

EMBRY-RIDDLE

Aeronautical University™

SCHOLARLY COMMONS

Publications

11-2016

Understanding Teamwork in the Provision of Cancer Care: Highlighting the Role of Trust

Elizabeth H. Lazzara

Embry-Riddle Aeronautical University, lazzarae@erau.edu

Joseph R. Keebler

Embry-Riddle Aeronautical University, keeblerj@erau.edu

Soosi Day

Deborah DiazGranados

Virginia Commonwealth University, diazgranados@vcu.edu

Minggui Pan

See next page for additional authors

Follow this and additional works at: <https://commons.erau.edu/publication>



Part of the [Human Factors Psychology Commons](#), and the [Psychiatry and Psychology Commons](#)

Scholarly Commons Citation

Lazzara, E. H., Keebler, J. R., Day, S., DiazGranados, D., Pan, M., King, M. A., & Tu, S. (2016). Understanding Teamwork in the Provision of Cancer Care: Highlighting the Role of Trust. *Journal of Oncology Practice*, 12(11). <https://doi.org/10.1200/JOP.2016.013854>

This Article is brought to you for free and open access by Scholarly Commons. It has been accepted for inclusion in Publications by an authorized administrator of Scholarly Commons. For more information, please contact commons@erau.edu.

Authors

Elizabeth H. Lazzara, Joseph R. Keebler, Soosi Day, Deborah DiazGranados, Minggui Pan, Michael A. King, and Shin-Ping Tu

Understanding Teamwork in the Provision of Cancer Care: Highlighting the Role of Trust

Elizabeth H. Lazzara, Joseph R. Keebler, Soosi Day, Deborah DiazGranados, Minggui Pan, Michael A. King, and Shin-Ping Tu

Embry-Riddle Aeronautical University, Daytona Beach, FL; Virginia Commonwealth University, Richmond, VA; Kaiser Permanente, Santa Clara, CA; and Repass, Cincinnati, OH

Abstract

Team science research has indicated that trust is a critical variable of teamwork, contributing greatly to a team's performance. Trust has long been examined in health care with research focusing on the development of trust by patients with their health care practitioners. Studies have indicated that trust is linked to patient satisfaction, adherence to treatment, continuity of care, and improved outcomes. We explore the construct of trust using a case example of a patient who received a surgical procedure for a precancerous polyp. We apply the principle of trust to the case as well as present the literature on trust and key definitions for understanding trust. Additionally, we apply the definitions presented to the specific case example by highlighting moments where trust is developed or violated. Lastly, we offer insights to health care practitioners on the development of trust in their own patient interactions to improve care.

CASE SUMMARY

The patient is an ex-Marine with a history of Gardner syndrome, diagnosed in 1966, who is under the care of Dr Larson for routine endoscopies and polyp removal. During the patient's annual examination at 71 years of age, Dr Larson noted a precancerous polyp at the duodenum and referred him to Dr Franklin for surgery. During the initial consultation, Dr Franklin recommended that the patient change his lifestyle before surgery, including smoking cessation. However, at the follow-up visit, Dr Franklin learned that the patient had stopped smoking a few days before and emphasized to the patient that he would not perform surgery until he stopped smoking for 30 days. Although disappointed by this decision, the patient followed Dr Franklin's instructions and was subsequently cleared for surgery 1 month later. The 12-hour Whipple procedure went

smoothly, and Dr Franklin expected the patient to recover without complications. Dr Franklin left for a previously planned vacation. However, the patient's condition took a sudden turn, with severe abdominal pain, and he was moved to the Critical Care Unit (CCU) and subsequently diagnosed with an abdominal abscess. Drs Auden and Gustafson, two residents in training under Dr Franklin, played key roles during this critical time by closely monitoring the care process through keeping in touch with Dr Franklin and communicating with the patient and his family, gaining their respect and trust. The CCU embodied a family-inclusive environment, with the Intensive Care Unit (ICU) team being responsible for the patient's care while Drs Auden and Gustafson continued to provide wound care with daily visits. While receiving care in the CCU, the ICU team called a family

ASSOCIATED CONTENT



Appendix DOI: [10.1200/JOP.2016.013854](https://doi.org/10.1200/JOP.2016.013854)



DOI: [10.1200/JOP.2016.013854](https://doi.org/10.1200/JOP.2016.013854); published online ahead of print at jop.ascopubs.org on September 6, 2016.

meeting. Originally, the family was told that Dr Gustafson was not part of the ICU team. Only after the family's request was Dr Gustafson included, and everyone gained a shared understanding of the patient's condition. Later, the patient was moved to the Post-Surgical Gastroenterology/Bariatric Unit and then to the Acute Care Rehabilitation Unit, where the family thought there was poor shared understanding, communication, and expectations among staff. On the patient's discharge from the hospital, Dr Geist resumed his role as the patient's primary care provider and further reinforced Dr Franklin's postsurgical directives with frequent sharing of goals and progress, which enhanced the relationship among these providers, the patient, and his family (see Appendices A and B, online only, for a timeline and full description of the case).

INTRODUCTION OF ISSUE/PRINCIPLE

Teams and multiteam systems represent the complex organizational structures in which health care is provided to patients. Teamwork is defined as the enactment of team-level attitudes, behaviors, and cognitions that affect how well teams perform,¹ and team science research has indicated that trust is a critical variable of teamwork, contributing greatly to a team's performance.

Trust has long been examined in health care, with research focusing on the development of trust by patients with their health care practitioners. Studies have indicated that trust is linked to patient satisfaction, adherence to treatment, continuity of care, and improved outcomes.^{2,3} Trust is the foundation for building an interpersonal connection⁴ and has been defined as the willingness to be vulnerable within interdependent relationships between individuals. Also, it is the foundation for driving important behaviors such as communication,⁵ as well as informing cognitive actions such as decision making.⁶ The definition of trust used throughout the remainder of this article is multidisciplinary, with trust defined as "a psychological state comprising the intention to accept vulnerability on the basis of positive expectations of the intentions or behavior of another."^{7(p395)}

We explore the construct of trust using a case example of a patient who received a surgical procedure for a precancerous polyp. Before we apply the principle of trust to the case, we present the literature on trust and key definitions for understanding trust. Next, we apply the definitions presented to the specific case example by highlighting moments where trust is developed or violated. Lastly, we offer insights to health

care practitioners on the development of trust in their own patient interactions to improve care.

