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and makes major decisions about his care. The physi-
cian—patient relationship is especially intense and pro-
longed and an important part of their work together
DoING CARE PLANS IN PATIENT CONFERENCES
consists of the management of symptoms and dis-
content, form and style of the interview should reflect
the technique of questioning, the management of patient affect, medical and psychosocial information
obtained from the patient and the communication to
the patient of information.

The instrument can be used in teaching, program planning and evaluation, and in medical research. The normative criteria outlined can be used to evaluate similar interviewing techniques and goals. Individual house officer scores can be used to provide feedback to the trainees, while pooled scores offer a means of assessing the success or failure of various teaching approaches.

Instruments which assess the quality and character of the doctor—patient interaction also make important contributions to medical care research. Once we can accurately de-
scribe the physician's interviewing behavior, we can begin to study the effects of the physician on the patient's behavior. We can study the interaction of physician and patient on the basis of the physician's selection of specific words or phrases. We can study the effects of specific interviewing techniques on the patient's behavior. We can study the effects of specific interviewing techniques on the patient's behavior.

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chiefly cared for geriatric patients, some devoted a unit to it, others to it with particular diagnosis on the part of the patient, as mental retardation, psychiatric illness, or blindness. All homes were licensed both as skilled and intermediate care facilities. Two were church-related (one Catholic, one Lutheran), one was nonprofit, and two were proprietary homes. The size of the homes ranged from 360 to 308 beds for the two largest to 122 and 99 beds for the smallest. The differences between nursing homes entered the practice of care planning as resources; they did not affect the practice as such.

In most homes, conferences are scheduled to last from one to two hours. Some homes set aside one afternoon a week for the activity director; some conferences others spread conferences of various kinds over the entire week. Care plan conferences typically include reviews of 3-7 patients per hour session. My participation in the different types of conferences at each home varied in duration. Several months were spent observing patient care conferences in a church-related home as part of a larger study of the social organization of care in the home (3, 12); I observed conferences in the four other homes for two months each. There was a rather formal scheduling of conferences in all the nursing homes, which in some cases had been held before me or in no problem in arranging observations. Instead, staff members in two of the homes even suggested that they could change their time if it conflicted with my schedule. Together with other participants who "took notes" in the sessions, I noted the primary thrust of conversations and the course of social interaction. My concern was not to gather all the details of ongoing conversation, but rather, to record conversation, gesture, and patterns of interaction as data about the social practice of making sense of patients in the service of completing care plans for them.

IDENTIFYING PROBLEMS AND SELECTING APPROACHES

to do care plans is practice to taking granted that patients have problems and that something can be done for them. It does not matter that one, two, or even many staff members may personally believe that problems do not exist at all in some patients or that problems found are, in many cases, problems assigned. It does not even matter that somebody publicly scoffs, in the midst of a conference that "all this, after all, is a sort of a put-on anyway, isn't it?" as long as it is not taken too seriously and its intellectual implications only momentarily dwelled upon. Two categories of problems may be distinguished: diagnosed problems such as blindness, gum disease, heart disease, arteriosclerotic heart disease, organic brain syndrome, diabetes, and chronic undifferentiated schizophrenia; and management problems such as the patient who "makes more work for the staff by trying to escape from the home, one who smokes a lot, or one who is vulgarly loud." Staffers are concerned chiefly with identifying material problems, resorting to the consideration of diagnosed problems when no managerial problems are present.

The transition from one category of problem to another is not always clear either. "something of them." They imply that each other to "come up with at least something" that may be the problem. Such cooperation is needed, but it is rare. Staffers are usually successful in interpreting some feature of a patient's daily activity as problematic, making it unnecessary for them to turn to diagnosed problems. In this regard, take the following excerpts from two patients' conferences at a church-related home. In another conference, the assistant director himself, the nurse, a social worker, the administrator, and the dietician. Only general short- and long-term goals are stated in this nursing home. Each service sets its specific goals outside the conference.

