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Collaboration practices in Intellectual (Learning) Disability Services' multidisciplinary teams

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Abstract

This thesis takes an approach that combines discursive psychology, conversation analysis and ethnography to explore how collaboration works in practice. Clinical guidance refers to collaboration as the chosen form of teamwork for multidisciplinary teams (MDT). Professionals in intellectual (learning) disability (I(L)D) services are advised by NHS England to collaborate in MDTs to address the multiple and complex needs of clients. However, clinical guidance for healthcare professionals uses the term collaboration without explaining what collaboration might look like. Previous research on collaboration focuses on the barriers and facilitators to collaboration, again treating collaboration as a concept that does not need explanation or exploration. The aim of this thesis was to explore collaboration, walking the line between producing high quality conversation analysis whilst making meaningful findings that are needed by healthcare professionals. The findings were framed by their clinical, relational and organisational domain, as these areas have previously been highlighted as important to healthcare professionals (Smart et al., 2018). Three I(L)D teams participated in the research. The researcher spent a one-week observation period, and ran three interviews with professionals from each team (a total of nine), to get a background on the day to day lives of the teams. 12.5 hours of team meetings were recorded for analysis.

Analysis of the I(L)D teams' interactions focused on three collaboration practices, arranged using the framework of clinical, relational and organisational domains. In the clinical domain, potential risk issues were found to be raised as concerns by healthcare professionals. If healthcare professionals raised the concern as their own opinion, early in a discussion, team members gave space in the meeting to hear the issue and provided advice. In the relational domain, laughter was observed to be used by team members to demonstrate orientation to

playframe and to soften trouble in interaction. Embedded laughter that occurred did not divert the focus of the meeting and was explored for its relational role. In the organisational domain, orientation to professional identity was used to negotiate tasks, particularly when resisting proposed task allocation. Using professional identity to successfully claim deontic authority allowed the delicate management of conflict in task negotiations.

All together these practices begin to uncover how healthcare professionals do collaboration. They demonstrate how power and authority is managed between professionals in MDTs to get work done, how they can use the limited moments in meetings to feel part of a team, and how the team can be used to share responsibility when making risk decisions. All these practices address key issues that are specific for I(L)D MDTs. Although they have been situated in a framework that splits clinical, relational and organisational domains, the individual practices are not limited to a single domain. However, the framework can help healthcare professionals understand and apply the findings to their own practice, both as a reflective tool and as strategies that they could implement.

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Chapter 1: Introduction

Collaboration is central to interprofessional teams globally, and for multidisciplinary teams (MDTs) in UK healthcare services. Despite the importance of collaboration there is a lack of clear definitions, with most research focusing on explaining concepts that lead to collaboration. This thesis focuses on collaboration itself, through examination of Intellectual (Learning) Disability (I(L)D) service MDTs in the UK National Health Service (NHS). It takes a particular stance that gives primacy to, and starts with, the people who are collaborating. It pulls together conversation analysis, discursive psychology and ethnography to develop an inside out perspective on collaboration. The argument is that by looking from inside out there is a better understanding of what collaboration actually is. This thesis will explain the problem with what is already known about collaboration; show how a different approach could help uncover collaboration; present a detailed background of the healthcare teams that were observed collaborating; and detail three collaboration practices from three key healthcare domains; the relational, the organisational and the clinical. First, this chapter will introduce the research problem and background of collaboration for UK I(L)D MDTs.

The Puzzle

This thesis' aim to understand collaboration came from a noticed disjuncture between the way collaboration is discussed, compared to the way collaboration in MDTs is discussed. MDTs are designed to allow collaboration to happen (cf. p.15). The United Kingdom National Health Service (NHS) forefronts collaboration in their policy documents (cf. Department of Health, 2012, 2015a, 2015b), and professionals understand the importance of collaboration and aim to work collaboratively. For example, a healthcare professional who participated in this thesis' research described the ethos for working collaboratively:

"*… we are part of a jigsaw for you know, … we're never going to be one thing to everybody, but everybody needs to put their little bit in*."

Despite policy documents and teams forefronting collaboration, how healthcare professionals achieve the goal of 'putting their little bit in' is relatively unknown. Policy documents and training guidance lack explicit detail on the process of collaboration. This is remarkable, especially as although healthcare teams and the government clearly highlight the importance of collaboration, collaboration in MDTs is often framed as problematic. For example, a normal response from healthcare professionals who asked about the thesis research question (initially 'How do multidisciplinary teams function?') was:

'*Well I can tell you how they function, not very well'* Junior Doctor, October 2016.

In the development of this thesis, a range of healthcare professionals and service users were consulted about their experiences of MDTs to help to understand the wider context of collaboration in healthcare services. A key driver for this thesis was to start from people's lived experience, so some quotes from the consultation have been provided below. The experiences people discussed highlighted the two sides; that collaboration was needed, but there were problems with MDTs working together. Many of the quotes below show that the problems with collaboration in MDTs are often related to issues with communication, or hierarchy.

'*Some of the bits that I've found more difficult is around being integrated into a team, thinking 'am I integrated or not, am I being listened to' in a really well established team with loads of experience but predominantly coming from a medical model'* Clinical Psychologist, 2018

"*We have had positive relationships with our MDTs but I have seen some shockers at case reviews - issues largely caused by professional egos! An MDT that values family voices and acts in a transparent way in partnership with family members can provide a strong support. This benefits the person*

in many ways, for example, incidents of crisis can be reduced and people can be supported to live meaningful lives. We have been fortunate in our experiences and have built up good relationships with MDTs. Although at times we may disagree about some particular issue the strong relationships that have been developed allows consensus to be reached. The trust between us and the MDT benefits our son." Parent of Service User, 2020.

"*I've worked as part of an MDT in secure mental health services. These would usually be chaired by the psychiatrist as responsible clinician, with nurses, psychologists, and occupational therapists, healthcare assistants and, for part of the meetings, the patient. In my experience, the MDTs which worked best were those in which everyone's voice felt heard, when ideas which were outside the status quo were welcomed and discussed, and when everyone present felt comfortable to have a dissenting opinion. Conversely, when psychiatrists dominated the discussion, didn't take other disciplines' ideas on board, or reacted badly to attendees who did not agree with them, then the MDT process tended to feel like a superfluous meeting to provide 'support' for whatever the RC was planning on doing with the patient anyway."* Healthcare worker, 2017.

"*Because my "scope" is so broad, and I have a background of science (rather than medicine) it makes my specialised clinical knowledge very limited. I have really appreciated being able to attend MDT meetings in the past, as they help me understand wider clinical context. It is also very rewarding to see my work contributing to patient care – I do not have a particularly patient facing role, so it is nice to see my contribution! Mostly when I have attended or been asked for a contribution to an MDT, my opinion has been well received and*

I've had nice feedback/interesting questions but I think this probably has a lot to do with the personalities in the room! For some reason consultant cardiologists seem to be a problem at both Trusts I have worked at." Medical Physician Expert, 2020.

Healthcare professionals' and service users' problematic discursive construction of MDT working, which they contrast with a need for collaboration, is evident from the range of professionals' experiences. There is almost an underpinning assumption that different disciplines can struggle to work together and collaborate even if they see it as important. Although these quotes have not been analysed as they arose from conversations with healthcare professionals and service users, they helped form the basis of this thesis' focus on collaboration in MDTs. The quotes are focused on MDTs more generally, but on p.15 it is argued that MDTs are the organisational site designed to enable collaboration. The puzzle emphasises the need to examine what actually happens in these teams, to help unpick the narrative around collaboration in MDTs and provide some detail on the practice of collaboration in healthcare teams.

Collaboration: Definitions in healthcare

Collaboration is tricky to define, despite the importance of collaboration in healthcare. This section examines what definitions have been applied to collaboration in the healthcare world. The NHS promotes collaboration as integral to their services in policy documents (NHS Improvement, 2018), particularly for both institutional and community I(L)D services (Principle 7.2, NHS England, 2015). However, collaboration is rarely defined in these policy documents. Collaboration is also discussed regularly in healthcare literature but is also rarely defined by researchers (cf. Kvarnstrom & Cedersund, 2006; Leipzig et al., 2002; Opie, 2000). Thus, it might be difficult for teams to understand what is meant by collaboration. Professionals may be assumed to have this knowledge and so definitions may seem unnecessary. However, as collaboration is often suggested to be a new or different way for healthcare professionals to

work, a definition might be able to provide clarity on what is expected from this way of working.

Professionals may draw on a common sense understanding of collaboration, e.g. that it is about people working together, but a number of researchers have also attempted to develop a theoretical definition to explain collaboration in healthcare. Building on the dictionary definition of collaboration: 'to work with another or others on a joint project' (Collins, 1991), researchers tend to emphasise that it is multiple professionals working together towards a goal (e.g. Bruner, 1991; Bronstein, 2003). More recent research on collaboration tends to focus on the broader concepts related to collaboration, rather than collaboration itself. For example, sharing, partnership, interdependency, power and a problem-focus are elements argued to be embodied by the term collaboration (See Chapter 2; D'Amour, Ferrada-Videla, Rodriguez & Beaulieu, 2005; Petri, 2010). However, Petri (2010) analysed the related concepts and created a theoretical definition of collaboration in healthcare: "..an interpersonal process, characterized by healthcare professions from multiple disciplines with shared objectives, decision making, responsibility, and power, working together to solve patient care problems…'(p.79). This definition is clearly situated within the healthcare context and may be helpful for professionals to understand collaboration above just working together. It highlights the requirement of multiple professionals, the interpersonal process and points to some of the concepts related to multidisciplinary working (such as power, D'Amour et al., 2005).

Definitions and theoretical understandings have a place in research that is attempting to measure collaboration, but they do not explain what collaboration looks like for MDTs in I(L)D services (cf. p.93 for the I(LD) setting). One issue with how collaboration definitions have developed is that they rely on concepts related to collaboration (see D'Amour et al., 2005) or they consider collaboration as a thing that is achieved. Chapter 2's literature review discusses the issue with conceptualising collaboration as a concept/thing further. This thesis proposes an

alternative approach to understanding collaboration that exposes the practices of healthcare practitioners who are collaborating. The approach moves away from needing to be able to define collaboration, looking instead at what people who are collaborating in MDTs actually do.

MDTs: a place for collaboration

Healthcare organisations globally, including those in the United Kingdom, tend to deliver their services via MDTs, although there is some debate over their use. Outside of the UK, MDTs are often referred to as interprofessional teams (cf. p.16). MDTs provide a space for collaboration and have been linked to specific benefits when delivering care, however there is some disagreement on the evidence to support the widespread use of MDTs in healthcare. MDTs are argued as important for tackling an increase in disease complexity: 'as the management of disease becomes more complex, it is important to involve all key professional groups in making clinical decisions for individual patients' (p.743, Taylor et al., 2010). Therefore, MDTs should provide an opportunity for an increase in communication between healthcare professionals, to enable better care decisions for patients. Centralising care provision in a single team is also argued to reduce the cost of care (Leape et al., 1999). Yet, evidence that suggests MDTs are better than other types of team at delivering care is missing according to Taylor et al. (2010). Regardless of the patchy evidence base for MDTs, the English National Health Service encourages the use of MDT working models to provide 'integrated care and support' for patients (p.6, NHS England, 2014). 'Integrated care and support' alludes to different healthcare professionals working together, making collaboration a key requirement for MDTs in the NHS.

What constitutes a MDT is contested and so it is important to clarify the use of MDTs in this thesis so readers are clear on what types of team are being referred to throughout. The Journal of Interprofessional Care (JIC) alludes to the variation in terms used, and the disputes between

different authors on the labels that teams are given (cf. Reeves, Lewin, Espin & Zwarenstein, 2010; Leathard, 1994; Lacey, 1998), providing submitting authors with a clear list of terms with definitions (Journal of Interprofessional Care, n.d.). Multidisciplinary teams are defined by two criteria: who is in the team " … composed of different academic disciplines … rather than different health and social care professions" and how they work together, "… members work alongside one another … [in] parallel rather than interactive work" (Journal of Interprofessional Care, n.d.). On the other hand, the NHS handbook of MDT development defines MDTs simply as teams of people from multiple disciplines who are involved in delivering care for patients (NHS, 2014). Key to an MDT is that there are more than two people in a team and more than one profession, so that there is collaboration across a group of healthcare professionals. However, MDTs in the NHS may not be called MDTs in the JIC, potentially limiting the impact of journal articles for some teams that they could influence.

Journals' adoption of the term interprofessional, rather than multidisciplinary, likely reflects the global use of the term interprofessional. The World Health Organisation's (World Health Organisation, 2010) Framework for Action on Interprofessional Education and Collaborative Practice, used the term interprofessional throughout. The WHO's framework called for interprofessional collaborative practice as a long-term solution to deal with health epidemics, natural disasters and a range of other issues that affect health systems all over the globe. The WHO argues that interprofessional collaboration can strengthen healthcare systems and improve patient outcomes, whilst addressing issues such as the global shortage in healthcare practitioners. Thus, the difference between journals' and the NHS's terms (interprofessional vs. MDT) reflects the global versus local focus, with teams in the UK aligning with the NHS five-year forward focus on multidisciplinary teams.

Despite differences in terminology used in the global academic (e.g. JIC/WHO) and UK applied world (e.g. the NHS) there are similar elements to all the terms used to describe similar

teams. The different terms, which include multiagency, multispecialty, interprofessional, transdisciplinary, multiprofessional, multidiscipline, are used and defined differently between and within the JIC (n.d.) and the NHS (NHS England, 2014). The essence of the terms is that they relate to teams of different people, with a range of job roles, working together. All the teams described by these terms have collaboration as a key element to the way they work. Despite the different ways that healthcare teams might be organised to meet the needs of their service, they are all meant to work together collaboratively. The term chosen is more about its recognisability to professionals who want to see if the research findings are applicable to them. The aim of this thesis is to create meaningful applied research for the participating teams, and as there is not the global focus that journals might have, therefore in line with the NHS the term MDT will be used throughout.

The creation of MDTs: a problematizing shift

Healthcare disciplines historically have worked separately and have been autonomous, so the move to create MDTs has been associated with problems in teamwork. Chapter 2 develops more on the barriers and facilitators that are related to collaboration between professionals in MDTs, but here the main assumption – that different disciplines will struggle to work together – will be briefly unpacked. The assumption that different professionals will find working together difficult seems to be born out of the historical development of healthcare professions. Established in the 18th century, professionalism in medicine developed through the creation of medical education, societies, regulation and specialism (Jackson, 2014). The turn of the 20th century saw the development of formal training for a wide range of the key professions to healthcare today, such as nursing (Able-Smith, 1960), speech and language therapy (Stansfield, 2020), physiotherapy (Nicholls & Cheek, 2006) and occupational therapy (Paterson, 2008). The formation of the NHS after the Second World War drove further establishment of these

roles (Paterson, 2008). These professions all had to make claims to their distinctiveness, which may make collaborative working in MDTs more problematic.

Regulation helped to establish professions, but they also developed stricter rules to enforce professionals being separate and autonomous. For example, psychiatrists have the ability to prescribe medication and therapy for mental health issues, whereas a clinical psychologist can only work with therapy treatment. These regulations are still relevant for healthcare professionals today. Regulation works to both ensure safe service provision to the public, and provides professionals clear income routes and job satisfaction (Berrie, 2012). Regulation also clearly marks which professional can do what, so there may be a sense of professional protectiveness over certain tasks both in the name of patient safety and job security. The standard way of operating before the move to MDTs kept different healthcare professions in their separate teams. The move to working in MDTs with other professionals may seem threatening and may paradoxically affect the ability of professionals to collaborate. Chapter 7 examines the impact of professional roles on interaction between MDT members to see if the assumption that it is problematic for collaboration is visible as professionals work together.

The change from the historical way of working in separate teams, to collaborative working in MDTs, is relevant for most healthcare services, particularly for those that were delivered in institutions. This is because many services moved from institutions to the community after a range of well-known reports highlighted the damaging conditions of institutions (Morant, 2006, cf. Foucault, 1967; Porter, 1987, Scull, 1981). The key principles of community care are that hospital admissions reduce, care is provided flexibly, there is more reliance on friends or family, health and social care become integrated and people receive care from MDTs in the community (Cowen, 1999). The integration of different health (and at times social care) professionals in MDTs is essential to the delivery of community care for a key reason. Hospitals and institutions allow for a number of specialist teams and the patient to be co-located, so there

is little need for MDTs. Care in the community is dispersed, and one way to manage an individual's needs is to co-ordinate care via a single team of different specialists who collaborate.

I(L)D services: The need for collaboration and MDTs

The focus for this thesis is on Intellectual (Learning) Disability services, instead of any other MDT that may also rely on collaboration to deliver healthcare. The decision was made to focus on I(L)D services due to what can be perceived as an increased need for collaboration. This section provides some background to I(L)D and the services provided to support people with I(L)D, to situate the perceived need for collaboration in these services.

Collaborative care, delivered by MDTs, is integral to I(L)D teams not only due to the dispersed nature of community care, but also due to the needs of the heterogeneous population. People with I(L)D often have a range of long term health problems that require continuous support from a number of different specialities (Department of Health, 2012). I(L)D (referred to as learning disabilities in the UK) is diagnosed based on having the presence of:

" A reduced ability to understand new or complex information or learn new skills

Plus

- A reduced ability to cope independently
- Both of which began before adulthood with a lasting effect on development."

(Department of Health, 2001).

It is estimated that there are 905,000 adults with learning disabilities in the UK (Emerson et al., 2011), with 21% known to services which provide specialised care and support.

Intellectual Disability Services offer support when mainstream health services are unable to meet adults with intellectual (learning) disabilities' varied needs (cf. Oxford NHS Foundation

Trust, 2018). In particular, individuals with I(L)D may have a reduced ability to understand their health issues, and may have communication needs that require specialist training for healthcare professionals to support. I(L)D services are commissioned in different ways by individual NHS trusts. Often there are a number of different teams that can support people with intellectual (learning) disabilities. For example, in Oxford NHS Foundation Trust (2018) there is a community team who offer specialist multidisciplinary support with physical and mental health, as well as daily living skills and communication. Alongside the community team, there are specialist teams (e.g. intensive support teams) who provide support for behaviours that are challenging and complex, for in-patients and for people with a forensic risk of offending. For some NHS trusts (e.g. Devon Partnership Trust, n.d.) there is not a general community multidisciplinary team for adults with learning disability. Instead, the focus is on supporting people to access mainstream services using primary care liaison nurses. Although there are differences between NHS trusts in their organisation of services, they are all guided by the Transforming Care Programme (NHS England, n.d.) and the Model Service Specifications document (which focuses on behaviours that challenge, NHS England, 2017), both of which emphasis the need for MDTs to support people with I(L)D.

Individual trusts' responsibility to commission intellectual learning disability services means that there is some variation in the professionals that constitute trusts' multidisciplinary teams and the work that they do. However, for the more specialised teams (e.g. that support behaviours that challenge), NHS England (2017) makes some recommendations of the professional roles needed to deliver the function of a specific team. For example, intensive support teams are advised to include learning disability nurses, occupational therapists, speech and language therapists, clinical psychologists, social workers, behaviour analysists, psychiatrists, pharmacists, support workers, educationalists and therapeutic specialists. The actual work the team might do can vary from trust to trust. The Model Service Specifications

document outlines the type of work that services should be doing to support adults with learning disabilities and behaviours that challenge. For example, a forensic team may do work that includes managing individuals through specific interventions, they may design training for privately employed I(L)D community support workers, and may liaise with other agencies (such as probation and the police) to help support someone with I(L)D moving through and away from the criminal justice system (NHS England, 2017).

Regardless of individual trusts' I(L)D service design, a theme throughout them all is that the I(L)D teams must work in a multidisciplinary way (NHS England, 2017) and collaborate to meet individuals' needs, avoiding major service failures (more detail is provided in the next paragraph on these failures). However, due to the variety in the types, form and function of teams in intellectual learning disability services, Chapter 4 provides detail on the different teams that participated in this research, including the work they did and the professionals involved. This was important given the different ways that individual NHS trusts commission intellectual learning disability services, along with the fact that all the participating teams were from different NHS trusts.

In the past 20 years moving to collaborative community care has been re-emphasised in I(L)D services due to a number of serious service issues. Mencap's Death by Indifference report (2007) demonstrated widespread neglect in care for people with I(L)D, resulting in a number of avoidable deaths, reiterating the need for change to institutional care. An investigation into Cornwall Partnership Trust (Commission for Healthcare Audit and Inspection, 2006) also found a range of abuse in institutional settings. More recently, a BBC Panorama special (2011) publicised the problems of abuse in institutional care at Winterbourne View hospital. This led to a number of government investigations and reports, all of which emphasised the need for multidisciplinary support for people with I(L)D (Department of Health, 2012, Department of Health, 2015a, Department of Health, 2015b). Although much of the highlighted abuse

occurred in hospital settings, advice for services both in institutions and in the community is to provide specialist collaborative multidisciplinary health and social care support to service users (NHS England, 2015).

Although collaboration is necessary for service delivery in I(L)D teams, it is not always perceived to be very effective. The puzzle highlighted in the beginning of the introduction, between the need for collaboration and the problematic discursive construction of MDTs, is also reflected in service users' experiences of MDTs in I(L)D services. Consultation for this thesis was held with the Plymouth Service Receiver and Carer Consultation Group in 2016, to understand how research on staff communication should be conducted. Consultants in the group discussed their experience of a lack of communication between staff members, which led to them having to repeat information multiple times to different professionals. Cutler, Morecraft, Craig and Kennedy (2019) also found a lack of information sharing between professionals in MDTs, which pushes the burden to explain issues on to service users. Although Cutler et al.'s (2019) participants were not specific to I(L)D, they all had chronic long-term conditions, comparable to users of I(L)D service. Service users' experience of MDTs further suggests more understanding is needed of staff communication practices to improve collaboration and service user experience. The experiences of service users echoes the issues raised by healthcare professionals (cf. p.11), further highlighting the importance of understanding how people communicate with each other when collaborating.