EXPLANATION OF ISSUE/PRINCIPLE

Although heterogeneous in the literature, several requisite facets comprise our understanding of trust. Although we discuss them individually, they are often used simultaneously when developing and evaluating trust. The first facet is that trust requires two or more interdependent entities (ie, individuals, teams, or departments).⁸ The second facet of trust is vulnerability, or the implication that something of value can be lost or degraded. This vulnerability inherently entails a level of risk. Because trust involves a level of vulnerability and risk, it also encompasses a level of uncertainty. Uncertainty ties into the third important facet of trust, maintaining positive expectations about outcomes despite the ambiguity. When trust is present among parties, there is an expectation of certain positive outcomes.^{9,10} These expected outcomes relate to the final component, the intentions and behaviors of the trustee, which is simply the realization that the other party does not aim or seek to be harmful.^{7,11}

Despite the agreement among researchers regarding these core facets of trust, there are varying perspectives on how to approach trust—behavioral, cognitive, and affective.¹² The behavioral perspective grounds trust in the observable choices and actions made by the trustee.¹² For example, many posit that cooperative behavior is a manifestation of trust because the type and frequencies of behaviors can infer trust.¹³ Meanwhile, others hold the perspective that trust is cognitively rooted when it is based in knowledge and information. The attitudinal perspective entails that rationale, logic, and data serve as the basis for the decision to trust.¹⁴ The final perspective is that trust is conceptualized affectively. Emotions influence how individuals perceive, interpret, and evaluate experiences, thereby affecting trust.¹⁵ Ultimately, emotions refine judgments and alter the extent of risk taking.¹⁶ The underlying belief is that emotions, especially positive emotions, induce fondness and attachment, which ultimately enhance the feeling that another entity is trustworthy.¹⁷

Regardless of the perspective of trust, traditional views of trust development posit that it is formed gradually over time.¹⁸ In essence, the frequency of interactions and communication allows people to display trustworthy actions, demonstrates their knowledge and abilities, builds rapport, and strengthens relationships.¹⁹ From a behavioral stance, as trustors begin to trust others, they are more likely to exhibit trustworthy

behaviors²⁰ and experience more trust. From a cognitive stance, these repeated interactions create a database of accumulated knowledge and behaviors in which trust assessments are formed.²¹ Trustors cull information by making observations of trustees' behaviors under various conditions.¹⁷ Indeed, this database of trust information allows trustors to make inferences and predictions regarding a trustee's motivations, intentions, and behaviors, and any deviations in trust are on the basis of corroboration from positive or negative outcomes.^{18,21,22} From an affective perspective, social exchanges and interactions invoke feelings that alter fondness and attachment and invoke cooperation through helping and prosocial behaviors.¹⁷

Unfortunately, interdependent entities do not always have the time to incrementally compile experiences and interactions. As such, skilled individuals from different backgrounds and expertise must quickly assemble and work interdependently for a finite period of time while performing urgent, high-stakes tasks.²³ In these situations, trust is known as swift trust. Swift trust does not rely on time, history, or the accumulation of evidence.

Wildman et al²⁴ postulated that, instead, swift trust is heavily influenced by propensity to trust, imported information, and surface-level cues. Propensity to trust is considered the baseline level of trust and is the extent to which an individual is willing to trust others.²⁵ Although it varies according to one's experiences, personality, and cultural background,²⁶ propensity to trust is presumed to be a stable individual difference that affects the development of trust. It is considerably influential under certain circumstances, such as at the beginning of a relationship,²⁷ when there is insufficient information available,²⁸ or when the trustworthiness of an individual is ambiguous.²⁹ Imported information refers to the preexisting knowledge, stereotypes, and preconceptions stored in one's memories and originates with previous personal experiences or third-party information provided by trusted sources.²⁴ Meanwhile, third-party information serves as a conduit of trust through disseminating information and common connections.³⁰ Finally, surface-level cues are the overt characteristics and clues present in individuals and the environment (eg, age, gender, or ethnicity).³¹ Surface-level cues provide immediately perceivable information; however, how those cues are understood and interpreted will be the major contributor to the development of trust.²⁴

Regardless of whether trustors rely on surface-level cues, imported information, propensity to trust, or even time and

history, trusting relationships do not operate in a vacuum. Relationships intrinsically occur within a context. The context determines particular consequences,⁸ defines vulnerability and expectations,²³ and shapes social norms and perceptions of trustees.¹² Ultimately, the context forges the need for trust and the assessment of trustworthiness.⁸ Despite the influence of context on trust, across relationships, even within the same context, trust will vary in form, breadth, and depth as cues and information unfold and ambiguity and uncertainty diminish.¹²

The variation in trusting relationships is affected by the aforementioned characteristics (eg, cues and information), but it is also affected by the occurrence (or lack thereof) of trust violations. Trust violations involve a trigger event in which the trustor interprets the trustee's actions as not aligning with expectations.³² Elangovan et al³³ postulated that there are two types of trust violations—couldn't and didn't want to violations. More formally, these violations are known as competence- and integrity-based violations, and occur when a trustee is unable to do something (ie, competence-based violation) or did something selfishly or deceptively.³⁴ Regardless of the type, trust violations prompt trustors to evaluate the event and the situation cognitively and affectively³³; that is, the trustor must evaluate the actual violation, the consequences (if applicable), and the path forward as well as manage his or her emotions. The trusting relationship will be altered unquestionably, but the specific modifications will likely vary depending on the assessment, reactions, and interpretations

Table 1. Summary of Trust Concepts

Trust Concept	Description
Imported information	Preexisting knowledge, stereotypes, and preconceptions ²⁴
Propensity to trust	Trustor's disposition toward trust ²⁵
Surface-level cues	Overt characteristics and clues present in individuals and the environment ³¹
Swift trust	Distinct form of trust specific to temporary systems ²⁴
Trust	A psychological state comprising the intention to accept vulnerability on the basis of positive expectations of the intentions or behavior of another ⁷
Trust violation	A trigger event in which the trustor interprets the trustee's actions as unexpected ³²

of the trustor and the reparation strategies performed by the trustee. Refer to [Table 1](#) for a list of the major trust concepts.