Reading from the patient's chart, a nurse has entered: "has a medical background statement. The patient counselor speaks next.

"Pastor: "You know she just sits there quietly in her room... you know, that you're keeping your eye on anyway. I just can't have them blank [care plan item]."

"Activity: "Well that was good for her. But then each of the patients is reviewed. I'd say she was down and gets down quite often, really. It's become way hard for us to get Emma to do anything more. She needs to come to crafts everyday. But now, we just want to see her move.

The social worker changes her earlier opinion about Emma. "Social Yes, she certainly is addicted to TV."

"Gladys Zimmer, is introduced. Activity: "We have anything on Gladys?"

"Worker: "about her dentures? It says here that she needs to have her dentures checked."

"Social: "So, I guess... I can say that the problem for Emma seems to be a kind of... general chronic depression and passivity that manifests itself in withdrawal? [pause]

"All agree. The approach to the problem is troubled over as the overall goal and about what this may be."

A second patient, Gudmard Zimmer, is introduced without a briefing. In this case, after a number of comments are made about what a good patient Gladys is, the social worker turns to the problem of someone who is unable to go to church. She identifies Gladys's chart suggests that Gladys's dentures might be causing her trouble. The appeal to dentures as a result of the social worker's impatience at not having a problem to work on leads to an ironic exchange with the general counselor and the social worker later in the review.

Social Worker: Gladys Zimmer is next. Does anybody have anything on Gladys?

Nurse: Gladys is such a good—in quotes—patient. You can't really care for them quietly in her room and doesn't bother anyone.

Activity: "Oh yes. She never gets in anyone's way. A problem was quickly noted by each participant and was said to result from the resignation of a floor nurse who had been a dear friend. In the other case, however, the "same" problem may have been located at considerable urging and said to be due to the patient not participating in the activity program of late.

Staff members can identify problems in any patient activity by, in effect, reading the activity as problematic. On occasion, they implement each other to read behavior in this way. Consider how the similar recreational activity of two patients becomes, in their separate conferences, "something to be respected", on the one hand, and a care problem, on the other. Sophie Tanus's review begins with a consideration of her friend's refusal to participate in recreation as a matter of individual rights. Staff members then zero in on some other behavior as problematic. In Emil Kramer's conference, however, the constraint of coming up with problems around which to organize a care plan suggests that the patient might be better off if this could be done about getting him more involved in activities. The final written care plans will show no evidence that the patients' recreational activities were initially described as identical.

Staff members began Sophie Tanus conference by spending considerable time discussing her ADLs (activities of daily living). At one point, her television watching is mentioned. "Social Worker: When I drop down her hill, I can hear it on. She watches TV all the time. I'd say she's a real addict."

"Activity: Yes. She certainly is addicted to TV.