The approach

This thesis took the approach of starting from the bottom up, exploring what collaboration actually looks like in I(L)D MDTs to make applicable, significant research for clinicians and their working practice. The approach developed to examine the *practice* of collaboration, as the interest for this thesis is what professionals do when collaborating, rather than examining

collaboration as an abstract concept that is assumed to be understood. It is important to note that the focus here is not on communication practices in general, but collaboration practices. The rationale for narrowing in on collaboration is due to the puzzle highlighted at the start of the introduction. Professionals are in support of collaboration, but they often suggest it is problematic. The approach of this thesis is to use a methodology that examines real life interactions and meetings between professionals that work in I(L)D services (cf. Chapter 4). Thus, although communication is what is under examination, the focus here has been to understand the patterns of communication that constitute collaboration.

The research was inductive, starting with data collecting and from there questions were developed from the data and from discussions with healthcare professionals and service users (Huma, Alexander, Stokoe & Tileaga, 2020). This contrasts with the deductive approach that begins with theory, for example with the broader concepts related to collaboration, and then designs data collection to match questions that arise from theory. The deductive approach is the dominant approach in psychology. However, there are limitations inherent in the approach, such as limiting new ways of thinking about a phenomenon and making it difficult to understand new phenomena (Spector, Rogelburd, Ryan, Schmitt & Zdeck, 2014). An inductive approach is more common in qualitative research, especially when using the methodology of ethnography, discursive psychology and conversation analysis. These methods only use a few predefined parameters, so it is not possible to predict (aka hypothesise) what will be found (Huma et al., 2020). Instead, the focus is on looking at what actually happens to discover and be open to what the research is showing.

One key aim of this thesis was to produce applied research. Here, what is meant by applied will be briefly unpacked. Applied research has been defined as research that aims to be useful and applied to specific public or private domains (Given, 2008). As such, the aim of the thesis was to create an understanding of collaboration that would be useful for I(L)D MDTs. Applied

research is often contrasted to basic research as a dichotomy, however it may be better to conceptualise the differences between applied and basic research as on a continuum (pg.17, Given, 2008). Generally speaking, research that sits more towards the applied realm is closely based on what happens in real life and what people actually do (Hofffman & Deffenbacher, 1993). The methodological approach taken in this thesis (cf. Chapter 3 and 4) focused on capturing what I(L)D clinicians do in real life. Many researchers have also used conversation analysis to do applied research. Applied conversation analysis has previously been discussed as taking a number of different formats (cf. Antaki, 2011). As this thesis' aim was to understand how I(L)D teams do collaboration, it could be most closely related to what Antaki names 'Institutional Applied CA', where the focus of the research is to describe how an institution carries off its work. However, as well as describing how collaboration is done, it was hoped that the research findings may inform clinicians' collaborative practice. Yet, as there was no predefined problem that the research aimed to 'fix', it could not be called 'interventionist' according to Antaki's definition.

Despite the lack of a predefined problem, this thesis also has parallels to what has more recently been named 'Reflectionist interventionist CA' by O'Reilly, Kiyimba, Lester and Muskett (2020). Reflectionist interventionist CA (RICA) is argued as useful for investigating an institutional setting when there is no a-priori notion that there are practices that need to be changed, or even if good (or poor) practice will be identified as part of the CA research. O'Reilly et al. (2020) argue that there is a subtle difference here, but a key idea is that this type of applied CA retains the core CA concept of 'unmotivated looking' (Sacks, 1984), in the sense that as research begins it is unclear what, or if any problem(s) will be identified. A key application of RICA is that clinicians can use CA to reflect on their practice in joint analysis sessions. This thesis' approach therefore draws parallels to O'Reilly's approach, as the aim was not to understand a deficit in collaboration in MDTs, but to understand the practices of

collaboration. Additionally, the use of joint analysis in this thesis is similar to RICA, which at times was used to help guide analysis foci. Overall, the type of applied CA used in this thesis may overlap with both Antaki's definition of Institutional Applied CA (as an aim was to understand how clinicians carried out collaboration) as well as RICA.

There is often an understanding that applied research, particularly in healthcare, will have a direct and obvious relationship to the people that receive the healthcare (aka the patients). The research for this thesis aimed to understand how, as a team, I(L)D MDTs undertook work that needs to be done for patients to receive care, but did not focus on direct interactions with patients. Although this could be seen as diverting attention away from interactions with patients, which may moralistically be seen as more important (and equally may be more likely to get research funding), this thesis' approach is that the core daily work that is done by clinicians where the patient is absent is under-examined and neglected. Patients (cf. p.22) recognise that the work that clinicians do together is key for their care, and that there is an overall benefit to teams collaborating well together whilst they are organising and managing patient care. Thus, this research is applied in the sense that it is applied to help understand, and potentially change, the way that healthcare professionals do their work. One strategy to help achieve application was the use of joint analysis sessions and feedback to the teams involved, to aid reflection on their practice.

A lack of prior understanding on the day-to-day practices which constitute collaboration 'in the wild' (see Chapter 2), called for an examination of what was happening in practice without prior judgement that something needs fixing. Belanger and Rodriguez (2008) argued that an inductive discursive approach was needed for understanding collaboration and teamwork in multidisciplinary teams, due to the lack of understanding of what it really looks like. The use of CA was approached from a psychological perspective, in combination with discursive psychology and ethnography, to begin to unpack practices of collaboration. This thesis began

from the bottom-up, working with I(L)D teams to understand how they functioned, and used ethnography, discursive psychology and CA, to help answer the research question, aims and objectives, that follow.

Research Question: What are the collaborative practices of multidisciplinary teams in intellectual (learning) disability services?

Aims:

- To take an inductive discursive approach to explore collaboration in a healthcare context and consider how this may change the current understanding of collaboration;
- Use an approach to conversation analysis that gives primacy to participant concerns;
- Contribute an understanding of collaborative practice for healthcare professionals

Objectives:

- Examine literature about collaboration in healthcare;
- Examine how discursive psychology and CA can highlight I(L)D MDTs' practices of collaboration;
- Use ethnographic methods to understand the context under examination and develop the analysis focus

Thesis structure

The next chapter is a literature review that examines how collaboration in healthcare has been understood and researched, with the aim of understanding how collaboration could be re-interpreted through a psychological lens. The literature review explains the broader concepts that researchers have related to collaboration. These include trust, respect, shared understanding and power. Researchers have conceptualised the concepts in terms of barriers and facilitators

to collaboration. These barriers and facilitators are synthesised in the review. The chapter concludes by discussing the issues with the methods used in previous research, and how these methods have led to a focus on barriers and facilitators to collaboration, rather than providing an understanding of the practice of collaboration in healthcare teams.

Chapter 3 provides an overview of this thesis' approach to understanding collaboration, through the combination of discursive psychology, conversation analysis and ethnography methodology. The chapter is a demonstration of how this approach can provide understanding of the practice of collaboration that has been missing from the research reviewed in Chapter 2. It shows that changing the perspective from overarching concepts around collaboration, to considering the detail of what is happening when teams are collaborating, can create meaningful applied research. The chapter explains discursive psychology, conversation analysis and ethnography, and provides the rationale for choosing them as the primary methods used in the thesis.

Chapter 4 details the design of the project and the context of the I(L)D MDTs that participated in the research. The chapter explains the recruitment of teams, along with how the design developed from the preliminary research, on four hours of data, to the more extensive full design that involved three teams and 13 hours of meeting recordings. The chapter also explains the complex ethical considerations vital to the thesis research. The second half of Chapter 4 provides an overview of the teams that took part in the research. The ethnographic observations were used to build the overview so that the research is clearly situated in the applied setting. The chapter finishes by explaining the analysis approach used in the thesis.

The main analysis chapters then follow. The findings are organised into three different domains that healthcare professionals find useful when thinking about their teamwork: the clinical domain, the relational domain and the organisational domain (Smart, Reed, Sztorc, Clancy & Connolly, 2018). These three domains were used as a framework based on the MDTs In Action

project finding that they are the key areas of interest for service uses, carers, clinicians and researchers (Smart, Reed, Sztorc et al., 2018). The domains are adapted from Smart, Reed, Sztorc, et al., (2018) and defined in this thesis as follows.

The clinical domain:	The clinical work that teams collaborate on, such as producing diagnosis and deciding on assessment – areas which are directly associated with work they have to do for the people with I(L)D they support.
The relational domain:	The interpersonal, both professional and informal, relationships between the people who are meant to collaborate.
The organisational domain:	The structures that team members have to collaborate within, such as the length of the meeting and the types of professionals in the team.

These domains were a helpful framework for the analysis chapters that follow, both to organise the analysis and to highlight areas of interest for healthcare professionals. A caveat to their use is that categorisation into different domains may overlook their intersectional and overlapping nature. This reflection is developed in the discussion (pg.202).

Chapter 5 exposes a practice from the clinical domain – how to gain input from other team members on a potential risk to a client. Using data from the preliminary research phrase, analysis focused on how healthcare professionals would often use the term ‘concern’ when raising a potential care risk to a client. Using the term ‘concern’ at different moments in conversation affects how receptive the team are to engage with the potential risk. The discussion explores the need for delicacy around raising risks, and how concern constructions may help healthcare professionals who may need to gain collaborative input on a risk in a team meeting.

Chapter 6 focuses on a practice in the relational domain: how laughter is used in team meetings. The chapter details analysis done on all instances of laughter in the second phase of data collection. Development of the analytic focus for this chapter arose through joint analysis sessions with clinicians. Alongside some well documented instances of the use of laughter (for example in management of troubles talk, and when moving into a playframe), the chapter details how embedded laughter is used and has the potential action of affiliating with other team members. The discussion explores the need for this type of laughter in MDT meetings and how it could help professionals to feel part of a group, which is important for collaboration.

Finally, the analysis in Chapter 7 focuses on a practice in the organisational domain and examines how different professionals work together whilst retaining their professional autonomy. Job role is an anticipated barrier to collaboration, so the analysis here focuses on how job role is orientated to when clinicians are negotiating a future course of action. Using epistemics and deontics, this analysis unpicks the pattern commonly used by professionals to claim the right to say no. The practice used demonstrates how professionals are able to retain their professional autonomy using subtle techniques that are delicate in maintaining positive social relationships with other team members.

Chapter 8 then discusses the findings and how they have answered the research question: what are the collaborative practices of I(L)D services' MDTs? The practices are discussed as part of a framework of clinical, relational, and organisational domains, but there is also a discussion on the nuance needed when applying this framework. The discussion relates the findings to both prior healthcare literature and conversation analytic literature. One of the main aims of the thesis was to create meaningful research for healthcare professionals, so there is an appraisal on how the research findings might be made useful to healthcare professionals, drawing on previous conversation analytic training models.

MDTs in Action

The research for this thesis was embedded in the MDTs in Action programme at the University of Plymouth. This research programme, led by Dr Smart, had not received support from a funding body, but brought together a number of researchers who were examining MDTs using CA. Most of the research projects were part of clinical psychology doctoral students' theses, and examined MDTs in different healthcare services (cf. Smart & Auburn, 2018). The student led nature of these projects meant that the research questions and findings were not necessarily strategically linked, but broadly group together under the umbrella of research that has examined MDTs by recording real life conversations between team members. Thus, this thesis has examined interactions in I(L)D services with a focus on collaboration, and could be linked to some of the previous MDTs in Action findings. For example an examination of memory clinics found that storytelling is used to share assessment information (Dickenson & Smart, 2018) and this could be related to knowledge sharing in collaboration (cf. lit review). Some further links between the findings in this thesis and the MDTs in Action project are reflected on in the discussion (cf. p.206). This thesis focus has been on the role of collaboration in I(L)D services specifically, but links across the research studies could be made more broadly, to eventually build a unified understanding of the practices of MDTs.

Reflection Box 1: Introduction

Throughout this thesis I have added in reflection boxes to document how some research decisions were made. These reflections discuss the journey I went on as a researcher, so that future researchers can understand how my own assumptions have shaped every stage of the research (Rolls & Relf, 2006). Reflexive notes also discuss my personal thoughts and my characteristics for future researchers to assess how they may have shaped this thesis, aiding the credibility of this body of work (Tong, Sainsbury & Craig, 2007). Within the reflection boxes are also comments on changes that have been made as a consequence of examination.

Here, I reflect on the choice of collaboration in I(L)D services as a research topic.

When I began my PhD I was interested in how professionals work together in psychology related services. My personal life meant that I had an awareness of multidisciplinary teams and the difficulties experienced by people who are members of MDTs. For example, one of my parents managed a Local Authority special educational needs team and would often reflect on the difficulties of working in a MDT. This is similar to the general statements included from people that I consulted at the initial stages of the research. Therefore, I held assumptions that working together to care for people with learning disabilities was complex, and that it was difficult, but also that I did not know very much about it. When I was previously employed as a carer, a lack of joined up care was a problem for the people I was supporting (all who lived with acquired brain injury). A lack of joined up care also seemed to be an issue dominant in I(L)D policy literature, but perhaps my own and other researchers' ways to approach understanding people working together was to focus on the difficulties, rather than the areas of ease. This could be a mistake, as the tasks that I(L)D MDTs achieve well could be as illuminating to understanding collaboration as the areas of difficulty. Equally, this is assuming a binary position where something is easy versus difficult. Discussion about this assumption with my supervisor helped me to understand how CA and discursive approaches move away from making an evaluation of services, to develop an understanding of 'how' those services work.

As a researcher, I am white British middle-class female, educated in psychology and psychological research methods to MSc level. I have a privileged background. This has meant that I cannot truly appreciate the experience of people living with I(L)D. Nor have I considered in this research how other identities may intersect with people living with I(L)D and the professionals that care for them. It is also interesting to think about how I(L)D is a

catch all term, which represents a diverse range of experiences and needs. On reflection, at the very start of the research process it may have been helpful to work with both I(L)D staff and people with I(L)D to create meaningful research questions for them, rather than just ask about the project after it has been created, enhancing any applied focus of this work.

The inexperience I felt about I(L)D services biased me towards the research methodology that I used – where it was very much data driven and aimed to be 'emic' as much as it is possible. However, CA is not a well-known method, which can be quite technical, so I also experienced a tension that it would by-pass the experience of MDT members. I was worried that I would be explaining to professionals we were looking 'just' at talk. I overcame this worry during regular discussion with my supervision team, as they had experience of working with healthcare professionals and using CA. They highlighted that although it wasn't easy, it was possible when sessions with professionals are well planned.

Outside of my general inexperience of I(L)D, I personally was aware of, and also motivated by, the long-standing issues of social justice for people with learning disabilities, and a mistrust of government policies to protect people's lives, particularly with an increasing neo-liberal agenda throughout the UK government for the past 30 years. I can be suspicious of what is often couched as providing agency, which can equally mean a reduction in funding. This may have motivated me to want to demonstrate what these teams actually do, and provide evidence of the key work they do to prevent further erosion of services. Thus, a felt lack of knowledge about I(L)D services and passion for social justice probably also kept my interpretations away from labelling services as bad versus good.

Chapter 2: Collaboration in healthcare services: literature review

This chapter details the findings of a literature review on collaboration in healthcare. The increasing legislative and policy emphasis on interprofessional collaboration, in the UK (see Chapter 1, Department of Health, 2012; Department of Health, 2015a, Department of Health, 2015b) and worldwide (World Health Organisation, 2010), has sparked a large body of research on various aspects of collaboration. These aspects include how collaboration can become a norm early in a professional's career (Thistlethwaite, 2011), how interventions can be put in place in current healthcare systems to improve collaboration (Zwarenstein, Goldman & Reeves, 2009) and healthcare professionals' experience of interprofessional collaboration (Weller, Barrow & Gasquoine, 2011). The key focus for this literature review was to find studies that provide an understanding of what collaboration looks like in healthcare settings. Chapter 1 included an explanation of how collaboration in rarely defined, particularly in policy documents, and that there is a lack of clarity on what collaboration is (cf. p.13). The aim of this review was to understand what is known about collaboration in the wider literature, as when healthcare professionals want to understand collaboration this is what they might normally refer to. Although this thesis takes a different approach to understanding collaboration (cf. Chapter 3), it was still important to review the wider literature to clarify what a new approach adds, and the different perspective it provides. D'Amour, Ferrada-Videla, San Martin Rodrigues and Beaulieu's (2005) did a similar review but did not focus on research from healthcare settings, and there was an opportunity to incorporate more recent research. The chapter begins with an overview of their findings and explains how their paper was used to develop the current chapter's literature review. The results section, which has synthesised the literature, shows that researchers have focused on factors that are barriers to or facilitators of collaboration. The discussion considers the problems of only focusing on concepts that are barriers and facilitators

to collaboration, presenting the argument for approaching collaboration from a discursive perspective (elaborated on in Chapter 3).

In their review, D'Amour et al. (2005) completed a systematic literature search to identify theoretical frameworks that could improve understanding of interprofessional collaboration in healthcare services and the concepts related to collaboration. Search terms included inter, multi, professional, discipline, team, occupation, agency and models in health field (see Chapter 1 for discussion of the wide range of terms used, and interchangeable nature of these terms). The concepts underpinning collaboration were synthesised and they found that two main features were related to the purpose of collaboration. First, a key driver for interprofessional collaboration is the need to act collectively to address complex client needs in healthcare settings. Second, to achieve the collective action professionals have to build a team that integrates the professionals' different perspectives, whilst having respect and trust. D'Amour et al. (2005) emphasise that collaboration is regularly referred to in the literature as a process, rather than a singular activity that professionals do. Sharing, partnership, interdependency and power were the main concepts that were related to the process of collaboration. However, D'Amour et al. (2005) argue that the theories and frameworks included in their review do not explain how these concepts work together as a process. Furthermore, the literature included in the review was often from a range of contexts (not purely healthcare) and did not tend to base conclusions on empirical data. Thus, it is unclear how accurately the concepts used in their framework are reflective of a healthcare context, although even within healthcare different services vary substantially.

Using D'Amour et al.'s (2005) review as a template, the current review aimed to understand what is now known about collaboration, specifically in healthcare settings. The current review updated D'Amour et al.'s (2005) findings and searched for papers that looked specifically at

collaboration in healthcare settings, incorporating any relevant research that had been published since D'Amour et al.'s paper. Thus, the objective was as follows:

To examine the literature about collaboration in healthcare and synthesise the concepts that have been used to explain collaboration in healthcare services.

Method

A meta-synthesis of the barriers and facilitators to collaboration was completed. A meta-synthesis selects, appraises, summarises and combines evidence to address the research aims (Erwin, Brothersome & Summers, 2011). To do this all the included literature was first assessed using the Critical Appraisal Skills Programme checklist and then re-read as a body of literature. Patterns in the literature were noted, along with any areas of consistency and inconsistency (Booth, Sutton and Papaioannou, 2016). The main findings of the literature were summarised (see Table 2 below), and then findings were grouped along the lines of similarities and divergence.

Literature review strategy

The literature review strategy involved two searches in 2017 (in March and June). The results of the searches were combined and then reviewed against the inclusion criteria. The main criteria were that the research focused on collaboration of healthcare professionals from multiple disciplines (cf. D'Amour et al., 2005), based on empirical data. D'Amour et al.'s paper was central to developing this meta-synthesis, so the first search found all the literature that had cited D'Amour et al.'s paper (Booth et al., 2016). Second, the following databases were searched: Scopus, Medline and PsychInfo, using the following search string: ((multi OR inter) AND (professional OR disciplinary)) AND ((team OR agency) OR occupation) AND collaboration AND models AND healthcare NOT education. Initially the search terms did not exclude education, but there is copious research on education, and this was not of interest for

the current thesis, so it was excluded. Grey literature was not searched for this review, as the focus was on academic papers based on empirical data. The titles of the results from all searches were screened for further review, and then the abstract if more clarification was necessary. The initial search produced a high number of duplicate articles and articles that focused on a disparate area – for example a case study of a surgical operation (the team involved were multidisciplinary, but the focus of the paper was on the procedure and outcomes for the patient). The inclusion and exclusion criteria were applied to the abstracts (see Table 1) to try to reach papers on collaboration in multidisciplinary teams in healthcare. After this initial screening, 117 journal articles were examined in more detail to see if they met the main criteria for this literature review. Following this second screening, 21 papers were identified as eligible for full evaluation. The flow chart in Figure 1 details the process of this review strategy.

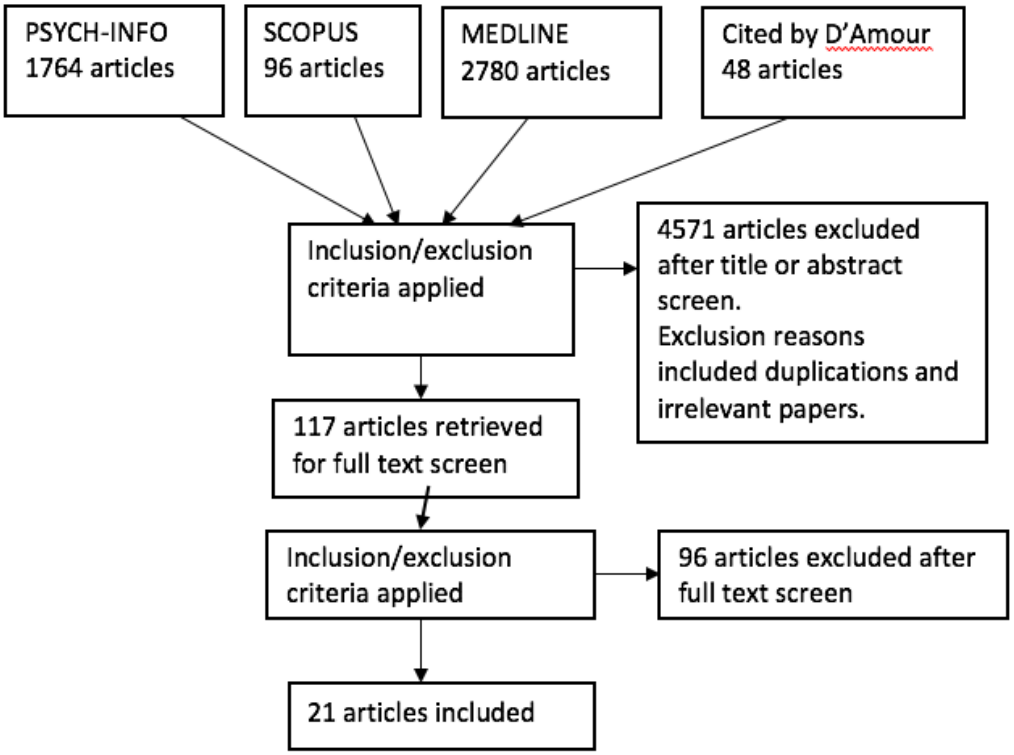
Table 1.

