dominates:

> I think one thing that comes up sometimes is what happens if, for example, a nurse and a physician or a respiratory therapist and a physician disagree about the management of the patient, because that's like conflict in any teamwork, which is how do we resolve the conflict? Who prevails? And at times I think people fall back on, well, I'm the doctor. I'm the one writing the order. So I have the authority (ICU 1 Interview, MD 1).

However, all ICU staff recognized the need for positive IPC, as this physician notes:

> Just working so closely with nurses . . . I think aligning with them [the nurses] from a very early time . . . made me view our teamwork in a particular way. You would not even consider rounding on one of the patients that was in the ICU if the nurse was not there, present at rounds. So to compare and have people round and not have the essential bedside nurse who's with the patient for 12 hours not be part of it and participating just boggles my mind (ICU 1 Interview, MD 2).

These views on positive interprofessional relations were also shared by family members, as this extract indicates:

> The nurse is doing most of the communication, and that was fine again because the MD is standing there providing the medical orders. She's moving around, she's talking, but she's also listening. They're respecting each other. You don't feel any type of tension. She's trying to follow his direction. He's trying to figure out what's going on and everything. They were working together. . . there was no superiority/inferiority, which can make tensions worse on the patient. You wouldn't believe it. Everybody was working together in harmony . . . I mean, one thing that's important too nobody wants to see, especially if you're really sick, nobody wants to see someone putting down somebody else because that would make me nervous. (ICU 2 Interview, Family Member 1)

Moreover, during ''periods of crisis'' (e.g. unplanned self-extubations, emergency resuscitations and end-of-life discussions with families) ICU staff were observed engaging in highly collaborative work, as noted in the following extract:

> An RN runs in and urgently grabs MD1's attention – I cannot hear their exchange, but MD2 does and clearly notes it. MD1 leaves quickly and returns from the patient's bed within 30 seconds, announcing, ''she's satting in the 60s and getting worse.'' The entire room gets rapidly up and moves with purpose, but without panic, to the bedspace. I follow them and much action occurs, including an order for the on-call anesthesiologist to come and perform an intubation. All nurses on the north side of the unit, and perhaps the entire unit become aware of the situation and people start showing up to help with the crisis. (ICU 3 Fieldnote, Jan. 29).

Family members also remarked on the ability of providers from across professions to come together during critical medical events:

> The first time his heart tanked. . . they called a code blue. RN1 was the nurse then. So all these people [ICU staff] converged on the room, and I was just standing outside, watching. I was pretty sure he was okay, and he was. But RN2 was magnificent. She happened to be the charge nurse that day. She went in and out of the room, and kept telling me what was going on. That was awesome, from my perspective. But it was fascinating to see all these people come together and take care of the situation (ICU 1 Interview, Family Member 1).

Family member involvement

In terms of family involvement data within these ICUs, there were several positive interactions between ICU staff and family members. One family member recounts:

> I know [my relative is] being well taken care of. And even though there are small issues with communication, misunderstandings are nothing in the big picture of things when people [ICU staff] have done their best (ICU 1 Interview, Family Member 2)

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Family members noted that their experience on the ICU was particularly positive when they felt they had a trusting relationship with the staff. Staff knowledge of the patients' history, frequent communication regarding the patients' condition and informal communication with the family helped to facilitate this positive relationship. For example, when asked if any ICU staff stood out, a family member responded:

> [The physician] wanted me to understand, and I got it just by his language. He wasn't agitated. He didn't make me feel like I was beneath him because I didn't have an M.D. behind my name. Actually, it was almost like a friend talking to another friend because he was kind, he was compassionate, and he was very understanding . . . He would say something, he would explain and then, ''Do you have any questions?'' And if I had a question, he'd gladly answer it. (ICU 2 Interview, Family Member 1).

Across the sites, interviews suggested that many family members took on the role of advocate for their sick (and often unconscious) relatives. Family members noted that they became the 'hub of information' for the patient, translating and passing on information to other family members who were present as visitors in the ICU or outside of the hospital in another location. Many family members also performed an assistive role that supported the care provided by the ICU staff:

> When we get to a point where he can start swallowing. I'd say, ''Could we crush up the pills and I'll feed it to him through his food?'' And the nurses would crunch it up as small as they could, and he'd swallow them. So we were trying, working as a team to help him even get to the swallowing process (ICU 1 Interview, Family Member 3).

Interviews indicated that family members were often engaged in discussions about the care of their relative. Some examples include conversations about treatment options, progress of care and end of life (EOL) decisions:

> You could tell that this is the direction, and [the clinicians'] whole goal was to get him through the procedure and into rehab as soon as possible, having chemo and radiation here. It's just a plan that every time I talk to the doctor, he said, ''This is where we're looking. This is how we're trying to get him so he can get out and get back home as soon as possible''(ICU 1 Interview, Family Member 3).