APPLICATION TO CASE

Establishing and Maintaining Trust: Traditional Development Trust Versus Swift Trust

The relationship between the patient and Dr Larson is representative of traditionally developed trust because it took time and included repeated interactions, reciprocating information, fulfilled promises, shared experiences, and predictability under uncertainty and ambiguity.³⁵ As an outcome of this well-established trust relationship, the patient, who is acting as the trustor, relied heavily on Dr Larson's competence and knowledge in making the decision to identify other physicians (ie, Dr Geist, primary care provider, and Dr Franklin, surgical colleague).

Conversely, Dr Franklin imposed a form of trust that needed to develop rapidly (ie, swift trust) on the recommendation from a trusted party (imported information) and knowledge of the new trustee's abilities. Swift trust relies heavily on the imported information surface-level cues of the potential trustee (ie, Dr Franklin's educational background, certifications, and excellent history as a surgeon).

The relationship between the patient and Drs Gustafson and Auden was also characterized by swift trust. They were Dr Franklin's residents assigned to the patient in Dr Franklin's absence and were well informed about the patient's medical status from his initial admission for surgery. The residents under Dr Franklin were likely more trusted by the patient because of their association with an already trusted party (third-party information).

Highlighting Trust Violations

To highlight a trust violation, Dr Franklin cancelled the operation when he learned that the patient had only stopped using tobacco a few days before his scheduled surgery. This serves as a trust violation because Dr Franklin expected the patient to adhere to his recommendations. Regardless of why the patient did not stop smoking sufficiently early, Dr Franklin maintained the boundaries and appropriate levels of practice by refusing to treat the patient. The patient also experienced a trust violation because he expected surgery, and to his disappointment, Dr Franklin would not deliver care as expected. The final outcome was positive because the patient made the necessary changes to his habits so that Dr Franklin could move forward with surgery.

Another noteworthy moment experienced by the family occurred in the CCU, a type of ICU when the family meeting was called, but the family was patronizingly told that Dr Gustafson was not a part of the ICU team. The ICU team may have considered it unnecessary to invite Dr Gustafson to the family meeting, but in this particular case, the trust established between Dr Gustafson, the patient, and the family was so strong that her absence in the meeting would have hampered trust toward the ICU team and could have potentially compromised a care plan to be formulated and executed.

Understanding the Role of Context

The 12-hour surgery complicated by an infection aids in highlighting the context of trust within and across medical units. A key moment highlighting the importance of context arose when the patient was moved to the CCU. The unit was welcoming and displayed posters exhibiting the care values of the staff to establish expectations. This provided an excellent context for the outside providers as well as for the patient and his family. Specifically, the context of any work environment is an important antecedent to the establishment of psychological safety (ie, willingness to take interpersonal risks).³⁶ In other words, it is the idea concerned with how open an interpersonal environment is to individuals speaking their minds or acting in ways they believe are appropriate without fear of repercussions or punishment. The psychologically safe environment provided by the CCU served as an appreciable context of patient-centered care that was noticeable to all parties involved.

Continuing Care and Trust

The continuity of care also aids trust in that it can facilitate the transition of swift trust to traditionally developed trust. Dr Franklin interacted frequently, provided honest appraisals, answered questions thoroughly, made eye contact, remained authentic and personable, joked appropriately, and interacted frequently. He served as a leader to make decisions effectively and communicate with his residents and Dr Geist throughout the process. This relationship, as well as their respective characteristics, also enabled Drs Gustafson and Auden to maintain continuity of care. Their actions of crossing unit boundaries to keep their care patient-centered highlights the behavioral perspective of trust—trust grounded in the observable choices and actions made by one's trustees.¹² The behaviors of these individuals to choose to continue caring for the patient aided in strengthening the patient and his family's

Table 2. Trust in the Case Described

Trust Concept	Individuals/Unit Involved
Traditional trust	Dr Larson
Swift trust	Dr Franklin
Trust violation	Dr Franklin, the patient
Affective-based perspective	Drs Franklin, Gustafson, and Auden
Cognitive-based perspective	Dr Franklin
Behavioral-based perspective	Drs Gustafson and Auden
Context and psychological safety	Drs Gustafson and Auden Critical Care Unit

trust in these providers.^{8,27} The pre-established swift trust the patient may have had for Drs Auden and Gustafson likely transformed at this point into a traditional trust relationship because of the repeated visits during this time of extreme vulnerability for the patient. They exhibited genuine caring behavior toward the patient and conducted daily rounds, even when they were not a part of the primary care team. In fact, their actions may have made them some of the most trusted clinical providers that the patient has had throughout his lifetime of health care experiences. Refer to [Table 2](#) for a list of the trust concepts and the applicable individuals.

IMPLICATIONS FOR CLINICAL CARE

Trust Development

The successful management of clinical care, especially in the cancer setting, universally requires establishing trust and often swift trust initially. With an understanding that swift trust is the foundation of these newly formed relationships, trustors must rely heavily on surface-level cues and imported information. Certifications, degrees, ratings, and other established metrics function as surface-level cues that indicate the trustee is deemed trustworthy by his or her peers.²³ Consequently, providers should display such indices openly to ensure that these are visible. Meanwhile, patients should seek referrals from trusted providers because professional opinions and the reputations of the referral are critical imported information that serves as the basis for swift trust.

Although these initial contacts primarily involve swift trust, cancer care and treatment are in most cases relatively intermediate- to long-term endeavors that involve multidisciplinary care. As such, providers should capitalize on the

longevity by ensuring that every interaction and communication serves to enhance the level of trust, leading to the transition to traditional trust. Such successful transition is important in maximizing care for patients and also critical to the successful and healthy practice of any provider and organization. A bedside manner that is communicative, informative, and reciprocal will foster trust because this style typically involves the display of ability and confidence, which trustors can use to assist in making trust assessments. Similarly, such a bedside manner will offer emotional support, promoting fondness.