Inclusion and exclusion criteria applied to the literature search

Inclusion	Exclusion
Collaboration is a central topic	Not peer reviewed
Empirical &/or theoretical	Student/educational focus
Qualitative and quantitative	Outcomes of collaborative working
Published between 1950-2017	Single professional role
Research in a healthcare setting	

Figure 1.

Flow chart of the papers reviewed



Quality of the papers in the review

The Critical Appraisal Skills Programme (CASP, 2018) Qualitative Research Checklist was used to evaluate the methodology of selected papers. The framework is designed for qualitative research. There were 18 qualitative studies and only 3 quantitative studies, so the CASP Qualitative Research Checklist was applied to all the research in this study for consistency. The CASP checklist was designed as a pedagogical tool, but is used widely for published systematic reviews. It aims to encourage critical appraisal of studies to ensure researchers are focusing on the validity of a study's results and how they can be applied to research questions. As a result, there are no scores of the studies, as it is designed for critical appraisal rather than ranking of studies. Critical appraisal tools are criticised for their lack of nuance when assessing validity (Hannes, Lockwood & Pearson, 2010), and lack of rigour overall (Crowe & Sheppard, 2011). Overall, due to their imperfection, it is important that critical appraisal tools are not relied on

for assessing studies. The CASP has been used for this chapter as a guide to critique, rather than an exclusion/inclusion tool, and its use here is critiqued in the discussion.

The CASP criteria were applied to all of the papers included in the review (see **Appendix A** for CASP criteria and assessment of the papers). 20 out of the 21 papers reviewed met at least half of the quality criteria outlined for qualitative research. The most common criterion that was unclear in the research papers was consideration of the role of the researcher and their relationship to the participants. Equally, there were often problems with the research design chosen to address the aim of the study. Results were not often rigorously substantiated, for example only using minimal quotes to support conclusions (cf. number 14). One paper (cf. number 19) did not include any of the data that was used to develop the conclusions in the paper, as it was reporting on a model in early development. Despite these quality issues, the decision was made to include all of these papers due to a lack of research that met the inclusion criteria, and the issues inherent to critical appraisal tools themselves (e.g. they appraise only the reporting of the study, Carrol & Booth, 2014). Although initial searches found 4688 papers, many of these were duplicates or did not meet inclusion criteria (e.g. by focusing on a single professional role). The impact of the quality of the papers will be explored in the discussion. The 21 research papers included in the review are listed in Table 2, which summarises the methodology used in the paper, the details provided about the study population and the main conclusions reached by the authors.

Meta-synthesis

To complete the meta-synthesis, all of the different findings, that tended to focus on facilitators and barriers, in the papers were drawn out as seen in Table 2 (Booth et al., 2016). Lists of all the facilitators and barriers and how they were defined across the studies were reviewed to identify the main recurring factors. Each article's factor explanation was double checked to

ensure the same meaning was attributed across papers. Often different factors had the same meaning yet were explained slightly differently. For example, a facilitator in Belanger and Rodriguez (2008) was described as ‘developing ways of working together through team building’ and by Robinson and Cottrell (2005) as ‘investing time and resources toward team building’. Thus, a term was chosen that would encompass the meaning of the factors in a succinct manner (i.e. team building). The author then interpreted how these different factors might relate to one another, considering how they might operate at different social levels.

Table 2.

Summary of the literature in the review

Number	Reference	Method	Study Population	Main outcome
1	Columbo, Bendelow, Fulford & Williams (2003)	Interviews on a case vignette & a critical incident	Mixed healthcare professionals and patients (n=100) UK	Different roles hold different mental models to explain mental health, which negatively impacts collaboration.
2	Farima et al. (2016)	Case study analysis based on interviews	Mixed healthcare professionals (n=22) Unknown location	Loose knit networks that had small numbers of informal interactions failed to build trust, preventing collaboration.
3	Fitzgerald & Teal (2004)	Focus groups interviews following participant observations	Mixed healthcare professionals (n=?) Australia	Collaboration was dependent on status perception, historical factors, education, experiences & individual's view of other roles.
4	McKean et al. (2016)	Semi-structure interviews	Local authority - mix of school, SEN and healthcare professionals England	Development of social capital (networks, norms and trust) is necessary for cohesion in collaboration - framework is presented.
5	McDougall, Goldsmidt, Kinsella, Smith & Lingard (2016)	Interviews with a 3 person unit – patient and two staff.	Mixed healthcare professionals and patients (n=23) Canada	Collaboration not about shared purpose, but embracing collaborative entanglement which involves non-human entities (e.g. the telephone).

6	Nugus, Greenfield, Travaglia, Westbrook & Braithwait (2010)	Semi-structured interviews, observations of meetings & everyday conversations.	Australian healthcare teams	Both competitive power and collaborative power are part of the negotiated order across settings. Doctors hold large amount power in range of settings.
7	Robinson & Cottrell (2005)	Observations of team meetings & interviews on issues arising, plus vignette based focus group discussions.	5 multi-agency teams in children services UK	Barriers: different models held to explain causes of issues, unclear roles, different power & status, different procedures held by agencies/groups; Facilitators: good communication(co-location), agreed objectives & common goals, team building.
8	Liberati, Gorli & Scaratti (2016)	Participant observations & discussions	Stroke unit, Italy	Disciplines still act in silos, based on historical work patterns and role identities, which prevents collaboration.
9	Korner et al. (2016)	Cross-section questionnaire	Range of specialist clinics Germany	Doctors tend to perceive better knowledge integration (KI); better view on KI correlates with better collaborative patient centred teamwork and performance
10	Rovio-Johansson & Liff (2012)	Interviews & observations at treatment centre.	Child & youth psychiatric unit Sweden	Difficulties found in collaborative interactions because of role confusion & interpreting situations based on professional identity.
11	Clark (2014)	Narrative analysis of literature	Various teams Unknown locations	Using a narrative approach in interactions is a helpful collaborative technique as it fosters attendance to different values and voices

12	Hunt, Spence & Mcbride (2016)	Semi-structured interviews, focus group & survey	Range of MDTs England	Use of regular meetings and having boundary spanning roles facilitate communication & sharing of expertise.
13	Caricati et al. (2016)	Cross sectional survey	Doctors (138) & nurses(359) Italy	Doctors' and nurses' commitment, either to their profession or the unit they work on, differentially impacts on their attitude for collaboration.
14	Janssen, Snoeren, Van Regenmortal & Abma (2015)	Observations of meetings, in-depth interviews & focus group	Geriatric MDT Netherlands	Empowering factors for collaboration are mutual trust, clear routines, improved links and insight into each other's roles.
15	Belanger & Rodriguez (2008)	Qualitative research synthesis	Primary care teams UK, USA, Australia, Sweden, Germany, Canada	Range of factors that can increase collaboration, including developing trust and respect, redefining professional roles and having effective communication.
16	Fay, Borrill, Amir, Haward & West (2006)	Correlation design – questionnaire	Breast cancer teams & primary care teams UK	Potential negative group processes are overcome by pursuit of a shared vision, high interaction frequency, trust and reflexivity. Multidisciplinary working was positively related to the quality of team innovation if there are good team processes.
17	Gum, Prideaux, Sweet & Greenhill (2012)	Ethnographic observation & semi-structured interview	Nurses and Ward Doctors in rural hospital Australia	Space design impacted on face to face interactions/communications and more face to face interactions were viewed as improving collaborative interactions.

18	Hudson (2007)	Evaluation based on questionnaires, meeting observation, interviews & case tracking.	Mix of nursing, social care and LA professionals UK	To create a collaborative team, promote a shared focus on delivering good service and have time to socialise within the immediate workgroup.
19	Jones (2007)	Open interviews	Range of occupational settings, including healthcare UK	Collaborative potential dependent on bi-axis model of personal-professional identity & taking-sharing control.
20	Lee et al. (2012)	Semi-structured focus group discussions	Two mental health services, 26 agency collaborators Ohio, USA	Key factors for collaboration: interpersonal skills, attitudes, professional qualities & contextual factors.
21	Sousa & Costa (2010)	Critical incident interviews using open ended guides.	Front-line healthcare professionals(n=117) Portugal	Collaboration affected by social skills (sympathy/warmth), professional skills (i.e. advice giving), demonstration of professionalism, and commitment to building relations with other professionals.

Results

Factors that related to collaboration from the included papers were selected during synthesis and these were then combined so that all the findings were summarised. The findings across the research papers focused on facilitators of, and barriers to, collaboration. The clearest way to conceptualise these barriers and facilitators was to relate them to their broader domains. The barriers and facilitators discussed in the research related to the individual domain, the team domain and the context domain (see Table 3).

Table 3.

Synthesis of the main facilitators of, and barriers to, collaboration. Numbers in brackets relate to the research papers as labelled in Table 2.

Domain	Facilitators	Barriers
Individual	**Communication** (2,7,12,15) • Interpersonal skills (20,21) • Use of narrative to explain issues (11) • Knowledge sharing (9,12)	Different mental models to explain the causes of patient's problems (1,7,10)
Team	**Team functions** • Agreed objectives and common goals (7,14,15,16, 18) • Team building (4, 7,15) • Clear roles (3, 14,15) • Respect (15) • Roles that span boundaries (12) • Mutual trust (4, 16)	Professionals' different roles, identities, status and power (3, 6, 7,8,13, 19)
Context	• Time (2,14, 18) • Co-location (7) • Use of space and other props (5,17)	Procedural differences in ways of working (7)

The individual domain contains all the factors that were related to the individual professional. Good communication was often described as a skill that professionals have. Interpersonal skills, use of narrative and knowledge sharing are all explained as individual attributes that sit within the communication domain. If individuals held different mental models to explain illness, it was described as a barrier to collaboration

The team domain contains all the factors that relate to the relationships between team members. Having agreed goals, clear roles and doing team building were found in the literature to be helpful for teams to collaborate. Additionally, the concepts of trust and respect, which could be a behaviour or an experience, between team members were included as facilitators to collaboration. Barriers to collaboration that were regularly discussed included differences in power, identities, and status between team members

The context domain contains factors that relate to healthcare teams' working environments, both in terms of their physical working environment and the organisation they worked within. If team members' working environment provides sufficient space and time for them to meet then it was found to be helpful for collaboration. Some papers focused on how the team's ability to interact with different props in their working environment, such as telephones, can enhance collaboration. A barrier in this domain occurred when teams of different healthcare professionals had to work together and were co-located but they were linked to different organisations that required them to follow different procedures.

Although the factors have been conceptualised as linked to different domains, these factors are interrelated. For example if the team is co-located they will have the opportunity to communicate more regularly, and if they have good individual communication skills, sometimes explained as good social skills or interpersonal skills, then it will facilitate collaboration. At the level of the individual team member, communication skills are key factors for facilitating collaboration between different professionals. At the level of the team

there are a number of factors that facilitate collaboration, for example establishing mutual trust and agreeing clear objectives. In the wider context that the individual and teams operate in, a number of factors facilitate collaboration. For example, if professionals are co-located it will be easier for the team to establish clear roles and individuals will have the opportunity to communicate regularly.

Although the research in Table 3 has discussed factors as either being a barrier to or facilitator of collaboration, it could be envisioned that what is described as a facilitator could also become a barrier to collaboration in its absence. For example, Belanger and Rodriguez (2008) found many studies describe respect as a facilitator for collaboration, so the absence of respect in a team may become a barrier (although it equally may have no effect on collaboration in its absence). Six of the papers in the review discussed single factors that could be both barriers and facilitators. Fitzgerald and Tea (2004) found that having strong professional identification could be good for collaboration if the professional viewed collaboration as part of their role. However, if the professional viewed their role as higher in status to other professionals then this element of their professional identity would be a barrier to collaboration. The papers that discuss factors as both facilitators and barriers have been listed in Table 4. The first five factors in the table operate mainly in the individual domain, where individual attributes held by professionals can either be facilitators or barriers to collaboration. However, Factor 6 operates in the context domain, as it is about the wider social context that the team and professional exist within, as Social Capital theorises that the networks a professional is part of, and the norms and trust within that network, can facilitate collaboration (McKean et al., 2016).

Table 4.

Table of factors from the reviewed literature that are both barriers to, and facilitators of, collaboration. Numbers in brackets link to the study description in Table 1.

	Factor	Description
1	Causation models of health problems (1)	Attributed to be helpful to collaboration if the model was shared, but a barrier if differed.
2	Professional identity (3)	If person views their role as collaborative it is helpful, but if they view their role as having a higher status then this can be problematic.
3	Knowledge integration (9)	Integrating knowledge helps achieve shared mental models- if professionals hold better views on knowledge integration, better collaboration and vice versa.
4	Individual's collaborative potential (19)	The individual practitioner can sit on a grid of being person-professional and taking-sharing control. The individual's personality enables development of respect, which enables sharing of control.
5	Power (6)	Can be used in interactions as either collaborative or competitive.
6	Social Capital (4)	Institutional and personal networks, norms and trust can either enable collaboration, or create gaps/incoherence that are barriers.

Discussion

The aim of this review was to examine the current understanding of collaboration in healthcare services. Findings were synthesised across different individual studies to understand how the literature presents collaboration. The review extended D'Amour et al.'s findings by focusing on collaboration in healthcare teams and by incorporating more recently published research. None of the 21 papers captured in the review were used by D'Amour et al., although 3 were published prior to D'Amour et al.'s publication date. To recap, D'Amour et al. found that collaboration occurs when there is a need for collective action to address client needs, requiring team building to encourage sharing, partnership, interdependency and power. Findings from reviewing the literature show that most researchers have focused on explaining factors that are barriers to, and facilitators of, collaboration, rather than focusing on the practice of collaboration. The facilitators synthesised in this review map onto D'Amour et al.'s findings. Collaboration is facilitated by good communication (identified through use of interpersonal

skills, narrative and knowledge sharing) and a team culture that builds clear roles, respect, trust and agreed goals. Context is the main additional domain of factors found in this review when looking specifically at healthcare teams. Context facilitates collaboration if time is provided to the team to meet together, if they work regularly in the same space together and the space they work within is designed for the team to work together (rather than being segregated into separate areas based on profession). However, these findings suggest that there is still a specific gap in what is known about collaboration itself.

The results section adhered to the realist perspective of the research in the review, which focused on factors which are barriers to, and facilitators of, collaboration. This perspective creates a knowledge base that conceptualises different factors that input into a team and leads to collaboration. Explanations of human behaviour that rely on input-output models have been critiqued before. Edwards (1997) argued that 'meaningful human actions are simply not organised on a factors and variables causal basis' (p.4). Instead, Edwards argues that researchers should move from creating idealised models of how things work, to actually studying the phenomena as it happens. Thus, although context, clear roles, good communication, respect, trust and agreed roles may be experienced as important to healthcare teams, we still do not understand collaboration as it happens. To understand phenomena, Edwards (1997) advocates for a discursive approach, stating when the phenomena of interest is most clearly seen in communication between people, communication (when and where it actually happens) is what should be examined. Belanger and Rodriguez (2008, included in the review) echoed Edwards (1997), stating that collaboration should be examined discursively (Chapter 3 explains this thesis' discursive approach that allows collaboration to be understood as a practice).

Part of the problem inherent to conceptualising collaboration as an input – output model, is that it is difficult to conceptualise collaboration as a singular thing that can be measured, either

qualitatively or quantitatively. Revisiting D'Amour et al.'s two-part definition of interprofessional collaboration in healthcare, the first part states that collaboration requires collective action to address complex client needs. Researchers are able to measure whether a client's needs have been successfully met by a team, but it is potentially more complicated to measure the process of collective action used for successful treatment of complex needs using post hoc surveys or interviews. The second part of D'Amour et al.'s definition states that a team should be integrated with trust and respect. Again, it is possible for researchers to measure how professionals rate their level of trust and respect for other team members, but it is harder to measure what an integrated team looks like or how trust/respect play their part in this integration. Thus, this may explain why researchers that use positive realist methodology have tended to focus on a single factor that impacts collaboration.

The research on collaboration that is available to healthcare professionals tends to be positivist and realist in nature, including the research that is qualitative in nature. The interviews (both open and semi-structured), focus group discussions, ethnographic observations and case analyses drew out specific factors that either the researchers or participants described as having an impact on collaboration. The only exception to this was Rovio-Johansson and Liff (2012, number 10 in table) who employed a discursive pragmatic approach and Clark (2014) who completed a narrative review. Rovio-Johansson and Liff (2012) argued that the treatment methods professionals advocate for are intertwined to their professional identity, which is discursively constructed. Although this paper demonstrated how the construction of identity is apparent in interactions, it was interpreted as linked to internal motivations of team members. Equally, Clark's (2014) narrative review emphasised that use of a narrative approach helps healthcare professionals understand their own relationship to their identity, which then impacts on their patient and team interactions. Thus, these studies that used a different approach to understanding collaboration, still reduced the findings to 'real' factors that affect collaboration.

Therefore, ‘professional identity’ in these two studies ended up fitting with the other ‘real’ factors highlighted across the studies that input into the team and affect the black box of collaboration.

There are limitations inherent to a research synthesis that may have contributed further to the focus on factors that are barriers to, and facilitators of, collaboration. The research studies included were distilled down to their key findings to allow an interpretation of the studies as a single body of work. These key findings tended to focus on barriers to, and facilitators of, collaboration, but aggregating these studies has likely lost some of their nuance. The studies all came from varied healthcare settings, both in terms of global location and healthcare population. The problem for this review is the validity of aggregating findings from healthcare systems that operate differently, e.g. combining findings from grassroots healthcare systems in Canada with findings from NHS run UK healthcare systems. Equally, the inclusion of studies that look at multi-agency teams that support people in the community alongside acute healthcare teams in hospitals. The two sides of the argument are that summing up research (particularly qualitative research) loses the rich human experiences captured, but on the other hand overcomes the critique that researchers are involved in ‘cottage industry’ where researchers are continually looking at the same thing in their own silo (Sandelowski, Dochery & Emden, 1997). These critiques provide a caveat for interpreting the findings, but the benefit is that all the studies in the review have the same core purpose of understanding how healthcare professionals collaborate together.

A further criticism of qualitative research synthesis is that the range of epistemological approaches in qualitative research, from social realist to constructivist approaches, prevents aggregation of findings across studies (Nye, Melendez-Torres & Bonell, 2016). The majority of the research papers in this review took a social realist approach, apart from Clark (2014) and Rovio-Johansson and Liff (2012). The approach to including them in the review was to

consider the key outcome and implications of their findings for collaborative working. Thus, for both these papers the key relevant findings for collaboration were how professional identity can affect collaboration. All the other studies interpreted their findings from a positivist realist approach. Therefore, rather than trying to understand the results from a different framework that may have provided different insights, the interpretation of the results reflected the social realist approach. The main rationale for conforming to this approach was to understand how the topic of collaboration is presented in the literature, and thus may be accessed by healthcare professionals.

Another critique of this review is the small number of papers that were included. There were not many relevant papers that met the search criteria. Even some of the papers included may not be the most obviously related to collaboration, as their key purpose was not labelled as collaboration. The decision to include them was made because they discussed the findings in terms of collaborating and working in a multidisciplinary team. The systematic approach to findings studies may have eliminated the opportunity to find relevant papers, particularly qualitative papers, which can be 'hidden' in databases due to the way that they are described (Nye et al., 2016). Therefore, the systematic strategy, which may have missed relevant qualitative research, may have further amplified the focus on studies that looked at factors that impact collaboration from a realist approach, rather than studies that might have tried to understand collaboration in a different way.

Of the studies that were included, the CASP highlighted a number of methodological problems. Although the CASP has been critiqued for only focusing on what is reported, rather than how research was actually done (Carrol & Booth, 2014), the reported information is key for readers' understanding. The majority of the research reviewed was qualitative research that relied on observations and interviews with professionals in healthcare teams. This is potentially problematic when the impact of how the researcher has interacted with the participants is not

appropriately considered. For example, Liberati, Gorli and Scarath (2016) report results from their observations and conversations with healthcare professionals. The majority of the extracts of data (9 of 10) that Liberati et al. (2016) used to support their results are 'conversationalist extracts', i.e. generated through conversations the researcher had with a healthcare professional. Yet the data extracts only present one side of the conversation, that of the participant. There is no indication of what the researcher may have said to elicit that response. Nugus et al. (2010) used focus groups and interviews in their methods, but only explain that participants were explicitly asked how they perceive a number of different thematic areas from interprofessional care literature. Exactly what the participants were asked is not made clear, and so it is not possible to consider how participants were prompted (or not) into their responses. These are just two examples, but they demonstrate issues that are relevant to much of the research used in this review. Potter and Hepburn (2005) explain in much detail why reporting extracts from interviews/conversations in this way is problematic. One key issue that they highlight is that an interview is an interaction, thus by not reporting what the researcher stated to elicit such a response, we cannot be sure how a researcher's utterance might have shaped the participant's response. Again, Potter and Hepburn advocate for a discursive approach to understanding phenomenon instead.

The studies in the review that collected data based on observations may have been well placed to take a discursive approach, however the observations were often not recorded. For example, Nugus, Greenfield, Travaglia, Westbrook & Braithwait (2010) and Janssen, Snoeren, Van Regenmortal & Abma (2015) only took notes during their observations of team interactions and made no video or audio recordings. As well as preventing a discursive analysis, the absence of recording means that the papers lack evidence (e.g. extracts of talk between participants) to support the authors' conclusions. The sensitive ethical nature of observing teams in healthcare settings may have contributed to a reliance on post-hoc recollections by both researchers and

professionals on their experience of collaboration. However, the reliance on post-hoc recollections further feeds into a system of research that is geared towards focusing on variables or factors related to a concept, rather than what that concept actually looks like. This is most clearly seen in participant interviews, as these tend to get participants to explain their experience of an event (e.g. Nugus et al., 2010), and participants commonly consider what went well and what did not (e.g. the facilitators and barriers) when making an evaluation.