However, family members also reported that communication often varied between ICU staff, making it difficult to maintain continuity:

> And it's not the doctors' fault. They're trying to do everything that they're supposed to do, which is to give me information – which is highly appreciated over no information, but I'd like to get consistent information that doesn't change between one doctor and another (ICU 1 Interview, Family Member 2).

In addition, family members found that on occasions poor interprofessional communication made it difficult to obtain consistent information about their relatives:

> Researcher: So you feel that you've received very conflicting information . . . ?
> Family Member: I think they try, but there are so many different teams. You've got your liver team that comes, your kidney team that comes, your ICU team that comes, and then there are respiratory therapists who come in. Then you've got the nurses, and they all change (ICU 1 Interview, Family Member 2).

It was also found that family members were the *filter* of clinical information about their relative between ICU staff. As noted above, due to the largely parallel nature of clinical work in the participating units, family members helped connect staff in the care of their relative:

> Well [my relative] was getting where he was just pressing the button before I would know it, and I'd jump up and I'd go, ''Why did you press the button?'' So I had to find out from him, and then I would call them [ICU staff] back and say, ''Could you send the aid because he needs a cleanup or could you send the nurse because he needs suctioning?'' . . . And they were more than willing to help out, but they were busy, very busy at times. (ICU 1 Interview, Family Member 3).

However, there was little involvement of family members or patients in rounds. Family members reported mixed feelings about the function and their participation in rounds. The following quote illustrates how rounding can feel troubling for family members in the absence of information from the clinical staff:

> Sometimes you can hear, and sometimes you cannot. But for someone . . . if I know I'm okay, then I'm all right. But if I'm concerned for my health – there's something that's going on – then I would wonder. What are they whispering about? What's wrong? Because it gives the impression that something is wrong, and that's why they're whispering, but I think they're just whispering just to have a private conversation about the case. (ICU 2 Interview, Family Member 2).

Family members also observed the use of computers and IT as a tool for staff to facilitate patient care and liaise with one another in a more structured manner. Even with these benefits, family members noticed some drawbacks:

> I understand that they're writing in everything that they do, but it does seem like they're spending an awful lot of time sitting in front of the computer screens instead of in front of people. (ICU 2 Interview, Family Member 4).

The physical design of the ICU, and the degree to which it facilitated family members' ability to be comfortable in the environment, affected the way families interacted with both their relative and the staff:

> I sleep in that chair most of the time. I have left, but get called back because my husbands really anxious . . . I have to go over to the children's center, in the children's building, in the children's wing and go in there and take a shower. And I have no problem with doing that, but there should be some place here . . . where they can say, ''Hey, you've been here. We can tell you're from out of town [you can use the facilities on this unit] . . .'' (ICU 2 Interview, Family Member 3).

Finally, ICU admittance policies, which were often organizationally defined and enforced by ICU staff, affected the degree to which family members felt they could be involved in patient care. Several family members expressed frustration when criteria for ICU access appeared to be selectively or arbitrarily enforced, as having this access was important to them. As this family member noted:

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... You can come in this place any time, day or night, 24 hours a day, come through that door with anybody. They're not like, ''Oh, you're only immediate family''. No. And I think that's great, because that's a big thing, for somebody to see patients. They could be here for a while, and you say, ''Oh, you can't come if you're not in immediate family''. I just don't think that's right. (ICU 2 Interview, Family Member 3).

Discussion

As presented above, a key emergent finding from data collected in these four ICUs was that interprofessional interactions, particularly between physicians and nurses, were terse in nature. Typically, these interprofessional interactions consisted of brief requests for clinical information or physician orders for patient-related tasks. Opportunities for extended interprofessional discussion to advance patient care were largely absent. As noted, the culture of IPC was also inhibited by profession-specific activities such as working on computers, and also clinical rounds. As a result, it was somewhat unsurprising to find that discussions of teamwork tended to be regarded as a profession-specific rather than an IPC activity. Indeed, this professional isolation was often emphasized by the staff spending large portions of time in their respective professional spaces. Such findings resonate well with the work from a small number of qualitative studies undertaken in acute care settings (Allen, 2002; Lewin & Reeves, 2011), which report similar patterns of professional and interprofessional interaction and collaboration.

While there continues to be a discourse that highlights the notion of ''interprofessional teamwork'' (Robinson, 2011), this study indicated that the notion of interprofessional ''knotworking'' (Engestrom, Engestrom, & Vahaaho, 1999) would appear more appropriate. Such an approach acknowledges that interprofessional interactions are more like *threads of activity*, which are tied and untied between different ICU staff, rather than traditional approaches to teamwork which involve regular and more collaborative interaction (Reeves et al., 2010).