Trust Repair

Even after trust is established, it will fluctuate as information unfolds, interactions materialize, and violations transpire. Despite the desire or intent not to commit a trust violation, such incidents may be a reality. After a trust violation, transgressors can implement a reparation strategy: apology statement (eg, "I'm sorry," "I apologize," or "Excuse me"), an explanation of accountability or responsibility, accounts of cause, an offer of repair, and a promise of forbearance.³⁷ Such strategies can be effective in reparation of interpersonal relationships because they reduce negative assessments and reactions as well as diminish anger.³⁸

Although one of the aforementioned strategies can be efficacious for interpersonal repair, the methods for repair at the organizational level are actually different. The purpose, to overcome salient negative perceptions and restore confident positive expectations, are the same.³⁹ However, the reparation mechanisms at the organizational level involve distrust regulation and trustworthiness demonstration.⁴⁰ Distrust regulation interventions entail implementing regulations, rules, and controls to deter unacceptable behavior. These regulations are particularly valuable when they are voluntary (as opposed to mandated) because the organization is viewed as diagnostic and proactive. Therefore, administration should seek to implement new policies voluntarily and openly. Meanwhile, trustworthiness demonstration involves exhibiting displays of competence, benevolence, and integrity repeatedly. Administration should enforce the newly minted policies and reward acceptable behavior accordingly, which will promote trust by sending positive signals aiming to restore the trustor's confidence.

IMPLICATIONS FOR RESEARCH

The application of trust principles to the case we have highlighted is motivated by the complexity of the construct of trust

and its importance in health care. Practitioners and patients intuitively understand the importance of trust for successful teamwork and patient safety. However, little research is dedicated to elucidating the role of trust in the provision of cancer care. Cancer care is characterized by many individuals, teams, and even multiteam systems; however, trust is traditionally viewed in terms of interpersonal relationships. Consequently, research is needed to determine how trust is developed, maintained, restored (when applicable), and calibrated at the interpersonal, team, and multiteam system levels. There is a dearth of research in health care that examines trust at these varied levels. Future research is needed to investigate the questions regarding the effective levels of trust at the varied levels of analysis (eg interpersonal, team, or multiteam) using qualitative and quantitative approaches, how trust evolves, how technology (eg, electronic medical records) affects the development of trust, what diagnostic tools are available in health care to measure trust levels, how context (eg, cancer care teams v primary care teams) influences trust development, and how best to repair trust with patients and colleagues. Although we posit that these are important questions to address, there are many other unanswered questions regarding trust in medicine. We urge practitioners and researchers to target trust as a crucial construct in the provision of health care because it is such an integral attitude and drives subsequent behaviors.

In conclusion, although optimal teamwork and patient care heavily rely on trust, it is often overlooked because of its intrinsic complexity in an often-fragmented health care system. The establishment of trust is a dynamic process dependent on multiple factors involving the trustor, trustee, and context. Considering the prevalence of cancer, the interdependencies of providers within cancer care, and the importance of trust, we strongly encourage researchers, practitioners, and administrators to focus on this integral component. We hope that this article stimulates the interest in and dialogue on trust. **JOP**

Acknowledgment

The production of this manuscript was funded by the Conquer Cancer Foundation Mission Endowment. D.D. was supported in part by Grant No. UL1TR000058 from the National Center for Advancing Translational Sciences (NCATS), a component of the National Institutes of Health (NIH). The content is solely the responsibility of the authors and does not necessarily represent the official views of NCATS or NIH.

Authors' Disclosures of Potential Conflicts of Interest

Disclosures provided by the authors are available with this article at jop.ascopubs.org.

Author Contributions

Conception and design: Elizabeth H. Lazzara, Joseph R. Keebler, Soosi Day, Deborah DiazGranados, Minggui Pan, Shin-Ping Tu

Data Analysis: All authors

Manuscript writing: All authors

Final approval of manuscript: All authors

Accountable for all aspects of the work: All authors

Corresponding author: Elizabeth H. Lazzara, Embry-Riddle Aeronautical University, 600 S Clyde Morris Blvd, Daytona Beach, FL 32114; e-mail: elizabeth.lazzara@erau.edu.

References

- Salas E, Cooke NJ, Rosen MA: On teams, teamwork, and team performance: Discoveries and developments. *Hum Factors* 50:540-547, 2008
- Fiscella K, Meldrum S, Franks P, et al: Patient trust: Is it related to patient-centered behavior of primary care physicians? *Med Care* 42:1049-1055, 2004
- Thom DH, Hall MA, Pawlson LG: Measuring patients' trust in physicians when assessing quality of care. *Health Aff (Millwood)* 23:124-132, 2004
- Bova C, Fennie KP, Watrous E, et al: The health care relationship (HCR) trust scale: Development and psychometric evaluation. *Res Nurs Health* 29:477-488, 2006
- Leonard M, Graham S, Bonacum D: The human factor: The critical importance of effective teamwork and communication in providing safe care. *Qual Saf Health Care* 13:i85-i90, 2004 (suppl 1)
- Olson BJ, Parayitam S, Bao Y: Strategic decision making: The effects of cognitive diversity, conflict, and trust on decision outcomes. *J Manage* 33:196-222, 2007
- Rousseau DM, Sitkin SB, Burt RS, et al: Not so different after all: A cross-discipline view of trust. *Acad Manage Rev* 23:393-404, 1998
- Mayer RC, Davis JH, Schoorman FD: An integrative model of organizational trust. *Acad Manage Rev* 20:709-734, 1995
- Bhattacharya R, Devinney TM, Pillutla MM: A formal model of trust based on outcomes. *Acad Manage Rev* 23:459-472, 1998
- Dirks KT: Trust in leadership and team performance: Evidence from NCAA basketball. *J Appl Psychol* 85:1004-1012, 2000
- Butler JK: Toward understanding and measuring conditions of trust: Evolution of a conditions of trust inventory. *J Manage* 17:643-663, 1991
- Lewicki RJ, Tomlinson EC, Gillespie N: Models of interpersonal trust development: Theoretical approaches, empirical evidence, and future directions. *J Manage* 32:991-1022, 2006
- Axelrod R: *The Evolution of Cooperation*. New York, NY, Basic Books, 1984
- McAllister DJ: Affect- and cognition-based trust as foundations for interpersonal cooperation in organizations. *Acad Manage J* 38:24-59, 1995
- Dunn JR, Schweitzer ME: Feeling and believing: The influence of emotion on trust. *J Pers Soc Psychol* 88:736-748, 2005
- Weber JM, Malhotra D, Murnighan JK: Normal acts of irrational trust: Motivated attributions and the trust development process. *Res Organ Behav* 26:75-101, 2004
- Williams M: Building genuine trust through interpersonal emotion management: A threat regulation model of trust and collaboration across boundaries. *Acad Manage Rev* 32:595-621, 2007
- Lewicki RJ, Bunker BB: Trust in relationships: A model of development and decline, in Bunker BB, Rubin JZ (eds): *Conflicts, Cooperation, and Justice*. San Francisco, CA, Jossey-Bass, 1995, pp 133-183
- Webber SS: Development of cognitive and affective trust in teams: A longitudinal study. *Small Group Res* 39:746-769, 2008
- Luhmann N: *Trust and Power*. Chichester, United Kingdom, Wiley, 1979
- Hung YC, Dennis AR, Robert L: Trust in virtual teams: Towards an integrative model of trust formation. Presented at International Conference on System Sciences, Kauai, Hawaii, January 5-8, 2004
- Kramer RM: Trust and distrust in organizations: Emerging perspectives, enduring questions. *Annu Rev Psychol* 50:569-598, 1999