This review demonstrates that although there has been more research on collaboration in healthcare services since D'Amour et al.'s review, much of that research has continued to focus on factors and variables, using participants' post-hoc recollections of collaboration to inform their findings. What is missing is a more nuanced view that would consider collaboration as part of an interaction order. A discursive approach can consider collaboration as a dynamic system that needs to be systematically observed, recorded and analysed (this idea is developed in Chapter 3). The inclusion criteria used in this review were quite limiting, which has potentially disregarded more suggestive work on the process of collaboration in healthcare or that explained the process of collaboration in other domains (e.g. collaboration in scientific research). However, the historical-social context of healthcare (see Chapter 1) means that it is not comparable to other domains, and to make meaningful conclusions papers must be based on real data. Despite this potential limitation, the conclusion would still be the same: a new approach to understanding collaboration is needed that utilises discursive methods. The next chapter goes on to explain how this can be done.

Reflection Box 2: The literature review

This ‘standard’ literature review, embedded in a thesis which is using CA and discursive approaches to understanding collaboration, highlights a tension I experienced. I both believed that a discursive approach would be best to answer my research questions and interests, but also wanted healthcare professionals, and other psychology academics, to see the value in such an approach. I thought that a literature review such as this was necessary scene setting, but also speaks to an agenda to demonstrate that what I was doing was relevant, and an anticipation that the discursive project I aimed to do would not have credibility without this type of literature review. Equally, at the time I was fresh to CA approaches, and doing a systematic literature review felt like safe ground, as well as good experience for my own future employability.

On reflection, this safe ground may have been too safe and I have potentially missed reviewing information that may have been equally as useful. For example, I could have chosen to review learning disability policies that mention collaboration, and bodies of work that have evaluated government policies (for example by charitable bodies) in the past twenty years. A thematic analysis may have highlighted the ways in which the mention of collaboration have changed, and what practical advice is given to professionals to understand how useful or not these policies may be. This type of review may also have reflected what healthcare professionals may access should they want to understand collaboration in a learning disability context.

As I knew I was going to be taking a different approach to the data, this likely led me to seeing the issues with conceptualizing barriers to and facilitators of collaboration, instead of examining it as a phenomenon itself. I also chose to not update the literature review at the end of my PhD, as a more up to date search did not uncover new information. However, this again may be reflective of the review’s search terms, whereas a more policy focused search may have highlighted new and different information about collaboration in intellectual learning disabilities that I was unaware of.

Chapter 3: Discursive approaches to understanding collaboration

This chapter explains how a different methodological approach to collaboration, that combines ethnography, CA and discursive psychology, can add an understanding of the practice of collaboration from the inside out. Chapter 2's literature review found most research has focused on factors that are barriers to, or facilitators of, collaboration. These factors were synthesised and conceptualised as operating at the individual (e.g. communication), team (e.g. respect, trust, identities) and context (e.g. time, co-location) domains. A main conclusion from this literature review was that most research has focused on factors that affect collaboration, rather than the practice of collaboration. The methodology used by previous researchers can help to explain why the practice of collaboration has been overlooked. As this thesis aims to understand how teams do collaboration, a different methodological approach is needed. Here, this chapter will first recap the methodological limitations from the previous approaches to understanding collaboration. It will then explain this thesis' approach, discussing how a different approach can address previous limitations and provide a way to understand the practice of collaboration, referring to terms from the findings in Chapter 2.

Chapter 2's literature review highlighted the importance of methodological choices when researching collaboration. The approach of most of the research in the literature review worked on the following basis: If I ask a question to a participant, I will gain an understanding of the experience of working collaboratively in healthcare. Therefore, the results draw on experiential reflections of healthcare professionals. By their nature, qualitative interviews elicit retrospective accounts of the participants' experiences of collaboration. These professionals will use the vocabulary available to them associated with teamwork (i.e. trust, mutual respect, etc.). Though researchers might take every care to ensure that such accounts are as 'accurate' as possible, they cannot provide the detail required to understand the organisation of collaboration within meetings. Such interview accounts are better regarded as the joint

accomplishments of the participant *and* researcher in producing a constructed version of the participant's prior experiences (Roulston, 2011; Potter and Hepburn, 2005, 2012). This epistemological approach does not, and cannot, aim to understand what happens when teams are collaborating.

The factors associated with collaboration in the domains of the individual, team and context are interpreted as tangible things from a positivist approach. The previous literature that mostly approaches collaboration from a positivist approach, discusses factors such as trust, good communication and mutual respect (see Chapter 2). The problem with these terms is that, from a discursive approach, they are accounting devices that refer to social and psychological processes. A team member may report that having good levels of trust is beneficial to collaboration, but it is unclear what that trust looks like and how it facilitates collaboration. As argued by D'Amour et al. (2005), although these terms may have some utility, "*They do not help us understand what transpires in the working lives of a group of collaborating professionals or the nature of their interactional dynamics.*"(p.126).

One further issue for consideration is the dual use of the term collaboration. Collaboration is both a descriptive and normative term. As highlighted by Reeves, Lewin, Espin & Zwarenstein (2010), collaboration is normatively assumed as the right way to work, which will lead to the best outcome for patients and staff alike. Reeves et al. (2010) highlight that often the research underpinning this assumption is scant. However, collaboration is also a way of working. This thesis is more concerned with understanding what people are actually doing when they are collaborating as a way of working, rather than an abstract thing that is achieved.

Understanding collaboration as a way of working requires a different epistemological approach. A discursive approach, which combines ethnography with a strong focus on conversation analysis, is the main methodology this thesis has used. Here the chapter will turn to explain what discursive perspective (DP), conversation analysis (CA) and ethnography is,

and can bring. This chapter will highlight that the collection and dissection of moment to moment interactions between participants can begin to unpick how healthcare staff do collaboration.

The approach

This thesis took the approach to combine ethnography, CA and DP, as the use of these methodologies allow researchers to start from examining what healthcare professionals are doing when collaborating. Ethnography focuses on the direct observation of participants in the 'naturalistic' setting, and was used to gain an 'insider's' view of how MDTs in I(L)D services normatively work together, providing the background context of collaboration practices. This was important as the author had no prior experience of working in those services. CA and DP similarly focus on direct observations of participants. The description of how CA and DP can be useful approaches for examining collaboration is adapted from the author's previously published work (Auburn, Smart & Tremblett, 2018). The basis of both a CA and DP approach is to describe and understand the organisation of social encounters drawing upon a detailed examination of the sequences of talk recorded in the setting in which they occur. They are methodologies that can be applied to both informal interactions and to formal, institutional interactions. The assumption of CA and DP is that it is through the fine details of talk and its accompanying non-verbal features that social contexts are established and maintained on a moment to moment basis. CA and DP focus on the organisation of individual turns of talk and what actions are being formed in such turns. Each turn of talk displays, often implicitly, the hearer's understanding of the prior utterance, which in turn forms the basis of their own turn. By monitoring each other's turns of talk, participants provide the basis for establishing a mutual understanding, and repairing that understanding as they go along if necessary. As such, no detail is too small to be relevant to the smooth continuation of a conversation. For example, back channel utterances such as 'hm mm' or 'ok' are often designed to ensure that the current

speaker maintains the speaking floor (Auburn, Smart & Tremblett, 2018). This detailed examination of talk using CA/DP, situated through an 'insider's' understanding of the teams from ethnography, was used to unpick the collaboration practices of healthcare professionals.

Research on collaboration in the review would often draw on interviews with healthcare practitioners, and CA demonstrates how questions can shape participant responses and are not neutral in the research process. Research on question design (e.g. Heritage, 2010) demonstrates that even changes to the smallest unit of talk can elicit very different responses. Heritage, Robinson, Elliot, Beckett & Wilkes (2007) examined the questions that doctors asked patients at the end of consultations. They were motivated by the rationale that patients would often visit the doctor with a number of issues to resolve, but only discuss one. Recordings of the doctor-patient interactions found that doctors would often ask 'Are there any other concerns?' However, by using the negative polarity item 'any', the speaker is setting up a normative expectation that the response will be a 'no', the 'preferred' response. In contrast, the use of 'something else' alters the polarity of the question so that the normative response is to respond affirmatively and so provide other concerns. Heritage et al. (2007) provided doctors with alternative questions to ask patients at the end of a consultation. When the doctors asked: 'Are there *some* other concerns that you would like to talk about?' over 90% of patients responded with further concerns. In contrast, when the question contained *any* rather than *some* less than 50% responded with further concerns. Heritage et al.'s findings demonstrate the impact of question design by researchers, but equally points to the need for team meetings and interactions to be examined to understand how collaboration is organised socially through participants' talk.

The Principles of CA, DP and Ethnography

An 'Etic'/'Emic' distinction

Ethnography, CA and DP can both be characterised as 'emic' approaches to understanding social interaction and collaboration. 'Emic' approaches contrast with 'etic', and the distinction maps onto the traditional-realist vs. discursive methodology used in psychology. 'Etic' approaches are generally characterised as an outsider's perspective which means that researchers' specialist terms and concepts are used to analyse a culture or group, rather than the distinctions and understandings drawn upon by the members themselves. An example of an 'etic' approach within the field of healthcare collaboration can be seen in the literature reviewed in Chapter 2 that used traditional-realist methodology. Most researchers used a range of social science concepts that were described as facilitators or barriers to collaboration; the factors were synthesised into different domains where they were conceptualised to take effect, 'individual', 'team' and 'context'. An analysis of collaboration in healthcare that examines factors in these domains has allowed researchers to make suggestions of where money might be spent to improve collaboration, or how to measure team attributes to determine if teams are effectively collaborating.

Etic approaches can provide a powerful analysis that can be used to inform policy decisions and recommendations about collaboration in MDTs. However, an 'emic' approach is a necessary preliminary to such 'etic' approaches. 'Emic' approaches are characterised as an 'insider's' perspective. Thus, ethnography, CA and DP provide an alternative 'emic' approach, which attends to the concerns, and orientations, of the participants as displayed in their everyday interactions. Therefore, from an emic approach it would not be appropriate to examine team interactions for their performance in terms of their degree of collaboration. Such a move would impose a researcher's perspective on what constitutes good or bad collaboration. Instead, team interactions can be examined for the collaborative actions participants themselves display and orient to. For example, rather than examining interactions in terms of whether they represent collaboration or not, good communication or not, examination focuses on what the

participants take themselves to be doing, such as demonstrating understanding or sharing risk with the team. Thus, the emic approach allows an understanding of how healthcare teams actually work together and collaborate.

Arber (2008) is a good example of an emic approach to understanding healthcare teams. Arber used ethnography and discursive methodology to understand MDT meetings in a hospice. Arber started by focusing on common practices that could be found across the MDT meetings. Questions were found to be asked disproportionately more frequently by nurses than other members of the teams. The design of these questions, and responses they received, were often hedged and displayed the delicacy of discussing medical matters when a consultant is present. Arber argued that this demonstrated an orientation to the authority and superior medical knowledge of consultants. One function of designing questions from a low authority position (e.g. 'I just wondered..', Arber, 2008) is that it allows for nurses to make a medical diagnosis of a patient's symptoms, without overtly challenging the consultant's medical expertise. Arber (2008) did not use conversation analysis to fully unpick the interactions, linking talk to a variety of outcomes but without a focus on collaboration. Thus, this thesis seeks to further the type of emic approach used by Arber (2008), combining CA, DP and ethnography to gain a more substantial insight into collaboration practices in MDTs.

Ultimately, the distinction between 'etic' and 'emic' is a loose one and there is often an interplay between these two levels of analysis. However, an emphasis on an 'emic' approach, which foregrounds participants' own orientation to the work they are undertaking when they are collaborating, can create knowledge that participants can themselves use to develop their practice (see Chapter 4 and Chapter 8 for further discussion on the application of findings for healthcare professionals collaboration).

Discursive Psychology

This section provides a background to DP to demonstrate how it can be used to provide an alternative approach to collaboration, using some of the factors from Chapter 2's literature review as an illustration. The background on DP also sets up the use of CA specifically in this thesis. CA is not always viewed as commensurate with DP (cf. Wetherell, 2007), as it is sometimes argued to place boundaries on what can be studied (e.g. by avoiding psychological issues). However, issues such as identity and trust are key to collaboration (cf. Chapter 2), therefore it is necessary to situate the use of CA within a DP tradition. DP is an emic approach to understanding the action of participants' talk and has a specific focus on how talk manages psychological concepts. A recent definition of DP is:

> *"Discursive psychology is a theoretical and analytical approach to discourse which treats talk and text as an object of study in itself, and* ***psychological concepts as socially managed and consequential in interaction****." (Wiggins, 2017, p 4. Emphasis added.)*

This definition highlights the key theoretical shift of DP in comparison to traditional psychology theories. DP derives from the notion that traditional psychology studies have missed a method that may help to understand human behaviour (Edwards & Potter, 1992), and have overlooked how psychological concepts are managed in interaction. Often psychology research uses participants' discourse (both written and spoken) to understand a phenomenon without questioning the techniques that participants use in their talk to construct a version of events. The ways that discourse is constructed has specific actions, such as managing the stake and accountability of the speaker (Edwards & Potter, 1992). As such, rather than taking a traditional psychology approach to research, that focuses on causal relationships of researcher defined concepts, it is interested in the normative way that human behaviour, visible in interactions, is organised (te Molder, 2015). Most of the prior research on collaboration takes a traditional psychology approach and looks at causal relationships, e.g. if

a team has a combination of facilitative factors from the different domains then it will cause collaboration. In contrast, the aim from a DP perspective is to understand how healthcare professionals normatively perform collaboration. Re-visiting the definition of collaboration, that it is professionals working together towards a shared goal, what might be of interest is how professionals negotiate a 'shared goal' in interaction. Equally, if mutual trust is important, how do professionals visibly negotiate access to each other's trust or perform that they trust each other.

The psychological concept of mutual trust will be unpacked here from a DP perspective, to demonstrate how DP can further understanding of collaboration. Mutual trust was a psychological concept in the team domain of factors that facilitate collaboration (cf. p.44). In general, the term trust refers to a person's state of mind that affects their behaviour towards another person. From a traditional-realist perspective trust is often explained as something that is developed through regular contact and training with other team members. In contrast, from a DP perspective, researchers would examine the use of trust in its discursive context and the action using the term trust has. In keeping with a traditional-realist perspective, D'Amour et al. (2008) identified trust as a key concept that team members must have for collaboration. D'Amour et al. used quotes in their paper to support the need for trust, from members of two teams, as follows:

1. "It's not necessarily that they don't place any trust in the CLSC [Community Health Centre], but if you don't know what goes on in a CLSC, or you know virtually nothing, it's like putting your child into the care of someone you've never met.... If the child is yellow, will they be able to see it's yellow? Will they be able to do their work? It's a demanding approach because neither sector knows the other." (p. 7)
2. "There was a problem of trust. Even the hospital nurses and the CLSC nurses didn't trust in each other. They questioned each other's competence in caring for the mother or baby. We realize now that the establishments know each other better.... It's still far

> from perfect, but in terms of harmonizing perinatal care, say, it's a lot better than it was." (p. 8)

In contrast to D'Amour et al.'s traditional-realist interpretation, DP would interpret these quotes quite differently. First, a DP approach requires consideration of where these quotes were produced and in this case they were produced in a research interview. As discussed in the problems of the literature on collaboration (cf. p. 51), such talk is a version of events produced specifically to account for something that the researcher has focused on in their questioning. As such, these versions attend to displaying an understanding and rational response to the issues that the researcher has raised. In the first quote (1), trust is initially used as a disclaimer (that the issue is not a lack of trust), before making a number of serious critiques about the lack of knowledge held on what happens in CLSCs (community health centres). Disclaimers are often used to soften a problematic account, so in this quote it softens the multiple problems linked to the CLSCs, by suggesting that there may still be trust. In the second quote, the term trust is used as part of a contrast structure to create a certain version of events. The 'problem of trust' and the lack of trust in each other are used to construct an extreme, negative version of how events used to be. The negative version of trust in the past, is then used to contrast with the present where it is 'a lot better than it was'. Thus, instead of a factor that facilitates collaboration, a DP approach views the use of the term trust as a way to negotiate telling about problems in collaboration. From the standpoint of collaboration, trust in these quotes is more an accounting device when explaining these problems which is prompted by the researcher's question, instead of telling us anything about how teams collaborate.

Chapter 2's literature review also included power in the team domain, as a factor that is a barrier to collaboration. Using D'Amour et al.'s (2008) paper again, we can examine how interview quotes might be interpreted differently from a discursive perspective. In D'Amour et al.'s paper they discussed power in terms of leadership and governance: stating that if governance did not

involve all partners and there was a high degree of top-down decision making there would be conflict. The below extract was used as an example of this:

> It's the four CLSCs against the hospital. No, they're not on an equal footing. Clearly, the hospital's medical power is very, very, very considerable, so there is a significant difference between the power we can have as a CLSC as opposed to what the hospital can have. (p.11)

Again, from a DP perspective the above response by an interviewee is creating a version of events to account for what is happening in their organisation. Power in this extract is constructed as something that has negative consequences through use of an extreme case formulation ('very, very, very considerable'). A contrast structure is also used to separate the CLSC (community health care centres) and the hospitals, rather than them being part of a collective entity. The phrase 'No, they're not on an equal footing', can be seen as a repetition of the researcher's question, again highlighting the need to understand what questions were asked of interviewees. The version of events in this quote constructs the CLSC as powerless, and subject to the control of the hospital. Therefore, any issues the CLSC may have are being constructed as outside of their control. A DP perspective shows that power can be used as an accounting device when researchers question participants about issues, rather than an abstract concept that is a barrier to collaboration. The understanding that a DP approach brings to these quotes provides a different perspective, but the interview based research methodology still does not provide an understanding of how teams do collaboration.

To conclude, a DP approach does not treat terms such as trust and power as providing access to participants' state of mind. Instead terms are treated as having rhetorical effect that enables the speaker to construct a version of events, which has a specific interactional action. Edwards (2005) discusses how the selection and use of descriptive words can help support a version of events and its legitimacy. Therefore, descriptive words can be used to help speakers construct

a version of events, where 'power' is integral and something that speakers are subjected to, with little individual control over the outcome. The constructions of these versions of events manages the speaker's accountability when responding to a researcher's questions. Many of the factors highlighted in Chapter 2's literature review were created from the terms that participants used in interviews. Using quotes from D'Amour et al.'s study, some of these terms have been reinterpreted from a DP perspective, highlighting trust and power as accounting devices, instead of casual factors of collaboration. Examining these interview extracts from a DP approach still does not highlight how teams do collaboration. However, this is not a limitation of DP, but instead is a limitation of research interviews that by nature ask participants to account for a certain state of affairs. To access how professionals actually do collaboration, CA can be used in combination with DP. The next section goes on to explain how this combination provides a method to examine talk between professionals to understand how they collaborate.

Conversation Analysis

This section explains the basic features of CA's fine grain approach to analysis, and how it provides a means of analysing talk in interaction. CA is a method that allows analysis of moments when teams are working together (cf. p. 107 for MDT meeting focus), which meets this thesis' aim of understanding what collaboration looks like in practice. First, this section introduces CA and then compares CA to DP. It then goes on to give examples of core areas of empirical work in CA, and comments on how they can be used to help to understand collaboration in practice.

Conversation Analysis has been defined as: "... an approach within the social sciences that aims to describe, analyse and understand talk as a basic and constitutive feature of human social life." (Sidnell, 2010, p.1). This approach is used in many discipline areas, including linguistics,

organisation studies, sociology and psychology. The theoretical basis of conversation analysis is that talk is the core of how society is organised (Clayman & Gill, 2004) and that social interaction is orderly at the micro level of talk. The orderliness is due to "shared methods of reasoning and action that all social interactants attend to" (pg. 2, Sidnell & Stivers, 2013). The focus of CA is on the systematic analysis of naturally occurring talk whether this talk is 'everyday' talk or institutional talk. Alongside the theoretical basis, Sidnell and Stivers (2013, p.2) have identified four distinctive features of Conversation Analysis:

- The goal of conversation analysis is to describe the overall structure of interactions.
- The data used in analysis are records of spontaneous, naturally occurring interactions, normally audio or video recordings
- These records (or segments of them) are transcribed in minute detail using a system based on Jeffersonian transcription conventions. The analysis proceeds by focusing on both the original recording and the corresponding transcription. Whereas the recording plays in real time, the transcription allows the analyst to 'freeze' the action in order to 'see' how interaction is organised.
- The analysis itself can be characterised as a qualitative, inductive method. It proceeds as a case-by-case analysis concluding with a series of observations about how normatively social interaction is organised as a collaborative accomplishment by the actors themselves.

At a basic level there are three principles which underpin the analysis of the naturalistic data and thereby social interaction in general. These principles are:

1. 'if I want to make a contribution to this interaction, then I've got to get a speaking turn';
2. 'once I've got a turn I've got to do something with it'

3. ‘I then need to check that the other person understands me and if not correct them’

These three basic principles correspond to three areas of empirical work unique to conversation analysis: rules of turn taking, sequence organisation of actions in talk and repair. Heritage (2012) argues that epistemics underpins these principles, driving conversation as participants aim to display and negotiate the knowledge that they have relative to one another.

The DP approach often uses techniques from CA, but the outlook differs in key ways. First, DP originated as an alternative and almost antithesis to the dominant experimental cognitive models prevalent in psychology (Edwards & Potter, 1992). A core assumption in experimental models is that cognition underpins all talk and behaviour. Proponents of DP would argue that this is an interpretive leap, and often use CA as a method to examine talk in interaction to see what action psychological concepts have in talk, as a rigorous way to examine observable phenomena. In contrast, CA has been used to examine talk, without the tight focus on psychological issues in talk. The fundamental focus of a CA analysis is also on the observable talk-in-interaction, without inferring beyond what is happening in the talk. However, in some rare cases, there has been more explicit, yet contested, reference to cognition in CA analyses (e.g. Drew, 2005; Potter, 2006), with Depperman (2012) suggesting there could be more explicit but cautious inferences to cognition in CA research (e.g. Depperman, 2018). In part, Depperman (2012) makes this suggestion as they argue that the language we have to describe phenomena leads to unintentional associations to cognition. However, this is not a reason to not follow the rigorous principles of CA. Some recent scholars have suggested how CA can be used alongside the more experimental forms of psychology (e.g. De Ruiter & Albert, 2017; Kendrick, 2017). This may provide additional information and data that could be considered alongside CA, but should not confound any CA analysis which focuses on analysis of talk within specific methodological boundaries. For this thesis, which is situated in the field of psychology, it is important to be aware of the care needed when CA or DP get used alongside

other methodologies so that interpretations do not get confounded and the rigorous methodology of CA is maintained. This is particularly important in an applied setting, with professionals who undertake psychological assessments, as people may want to infer speaker's cognition. This requires consideration when running joint analysis sessions with professionals (see p.110 for comment on using joint analysis for this thesis).