"Social Worker: Side conversations and joking about the absurd consequences of matching too much TV. The activity director changes the subject."
Participants resolve disparities by doing a hyperverbal type of thinking, with a person’s theory work, of course, at all points of care planning, not just in dealing with disparities. But, considered effort for the circumstance in the resolution of disparities. The identification of problems when some are present is more a matter of exploration and dredging (sometimes rather urgent) then theorizing and testing. In resolving disparities, each staff member’s opinion is taken to be a potential interpretation of the “actual” progress of the patient — in the course of con, such staff members engage in considerable discussion — some detailed and impassioned, some curtained and glib — over the merit of one interpretation or another. They also construct linkages between interpretations in order to make them reasonably fit together as features of the patient’s life (cf. the practices of “filling in” [7], pp. 178-180) and “reconstructing biography” [4, pp. 158-191]. For example, should one staff member describe a patient as charming and well-mannered and another report that the patient, on the contrary, is crude and headed, they attempt to resolve the difference. They make use of well-recognized categories, such as “the patient is playing games with us”. Sometimes, they suggest that a disparity is a result of misperception by a staff member implying that there is objective sense in patient’s lives, discoverable when properly perceived. Except in typically thoroughly meaningful, staff members do not deal with disparities in perception beyond what they know about the patient in the light of which sense is constructed through their own deliberations. Having offered accounts for seeming disparities in the problem of lateness, conference participants proceeded to “test” them by offering evidence for or against them. They take on the meaning of available or missing information. The process of problem identification is more complicated in practice. For one thing, each review occurs within a context of relevant and unfolding contingencies that include diverse kinds of information about each patient and emergent interpretations by staff members of the meaning of available or missing information. One cannot specify, beforehand, what meaning a particular instance of patient behavior will come to have around any given treatment they take on their meaning in the course of the staff. As staff members plan health care in patient conferences, the process of problem formulation is oriented to the resolution of the particular cases at hand. Except for what they already do not act on, the general consistency of their judgments nor over the validity of attributing problems to patients. The consistency of a patient’s behavior “by identification” as staff members fail to be treated by them as mere constructs, as artifacts of their deliberations. While staff members occasionally speak of “the things you come up with because you have to”, such recognitions do not constitute a theme of describing what a staff member believes to be problems in the patient’s recent behavior. In practice, staff members attend to ostensible patient care realities, which usually appear or temporarily hidden. On that basis, they produce “trustable” sense out of the patient knowledge and experience they bring to conferences.

DEALING WITH DISPARITIES

Participants do not always face a lack of problems. They often encounter a surfeit of opinions about the patient’s problems. After a briefing, it is not unusual for each participant to offer his or her independent opinion to a particular patient’s behavior “of late”. Some may consider it to be, as they often say, “a real put”, “very erratic” or “confused and disoriented”. Others may report that they “really haven’t seen any of that”. Still others may simply be too busy to be watched. In the case of a few problems, the patient does pose more serious kinds of problems. How do staff members manage such disparities in identifying the actual problems of the patient?
Doing care plans in patient conferences

When problems and approaches have been specified, participants are ready to formally enter them into the patient's care plan. Typically, it is at this point in the conference that care plans are set in order to complete the plan. The procedure for recording problems, approaches and results onto care plan forms varies. One procedure is to complete a service-specific plan following each individual service's identification of problems. A second procedure is first to identify general problems and then to ask participating service representatives to specify the problems for their respective departments. For example, a director of nursing states: “Okay. So the problem is too work on getting Timothy involved and not so wound up in himself. Nursing first then: [Turns to charge nurse] How do you want to put that? The social worker is then asked for her comments: “New social services. How do you see it?” This continues until each participating service has been surveyed for formulation. A third procedure is to limit the conference to the identification of current problems, with the expectation that the respective services later will complete written care plans in accordance with conference proceedings.

As far as practice is concerned, a number of activities between the time problems are identified and approaches selected, and the time they first appear in writing. While the procedure for recording care plans varies from service to service and the problems discussed and identified are often wide-ranging and complex, they are surprisingly homogeneous on paper. What accounts for this? When it comes to the matter of putting down on paper the problems, approaches, and goals, staff members think of problems as really an indication of her dependence need and insecurity. The rest of the conference is organized according to this need. No one admitted that he misperceived Frances, though this is not uncommon in staffings. What was perceived and reported by some staff members took on a different meaning when the psychologist suggested that they “were all right, in a way”. What led to this change was itself the real issue: namely, the covert manipulations of a rather insecure person. This theme seemed to make everyone feel more at ease. Both reports of Frances' problems and lack of problem became, as was now obvious, symptoms of her real problems.

Anxiety are expressed by several members in several different ways: 1. atmosphere of fear is made more apparent by the fact that staff members are generally afraid to address issues of concern. 2. Staff members are often afraid to discuss concerns in a critical manner. 3. Staff members are afraid to challenge the authority of the psychologist. 4. Staff members are afraid to address issues of concern in a thorough manner. 5. Staff members are afraid to admit to their own feelings. 6. Staff members are afraid to address issues of concern in a direct manner.