Nevertheless, despite the limited nature of interprofessional communication, relationships between staff across these ICUs were generally cordial in nature. Moreover, during the shift from ''usual state'' to ''crisis state'' when, for example, an emergency resuscitation occured, staff came together quickly around the patient, collaborating and communicating in an effective manner to resolve the crisis. These shifts in interactions – from one of limited collaboration to a collaborative mode – have been found elsewhere in the ICU literature (Piquette, Reeves, & LeBlanc, 2009), suggesting that while professional separateness is a common form of interaction across these settings, when a knotworking approach to IPC appears more dominant, staff can rapidly shift to a highly collaborative manner during short periods of crisis. Such a finding acknowledges the importance of how changes in ''processual factors'', such as urgency and complexity of tasks (Reeves et al., 2010) linked to delivering care in an ICU setting, can have a pronounced effect on the nature of IPC.

Due to the critical nature of the ICU, family members typically act and are recognized as a proxy voice or surrogate decision maker for their relative (Apatira et al., 2008; Davidson et al., 2007). Our emergent findings were consistent with this phenomenon, as only one patient was able to participate in an interview with his family member. As a result, the bulk of our findings concentrated on family member involvement in the ICU, which as some authors have argued, may differ slightly from patients' perspective of their care preferences (Pardon et al., 2010). However, our findings indicate that when patients were unable to communicate for themselves, many family members played key roles as advocates, translators and central hubs of information for their relatives, as well as being care providers. This finding supports previous literature that cites family involvement in the ICU as being profoundly influential for patient outcomes (Davidson et al., 2007) and highlights the importance of investigating the family members' role in the delivery of interprofessional care.

Studies of family members in the ICU have centred on dynamics of care, such as family needs and coping (Schenker et al., 2012; Wendler & Rid, 2011), EOL decision-making (Huffines et al., 2013; Luce, 2010) and communication between family members and care providers (Jacobowski, Girard, Mulder & Ely, 2010; Hwang et al., 2014). Family member involvement continues to be studied during specific ICU events including the family conference (Curtis & White, 2008), presence at resuscitation (Howlett, Alexander, & Tsuchiya, 2010; Pasquale, Pasquale, Baga, Eid, & Leske, 2010) and a small body of literature has examined participation during rounds (Cypress, 2012; Santiago, Lazar, Jiang, & Burns, 2014). These are indeed moments where family members and care providers come together in the ICU and have been captured within the emerging data in this study. However, these data also suggest that family member interactions with staff are not merely isolated to specific events during the ICU stay, but occur over time and with a changing array of staff. For instance, family members often facilitated continuity between professionals by acting as the *filter* of, at times fractured, clinical information. This filtering role was performed by family members on a continuing, daily basis and supports the use of an ethnographic approach to capture this ongoing relationship. Factors that at times impeded family members' ability to provide stability were organizational in nature, including ICU admittance policies that were sometimes perceived by family members as being arbitrarily enforced, as well as broader social, cultural and economic factors.

The family member and care provider relationship is a central theme within these findings. In the interviews, each family member detailed a very positive relationship with at least one care provider, characterizing these staff as being sincere and positive. Staff knowledge of patients' histories, combined with frequent and informal communication, also helped to facilitate trusting patient-provider relationships. Exploring interactions between family members and staff is cited as a significant area of inquiry because the way these exchanges are mutually experienced can influence further interaction (Söderström et al., 2006). Our findings are consistent with this literature from both observations and interviews with family members and care providers. Engaging in the complexities of patient–family relationships, as well as relationships with professionals, fosters a humanistic care ethic (Day, 2006) and a more nuanced understanding of interprofessional practice and family involvement in the ICU.

Concluding comments

This article presented emerging themes from an ethnographic study of IPC and family involvement in North American ICUs. A key finding from these sites was that interprofessional interactions tended to be terse in nature. Indeed, at these sites, it was often noted that for long periods of time staff were focused on completing their profession-specific activities.

Nevertheless, during periods of clinical crisis, these staff shifted from working as parallel teams into a highly collaborative interprofessional team. In relation to involving family members, the findings indicate the importance of examining family involvement in the ICU as it occurs over time with a multitude of staff and care teams. This extends previous research, as the dynamics of interprofessional practice and family involvement in the ICU are largely absent from the literature. The use of the

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interprofessional framework (Reeves et al. 2010) has, so far, been useful in framing data collection and analysis activities around IPC and family involvement. It remains to be seen, as the study progresses and data are gathered in four more ICUs, how this framework will perform, and whether some modification will be needed in order to draw conclusions about IPC and family involvement that are applicable to a broader context.

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Declaration of interest

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