23. Meyerson D, Weick K, Kramer R: Swift trust and temporary groups, in Kramer RM, Tyler TR (eds): *Trust in Organizations: Frontiers of Theory and Research*. Thousand Oaks, CA, Sage, 1996, pp 166-195
24. Wildman JL, Shuffler ML, Lazzara EH, et al: Trust development in swift start action teams: A multilevel framework. *Group Organ Manage* 37:137-170, 2012
25. Burke CS, Sims D., Lazzara E, et al: Trust in leadership: A multi-level review and integration. *Leadersh Q* 18:606-632, 2007
26. Hofstede G: *Culture's Consequences: International Differences in Work-Related Values*. Beverly Hills, CA, Sage, 1980
27. Schoorman FD, Mayer RC, Davis JH: An integrative model of organizational trust: Past, present, and future. *Acad Manage Rev* 32:344-354, 2007
28. McKnight DH, Cummings LL, Chervany NL: Initial trust formation in new organizational relationships. *Acad Manage Rev* 23:473-490, 1998
29. Gill H, Boies K, Finegan JE, et al: Antecedents of trust: Establishing a boundary condition for the relation between propensity to trust and intention to trust. *J Bus Psychol* 19:287-302, 2005
30. Kniffin KM, Wilson DS: Evolutionary perspectives on workplace gossip: Why and how gossip can serve groups. *Group Organ Manage* 35:150-176, 2010
31. Stahl G, Maznevski M, Voigt A, et al: Unraveling the effects of cultural diversity in teams: A meta-analysis of research on multicultural work groups. *J Int Bus Stud* 41:690-709, 2010
32. Elangovan AR, Shapiro DL: Betrayal of trust in organizations. *Acad Manage Rev* 23:547-566, 1998
33. Elangovan AR, Auer-Rizzi W, Szabo E: Why don't I trust you now? An attributional approach to erosion of trust. *J Manag Psychol* 22:4-24, 2007
34. Kim PH, Dirks KT, Cooper CD, et al: When more blame is better than less: The implications of internal vs. external attributions for the repair of trust after a competence- vs. integrity-based trust violation. *Organ Behav Hum Decis Process* 99:49-65, 2006
35. Rempel JK, Holmes JG, Zanna M: Trust in close relationships. *J Pers Soc Psychol* 49:95-112, 1985
36. Edmondson AC: Psychological safety, trust, and learning in organizations: A group-level lens, in Kramer RM, Cook SK (eds): *Trust and Distrust in Organizations: Dilemmas and Approaches*. New York, NY, Russel Sage Foundation, 2004, pp 239-272
37. Blum-Kulka S, Olshtain E: Requests and apologies: A cross-cultural study of speech act realization patterns (CCSARP). *Appl Linguist* 5:196-213, 1984
38. Scher SJ, Darley JM: How effective are the things people say to apologize? Effects of the realization of the apology speech act. *J Psycholinguistic Res* 26:127-140, 1997
39. Kim PH, Ferrin DL, Cooper CD, et al: Removing the shadow of suspicion: The effects of apology versus denial for repairing competence- versus integrity-based trust violations. *J Appl Psychol* 89:104-118, 2004
40. Gillespie N, Dietz G: Trust repair after an organization-level failure. *Acad Manage Rev* 34:127-145, 2009

ASCO's Year-Round Member Referral Campaign

ASCO members: Your personal referral conveys more to a prospective member than any ad or brochure ever could. The Member Referral Campaign is our way of saying "thank you" for sharing the value of ASCO membership with your colleagues.

How to refer: Simply provide your nonmember colleagues with your ASCO ID number for them to enter with their membership application at join.asco.org, and begin earning credit!

At the end of the annual cycle, you will receive credit for the total number of referrals you have made:

- Refer two new members and receive a \$10 credit
- Refer five new members and receive a \$50 credit
- Refer 10 new members and receive a \$100 credit

Not an ASCO member? Earn your ASCO member colleagues credit for referring you when you complete the membership application at join.asco.org. Once you are inducted, you can begin earning credit for your own referrals!



American Society of Clinical Oncology

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Understanding Teamwork in the Provision of Cancer Care: Highlighting the Role of Trust

The following represents disclosure information provided by authors of this manuscript. All relationships are considered compensated. Relationships are self-held unless noted. I = Immediate Family Member, Inst = My Institution. Relationships may not relate to the subject matter of this manuscript. For more information about ASCO's conflict of interest policy, please refer to www.asco.org/rwc or jop.ascopubs.org/site/misc/ifc.xhtml.