The theory and work theory of testing patient conference add to the life of its own to what is known about patients. Staff members are far from being mere processors and evaluators of patient care information. They do not give equal attention to all known problems but dwell on those that are expressly or symptomatically difficult to evaluate. The reasons for this are many, but the most obvious is the fact that patient care is provided in an environment where time and resources are limited. The second reason is that patient care is provided in an environment where time and resources are limited. The third reason is that patient care is provided in an environment where time and resources are limited. The fourth reason is that patient care is provided in an environment where time and resources are limited. The fifth reason is that patient care is provided in an environment where time and resources are limited. The sixth reason is that patient care is provided in an environment where time and resources are limited. The seventh reason is that patient care is provided in an environment where time and resources are limited. The eighth reason is that patient care is provided in an environment where time and resources are limited. The ninth reason is that patient care is provided in an environment where time and resources are limited.

The written presentation of problems, approaches, and goals on care plans is frequently marked by jokings and sarcasm. Staff members tease each other about “how fancy a problem sounds in writing and how significantly it changes who we are”; “it’s just not right”; “you must be writing down medical jargon”; “why does it sound too good to me?” Why don’t you say it any other way? “It’s just not right.” Consider an excerpt from Margaret’s concern conference as staff members deliberate over what to say for short-term goals:

Nurse: So what do you want to say for the goals? Short-term first.

Activity Director: We’re hea having considerable success in getting Margaret to participate in things lately. You know how she’s got the sweet tooth. She just loses her candy. I offer some candy if she comes to activities. You know (chuckles) kinda belch her. So how about a goal of some sort like bringing her candy so as to get her more involved?

Nurse: God! We can’t put that down. Why don’t we say, “positive reinforcement”, not “belchery.”

All laugh.

Social Worker: Yeah. I think that sounds a lot better.

Activity Director: Okay. So we put it... [Slowly reads what she writes down] “Use positive reinforcement to acclimate to facility”.

Social Worker: [To all you, you really have to give Judy [turns to activity worker] credit for her fancy-pants way of saying things. Right on.

In another nursing home, a staff member tout’s the ability of an occupational therapist, as participants deliberate over the social service goal. In this home, social workers are set for each service offered in addition to overall goals.

Activity Worker: How about “extend ADL’s”?

Social Worker: No... but that’s an activity’s problem. You can put that down in your section.

Activity Worker: [To group] One goal would be to increase self-sufficiency. How about “increase self-sufficiency”?

Social Worker: [To group] What about “increase self-sufficiency”?

Activity Worker: [To group] And the other one? That’s a neat one, isn’t it? Or how about “increase socialization”, or “reorient to reality as needed”?

Social Worker: [To group] A silly.

Activity Worker: You should hear some of the ones that Susan [absent occupational therapist] used to use. Boy, they were beauties... like, “increase independent activities”, “reduce anxiety”, “involve in activities of daily living”, “encourage appropriate behaviors”. She’s really great at it.

Nurse: [Finished writing] Okay. That’s all I have. I put “encourage peer interaction and encourage emotional stimulation.” Wasn’t that fun?
Activity Worker:

Deliberations over how to write problems, approaches, and goals are not always as extended as in the preceding excerpts. Frequently, a short, but pitiful concluding sentence is readily approved. As one staff member concluded: "So, then, we'll say that the social service problem is "disorientation as to time and place", and the approach and goal to 'maintain and return to reality as needed. Sound okay?" With no one objecting, the care plan is completed, despite the next patient's conference beginning.

Extended behavioral jargon is used in completing care plans. There is a stock of standard phrases commonly used. In one case, all staff members came to recognize it. Its repeated use in completing care plans homogenizes patients' problems, approaches to their care, and treatment goals.