Another difference is that CA is traditionally focused on the organisation of talk in 'everyday' settings, whereas DP tends to start from a domain of interest and the actions that talk have in that domain (te Molder, 2015). However, this distinction is not concrete as many CA scholars are interested in institutional talk (e.g. Drew & Heritage, 1992) and applied CA (e.g. Heritage et al., 2007). For this thesis, a DP approach that uses CA is appropriate as it allows an explanation of the action of talk within a certain domain (I(L)D services), and how it relates to collaboration (a psychology concept).

Here this chapter will explain some of the key features of the organisation of talk that forms the basics of CA, and will relate these key basics to how they may help to understand collaboration, using extracts from MDT meetings collected for this thesis.

Turn taking

Turn taking was one of the initial areas of focus when Sacks, Schegloff and Jefferson (1974) were developing CA. Turn taking rules are important for a person to be able to engage in social interaction, and for institutions to run smoothly. Turn taking has a normative structure that is followed in interaction to manage the exchange of turns. This system is based on the idea of the Turn Construction Unit (TCU) which participants understand as a self-contained completed stretch of talk. A TCU can be very short (one word, e.g. 'Fine') or a much longer stretch of talk. Co-participants in talk monitor the speaker's talk for the likely end point of a TCU. The end of a TCU allows for a new speaker to start talking, or for the current speaker to continue.

These opportunity points are known as Transition Relevance Places (TRPs). The following is an example of talk from a multidisciplinary meeting where there is a smooth exchange of speakership.

Extract 1: Multidisciplinary team meeting: Transition

ZRef 3.12.18. (Man: Manager; CN2/3: Community Nurses; Cha: Chair)

```
1  Man: so the only one, you'll help (AP) if we don't hear
2       anything because it went out on Friday so should have
3       got it yesterday so if we don't hear today we need to
4       be something tomorrow really
5  CN3: yep yep
6  Cha: okay um and the other person is (cl24) I don't know
7       anything about this so I can read through the notes
8  CN2: no I picked her up last week
```

In this segment of talk, we can see that the Manager is providing a formulation of the next action that the team need to take in lines 1 to 4. The Community Nurse (CN3) who has previously been involved in the conversation (as they are closely involved with the client under discussion) monitors the Manager's talk for the TRP at the end of line 4. The CN3 responds immediately to the Manager's formulation, with two tokens of agreement, in two TCUs, composed of two single words ('yep yep'). The CN3's response not only demonstrates that they understand what the manager has said, but also that they understand the action in the Manager's talk that allocates the work to the CN3 without directly naming her. The CN3's response is then taken by the Chair as the close of that client, and so they claim the floor at line 6, with 'okay' (it in itself a TCU). Every turn at talk does three things: displays the current speaker's understanding of the prior talk, initiates an action and sets the context for the next action.

This extract follows a typical agenda change sequence found in MDT meetings: first comes a high grade assessment (HGA) plus 'okay' then a moving on statement (Smart, Froomberg &

Auburn, 2018). In extract 1, the CN3 provides the HGA on line 5, followed by the Chair on line 6 doing the 'okay' and continuing with a moving on statement. These types of agenda change segments show the ability of participants to manage turn taking and maintain the progressivity of meeting talk. Maintaining the progressivity of talk via an agenda change sequence is one way that professionals can do collaboration, as they are working together towards a common goal – to discuss all of the clients in the allotted meeting period.

The segment of talk in extract 1 demonstrates participants' ability to manage turn taking, but it also constitutes an institutional meeting in the way that turns and actions are formed in each TCU. The individual participants' roles are constituted within these TCUs by the actions that they perform. The fact that the Chair comes in at line 6 with 'okay' and moves the talk on to the next client, demonstrates that as the Chair it is normative for them to move the talk along and they have the right to do this (especially as they are moving the turn away from the Manager). Other members of the team accept their turn, and interaction continues without any dispreferred markers in line 8. Dispreferred responses are usually delayed, mitigated, accounted for and/or are prefaced. In contrast, preferred responses to a turn often accept an offer or grant requests (confirming the design of the prior turn), and are produced immediately after the first turn without mitigation (Lee, 2013). Understanding normative turn taking procedures in MDT meetings is helpful to see how professionals orient to different roles in a meeting, which may be relevant to the importance of professional identity raised in the findings of Chapter 2 (cf. p.44), and how disruption to this sequence may affect collaboration.

Sequence organisation

One basic sequential organisation of talk that initiates or brings off some action is adjacency pairs. Adjacency pairs are composed of two turns by different speakers that are placed one after the other (adjacently). They are relatively ordered, there is first pair part and a second pair part,

with the first initiating a sequence and the second responding to the first pair part. Common examples of this are question-answer, invitation-acceptance.

Extract two is an example of a basic adjacency pair. In this example, the Social Worker in lines 1-2 produces a yes-no interrogative. This yes-no interrogative is the first pair part which sets up the next relevant action as agreement or disagreement (Raymond, 2003). The interrogative is designed so that agreeing that the CHC team only help people who meet the I(L)D criteria would be dispreferred. The use of 'just' (Drew, 1992) proposes a boundary on the CHC role, which has a negative connotation that would require an account if the CHC agreed. On line 3 however, the CHC comes in with the second pair part in disagreement. Examining the format and content of adjacency pairs allows us to get a sense of the agenda and concerns of the organisation members. The Social Worker's first pair part tilts towards a no preference, suggesting they already know that they will respond in the second part with a 'no'.

Extract 2: Sequence organisation

PB-TA-E15 (SWo: Social worker; CHC: Continuing healthcare Nurse; Cha: Chair)

```
1  SWo: [do you just work with] CHC assessments who are
2       in↓ are within the team
3  CHC: no
4  SWo: or yeah
5  Cha: no you do CHC separate to=
6  CHC: =CHC is separate
7  SWo: mm
8  Cha: so
9  CHC: it's anyone with a learning disability
10 SWo: yeah
```

Extract two is a segment of a much longer sequence where the Social Worker is trying to access some support for a client from the I(L)D team (the full extract can be seen in Chapter 6, cf. p.153). Support has not been forthcoming up to this point, so the construction of the question

attempts to try to position the CHC nurse as someone who might be able to help, in a delicate way through questioning. The Social Worker's turn in line four is anticipatory of a 'no' response, and is designed to require an account for anything other than a no. Line 4 continues from where the Social Worker left off in line 2, without paying full heed to the response by the CHC nurse in line 3.

This extract shows how professionals can use question design to manage difficult issues: the Social Worker knows that the CHC nurse may be able to offer some help, but at this point in the conversation (around 8 minutes into an interaction on this specific client) it has not been offered. Rather than directly stating to the CHC nurse that they should offer some support, which may damage working relationships, questioning can allow this conclusion whilst maintaining collegiality (cf. Arber, 2008). The interaction practices used in MDT meetings to manage both the need to maintain positive working relationships whilst pursuing help for clients is another way to start understanding how professionals do collaboration in MDT meetings.

Repair

Repair is a key method in talk to maintain an intersubjective understanding of a talk's topic between participants. Repair can be seen in talk when the smooth progress of talk is suspended, whilst one of the participants attends to possible trouble in speaking, hearing or understanding. There are two main types of repair: self-initiated repair and other initiated repair. Self-repair is where the current speaker attends to trouble in their own talk. In other initiated repair the current speaker is either provided opportunity to repair their talk, or the other speaker provides the repair. Overwhelmingly there is a preference in talk for self-repair. (Kitzinger, 2013). The following is an example of self-repair, taken from multidisciplinary team meetings.

Extract 3: Self repair

TB Ref 9 33:51 (Man: Manager; CPy: Clinical Psychologist)

```
1  Man: >okay< so ↑that's the four on there: isn't it so we've got one
2       in here ↑yeah
3  CPy: y:eah
4  Man: <is >there another < ↑sorry↓ >is there another< I wasn't
5       listening then ↑was there another one or is it this one↓
6  CPy: I think it's this one
```

In extract 3, the team are discussing if there is another referred client that they need to talk about. In lines 4 and 5, the Manager self-repairs, from 'is there another' to 'was there another'. This repair transforms 'is' to 'was', demonstrating the knowledge that this might have already been stated. The Manager has emphasised the reason for this repair within their talk ('sorry….I wasn't listening'). The transformation, along with the apology, has the action of demonstrating deference to the other team members. If the Manager had kept 'is', rather than 'was', they might have opened themselves up to the possibility of other repair. Extract three instead demonstrates the preference for self-repair.

Extract 4 is a clear example of other repair. In this extract the Chair is beginning a new agenda point to discuss a client in line 1. In lines 2 and 3 the chair explains the timing of when the client was referred. They finish their TCU ('now'), then take an inbreath ('.hh') which demonstrates them preparing to speak again. The Clinical Psychologist at line 4 comes in, in overlap, with a clear and emphasised 'no'. This causes a gap in the interaction. The Clinical Psychologist then goes on to account for the 'no' – the Chair had got the timings wrong. The Chair then takes this on board in line 7, through repetition of the Clinical Psychologist's words.

Extract 4: Other repair

TA Ref 25.6.18 (Cha: Chair; CPy: Clinical Psychologist)

```
1  Cha: so we've had (cl1 name) .hh who
2       was refer:::ed (1.0) on the eighteenth so a couple
3       of weeks ago now .hh   [I
```

4 CPy: [**n**o
5 (2.0)
6 CPy: that’s last week
7 Cha: **l**ast week
8 CPy: hu heh hehe (snort)°heha°

As a common feature of talk that helps maintain intersubjective understanding, repair can be used to understand interaction that demonstrates collaboration.

Epistemics

Heritage (2012) developed the understanding of the basic structure of talk, stating that underpinning all talk is epistemics, with turn design, sequence organisation and repair all moving to establish an information equilibrium between participants. The notion of epistemics is helpful to understanding collaboration in MDTs, as an argument for healthcare professionals to collaborate in MDTs is to share information. Key to the discussion of epistemics is the contrast between a person’s epistemic stance and their epistemic status. Epistemic status is concerned with how knowledgeable participants in conversation see one another about a certain topic. Epistemic stance is how participants position themselves through the design of their talk – as such, stance and status may be incongruent. This is important, as positioning yourself as more, or less, knowledgeable on a subject than you might actually be can have a clear action in talk – e.g. questioning another team member on a subject that you already know about may work to delicately highlight an issue in a client’s care. In terms of collaboration, careful positioning in talk can help to maintain working relationships, whilst addressing clinical issues.

The difference in epistemic stance between participants is shorthanded by Heritage (2012) to participants being K+ (relatively knowing) or K- (relatively unknowing). Taking a K- position in conversation can be used to open a topic and elicit information, close a topic, and change the conversation topic. Equally a K+ position can be used to initiate conversation, e.g. to provide news, to answer requests of information and for making assertions. Participants’

movement between K+ to K- in conversation is argued by Heritage (2012) to be the driving engine of conversation.

Although Heritage applies the premise to all talk, the role of epistemics could be more heightened and obvious when MDTs are collaborating. For example, MDT meetings (a key site of collaboration, cf. p.109) are often designed for information sharing, whether that is information about the client, organisational procedures or technical information held by different professions. Extract 2 is repeated here to demonstrate the role of epistemics with relation to organisational procedures.

Extract 2: Sequence organisation

PB-TA-E15 (SWo: Social worker; CHC: Continuing healthcare Nurse; Cha: Chair)

```
1  SWo: [do you just work with] CHC assessments who are
2       in↓ are within the team
3  CHC: no
4  SWo: or yeah
5  Cha: no you do CHC separate to=
6  CHC: =CHC is separate
7  SWo: mm
8  Cha: so
9  CHC: it's anyone with a learning disability
10 SWo: yeah
```

Previously this extract was used to demonstrate adjacency pairs, focusing on the SWo's question design and how it made a no response preferred. However, the question design and adjacency pairs used in this extract are underpinned by epistemics. The SWo is pursuing help from the team. The pursuit of help is achieved through consistent questions from the SWo in a K- stance. The question design in lines 1 and 2 presents the SWo in a K- stance about CHC assessments. The question design elicits the knowledge that CHC assessments are available to anyone with a learning disability, not just those who are managed by the team. The responses

by the SWo (line 7 and 10) demonstrate that actually this information is not new, and that they already were in a K+ position about CHC assessments, as there is no change of state response (Heritage, 1985). So in this extract knowledge is used to create displays of epistemic equilibrium – now the SWo has established they could get some help and made it evident in the talk, the conversation on this client (which has been very long to this point), meets closure based on the established equilibrium. In this way, the SWo manages to use knowledge to get some collaborative input from other healthcare professionals.

Although Heritage (2012) would argue that epistemics drives all conversation, this argument is commented on as relatively radical in CA literature (Drew, 2012). Heritage has gone so far to relate their concept to evolutionary theory of language production, but three questions remain unanswered. Drew (2012) argued that these questions are: 1) what is the social need to achieve knowledge equilibrium in talk, 2) are people consistently (subconsciously) tracking another person's knowledge stance in relation to their own, 3) when epistemics are said to underpin all talk, does it prevent other accounts of what is happening in conversation to be considered by researchers . Thus, it is necessary to be cautious when applying epistemics to analysis as it is pervasive, yet it might lead to the analyst overlooking other accounts of the action in talk. This is pertinent when analysing conversation to understand collaboration, between members of healthcare teams who by design are bought together to share knowledge.

The role of morality in talk, referred to as deontics in CA literature, is often discussed in parallel to epistemics. There has yet to be any claims that deontics is a key driver in conversation, but it has been explained in a similar fashion – participants are argued to have deontic stance and status, and can position themselves with different moral rights in conversations (e.g. to tell someone what they should do, Stevanovic & Svennivig, 2015). This thesis draws on both epistemics and deontics to analyse the role of professional identity in collaboration (cf. Chapter 7). As explained in Chapter 7, both deontics and epistemics are relevant to collaboration

between multiple different professionals, as decisions must be negotiated on both who can do a piece of work, alongside who should do a piece of work.

Overall, CA has the capacity to understand the action of interactions as they happen, which is a tool needed for examining MDT meetings and the process of collaboration as it happens. For this thesis, it is helpful as a tool used in combination with DP as the research question is broader than purely understanding the structure of institutional talk. The aim of this thesis is also to understand collaboration in quite a specific setting: MDTs in I(L)D services. To understand the specific action of talk in this domain, it is important to have a broader knowledge of I(L)D services. With no prior experience of working in I(L)D services, and a lack of published literature about how I(L)D services operate, the approach was taken to additionally complete some ethnographic observations of I(L)D MDTs. Combining CA and ethnography is contested, so here this chapter will give some background to ethnography, how it can be combined with CA, and how it was used to help understand collaboration.

Ethnography

This section explains this thesis' approach to using ethnography, how ethnography is relevant for understanding collaboration and why it has been used in combination with CA and DP. It first provides some background to ethnography, then it details some debates on how it can be combined with CA/DP, and finally it explains how this thesis has used ethnography to help understand collaboration in practice.

Researchers using ethnography tend to seek understanding of how people operate in a particular context. Ethnography is a difficult thing to define, due to variations in how it is explained and understood. One way to understand ethnography is as a method for understanding the culture of groups, uncovering how meaning in a group is constituted, which allows an understanding of members' actions (Liamputtong & Ezzy, 2005). Therefore, an attribute of a culture, such as a preference for meetings to talk about clients, is only understandable in its context and social

organisation that create a specific meaning for meetings to be the site for this work (Hammersley, 2018). As such people's behaviour needs to be explained in terms of the situations that they face (rather than some internal characteristic). Some key features of ethnographic work include a long period of data collection, from naturally occurring settings, relying on participant observation and a range of data that documents what actually happens in a particular setting, giving significance to the meanings that people in those settings ascribe to their activities/culture (Hammersley, 2018). However, these features can be contested due to the range of different theoretical or methodological positions that ethnographers embody. To overcome disagreements, Hammersley (2018) suggests the following are key assumptions underpinning ethnography; there should be direct observations of participants, observations should happen in naturally occurring situations, and accounts of participants from observations are more valid than formal interviews that are not context sensitive. Although these assumptions provide quite a 'thin' explanation of ethnography (Hammersley, 2018), they highlight the key elements that can be applied to different research projects. Interviews are often used as a method for data collection in ethnography, but it is essential that they are not the only method of data collection (Atkinson, 2014). The aim of ethnography is to gain an emic understanding of participants' worlds, whilst being a researcher from the outside who can see what might be normal for participants, as specific to their lived context.

Combining CA/DP and ethnography

The difference between CA and ethnography's epistemology may seem subtle. CA developed within the field of sociology and many original CA scholars had a background in ethnography. At the inception of CA, ethnography had not specifically been employed to explore language or interaction (Maynard, 2013). To change this, CA developed as what could be called a communication ethnography. Both ethnography and CA share a focus on the situated worlds of social life accessed through direct observations. The steps of analysis are similar – lengthy

observations are made and specific points of interest are then explored to build an understanding of social life (Green, Skukauskaite & Baker, 2012). However, CA diverges from ethnography in three key ways. Ethnography aims to provide an insider's point of view from careful observations of communities. CA does not claim we can have an insider's understanding, only that we can understand the action and consequence of turns at talk. Secondly, CA tends to look for similarities between communities where people are talking, rather than exploring a distinctive context (Maynard, 2013). Finally, CA provides proof (through data excerpts) when drawing conclusions, which tends to be missing from ethnographic reports. The use of proof that focuses on the action of talk is probably the key distinction that makes combining the two methods problematic. CA relies on evidence from interaction to draw conclusions, keeping the focus on the consequence of action in interaction. Maynard (2005) describes this as a move from the 'what' is happening of ethnography, to a 'how' it is happening of CA.

The initial aim of CA was to try to understand everyday talk, hence the focus on similarities of interactional practices across communities. However, as CA has established a basic understanding of everyday talk, scholars have moved to understanding different specific contexts. For example, by looking into areas of institutional talk (Drew & Heritage, 1992). Institutional talk is often comparable to everyday talk, but at times there are specific differences in the action and sequential organisation that talk has, along with the impact of participant rights (e.g. a Chair's right to move talk along an agenda in MDT meetings). Often understanding these actions requires some background knowledge on the specific institutional setting, which researchers might not have. Ethnography is often used by researchers to understand how participants might orient to, and be restricted by, the context. It is common for applied CA studies to use ethnography to understand the institutional actions talk has (cf. Antaki, 2011), and it is often briefly mentioned in published work in a healthcare setting (e.g.

Stevenson, Pelletier, Gibson, Park & Chrysikou, 2018; Finlay, Walton & Antaki, 2011). However, once background information from ethnography has provided the contextual information, CA would aim to see how participants build the context in their interactions. For this thesis the context is very specific – I(L)D teams in the NHS. The researcher had no background in the context. Maynard (2005) suggests that when there is missing knowledge, CA researchers should use ethnography to help explain 'unfamiliar terms, phrases or courses of action' (p.67) for CA. Thus when moving to specific applied settings, it is helpful to use ethnography to inform the use of CA.

The combination of DP and ethnography also has been discussed as contentious. An ethnographer may take issue with the analysis of talk for the action it has and the how psychological issues are done in talk, rather than trying to represent participants' perspectives on the role of language in an institution (Tustin and Maybin, 2007). There is not much discussion on the use of both ethnography and DP in the literature, apart from by Tustin and Maybin (2007) and Wetherell (2007). The focus in both their papers was on linguistic ethnography, and the lack of direct discussion on combining the two methods may reflect the variations in how ethnography can be used (Hammersley, 2018). The main issue Tustin and Maybin (2007) raised with DP in comparison to ethnography is that it imposes an outsider's perspective. They critiqued Wetherell's (2007) paper that had used DP to analyse identity, stating it created an outsider's view of identity due to a lack of researcher involvement in the setting that was examined. This was argued to not align with the ethnographic principle of giving primacy to participants' perspectives (Tustin & Maybin, 2007). It could be argued that DP does actually give primacy to participants' perspectives as it demonstrates what participants themselves are orienting to, rather than an ethnographer's interpretation of this. Nonetheless, the combination of ethnography and DP in this thesis anchors the analysis in healthcare

professionals' working world, and provides a method for this thesis to understand both the 'what' and 'how' of collaboration.

Using ethnography to understand collaboration

This thesis has used ethnography (observation and interviews) to understand collaboration, helping to clarify understanding of specific meaning of certain terms and ways of working. Ethnography was also combined with DP and CA to get a deeper understanding of the context that the participants work within. As highlighted in Chapter 2's literature review, an additional domain of factors that researchers argued affected collaboration was the context that healthcare professionals work in (cf. p.44). Therefore, not only was it important to use ethnography to clarify specific meanings of certain terms, it was also important to understand the organisational systems that the MDTs worked within. This approach aligns with Maynard's (2005) explanation of how ethnography can be used with CA, and also addresses Tuskins and Maybin (2007) concern that DP/CA draw conclusions on the action of interaction without awareness of the participants' working life. It also allows for conclusions to be linked to the specific services that the teams work in and how the findings work in terms of the teams' collaboration practices.

Alongside providing background to the specific context of the research, this thesis furthered the use of ethnography, beyond Maynard's suggestions, to help inform the focus of analysis. The first analysis chapter (see Chapter 5) developed in the traditional DP/CA way. A range of meeting recordings were listened to multiple times and analysis focused on understanding specific practices of interest - how does the use of the term 'concern' impact the interaction. However, the focus of the second two analysis chapters (Chapter 6 and 7), were developed in part from the ethnography. CA allowed the insights from the ethnography to be critically approached, unpicking claims from participants and from observations. For example, interviews and interactions with the teams led to a focus on laughter when team members

explained how they thought humour was important to good team functioning. The focus on professional identity was initiated partially from the notion that team members found clear job roles important for collaboration. Despite using these ideas as a starting point for analysis, CA principles were applied. Hence, although the focus of the team was on humour, laughter was examined, as humour would require an imposed criterion of what humour is (one of Schegloff's (1997) critiques against the use of ethnography). Additionally, although professional identity was examined, the focus was on how professional identity was oriented to in interaction and the action of this orientation in talk. Furthermore, the analysis chapters stand on the provision of data to support conclusions, which are then open to interrogation by other researchers who can check the validity of the conclusions.