Elizabeth H. Lazzara

No relationship to disclose

Joseph R. Keebler

No relationship to disclose

Soosi Day

No relationship to disclose

Deborah DiazGranados

No relationship to disclose

Minggui Pan

Stock or Other Ownership: Exelixis, Clovis Oncology, Celldex Therapeutics

Mike King

Employment: Repass, LHC

Consulting or Advisory Role: Repass

Travel, Accommodations, Expenses: Repass

Shin-Ping Tu

Stock or Other Ownership: Abbott Diagnostics, Johnson & Johnson, McKesson, Medtronic, Pfizer

Appendix

Appendix A: Timeline

January 16: Annual appointment with Dr Larson; procedures performed, including sigmoidoscopy and endoscopy with removal of polyps. Referral to Dr Franklin, surgeon.

January 28: Consultation No. 1 with Dr Franklin.

February 8: Consultation No. 2 with Dr Franklin.

March 17: Consultation No. 3 with Dr Franklin.

March 27: Consultation with Dr Geist, internist (the patient's primary care physician).

April 1: Surgery (12 hours).

April 3: Began walking the unit two times per day.

April 5: Drs Franklin and Larson are on vacation/out of country. The patient walks three times around unit. Introduced clear liquids (30 mL per hour). Moved to Floor 15 in anticipation of impending discharge. Nutritionist visited and provided liquid nutrition supplement (three times per day)

April 6: Walking reduced to once around the unit; diarrhea, peripherally inserted central catheter removed. Not taking in any clear liquids. Wanted ice cubes and a cold cloth on his head.

April 7: Pain in right shoulder, uncomfortable, pain, diarrhea, nausea; MedAlert team called. Blood tests, x-ray, ECG, mild heart attack.

April 8: Continued concerns, additional blood test, vancomycin-resistant enterococci identified, ultrasound of heart performed, drain added to reduce fluid behind kidney, peripherally inserted central catheter placed. Moved to Critical Care Unit, Floor 9.

April 9: Intensive Care Unit team takes over; kidneys failing; placed on continuous dialysis.

April 13: ECG, continued dialysis.

April 15: Improved in the AM. Family left for 6 hours but was called back when blood pressure dropped significantly and oxygen level could no longer be maintained at a satisfactory without a ventilator. Vented late in the PM.

April 16: Ventilator, dialysis, ECG.

April 17: Drew fluids from between lungs and chest cavity.

April 19: Drs Franklin and Larson return. X-ray performed. Blood count fell; given two units of blood.

April 20: X-ray performed. There was evidence of hematoma in stomach lining. Another unit of blood was given.

April 24: The patient was taken off the ventilator and dialysis machine, but remained on oxygen. He was moved to Medical Telemetry Unit on Floor 9. He still needed continuous monitoring of vital signs, glucose levels. This was a temporary placement until a bed opened up on the Post-Surgical Gastroenterology/Bariatric Unit, Floor 8. Visited by Clinical Leader II to discuss goal of getting the patient in the Acute Care Rehabilitation Unit as a step-down placement.

April 26: Moved to Post-Surgical Gastroenterology/Bariatric Unit, Floor 8. Nutritionist consulted; jejunum tube feeding. Had difficulty finding a suitable nutritional supplement for the patient's system.

May 1: Last day of rotation for Drs Auden and Gustafson.

May 8: Discharged from hospital.

May 15: The patient sees Dr Geist for follow-up. She will manage his blood pressure and his diabetes. She has had several phone consultations with Dr Franklin about the patient's progress in the hospital and follow-up.

Appendix B: Case Description

The patient was a 71-year-old Marine with a family history of familial adenomatous polyposis and personal history of Gardner syndrome. His general health was good, other than a history of high blood pressure, being overweight, smoking one pack of cigarettes per day, and drinking one to two beers per day, with limited exercise. His Gardner syndrome was diagnosed in 1966. Subsequently, he had the whole colon except for 6 inches removed to prevent colorectal cancer and had been under the regular care of Dr Larson, his gastroenterologist, with annual endoscopy, sigmoidoscopy, and polyp removal.

In January 2015, Dr Larson noted one large polyp with precancerous changes in the patient's duodenum near the pancreatic duct. Dr Larson felt it was time to do something about it before the polyp advanced to the cancerous stage. He referred the patient to Dr Franklin, one of his surgical colleagues at the medical center.

Family member perspective: Dr Larson had been my husband's doctor for many years and had a remarkable personal style that engendered trust by taking time to talk with us before procedures, explaining what he was going to do, what to expect, and doing so in a patient, unhurried manner. He positioned himself in close proximity to the patient, with positive body language and voice/inflection. He

gave what felt like his undivided attention to both the patient and the family members. We had utmost trust in him and whatever he recommended. Therefore, a referral to Dr Franklin by Dr Larson was an implied endorsement.

At the initial clinic appointment with Dr Franklin, the patient appeared guarded or nervous; he talked with a loud voice, made jokes, talked a lot, and occasionally got in the space of others in the room. Dr Franklin was nonplussed, allowing him plenty of time to tell tangential stories while the rest of his family was eager to get their questions answered.

Dr Franklin began his consultation by reviewing the patient's extensive medical history. It was evident that Dr Franklin had spent considerable time reviewing the records from the previous clinic and hospital visits before this consultation. He clarified details and shared observations about the patient's surgical history. It was apparent that he had also discussed the patient with Dr Larson. Dr Franklin explained that the procedure would result in removing the patient's bile duct, gallbladder, duodenum, and part of pancreas, then reattaching the top of his small intestine to the pancreas and what remained of his stomach. He used a diagram, talked in a comfortable manner, sprinkling in a bit of gentle humor along the way. He did not appear at all put off by the patient's abrupt manner or the many questions asked by his family.

Dr Franklin was firm in his expectation that the patient do a number of things in his prehabilitation phase:

1. Stop smoking (be smoke-free for at least 30 days)
2. Exercise every day, walk at least a mile 5 to 7 days a week
3. Reduce his alcohol intake (preferably stop)
4. Eat healthy, lose weight
5. Take a multivitamin daily
6. Monitor his blood pressure three times a day
7. Connect with his primary physician, Dr Geist

Although the patient believed that this appointment would be the presurgical consultation, with surgery scheduled immediately thereafter, Dr Franklin ended the 2-hour consultation by making an appointment in one month.

In the follow-up appointment, Dr Franklin was unhappy to hear that the patient had just quit smoking the week before. Dr Franklin told him that he would not do the surgery until the patient had stopped smoking for at least 30 days. He explained that this would give his lungs time to cleanse themselves and provide Dr Franklin with the best of conditions under which to do the extensive surgery. Although he was stern, he was also very clear about why he was having the patient go through a prehabilitation regimen.