Staff members vary in their ability to use behavioral jargon. In some nursing homes, particular staff members may be reputed for their ability and may be called upon for suggestions. The one staff member who implicitly enjoys such a reputation—without a proven demonstration of his ability—is the consulting psychologist. When a consulting psychologist (less commonly, a psychiatric) participates in patient care conferences, he is readily asked for help in how to "put things." New staff members are socialized to use standard phrases. In one conference, a veteran social worker and occupational therapist made a point of this to a young, recently hired activity worker.

Social Worker:

[To the new activity director] The major problem of this case reviews is to try and come up with something new and different on each patient. That's kind of hard sometimes. Of course, you've got the jar things that you can say and that's what you can always slip into in a plan. But you've got to kind of vary it sometimes... so it looks like you've been at least thinking about it. You see, technically, the short-term goals should be met in six months and the long-term in a year... but u-a-u... with people in nursing homes [with their eyes and things], you can't really expect very much. They stay pretty much the same. Of course, you can't really put "nothing" in the care plan goal either. It's pretty true but the state won't go for that. So you put something down that sounds sort of in-between... something... uh... that's not too fancy that anyone would know that you just don't meet it and something that's not too hopeless either.

Occupational Therapist:

It won't be so bad once you're around awhile. You'll catch on. You'll see. We know you've got it up here [Points to her head] but you've got to learn--we all have to really—I mean how to play it into the system.

PRACTICE AND ACCOUNTABILITY

In recent years, there has been much concern over how to make the nursing home industry more responsi-
ble in the care of patients. Some demand stricter controls while others suggest the need for better-trained service providers [16, 17]. Data on the social organization of care planning show, however, that no form of control and/or training could completely eliminate staff discretion and interpretation in patient care considerations. Discretion and interpretation are necessary features of the attempt to engage in mean-
ingful and acceptable care planning. This is true to the limits of accountability.

Some form of accountability is possible. Some limi-
tations might be placed on what can be claimed in plans, approaches, and goals. But this would con-
tain the acceptable stock of standard phrases. Con-
ferences might be opened to outside observations.

Moreover, the routine participants who, on oc-
casion recognize their own practice (within humor and sarcasm), outsiders could see and note technical shortcomings that could not take serious ex-
ception to practice lest they raise questions about the ostensible realities of care planning and inspection al-
together, such as whether patient problems are as much an artifact of planning and accountability as of patient difficulties. The patient himself—the inter-
preted representative might be allowed to participate in his care conferences, as a patient right with the expec-
tation that patient presence would serve to mediate staff discretion in care planning. This, however, would intro-
duce yet another set of interpretive contingencies into the practice of care planning. The content of care plans might turn out to be different than it otherwise would be, but it would not displace the discretion and interpretation necessary to do meaningful care plan-
ing. Moreover, there is reason to believe that staff members would make use of various strategies to manage patient input into care planning [18].

In all work, there is a point at which formal and informal rules are articulated with the unique con-
tingencies of each work application [9, 10]. The ac-
complishment of each application is dependent on the abilities of participants to work through the partic-
ular contingencies of each. Like other matters of practi-
cal everyday life, to "do" care planning is to actively con-
struct and integrate things known about patients into reasonable and acceptable products. The work of care planning involves the structural and integration of varied perceptions of, and interests in patients, on the one hand, with interpretations of accountability, on the other. Articulating these contingencies is the col-
duct of care conferences, participants manage to ac-
complish the work expected of them. As in other matters of everyday life, the "doing" of care planning is as much an artifact of participants' practical efforts as it is an outcome of putting their skills to work. The issue of accountability only addresses the latter.

In its practice, the work of accountability tacitly ur-
ges staff members to search for "(some up with)
reasons in patients' lives in order to understand.
It tacitly urges staff members to present their findings in an organizationally acceptable manner. While staff's orientation to patients in conference produces accountable evidence of care, it also is a process of reality construction. In attending to patients as they do in care conferences, staff members virtually risk themselves to see through to clear-cut patient care problems, approaches, and goals as an integral feature of deliberating over them. The "doing" of care plan-
ning is what makes related issues of accountability possible.

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