An additional rationale for using ethnography was the perception of conversation analysis as a specialist analysis technique (Smart, Reed, Tremblett & Froomberg, 2018). The epistemology of conversation analysis demands a change from the realist perspective that is familiar to healthcare professionals, to consider focusing on the action in interaction and how context is created and maintained in interaction. CA is sometimes thought to disregard the context that healthcare professionals work within. Unlike traditional CA studies, which examined everyday interactions, when looking at applied settings researchers are examining a world of which they may not be everyday experts. Along with helping the researcher understand the applied setting, ethnographic inquiry can also help a researcher to demonstrate more credibility to their findings. This is important because if researchers claim an understanding of a setting from examining the minutiae, without understanding the applied setting, they may find it difficult to 'sell' the findings back to the people that they are meant to help.

Conclusion

This chapter has explained how the combination of ethnography, DP and CA provided a method for examining collaboration from the inside out, which was important for the aim of

this thesis. Ethnography was used to ground the research, providing an understanding of the context and specialist setting under investigation, and also helped to guide some analytic decisions. Both DP and CA were used to understand the design and action of talk as it happens. For this thesis, the value of combining the three approaches can be explained in terms of the different meanings that underpin and provide some understanding of I(L)D team members' collaborative practice. The finding from Chapter 5, which examined how the term concern is used to raise a potential risk to a client, will be used to briefly demonstrate this. At the micro level, CA provides an understanding of the structure in talk that I(L)D team members attend to. Thus, in terms of Chapter 5, it provides an understanding of when in a conversation it is oriented to as sequentially appropriate for team members to raise a concern. DP provides an understanding of how the features of talk are managing accountability for team members. Thus, in terms of Chapter 5 and the use of concern to raise a potential risk issue, the DP perspective provides an understanding of why it is raised as a 'concern' rather than using the term 'potential risk' in terms of the accountability work the term concern does for team members. Ethnography provides the understanding of how this feature of talk (concern constructions) is bound by the context of I(L)D services. As such, we can understand the meaning of risk management as a core clinical concern, yet how raising a potential risk holds possible negative implications for individual team members. These three methods help to provide some understanding of how behaviours make sense for I(L)D team members and how collaboration is done.

They were the appropriate tools for understanding collaboration as it happens, and allowed the research to move beyond the factors based approach to collaboration that has come before (see Chapter 2). This thesis has a meeting talk focus (cf. p.109). Meetings are the designated official place where multiple professionals are brought together, to work together (and thus collaborate). Using CA/DP to analyse these meetings provides an opportunity to delve into the

emic orientation of the teams. Understanding what is occurring in these meetings highlights the actions that teams orient to for collaboration, instead of trying to understand collaboration through the lens of a researcher. Furthermore, the approach demands no retrospective recollection and minimises the focus on a reliable witnesses. This thesis' research question is 'what are the collaborative practices of MDT in I(L)D services?'. The use of CA/DP can unpick what the collaborative practices are, and the ethnography can ground the analysis in the context of MDTs in I(L)D services. The next chapter (Chapter 4) provides the research design, along with the context of the research built from the ethnography.

Reflection box 3: The methods

This chapter discusses the three different methodologies I used in the thesis. Additions were made from the viva voce about the theoretical basis for the different approaches, and the value of using all three for the purpose of the thesis.

Using all three methods became really important to me, especially adding in some more ethnographic context. The addition mainly was a result of a concern I held that CA alone would not give me enough information on the working life of professionals to create credible research. I think this reflects how I approach work – with a need to be armed with as much knowledge as possible. It also reflects my own concern of being viewed as an outsider by team members if I built an understanding of collaboration from meeting recordings alone. This perhaps spoke to concerns of the tension between the knowledge held by the professionals in the team, and the knowledge held by me as a researcher. The professionals understand I(L)D services, and the work done, and I did not. However, at the end of the thesis my knowledge of the work done in I(L)D services would still not be the same as the professionals, in the same way that understanding of any phenomena is not the same individual to individual. What I learnt from reading and discussions with my supervision team, was that the true value of the use of the three methods, was to try to understand how collaboration practices made sense in I(L)D MDTs as an outside member. Thus, rather than me viewing myself as an outsider being a problem, I could shift to understanding it as a benefit, as it allowed me to question what could be viewed as mundane elements of I(L)D teams interactions, such as 'why that, there?' when 'concern' was used.
Equally, I was completing a thesis in a psychology department as the only student using CA for a PhD. Embedded in a world of quantification, surveys and interviews, I think I was probably also concerned to build a PhD based on a single method, and what that might mean for my future employability.

Chapter 4. Method and Context

This chapter explains the methods used to collect and analyse data to gain an emic insight into collaborative practices of MDTs in I(L)D services. It also provides the contextual background of the teams involved in the research, which is important for positioning the analysis chapters that follow. Chapter 1 explained the importance of collaboration in I(L)D MDTs. Chapter 2 described previous research on collaboration, and how the focus has been on modelling factors that are helpful or barriers to collaboration, without a clear explanation of what collaboration looks like. Chapter 3 outlined a discursive approach to understanding collaboration that can provide an inductive way to understand collaboration from an emic perspective of healthcare practitioners. This chapter explains how the discursive approach was implemented for this thesis. First, this chapter explains the research design. After an overview of the design, the ethical considerations central to the research are discussed. The chapter explains how the data was collected, before describing the research context. Finally, the chapter concludes with an overview of the approach taken to data analysis.

Design

This section explains the inductive discursive methodology adopted by this thesis that is 'emic' in its approach to understanding how I(L)D healthcare professionals engage with collaboration as a social practice (see Chapter 3). The approach allowed the research to start from observations of teams and their meetings. The research began, and was embedded, in a wider MDTs in Action project at the University of Plymouth. The MDTs in Action project combined research across academics, clinical psychology doctoral theses, and input from service users and stakeholders on multidisciplinary teams in healthcare more broadly. A major output from this project can be seen in Smart and Auburn's (2018) book that discursively explored MDT meetings. Involvement in the wider project provided the opportunity to begin with data

collection and examination of meetings that had already been recorded. These meetings had no service users or researchers present when they were recorded. A number of these meetings were transcribed in the initial stages of this PhD. Chapter 5 presents the analysis from the initial stages of this PhD. There were a number of questions raised in the initial stages of research around what I(L)D MDTs did, how they were managed and how they were organised. As a researcher with no direct prior experience of working within a specialist or primary healthcare service it was important to address the lack of personal knowledge about the context in which the data was collected. The emic approach that the research aimed to take may have been negatively affected by a potential lack of credibility from the point of view of healthcare professionals. This lack of knowledge informed the subsequent research design.

This design required recruitment of three community I(L)D teams to participate in the research. There were three data collection strands to the design of the research:

Strand One: The observations

A one-week observation of each team in their main office, to observe how the team worked and interacted with one another.

Strand Two: Semi structured interviews

Semi structured interviews with three members of each team that aimed to understand the professionals' roles, team goals, and their understanding of collaboration.

Strand Three: MDT meeting recordings

Five hours of meetings were recorded from each team, of any team meeting where the client was not present. These meetings would be analysed using conversation analysis.

Ethics

The ethical approval for this thesis was received in two parts. First, the preliminary research (see Chapter 5) was completed on the basis of becoming a named researcher on an already

approved ethics application. The wider MDTs in Action team had previously received approval for the MDTs in Action research project, named 'Multi-disciplinary teams in action'. The approval encompassed a number of clinical psychology doctoral theses, different research apprentices and Dr Smart's research. The National Research Ethics Service and the University of Plymouth provided approval for that project. The author received ethical approval to complete research via an ethics amendment from both the University of Plymouth and Research and Development departments of two NHS trusts. This provided access to named NHS trusts to record team meetings (composed only of NHS staff).

The development of the thesis research in phase two required a full HRA ethics application specific to this thesis, which accounted for the ongoing nature of the data collection and widened the scope of the research from just meeting recordings, to conducting some observations and interviews. The research was designed in line with the British Psychological Society Code of Ethics and Conduct (2009, 2018), alongside the Health Research Authority (HRA) and University ethical requirements. Participant information sheets (**Appendix B**) and consent forms (**Appendix C**) were designed in line with HRA requirements. A National Research Ethics Service committee was attended to answer questions about the research project and clarify any concerns that the committee had. The questions addressed how staff who did not want to participate in the research would be managed, who would have access to the recordings, and the committee wanted more detail on the interview schedule. All questions were answered successfully and full HRA approval was received (dated 6th of March 2018; **Appendix D**). The approval was then forwarded to the University of Plymouth Research Committee and the nominated NHS Trust to provide a research passport. Approval was also received from every subsequent NHS trust involved in the research (3 in total) and the trusts issued confirmation of access to the sites.

Alongside HRA approval, the Confidentiality Advisory Group (CAG) provided advice and approval for the research project. The CAG provided advice for how to manage patient identifiable information. The research focus was on team interactions, and although the team would consent, the interactions would inevitably include discussion of confidential patient information. The advice was to remove all patient identifiable information from the recording prior to leaving the NHS sites. Additionally a Caldicott Guardian from one of the trusts provided approval for the research as the responsible body for protecting confidentiality of information

Data was securely managed and stored after all identifiable information was removed. Data was only stored on encrypted devices when in transit, stored long term on an encrypted cloud service, provided by the University of Plymouth, and a backup encrypted USB was stored in a locked cabinet in a locked room. All data was handled in line with the Principles of the Data Protection Act 1998 and the Data Management and Information Security Policies of the University of Plymouth.

Gaining access

Ethical approval was required before teams could be formally approached and recruited. However, the HRA application required demonstration that there were NHS trusts willing to support the research. Therefore, the research was discussed with NHS teams who had taken part in the preliminary research to determine if they might be willing to continue with the body of research. This included discussing the research with the head of the NHS trust's learning disability service along with the teams that had previously participated and the trust's research and development department. The main concern raised by teams was the ethical management of patient information, which was managed in the project ethics protocol. The only other issue raised was the impact to researchers, due to the potentially sensitive and distressing nature of the discussions some of the teams have (specifically with regards to Team B, a forensic team).

Reassurance was provided through the researcher's supervision team that any issues the author experienced would be managed through the supervision process.

Although teams that had taken part in the preliminary research were approached for the thesis research, there were some changes to the teams that took part. One of the teams that had previously taken part in the MDTs In Action project, whose data was collected in the preliminary phase of this thesis, was no longer able to take part. The team made this decision due to internal team issues (e.g. changes to staffing). Two of the teams (team A and C) that had already taken part, agreed to participate in the new research project. Two further teams were visited and were open to involvement in the research. One of the teams was not solely a community team, also holding responsibilities for in-patients. As such, the team would not have met the ethical requirements of the study, due to the impact of having patients on site during observations whose consent would be needed. The other team could meet the ethical requirements and are described below as Team B.

The majority of time spent gaining access to a team is via gatekeepers, rather than the team members who will be participating in the research. The power dynamic of these gatekeepers was reflected on for this research. The HRA, research and development department of the trust and service manager approved the research, which may have created a situation where team members found it hard to deny consent. Reflections around this dilemma were discussed in more detail in Smart, Dickenson, Tremblett, Mhlanga & Aikman (2018). The main points from the paper were that it is important to have one to one conversations with participants where possible and give ample opportunity for them to demonstrate if they do not want to participate in the research.

Data Collection

Data was collected in two phases. In the first initial phase, previously recorded data was transcribed and new data was collected during April and May of 2016. Data collected during

the initial phase was purely meeting recordings (used for Chapter 5). The second phase of data collection was carried out slightly differently. The aim was to collect 5 hours of meeting recordings from each of the 3 teams that took part in the research project. Alongside the meeting recordings, a one week observation of each team took place in their main office space to observe the day to day functioning of the team. These observations took place in June 2018, November 2018, and January 2019. Interviews were also run with the three different team members per team, in October and November 2018, November and January 2018, and February 2019.

Observations

Observations took place in the main office of each of the teams. Two of the teams (Team A and C below) had hot-desking offices. In the hot-desking offices, observations took place from a range of different desks depending on their availability. The third team were smaller (Team B below) and observations took place from an allocated desk. All team members were aware of the research project after attending team meetings about the research. When team members entered the office the researcher held an informal conversation with them about the research and consent forms were signed if the team member was happy (there were no instances of non-consent). Consenting was a regular process, as team members would often work part time or be out visiting clients. The observation notes captured a wide range of behaviours, and the aim was to make note of the types of things people talk about, the movements in the office, where people sat, and what all the different job roles were (see **Appendix E** for an example of the types of notes taken). Following Rampton, Maybin and Roberts (2014) notes were driven by what participants were doing rather than sticking to a strict focus on collaboration.

Interviews

Three members of each team also took part in interviews. The recruitment aim was to interview a range of people based on their different positions and hierarchies in the team. Participants

were approached based on the observation of practice (Hammersley & Atkinson, 2007). However, this was dependent on the willingness and availability of specific staff members. The interviews were designed to answer any queries arising from the observations and to get an understanding of collaboration from the team members themselves. The semi structured interview schedule was designed after completing the observation week with Team A. This was approved by the HRA as an amendment. The schedule raised questions about how professionals characterised the ways that they work, what they felt helped and hindered the ways they work, and the importance of the MDT meetings for them. See the full semi structured schedule in **Appendix F**. The interviews lasted between 20 and 40 minutes, were recorded and transcribed verbatim.

The observations and interviews formed the ethnographic element for the context of the research, which this chapter covers from p.93.

Meeting recordings

The plan was to audio and video record MDT meetings to capture interactions between members of the teams. There was 12.5 hours total audio and 2 hours video available from the initial research phase. These data come from a range of MDT meetings from four different teams in I(L)D services. Only two of the teams that had previously had collected data from them were able to take part in the second research phase. One other team were recruited from a different NHS trust and recordings were also made of those meetings. The meetings recorded for Chapter 6 and 7 were recorded during the observation weeks, so the researcher was present in the meetings. The teams often were not comfortable to be video recorded, so they were audio recorded only. The recordings were made using a Zoom H4n Pro Handy Recorder. The total length of all the meetings in the second phase of the research was 12 hours and 37 minutes.

Research context

This section provides an overview of the research context based on information gathered during the observations and interviews. The overview helped to develop the focus of analysis and situates the analyses presented in Chapters 5-7. NVIVO was used to organise the observation notes and draw out concepts from the interviews that seem relevant to collaboration. The background to the teams and the concepts from the interviews map onto the different collaborative domains that frame the analysis chapters; the organisational, the clinical and the relational (cf. p.28). In the clinical domain, background to the teams' clinical focus is provided. The background to the team also includes the teams' organisation and the teams' working environment (highlighted as important in the literature review, cf. p.44). Each team's working practices are discussed, based on the observations and issues that interviewees focused on. Most of the working practices focus on relational issues (e.g. having caring team, cf. p.98) and organisational issues such as role clarity (cf. p.102). Thus, the ethnography further emphasises the relevance for healthcare professionals of focusing on these three domains as the framework for understanding collaboration practices in I(L)D MDTs, as these were the areas that participants in this research also oriented to.

The critiques made in Chapter 2, on the problem of using interviews and observations to provide direct access and understanding to people's experiences, need some consideration here. The following descriptions of the teams use extracts from interviews as accessing a version of how team members describe and reflect on how they work. The version that has been constructed here is based on a researcher understanding of the teams and the professionals' explanations of the team. As such, it is a construction, rather than necessarily an accurate or truthful account. Although the way that the professionals talk about their team could have been analysed, the focus for this section was to provide a description of the research setting and understand the areas that participants see as important for collaboratively working together. As

such, the three teams are described here. However, the descriptions are followed by a summary of the ways the interviewees described collaboration, drawing on a discursive approach to interpret what those descriptions mean.

Team A

Team A supported adults with I(L)D in a large rural catchment area in the South West of England. The team were one of four community learning disability service teams within the local NHS trust. The sub teams in team A were the Intensive Assessment Team (IAT), the Primary Care Liaison Team (PCL) and the Continuing Healthcare Team (CHC). The IAT team were the only multidisciplinary team during the observations, as the PCL and CHC team only contained nurses or assistant practitioners who supported the nurses. However, these three teams often worked closely together. The remit of the IAT was to support people with I(L)D who are highly distressed, or causing others distress. The PCL team supported adults with learning disability to access mainstream services – this could range from hospital appointments, GP surgeries, to dentist and opticians. The CHC team gathered health evidence on the needs of people with learning disability to determine what healthcare funding they can access. These teams worked closely together to support adults with learning disability, so for the purposes of this thesis they are considered as part of a single team as during observations and interviews they worked as a single team.

A number of different professional roles are needed to support adults with learning disabilities, which was reflected in the composition of Team A (see Table 5). As previously mentioned, only the IAT team were multidisciplinary and consisted of a range of professionals including Occupational Therapists, Psychologists, Psychiatrists and Nurses. Information posters about the team were displayed onsite, and the information about the people in the team has been duplicated in Table 5. During the observation week, there were differences between the team members on the information poster and in the office. The difference was likely to be due to the

age of the signage, however may also be because some team members were on leave or absent during the observation period (in mid-summer when people have caring responsibilities). In addition to the team members listed in Table 5, a social worker sat with the team for two days per week, to enhance communication between agencies. However as they were not employed by the NHS Trust they have not been included in the table, as they were technically from an external agency.

Table 5.

Discrepancies between the information poster and researcher observations of Team A membership (red highlight signifies a decrease in staffing, green signifies an increase in staffing).

Team	From Signage		From observation	
	Role	Number	Role	Number
IAT	Clinical Team Leader	1	Clinical Team Leader	1
	Acting Clinical Team Leader	1	Acting Clinical Team Leader	0
	Community Nurse	3	Community Nurse	3
	Speech and Language Therapist	2	Speech and Language Therapist	1
	Occupational Therapist	2	Occupational Therapist	2
	Physiotherapist	2	Physiotherapist	0
	Psychologist	3	Psychologist	1
	Psychiatrist	1	Psychiatrist	1
	Business Support	2	Business Support	1
	Assistant Practitioner	2	Assistant Practitioner	1
	Medical Secretary	1	Medical Secretary	1
	Assistant Psychologist	0	Assistant Psychologist	1
	Occupational Therapy Technician	0	Occupational Therapy Technician	1
CHC	Nurse	1	Nurse	1
PCL	Nurse	3	Nurse	3
	Assistant Practitioner	1	Assistant Practitioner	1

Team A received their work via referrals into the service. The referrals tended to be from GP practices, social care staff, or were internal referrals from members of the team. Initially, referrals were received electronically to the team. The daily ‘duty’ team member checked the new referrals to determine if there was an urgent need, or if the referral should be discussed at

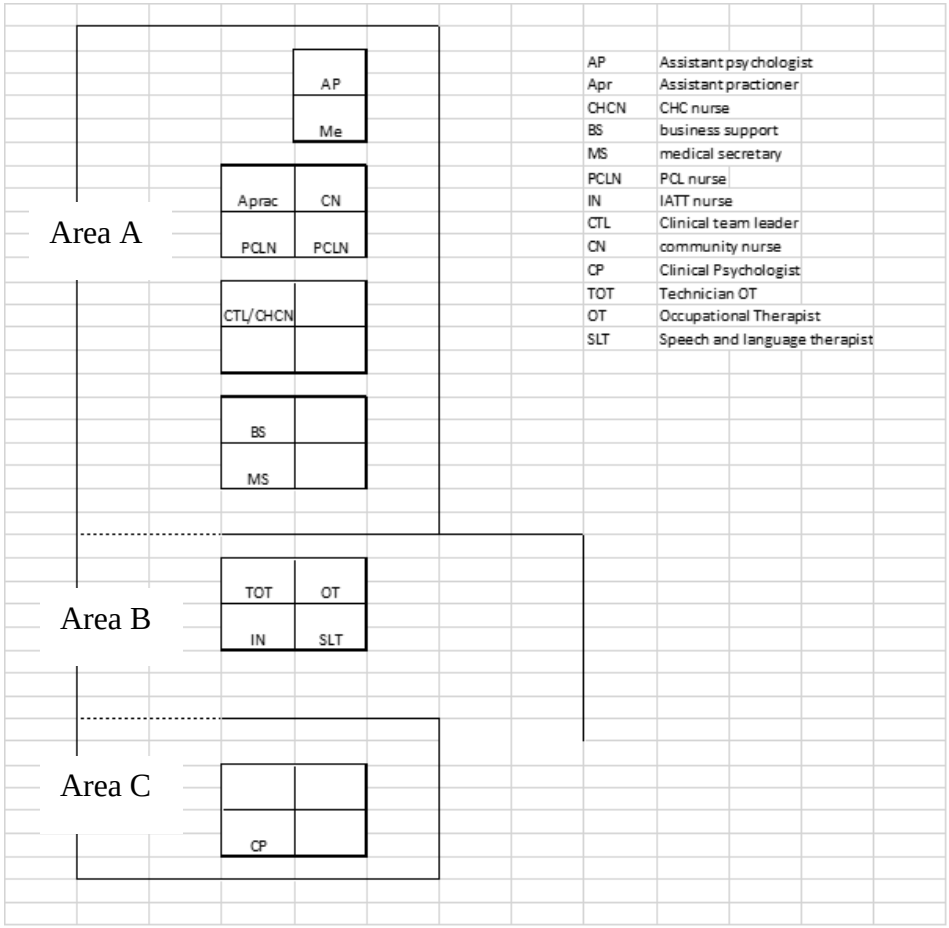
an allocation meeting. There were often informal discussions held between team members in the office to make these decisions, which tended to involve sharing historical information on the client. Referrals were officially reviewed in a Monday morning allocation meeting. Unless there was an obvious need for urgent action, the Assistant Practitioner was allocated the client to complete a visit and gather information for a SBAR (situation, background, assessment and recommendation). Once the SBAR was completed the team planned what action they needed to take (e.g. a specific piece of work, or more assessments). The multidisciplinary meeting was the official space for making decisions, but prior to the meetings team members would often have had discussions about the referrals.