Family member perspective: My husband was not happy about all the contingencies that Dr Franklin had put on his presurgical lifestyle. He referred to Dr Franklin as being priggish and overly cautious in our private conversation. He said that he had been through three similar surgeries already and knew how it went. He knew what he would have to do to get back on his feet: "Marines pull themselves up by the bootstraps."

During the following days, the patient eliminated snacking, reduced beer intake, stopped smoking, and began going to the local gym every other day to run a mile on the treadmill machine and a mile on the rowing machine. By the time he returned to Dr. Franklin a month later, he had lost 3 pounds.

In March, the patient and his family returned to Dr Franklin's office. Dr. Franklin was accompanied by his chief resident, Dr. Gustafson, and a medical assistant, and cleared him for surgery. Dr Franklin asked the patient when he wanted to have the surgery. The patient said April 1: "April Fools' Day couldn't be a better day to do it."

On April 1, the patient went into surgery that began at 8:30 AM and ended at 8:30 PM. Dr Franklin met with the patient's family after the surgery and talked about the 12-hour surgery. He told them that "it took the first 7 hours to get through all the scar tissue that had formed from previous surgeries" and that once they were through the tissue, the surgery went smoothly, without any concerns. The large polyp was sectioned and taken to pathology, where Dr Franklin was able to see the nature of the growth and tentatively say it did not have cancerous cells. No blood transfusions were needed during the surgery. Consequently, Dr Franklin expected the patient to progress without complications over the following days while in the postoperative section of the Critical Care Unit (CCU).

On the second day, the patient was able to get up and sit on the edge of the bed. He was lucid and did not complain of any pain, although he occasionally said he felt uncomfortable. He was able to use the self-administered pain pump as needed and was conservative about using it. He was able to ambulate around the unit.

Over the next 4 days, he was more alert. He did not run a fever, and his blood pressure was acceptable. The epidural was discontinued on April 5, when the family was told that it was no longer working. He was ambulating up to three times per day around the unit. He was then moved to a general recovery floor.

Dr Franklin left on a previously planned vacation but told the patient that he thought he would be one of the rare patients who would make it home by day 7 because he was making such good progress.

On April 6, the patient began to complain of more pain, and his stomach was quite distended. He had been cleared for a clear liquid diet; however, he was not interested in trying to take anything orally except for very small amounts of diet root beer. He tried a small amount of Jell-O and vomited. He began to experience uncontrollable, explosive diarrhea. On one occasion, the family noticed that a large amount of brownish fluid was leaking onto his bed sheet where it came into contact with his incision.

That night, he complained of pain on his right side, radiating up his shoulder and into his neck. He said he had a headache. The family called the nurse, who called the resident doctor, Dr Gustafson. Both Dr Gustafson and another resident, Dr Auden, had been attending the patient morning and night on rounds and occasionally stopped in during the day, as well. Both had a very quiet demeanor. Neither doctor moved quickly or spoke rapidly. Dr Gustafson presented herself in a quiet yet competent manner, making a point to connect with both the patient and the various family members in the room. She consistently talked about his progress and what her goals were for the day or the hour. She referenced Dr Franklin, even though he was out of country. The family knew that the residents were in touch regarding the patient.

As his general agitation and pain in his shoulder and neck increased, the MedAlert team, which is a team of at least seven doctors, nurses, and specialists, were called to his bedside. An ECG was performed, blood was drawn, and the monitors and nurse notes were reviewed. Family members suspected that he could have had a heart attack. Within hours, he was moved to the CCU again.

The next day, more blood was taken, and it was determined that he may, in fact, have had a mild heart attack. Additional medications were begun. An infectious disease doctor came in and said he thought the patient had an infection, and blood cultures were performed. Dr Gustafson opened his incision (from the top down, about 6 inches) and probed the opening. She found fluid behind the kidneys and in the chest cavity. Drains were placed in two different locations to draw off fluid from the various pockets. There was discussion about possible leakage of stomach fluids into his abdomen. It was determined that he had a vancomycin-resistant enterococcus infection, which necessitated that everyone suit up and wash their hands every time they entered the room. There were so many professionals from so many different specializations in and out of the room that family members could not keep track. They tried keeping notes for one another and a list of questions to ask. They spent a good deal of the time either watching the patient's face or the monitor readings. Because of concerns that the CCU staff was entirely new to them and unfamiliar with the patient's medical history, the family created a picture wall in the CCU room with pictures of him doing all the things that he liked to do, pictures of him with his various family members and friends, and artwork drawn by his youngest grandchildren. It inspired many conversations with staff as they came in and out of the room.

Family member perspective: The collective practice of the CCU team was very family inclusive. We were allowed to be present for discussions between team members at rounds, with residents, and with consulting medical staff. We were debriefed after every visit by a member of his medical team. There appeared to be no limits on visitors, regardless of age (he had visits from his grandchildren ranging in age from 5 to 26 years). Although everyone Purred in and Purred out of the room, none of the visitors were expected to gown up, even though all medical staff did. At least one person slept in his room on a pull-out bench/couch and sometimes a second person slept in a reclining chair. We were never treated as if we were in the way, and even the simplest procedures were explained to us and to him (even when he was comatose). He was always treated with the utmost of competence, patience, respect, and dignity.

The dive continued downward; each day, something new presented itself, with subsequent tests and trips to radiology for computed tomography scans and x-rays. As the patient got sicker, he was unable to be moved for tests because he was so unstable. As his kidney function diminished, he was placed on kidney dialysis to give his kidneys a chance to heal. He was receiving oxygen throughout his time in the CCU, but it became necessary to put him on a ventilator, which he fought vigorously.

Within the CCU, there was an Intensive Care Unit (ICU) team who was responsible for directing a coordinated multidisciplinary team approach to the care of critically ill patients, such as the patient. Although the patient's care had been turned over to this specialized team, Drs Auden and Gustafson continued to participate in rounds morning and evening; every other day, Dr Gustafson repacked the open incision, redressed it, and set up the wound vacuum. Dr Auden inspected the drain sites for infection and the drainage bags for color and output volume.

Family member perspective: We had the opportunity to watch this young resident bloom in the month that he was with my husband, gaining bedside manner and confidence in his work. He was able to establish a rapport with my husband that was respectful and at the same time competent. He worked well with his chief resident, Dr Gustafson, and Dr Franklin on return from his out-of-country holiday. Dr Franklin was open with family members and was always fully available to them when he was present during morning and afternoon rounds. He was up to speed on the unexpected occurrences that took place in his absence and assured us that the ICU team was doing everything

they could. His presence and that of his two resident physicians gave us the support and confidence we needed to be present and supportive for my husband during his hardest days and nights.

After several crucial days in the CCU during which the patient had periods of delirium and was semiconscious, the family was told that there would be a family meeting, and everyone should plan to be there. The patient asked who was in charge of arranging the meeting and whether Dr Gustafson would be there (Dr Franklin was still out of the country). He was patronizingly told that Dr Gustafson was not a part of the ICU team and would not be attending the meeting. As an afterthought, he was told that Dr Gustafson was probably busy in surgery.

Family member perspective: I was so taken aback that I said that I expected her to be there because she had been with my husband from the day we had our first consultation through his initial recovery and with him through the plunge. I added that we trusted her view of things and her opinions. I was told that they would look into it but could not promise anything. It was clear this was not standard operating procedure. Dr Gustafson soon appeared, and I repeated the story to her. She flared ever so slightly and said, “I will be there, don’t worry.” Several hours later, a social worker returned to tell me that she had talked with Dr Gustafson, and she would be at the meeting. It was my impression that this potential omission was as much about her resident status as it was that she was not on the ICU team. After this meeting, the family and the clinical care team gained a shared understanding of how to proceed in the management of the patient’s care.

When it appeared that he was stable enough to be taken out of the CCU to radiology, the patient was transported for a computed tomography scan to ascertain whether he had internal bleeding. There was evidence of a mass. It was unclear whether it was in his stomach, in the lining of his stomach, or outside his stomach in his abdomen. After repeated consultations across disciplines, it was determined that there was a grapefruit-size hematoma in the lining of his stomach. There were differing opinions about whether it should be drained. Dr Franklin had the final word—do nothing and let it gradually dissipate over the coming weeks.

Twenty days after surgery, the patient was moved from the CCU to Medical Telemetry for 2 days while they waited for a bed in the Post-Surgical Gastroenterology/Bariatric Unit. This unit was on the same floor as the CCU but outside the new part of the hospital. The new room was a single-patient room (because of his vancomycin-resistant enterococcus infection) but very small and not friendly to family accompaniment. This came as a rude awakening for the eight primary family members who had taken turns being with him at all times, day and night. There was no room for someone to sleep in the room, and staff appeared unfamiliar and uncomfortable with family hovering. The unit was noisy, hot, and crowded. Coming from the spaciousness and solitude of the CCU, this was psychologically uncomfortable for family members. The only continuity of care, it appeared, was in the early morning visit (rounds) by Drs Franklin, Gustafson, and Auden, who came every other day to check his wound dressing and change the silver nitrate in the wound vacuum.

A room came available in the Post-Surgical Gastroenterology/Bariatric Unit, and the patient was moved there. Although this room was the same size as the one he had come from, the staff made a point to make it comfortable for at least one family member to stay in the room, and often there were two persons there. He continued to be seen daily by the infectious disease doctor. Drs Franklin, Gustafson, and Auden were there morning and evening to check in with him and talk about what they anticipated may come next. They shared specific goals for each day in the morning, and during evening rounds, they reviewed the results of the interventions of the day.

Family member perspective: This was very helpful. We were treated with utmost respect by staff on this floor. Regardless of which staff person was on duty during the rounds, each was engaged with Dr Franklin and with his residents, offering descriptive observations, asking for recommendations, and staying to watch the wounds being redressed.

After several days in the Post-Surgical Gastroenterology/Bariatric Unit, the patient was discharged and readmitted into rehabilitation, 1 month after his initial surgery. The move into the Acute Care Rehabilitation Unit on the floor above the patient’s previous room in the Post-Surgical Gastrointestinal/Bariatric Unit was physically smooth and facilitated by the Clinical Leader II, who had been following the patient since late in his ICU stay. The room was spacious and allowed for family members go in and out of his room without getting in the way.

Family member perspective: From the day he arrived, we understood that he was likely to have a 5-day stay, assuming he met his goals. It soon appeared that our goals for him and the goals of the unit were upside down; we were told that the surgical team would continue to take the lead in the medical issues, whereas the rehabilitation unit team would take the lead in the rehabilitation process. In theory, this made sense. In practice, it was much different because the conditions that were preventing him from going home were multiple physical/medical conditions that needed close attention and that conflicted with actively participating in rehabilitative therapies.

May 1 also marked the change date for the residents working with Dr Franklin, and three new residents took over for Drs Auden and Gustafson. Both continued to drop into his room at least once a day as visitors, which was comforting to the patient and his family. The new

residents had followed his progress while he was in the postsurgical unit and made the family's transition as smooth as they could. However, it was very hard for the family to shift their confidence and trust to the new team. In addition, the nursing staff on the rehabilitation unit did not appear to be accustomed to attending to the chronic conditions that the patient struggled with every day. He needed frequent personal hygiene attention. It appeared that his daily needs were not consistent with the kinds of needs most commonly served in the unit. Each day, the unit staff indicated that he was meeting his therapy goals, which would lead to a May 5 discharge. Yet, he was not meeting the goals that the family thought were essential for his discharge home. Placement in the rehabilitation unit was extended until May 8. It appeared this discharge date was negotiated among Dr Franklin, the head of the surgical team, the Acute Care Rehabilitation Unit Director, and key staff. There was a sense of tension around this, but nothing was never explicitly said.

One week after discharge, the patient saw Dr Geist in the rehabilitation unit. It was clear from talking with her that she and Dr Franklin had a good working relationship, and they were sharing information and goals by phone. This gave the family confidence in her and was comforting to them. She asked the patient good questions, was patient with his sense of humor, and reinforced Dr Franklin's directives to take in more liquid nutrition so that he could be transitioned off the feeding tube, which he hated.