Working environment

Team A's office arrangement made it easy for staff to have informal discussions about clients. The team sat in an open plan office with a hot desk system. The only fixed desks were for the business support administrator and the medical secretary as they never work outside the office. The hot desk system allowed staff to choose a free desk as they arrived into the office, with no members of staff 'owning' a particular desk. The main room had 14 available desks and there were two connected rooms with four extra desks in each (see Figure 2). Although all desks were available for staff to work on (bar the business support and medical secretary desks), office area C (Figure 2) was known as the 'Doctor's' office – i.e. it was generally used by the Psychiatrist and Psychologist.

Figure 2.

Floor plan of Team A's office. Includes use of the office space by professionals during the Monday of the observation period. Dotted lines represent doorways.



Working practices

Informal communication between members of Team A was regular and prominent in my observations. Team members were regularly in and out of the office in between visiting clients. On arrival into the office, it was common for most professionals to greet the team and offer to make hot drinks for anyone that needed one. The informal check-ins had a few social purposes. On arrival back from a visit, it allowed for an informal debrief of the case. If it had been a particularly difficult case, professionals were then able to 'off-load'.

Quotes: Debrief

> "..y*ep you have a debrief and yeah it's not a problem, there's always someone around you can um off load onto oh wait there's always someone around*.." Int1. Team A.

The check-ins also helped to foster open communication within the team, and the team members often reported that they felt cared for and supported by their colleagues. Open communication on both professional and personal issues had a mutual benefit, with conversations regularly flowing from the personal to the professional and vice versa.

Quotes: Caring

> "…*everyone is just so friendly that they just want to help you to help them as well, cus and I think that's just what everybody is just, and everyone I suppose just because of the nature of the job everyone is just caring*…" Int2. Team A.
>
> "…*it's a lovely team, it's really welcoming and really lovely and I think I've come in and everyone's really helped me and I've been able to go out with each member of the team and kind of seen what each member does*…" Int3. Team A.
>
> "…*we're quite touchy feely so we cuddle quite a bit as well so um I think we are all generally invested in each other and look after each other as well*…" Int1. Team A.

Members of Team A often described the team as being without a hierarchy in contrast to teams that they had worked in with a pronounced hierarchy. Team members linked the lack of pronounced hierarchy to feelings that they were listened to and heard, no matter what their position in the team was. Despite the lack of hierarchy, team members had different lengths of employment in the service. Therefore, they brought a range of professional experience and knowledge about clients to the team.

Quotes: Flattened hierarchy

> "*..there is a hierarchy and we know the hierarchy but it's quite a flattened and dampened down hierarchy where everybody's opinion is listened to we tell the consultant to be quiet*.." Int1. Team A
>
> "*..I think as well compared to other teams here we have a very flattened hierarchy but obviously when hierarchy needs to come out for certain situations or difficult discussions it does*.." Int3. Team A
>
> "*..I don't really feel that there is a hierarchy that's what I was nervous about when I first kind of started or before I started I thought gosh you know there are so many, in one meeting there are the psychiatrist there and then all the nurses there and then the psychologist and then there's us and you think gosh but everybody listens to what you are saying I don't feel like what you say is, isn't relevant I genuinely think they appreciate everything that you say*.." Int2. Team A

Team A was one of the teams in the preliminary phase of the project, and so perhaps one of the teams that became well known by the researcher. The team were always very welcoming and enthusiastic to take part in research. The management and team structure changed throughout the 4 years they participated, yet the impression of the team was consistent throughout.

<u>Team B</u>

Team B was an unusual team in comparison to the two other teams that participated in the research. Although still a community learning disability team, they were a specialist forensic team (FCLDT: forensic community learning disability service). The team worked with people with a learning disability who had been convicted of an offence, or who were at risk of offending. Their aim was to reduce offending behaviour, often through providing courses in life skills. Referrals to the team predominantly came from criminal justice services, community learning disability teams and social services. Alongside working directly with individuals to reduce offending behaviour, they also completed requests for risk assessments of individuals.

Team B was highly specialised and consisted of just six team members. The team worked within a single NHS trust, which spanned 2200 square miles with an estimated population of 1.8 million. Despite this wide catchment area, fewer people needed this service. Alongside work for their own trust, the team received commissioned out of area referrals from trusts that did not have a specialist forensic learning disability service. Psychology and nursing were the two disciplines in the MDT. The team manager had a nursing background. There were two clinical psychologists, a learning disability nurse and one preceptee nurse. A preceptee nurse is employed on a temporary contract to gain experience after graduating from a nursing degree. The team also had one member of administrative staff. The only full time members of staff were the learning disability nurse and preceptee nurse.

Team B had recently experienced a number of staffing and structural changes. A manager and a clinical psychologist, both of whom had worked in the team for many years, had left. The remaining clinical psychologist took over the management role for the team until the new team leader could begin. At the beginning of the observations the new team manager, new clinical psychologist and preceptee nurse had only worked for the team for a few months. The long-standing clinical psychologist was the main point of contact for the research project. Given the amount of change the team had experienced, they thought it would be beneficial to use the research process to reflect on the team's working practices.

Team B held a monthly meeting to discuss all new referrals. The low frequency of these meetings compared to other teams is due to the team's size and specialism. Workload management was key for the team due to their size and limited capacity. Despite only meeting monthly to formally discuss referrals, urgent referrals were managed in the office as they were received. Due to the nature of their work, Team B received referrals from community learning disability teams, social workers and probation officers. It was common for Team B to work closely with these other agencies to meet the needs of the client.

Team Environment

The team worked in a very small office in a NHS trust building, which was also home to a number of other NHS services. The entrance to their office had no door, and was more of an archway from a corridor. The corridor was shared with a number of different teams. Even though the office was small, there was ample space for an allocated desk per team member. However, many of the team members worked part time, and spent most of the time visiting people in the community, so it was rare that all staff members were in the office at the same time. A white board was updated to keep track of where team members were, and when they should return, to safeguard lone working with the forensic population.

Working practices

Building relationships was a common theme discussed by team members in interviews. The team often reported a lack of coherence and cohesion between team members due to recent changes in personnel. Interviewees often raised the need to get to know each other, both formally and informally. Working predominantly off site meant there were not many opportunities to chat about personal matters. If team members were in the office discussions tended to prioritise work matters over personal matters. When team members worked off site together there was more opportunity to discuss personal issues. Team members explained that informal chats were most helpful for debriefing client visits. The team felt to build better working relationships they needed the opportunity to create a shared vision, to develop concepts such as values, philosophy of care and shared goals.

Quotes: Building relationships

> *"..getting to know each other, looking over the year acknowledging that yeah it's been really hard like the team leader before she was, I, I think she was um manager for something like sixteen years.."* Int1, TB.

".. team members kind of bring to the team and previous experience, experience of working in different settings and how that can contribute I suppose, we're in that process of fitting that all together again.." Int 3, TB.

Team B reported that clarifying both job roles and the team hierarchy were key issues. The management structure in the team had changed with the recent personnel changes. The changes led to the clinical psychologists having a higher pay band than the manager, leading to confusion around the hierarchy between the clinical psychologists and the manager. The clinical psychologist that had temporarily managed the team before the current team leader was aware of these issues. Determining who should do what, between the management and clinical psychologist, was raised as a delicate issue for both parties.

"..hierarchically, is that a word, lower than others because obviously there are two doctors on the team the psychologists are far more intelligent than me, far more highly qualified and I'm very aware of that.." Int 1, TB

Despite confusion on roles and hierarchy, high levels of support were described as a vital part of team life. The two newest members of the team explained this was a key team quality. The opportunity to talk to colleagues and the freedom to ask questions were described as attributes that demonstrated the team's supportiveness.

"..I think they were all quite stressed with what was going on um but yeah they've been very very supportive.." Int 1, TB.

"..but everyone was just really welcoming and just made me feel really comfortable and gave me a place in the team which was nice so it was good, it was good yeah.." Int 2, TB.

The team discussed a range of external factors that affected their ability to collaborate. The Trust's restructuring of the team created the circumstances where they needed to clarify roles and build a team ethos. The small work space meant that it was easy for colleagues to approach one another for help, but when they were trying to focus on work or make phone calls the noise could be disruptive. The manager did not have control over the team's budget; higher management made staffing decisions and they could not invest in team building exercises.

"..no autonomy over our budget which is really annoying because we have, I haven't even seen it because we have um we generate an income.." Int 1, TB.

"...our preceptee came to us I was told, wasn't asked I was told I was having a preceptee.." Int 1, TB.

The small size of Team B meant that changes in the team had a big impact, which was not as evident in the larger teams that also had regular staffing changes. The team openly acknowledged a level of tension between staff members about who should do what, and meetings often focused on working out the correct working procedure to follow. Moving forward the team planned to hold two away days to address these issues and foster clarity in their roles, their focus, and also to get to know each other.

Team C

Team C were a general adult learning disability community team. They were a very large team, reflecting the geographical area that they covered. Around thirty members of the team took part in the observation week. Team size fluctuated based on staff absences and the intake of placement students. The professionals that worked for Team C were very similar to Team A with the addition of senior community support workers and a specialist dietician. At the time of my observation, the team manager had a nursing background. The manager was transitioning to retirement, so during the week of my observation they were reducing their working days to two per week, with another manager covering the other three days.

Team C received their work through referrals into the team. Similarly to Team A, these referrals came from GPs, social workers and providers of care to people with learning disabilities. Team members could also refer clients to other team specialists, for example if nursing were supporting a person they felt needed additional support from a speech and language therapist they could make a referral to speech and language therapy (SALT). Referrals tended to enter the team via email, and team members triaged the emails on a rota basis. Referrals were

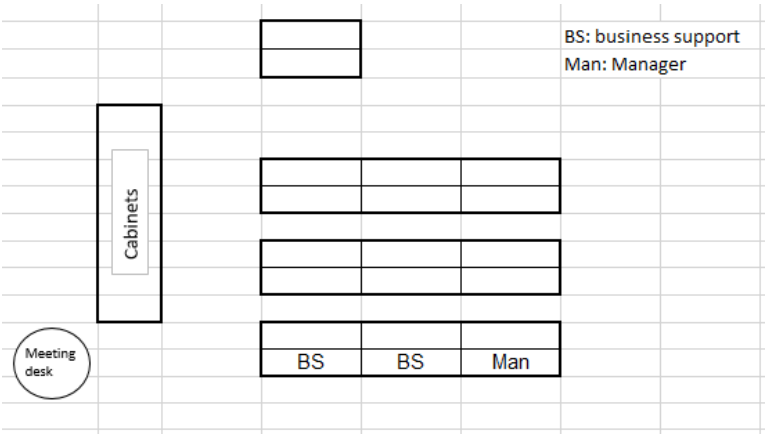
screened daily by the two members on triage, to decide if the team could meet the client's need, and which specialist on the team could help. For example, in clear cases they would forward on the referral to SALT support for someone with speech and language needs. The triage process allowed urgent cases to be dealt with immediately. However, all referrals were discussed at weekly meetings. The meeting gives all the team members an opportunity to discuss a client's care and for information to be shared.

Team Environment

Team C were based in a rented office in an industrial estate on the outskirts of a main town. The office block housed many different businesses and services. Team C's office space consisted of three banks of six desks in a row (see Figure 3). Behind these desks there were another two banks of two desks that could also be used by the team. One side of the three banks of desks had windows, and to the other side of the banks was storage for the team – big cupboards and filing cabinets. Although the office was a hot-desking office, the team manager and two administration staff (business support) had permanent desks.

Figure 3.

Floor plan of Team C's office



The office space was designed for hot-desking, so at times space was limited. For example, most staff attended the weekly referral meeting, and on the same day worked from the office. As there was insufficient desk space for all members of staff, people would work from the

meeting desk or would squeeze into areas on laptops. The focal point of the office was a white board situated behind the manager. The board listed all the staff and tracked their daily whereabouts (on visits, working from home or on leave). Staff would update the board on departure and arrival to the office.

Working practices

Working from home was a common work practice, due to the extent of the team's catchment area. A common group of staff worked from the office most days, but often people would work from home or be out on client visits. Working from home was associated with high productivity, but low team cohesiveness as team members did not get to see or know one another.

> *"..people will choose to work from home because it's better for actually getting work done but I do think you lose that interaction of just general discussion.."* Int3. TC.
>
> *"..in some ways it's great because you do actually do more MDT working as sometimes you listen across the desk and you go oh I know that person you're talking on the phone about or you can help someone because they're looking petrified on the phone but then in other, a lot more people work from home now and then some people on the team don't come in so often and then you feel like you're missing their input so it kind of works both ways it's good and bad.."* Int1. TC.

As the team often were not present in the office, the weekly MDT meetings were key for staff to see each other. The meetings provided a space for staff to share their experiences from lone working with clients, and everyone could gain a broader understanding and education on managing care. However, as the team was so large, the meetings were sometimes deemed a waste of resources, particularly when discussions were around clients they did not work with.

> *"..sometimes people will bring cases to just say this was really unusual and this happened and I learnt from it so it's quite good learning for the rest of the team so I think that's quite a good function.."* Int1. TC.

Although a MDT, Team C were observed to work within their specific disciplines more so than other teams. The individual disciplines (e.g. nursing) would have their own meetings, do separate team-building activities, and have their own referral inboxes. Staff would often refer to their discipline as their main team, subsidiary to the overall MDT. The observed divide between disciplines may be due to the team size – a large group of 30 people are likely to splinter into smaller groups. Although it was observed that to some extent the team worked in 'silos', this did not seem to affect how team members viewed working with other disciplines.

> *"I think I would say I'd probably work with most of the other disciplines.."* – Int 3. TC.

Team C were the team with which it was most difficult to build a research relationship, in part due to the size of the team and difficulties having meetings with them all. The interviews held with Team C predominantly focused on organisational issues on what they did and how they did it, rather than what it was like to be part of the team. The interview focus possibly reflects that the team equally didn't feel as comfortable with the researcher as other teams. It was sometimes difficult to be in the office as the space was at such a premium. It was the researcher's role to manage this better, and on reflection it may have helped to have worked over a longer period with the team to engender more trust which may have led to some richer insight into their team functioning. However, as the focus of this thesis is more so on understanding collaboration practices in interaction it was not such a key issue to address, but may have been had the observations and interviews been developed into more of a thematic analysis.

Participant definitions of collaboration

As part of the interviews, two thirds of the interviewees (those from Team B and Team C) were directly asked what they thought collaboration is. Team A were not directly asked this question as they were the first team to be interviewed, and on reflection after the interviews it seemed

important to include the question to future participants. The researcher often asked the question at the end of the interview, for example stating ‘um I guess what is your idea about work, what is working collaboratively with people’. There was no identical format to how the question was asked, but it is important to reflect on the construction of the question when analysing the participant responses.

All the participants that were asked about collaboration, drew on the notions of working together and either sharing information or sharing goals. Interpreting the responses from a discursive approach means that rather than giving direct insight to participants’ internal thoughts, their responses can be analysed for the action that presenting a certain version of events has and the different ways that they construct collaboration. The responses have been interpreted as drawing on common discourses around collaboration. As healthcare professionals in the NHS they are encouraged to work collaboratively (cf. Chapter 1). Therefore, it is unsurprising that when asked to describe collaboration participants drew on a common idealised version. The notion that team members are drawing on an expected, and potentially idealised, discourse of what collaboration should look like can be seen from the response below:

> “ Int1: *I guess working together and sharing information*
> Me: *mm yeah*
> Int1*: that’s what it means to me*
> Me: *yeah*
> Int1: *and sharing good practice bad practice, that’s what it should mean I don’t know if that’s how it happens in practice*”

The interviewee presents the notion that working together along with sharing information and working practices is what collaboration ‘means to (them)’. Although some participants were asked specifically what collaboration means to them, this interviewee was actually asked ‘what it means in these sorts of services’. Their response constructs a version of collaboration that is

specific to them, perhaps not everyone. The disclaimers around how collaboration is meant to be versus how it might 'actually' be, aligns the interviewee with a problematised version of collaboration also seen in the consultations in the introduction (cf. p.11). In this extract, the version of collaboration is constructed as idealised, through the comparison to 'how it happens in practice'. This comparison suggests that in 'real life' professionals do not always work together and share information or practice. Thus, the way that interviewees described collaboration is a presentation of the collaboration 'ideology', rather than the 'reality' of collaboration.

The interviewees' descriptions of collaboration highlight an important point about methodology. Understanding collaboration via interviews with healthcare professionals is likely to reproduce common discourse around collaboration, which this thesis has already highlighted as problematic in Chapters 2 and 3. The reproduction is particularly likely in the interview context when the interviewer could be argued to be testing participants' understanding and if it is the 'correct' understanding. Furthermore, descriptions of collaboration will be working to support and create a certain version of events. In some interactions the aim may be to demonstrate that a team are good collaborators, in other interactions they may be constructing a problematised version of collaboration. Thus, the professionals' response to what collaboration is further supports the aim of this thesis to examine collaboration directly by focusing on what is happening during team meetings.

Context summary

The aim of this section was to provide an overview of the teams that participated in the research, and the types of issues that were relevant to how they worked together and collaborated. This helps to situate the analysis chapters, but also helped to develop the analytic focus. The observations of what the teams do when working together, along with what participants oriented to in the interviews, map on to the different domains (clinical, relational and

organisational) that frame the analytic chapters and have previously been argued as important to both service users and healthcare professionals (Smart, Reed, Sztorc et al., 2018). It also demonstrates the rationale for focusing on analysing interactions from MDT meetings, as often these were the official sites for teams to collaborate to make decisions, and at times were the only points when all the team came together. The next section details the analytic approach to the meeting recording where different practices were viewed through the lens of collaboration.

Analysis

This section explains the approach to the analysis of the meeting recordings. The data analysis followed discursive psychology principles and conversation analysis as discussed in Chapter 3. What follows here is a brief overview of the methodological process of choosing areas to focus on and this discussion is further developed in all of the analysis chapters to follow. This section also explains the role of joint analysis and data sessions in developing the analysis for the chapters.

All of the meetings recorded were first orthographically transcribed. The approach to focusing on areas for analysis then followed a similar process to what has recently been named as reflective interventionist CA (O'Reilly, Kiyimba, Lester & Muskett, 2020). This is a version of applied CA that aims to retain the core CA concept of unmotivated looking (Sacks, 1984), whilst considering the implication of findings for participants. Thus, the starting point for analysis was not based on a problem that has been considered a-prior, and analysis was inductive and data driven.

Chapter 5 was developed from some data that had already been collected for the MDTs in Action project. From transcribing and repeated listening, the term 'concern' was identified as having a particular interactional function for the teams. This was highlighted through analysis in data sessions (cf. p.111), where other members of the data sessions also attended to the use of the term concern and the clinical relevance it had for the teams. To understand what action

'concern' might have, two meeting recordings were chosen to analyse all of the instances of the use of the term 'concern'. The meetings provided over four hours of data, and provided a manageable scope to understand concern in the context of the meetings as a whole, e.g. in terms of the amount of participants discussed per meeting. All extracts were developed using Jeffersonian transcription conventions (**Appendix G**). Analysis was advanced in conjunction with attending a 'CA and Healthcare Interactions' workshop at Loughborough University. At the workshop, the initial analysis was presented to other researchers that use CA to examine healthcare interactions. The analysis also benefitted from guidance from one of the workshop leaders John Heritage. The resulting output was Chapter 5, and was also published as part of 'A discursive exploration of team meeting practices' (Smart & Auburn, 2018). Further detail on the development of the collections and analysis of how concern constructions are a clinical collaborative practice can be found on p.115.

Chapter 6's analysis developed from data collected from the second phase of the research project that explicitly focused on collaboration. Initially, the focus was on the use of 'I think' by healthcare professionals to present ideas to the team, and what action that had. In the early stages of development some extracts were taken to a joint analysis workshop with Team A. However, when the team listened to the extracts they were mostly interested in humour between team members, and reflected that humour was important to the team working well together. Humour is notoriously difficult to define and pin point in interaction, so the analysis focused on laughter and what function it might have for the team (further described in Chapter 6). All instances of laughter were extracted from the team meetings that already had been orthographically transcribed. These were then developed using Jeffersonian transcription conventions. Different collections were then made on the basis of the different actions that the laughter had in interaction. The result, which focused on the embedded use of laughter and its role as a relational collaborative practice, can be seen in Chapter 6.

Chapter 7's analysis focused on the way that job role is used in interaction to achieve different aims. The focus here developed through the observations and interviews with the teams, which highlighted role clarity as important (cf. p.102). Meetings were then listened to with this in mind. It was harder to pin point the instances of where job role was used, so the decision was made to focus on areas in the meetings when there was some form of negotiated decision on who was going to do what work. This decision was made as job role is defined by what work that role will undertake. The extracts found across all the meetings were again transcribed using Jeffersonian conventions and analysed, with the results of the organisational collaborative practice available in Chapter 7.

Developing analysis with data sessions

Part of the process of developing the analysis for the chapters was using data sessions with both researchers and the teams. For all of the chapters, this involved running data sessions with either CARP (Conversation Analytic Research at Plymouth) or this thesis' supervision team. These sessions helped to guide analytic decisions, and check that others could identify the same analytic features. CARP had researchers from a range of backgrounds, including students of various academic levels, people with understanding of services from a client perspective and clinicians who work in services (e.g. clinical psychologists). At times it was also possible to run joint analysis sessions with one of the MDTs. This was useful for the interventionist (cf. O'Reilly et al., 2020) aims of the research (cf. p.23 for further elaboration), but also to guide the analytic focus. The joint analysis session followed a similar process as detailed in Smart, Reed, Tremblett and Froomberg (2018). Extracts from the team's meetings were taken along to the workshop. The team were provided a short summary of what CA is, and Jeffersonian transcription conventions, then the majority of the session was spent listening to the extracts and getting the team to attempt analysis. Although running joint analysis with healthcare professionals has to be carefully managed to balance the researcher's and participants' aims

(cf. p.207), it was an important part of trying to develop analysis that was relevant and meaningful for healthcare professionals.

Conclusion

This chapter has explained how this thesis' research was designed to get an emic insight into collaboration within I(L)D MDTs, as inductively as possible. Details of the research design, data collection and analysis have explained the process of gaining this emic insight by starting with what the teams actually are doing when they work together. The I(L)D teams' context provides a detailed understanding of the team, to locate the practices of collaboration within what they do and see as important. The framework of understanding collaboration practices in the clinical, relational and organisational domains was reflected by the ethnographic findings, as what the teams did and discussed as important maps onto this framework. The data collected for this thesis were rich and contained a vast amount of information that could be analysed. It is clear that the decisions made to focus on certain areas limits the extent of the analysis, however by starting with areas that are meaningful for healthcare professionals the analysis chapters that follow start to unpick the collaborative practices of MDTs in I(L)D.

Reflection box 4: Method and context

The reflective notes made throughout my ethnographic observations, and when I ran the interviews, speak to the tension I felt as a researcher in a clinical space. My notes focused on the assumption and expectation that I was burdening the teams whilst doing the research. I understood NHS employees as overworked and underpaid, and that taking part in research is above and beyond what they potentially wanted to be doing. Some of these assumptions may be accurate. However, notes I made also suggest that some of the team members valued having a researcher in, as a chance to consider their role and due to the novelty of someone taking an interest. These assumptions led to a danger of the feeling that I was a burden seeping into the interviews. I think at times I could have questioned the assumptions and narratives of interviewees more, but I was worried about taking up too much time of the professionals. This likely fed into the findings of the interviews, which could have had more depth if the initial responses to what they said were explored more. For example, a team member stated, "*people will choose to work from home because it's better for actually getting work done but I do think you lose that interaction of just general discussion..*" Int3. TC. This response could have been unpacked further, to understand what it is about general discussion that seems good for collaboration to team members.

I also took quite an open approach to observing the teams, which on reflection may not have been the best way to have gained an understanding of collaboration. Alternatives approaches could have been taken, including using the framework of the analysis chapters and focusing on observations in places that may have related to clinical, relational and organisational features of the MDTs working together. However, I am not sure how easy it would have been to separate the observations into these distinct groupings, and this would have been slightly outside the aims of the observations.

I chose to complete semi-structured interviews with team members. I assumed that this would provide an opportunity to understand the experiences and perspectives of team members, which felt really important. I likely felt this was

important due to my background education in psychology, where feelings are often used to explain behaviour. Yet, the theoretical perspective of the methods used in this thesis moves away from the types of understanding that interpret answers to interviews from a realist perspective (as was critiqued in chapter 2). The use of these types of interviews, having done the literature review, potentially biased my interpretation and let me to see similar ideas that were highlighted by other researchers (such as trust and respect).

In the viva voce, alternative ways to approaching incorporating I(L)D MDT members' perspectives were discussed. For example, data-prompted interviews could have been held (Kwasnicka, Dombrowski, White, & Sniehotta, 2015). Data prompted interviews are often used in healthcare to help trigger ideas and reflections from participants, to help address research questions that are harder to answer when using traditional interviews (Henry & Fetters, 2012). For example, they have been used to understand patients' perception on when to visit their family doctor (Llanwarn, Newbould, Burt, Campbell & Roland, 2017), family doctors' perceptions of their decision making process when prescribing antibiotics (Colliers et al., 2020), the experience of music therapy (Flower, 2014) and how patients and doctors use non-verbal cues in consultations (Henry, Forman, & Fetters, 2011). For this thesis, it may have helped improve participants' memories of meetings and enhanced focus of the participants' reflections on collaboration specifically in meetings. It could also be used to develop a reflective exercise with a group of participants. Data-prompted interviews may have provided an understanding of how participants made sense of their actions in the meetings, and how they perceived their actions related to collaboration in MDTs. Equally, recordings of the meetings could have been developed into training, for example through use of the conversation analytic role-play method (Stokoe, 2014).

Chapter 5. Clinical Collaboration: Risk in the MDT

This chapter focuses on an area of clinical work that MDTs in I(L)D services have to collaborate on; whether or not there is a potential risk to the clients that they are working with. One of the major drivers for moving I(L)D services to the community was to tackle the damaging and at times abusive conditions of institutions. Since the move to the community, there have been further highlighted cases of abuse, for which one solution from government policy is to have increased collaboration between professionals using MDTs (cf. p.15). Thus, the risk of abuse is high on I(L)D teams' agenda, and this chapter discusses how teams collaboratively manage the risk to a client in interaction, in part through the use of the term concern. This chapter has been developed from the author's previously published work (cf. Tremblett, 2018). First, this chapter discusses the different types of risk for people with I(L)D and how risk of abuse is a particularly delicate matter for teams to manage. It then goes on to discuss previous research on the use of concern constructions around risk, followed by some background on the structure of MDT meetings, which is important for understanding the impact of a concern construction and how it can gain (or not gain) collaborative input from the team. The analysis then follows, before the chapter moves to discuss some conclusions around concern constructions as a collaborative practice for healthcare professionals in the clinical domain.

The potential risk of abuse for people with I(L)D tends to be bracketed into more general safeguarding guidance for any vulnerable person in the UK. Abuses that fall under safeguarding procedures are physical, domestic, sexual, psychological, financial/material, modern slavery, discriminatory, organisational and neglect/self-neglect (Department of Health, 2020). The guidance is clear that any member of staff who becomes aware of abuse has a responsibility to report the abuse (Department of Health, 2020). Therefore, there is an organisational mandate to deal with cases of abuse in a specific manner (for example by

reporting it). Guidance documents (e.g. Department of Health, 2020) treat abuse in a straightforward manner, e.g. if there is abuse it should be reported, and do not detail methods for managing potential or suspected abuse. It is more in education that staff are trained on how to recognise abuse in people with I(L)D (e.g. Bickerton, 2011). Often the delicacy that staff have to manage is the balance between the person's rights to live how they choose without state interference versus the seriousness of the abuse, often referred to as the threshold for outside interference (Brown, 2003). At times the decision is not obvious, for example whether an individual can retain their right to live independently if they are unable to clean themselves properly. These types of decisions benefit from collaborative input from MDT members.

Previous research had identified particular practices when discussing the potential risk of abuse to someone. Looking at a child protection hotline, Potter and Hepburn (2003) identified that people would open a discussion around the risk of potential abuse using a concern construction. Potter and Hepburn (2003) argued 'concern' constructions have a specific institutional function for both the caller and the helpline worker, often a child protection officer (CPO). 'Concern' openings notified the recipient (i.e. the CPO) of the beginning of an extended telling sequence, rather than being a self-contained action. Therefore, it provided space in the interaction for the caller to detail the full story and head off an early assessment from the CPO. The 'concern' would then be collaboratively unpacked between the caller and the CPO – becoming a more concrete issue, through elaborative questioning in the interaction. Concern constructions implicitly constitute an epistemic imbalance between caller and CPO in terms of their respective domains of knowledge (cf. p.73). They can be heard as constructing a neutral version of the incident that has prompted the call. As the 'concern' construction allows for discussion, the CPO can bring their knowledge of what should and shouldn't be treated as abuse to help the caller and CPO reach some form of conclusion. In comparison, if a caller refers to the reason they are calling as a 'problem' the reason is treated as something more concrete rather

than something to be worked out together between the caller and the CPO. The opening as a concern construction and the subsequent unpacking is a clear template for collaborative examination of an issue.

There are some fundamental similarities and differences in Potter and Hepburn's (2003) corpus and I(L)D MDT meeting interactions. They are both areas in which it is appropriate and expected that the interaction will focus on some issue to do with a person. In the child protection helpline the differences in epistemic stance are clearly demarcated. The CPO will have epistemic access to what is or isn't a potential child protection issue, but the caller has (normatively) first-hand knowledge of the actual circumstance between the child and the potential abuser. Hence, between the caller and CPO it is necessary to collaboratively unpack the issue to bring together these different epistemic domains to determine what the right course of action for the child is. In the I(L)D MDT the epistemic domains between team members are likely to overlap, both in terms of first-hand experience and professional knowledge. The person raising a concern may have access to personal first-hand information about the client. However, other team members may also have personal knowledge of the client that can be brought to the discussion. In addition, each team member will have different professional knowledge that can be brought to the discussion (Heritage, 2012). For example, a psychiatrist may have an understanding of how medication could be affecting an unusual incontinence problem, whereas a psychologist may have an understanding of anxiety issues that could be affecting the same problem. Anspach (1993) highlighted different knowledge domains in neo-natal team decisions, with nurses focusing on their knowledge relating to normative social behaviour, whereas doctors would focus on their knowledge relating to scientific information. In comparison to the child protection helpline the different epistemic domains I(L)D MDT members bring to the same issue may result in a difference in function of using a 'concern'

construction. In addition, the multiparty nature of MDT meetings, and structure based on an agenda led by a chair, may mean the sequence of concern constructions differ.

The organisational structure of discussions in I(L)D MDT meetings may have an impact on when it is possible to get collaborative input on the risk of potential abuse. In Potter and Hepburn's (2003) data, callers would present something as a concern in one of the first turns available after the call openings (e.g. after the greeting by the CPO). In I(L)D MDT meetings there is no single call between two people about a single case, team members are discussing multiple cases between multiple people, and the purpose of the meetings is not to report cases of abuse (it is to assess referrals to the team, cf. p.95). An institutional interaction with a more comparable structure is emergency department MDT meetings. Seuren et al. (2019) examined the structure of emergency department MDT meetings, which are completed ad hoc as part of ward rounds. They found that team members work collaboratively towards a standard structure, which can crudely be explained as follows: opening, case introduction, case presentation, sharing additional information, developing candidate diagnosis, developing a work plan, formulating the decision and closing. Seuren et al. (2019) show there is a clear orientation of team members to add additional information regarding a client in the normative structure of the discussion. I(L)D MDT meetings may also have a structure where it is normative to add information like the potential risk of abuse, which may affect the likelihood of gaining collaborative input.

Although similarities can be drawn between emergency department MDT meetings and I(L)D MDT meetings, as they are both multidisciplinary, focused on discussing multiple clients and in a healthcare setting, there are some key differences. The focus for emergency department MDT meetings is to make a diagnosis and create a work plan, whereas many of the I(L)D MDT meetings recorded for this thesis were allocation meetings. Allocation meetings are designed for I(L)D MDTs to determine if they can accept referrals to the team to do some work, and to

revisit discussions about clients from previous meetings that the team needed further information on. Next the chapter will give a brief overview of the common structure of I(L)D MDT meetings, to provide the context of the constraints of when a team member might be able to raise a potential risk of abuse.

Community I(L)D teams' meetings are agenda led (Smart, Froomberg & Auburn, 2018). At most meetings the chair, and at times all the other members of staff, will have a list of all the clients due to be discussed in the meetings. An example of how the discussions are broadly grouped is as follows: first would be a discussion of the new referrals, followed by a discussion of cases that have been 'brought back' from a previous meeting for further updates. Then a discussion of any complex ongoing cases the team are managing, moving on to discuss safeguarding alerts (where they have had notification of formally raised cases of potential abuse). Finally they would discuss service improvements (where the team might work with a provider to address any regular issue they might have with their service), followed by any other business.

In each of these sections, a number of different clients might be discussed, and the discussion of each client follows a rough structure. The chair would first state the name of the client to be discussed. If no team member has been dealing with the client, the referral would be read to the team. If a team member has already been dealing with the referral they would self-select to begin to speak and provide some background on the client. If the team member does not self-select they would be selected by the chair. The team may then add in additional information, or ask additional information, about the client. Within this discussion there is often a course of action outlined, either in the initial update by the team member or by the end of a discussion between the team members. The chair would then move on to the next client on the agenda by stating their name. Smart, Froomberg and Auburn (2018) have further detailed the role of the agenda in MDT meetings and how teams move from one agenda point to the next, using a

range of discursive resources. Although Smart, Froomberg and Auburn. (2018) discuss the management of agenda as having implications for collaboration, the structure has not been analysed here, as it was outside the scope of the analytic focus. However, it is helpful to understand the collaborative uptake, or not, of the potential risk of abuse in I(L)D MDT meetings.

The data

This analysis focused on two MDT meetings. One meeting was 1 hour, 37 minutes, 53 seconds long, and 16 different clients were discussed. The second meeting was 2 hours, 22 minutes, 5 seconds long, and 25 different clients were discussed. Within the meetings, all the different mentions of 'concern' were analysed. The initial focus on 'concern' came from 'unmotivated looking', an underpinning concept in CA (Sacks, 1984). The recordings were initially approached with the broader, initial question of 'How do multidisciplinary teams function in I(L)D services'. Careful listening and re-listening of the recordings, led to an interest in the use of the term concern (see Chapter 4, p.109). All instances of the use of the term concern were then extracted from the recordings. If concern had been mentioned more than once in relation to a single client it was a single extract, unless the subsequent mentions of concern were not related to the initial mention of concern. This was so that the analysis could focus on how healthcare professionals were using the term concern, and what sequential impact the use had. The extracts were categorised iteratively during analysis, with consideration to the sequential organisation, the action and the content of the concern.

Concerns were discussed in relation to clients in 15 extracts. Out of the extracts, three concerns related to health risk, and 12 concerns were related to abuse risk. Out of all the clients discussed across both meetings, 29% of clients had concern mentioned in their discussions. The extracts were categorised based on the collaborative actions that they had, and have been referred to

here as openers (5 extracts) and non-openers (10 extracts). All names of people and places in the extracts are pseudonyms.

Openers

The concern extracts that are openers were designed in a way that led to collaborative input from team members to assess the likelihood of the potential risk of abuse to a client. The main feature of concern constructions labelled as openers is that they were constructed as subjective assessments, which belong to an individual. If the subjective concern constructions came at the start of the new sequence on a client team members would respond to the construction with turns designed to collaboratively unpack the concern. Below is an example of a subjective assessment, taken from Extract 1:

Extract 1: C:FE4:50.53

Sky: ↓um my concerns were that <mum is due to be> discharged from hospital

This assessment by Skye, that she has concerns related to the client's mum returning home from hospital, is part of a longer extract that is provided below. This longer extract demonstrates some key features of both the structure of how clients were discussed in these meetings and how subjective assessments were responded to by other team members. The features can be described by the following stages:

Stage One: The introduction: The clients name is provided by the chair, followed by a short description of the client and the subjective assessment of a concern

Stage Two: An extended uninterrupted telling – At this stage the team member will explain the issue in detail to the team

Stage Three: Collaborative unpacking: Other team members will respond to the presentation of a subjective assessment that uses concern with turns designed to unpack it.

Extract 1: Speaker owned concerns: C:FE4:50.53

Cha:Chair; Sky: Skye; Alf; Alfred; Joa: Joan

Cha: Luke Chatford? Skye

Sky: er:: yeah so: Luke (.) >has been discharged from hospital now he's back living at ho:me< with Findway care 24-7 although (.) um (.) Findway aren't going to be his provider for much longe:r and the reason behind it is because when social care went through their tenderng process, Findway didn't apply to be part of it °(thing to get a thing for social care to cover this)° and they're also quite expensive, apparently? and so er: the social worker and the solicitor °who was Luke's appointee for-° (.) um looked to see if Luke could you know substitute the costs but he can't it would work out too ↑expensive so that's why they're looking for a new provider: ↓**um my concerns were** that <mum is due to be> discharged from hospital and come home and they were ↑originally sharing a bedroom ↓apparently there are plans to: um move mum into lounge with the hospital bed and the hoist (and all the things) she needs for her needs so >Luke will stay in the bedroom< mum will have the lounge as her bedroom so they have (.) privacy at ni:ght and <mums needs also> needs care from a provider which mums going to pay for herself so mum's still in hospital until a provider can be found which which ( ) um so it's just a

real concerning situation, the I've done nursing need assessment and the carer reports that °you know° Luke does s:o much better when mum's not ther:e when mum's not there? when mum's not interfering with the- the care side of things they know Luke can do that Luke can do this °but° like when they try and go out >mum was saying< don't- don't leave me Luke wants to stay here with me and ↑Luke will respond to that ↓erm so (.) I- I know they have a right to family life and there's no reason why she shouldn't come home but it's just- when she comes home the impact that's going to have ↓I mean it's a tiny house (.) anyway and

Alf: can you evidence that.

Sky: sorry?

Alf: can- can anyone evidence (.) that Luke can function (.) better in isolation than in the company of mum,

Sky: we:ll

Alf: is there enough evidence to

Sky: well Findway aren't very good at doing recording that's the only thing,

Alf: and [then the]re's no point actually

Joa: [but is:]

Joa: is she going to be significantly cha:nged >↓when she comes ho:me< I mean will it still [b]e an issue?

Sky: [yeah]

Sky: she's going to fluctuating capacity

The first stage of this sequence, the introduction of the client (lines 1-13), has a specific interactional role of opening up space in the meeting for the team member to go into detail about the service user issue, without being interrupted. In Extract 1 at line 1 the Chair allocates the floor to Skye to discuss a specific service user (Luke). Skye then begins by providing background detail to the client's case. As well as orienting to a normative way to begin a new referral to the team, the background information sets the scene to make the concern relevant in the interaction. This may be similar to the work by Sikveland and Stokoe (2016) in a mediation helpline setting, which found that if the relevance of the mediation had not been established prior to the call taker suggesting a mediation path, people did not engage with suggestions of mediation. Thus, by providing these details prior to stating it is a concern, the speaker is explaining why the concern is relevant.

Prior to Skye's production of their subjective assessment, there is a floor holding 'um' on line 14. This 'um' seems to signal a transition from description to a subjective assessment, and may cue the listener that something problematic is to come (Emmison & Danby, 2007). The 'um' is then followed by 'my concerns were that' (line 14). This subjective statement seems to preface a new angle on the client's story, which might not have been obvious from the previous description Skye had provided. The previous description had focused on the issues relating to Luke's placement options based on his finances. Skye's concern construction transitions the talk to discuss issues relating to Luke's mum, and the potential risk to Luke if they live in the same place.

There are two key functions of this concern construction that will be described in turn; first it suspends turn transition, and second it acts to demonstrate subjectivity in the concern. Similar to storytelling prefaces, the concern construction seems to have the action of suspending turn transition until the telling is complete (Stivers, 2013). Stage two of this sequence, the extended telling (lines 15-35), shows this suspension in the interaction. There are points in this stage of

the extract that it would be appropriate for other team members to take a turn at talk. For example, at line 23 'which which ( )' a transition relevant place (TRP) due to a trailing off of talk and reduced tempo (Clayman, 2013) and line 31 '↑Luke will respond to that' where the pitch peak on 'Luke' projects an end of a turn construction unit, and thus a TRP (Clayman, 2013). However, there is no transition to another speaker until line 36. The transition does not happen earlier than this, as it is only by line 33 the action of telling the story can be heard as complete; it is clear at this point to recipients that Skye has finished discussing the issues as she repeats a problem already highlighted (first in lines 26+27, then in lines 33-34). The trailing off of talk and reduced tempo that occurs in this extended telling also allows for collaboration. It demonstrates a vague unworked course of action and a need for assistance with this issue of potential risk to Luke's independence through the impact of his mum's behaviour.

The second function of this concern construction is that it acts (at least initially) to show that this is a subjective assessment. Edwards and Potter (2017) discuss how subjective assessments present an attitude of a speaker that has a particular interactional function. They can avoid potential conflict, and allow for disagreement, as it presents something as a matter of opinion. Subjective assessments also can manage entitlement to assess something. This can be important for collaboration in MDTs as it orients to the need for a team to make an assessment, rather than just an individual who may not have the entitlement to be the sole assessor, and it also allows for other team members to disagree. If something is just a single professional's opinion, it is easier to challenge, than if something was presented as concrete. Thus, it can be used as a collaboration technique to provide other team members the opportunity to disagree.

Interestingly, in this extract Skye begins with a subjective assessment ('my concerns were that' line 14), and then moves to provide an upshot of the situation using an objective assessment ('it's just a real concerning situation' lines 23-24). Edwards and Potter (2017) demonstrated that fusions between objective and subjective assessments can manage the speaker's

accountability. If Skye is concerned, the concern should be accountable by the situation being concerning. Although this might dampen the opportunity for disagreement around the potential for risk, the continued use of the term 'concern' rather than 'potential risk' in the objective assessment still speaks to the undetermined nature of the potential risk, and the need for collaborative help to assess the risk.

The third stage of this sequence, the team collaborative assessment, begins at line 36 with Alf's interrogative 'can you evidence that'. Alf's interrogative shifts from the story about Luke to Skye's ability to account for their assessment through use of a second person pronoun (you). Joan joins in at line 47 with the interrogative '… I mean will it still be an issue.' These interrogative questions are unlike post story telling responses which tend to evaluate with a preference for affiliation (Stivers, 2013). Instead, the team design their questions to challenge Skye's concern, but they do not display the normal discourse markers that occur when making a non-preferred response (e.g. delays, prefaces, mitigations and accounts, Pomerantz & Heritage, 2013). For example, Alf's interrogative shows no delay and is very directive. The lack of non-preferred discourse markers, and direct questioning by the team around the concern, demonstrates an institutional orientation to collaboratively making an evidence based assessment on the potential for risk. The use of both a subjective and objective assessment opens Skye's assessment to disagreement and challenge, which the team take up. Presenting first as a subjective, opinion-based assessment ('my concerns were that') both allows for an uninterrupted telling, and opens the floor to other team members to input to the assessment.

Speaker owned concerns led to collaborative input by other member of the team to assess the potential for risk if they were positioned within the first stage of a client discussion – after the chair had said the client's name, during a team member's background presentation of the client. This happened twice in the corpus, which may seem like a small number of instances, however not every client will have a potential risk that a team member wants the team to assess. When

they did, the importance of raising it early in the client discussion is highlighted by a speaker owned concern that was raised late in a client discussion. Extract 2 is an example of a speaker owned concern that was raised ten minutes into a client discussion.

Extract 2: Late Speaker Owned Concern: SE6:1hr54

Mol: Molly; Jim: Jimmy; Kay: Kayleigh

1	Mol:	[↑**I'm a bit concerned** >as well looking at the
2		patient< profi:le (on)nearly most of the
3		geepee:s assessments are home vis↑ts (.) they
4		↑don't >seem to be< taking Tom to er appointments
5		very much so=
6	Jim:	=that geepee does go out there a lot
7	Mol:	b↑ut I'm I'm you know↓ they're- they're ↑in ↑the
8		↑middle ↑of ↓no:↑whe:re it's it's (pfft)>they
9		need to get out< really
10	Kay:	(°bet you loved it didn't ↑you°)

In Extract 2, Molly raises a subjective concern about the client regarding if the provider is taking them out the house (line 1). In comparison to speaker owned concerns in a stage one position, which are afforded the space in the meeting for an extended telling, this late speaker owned concern has an early transfer of speaker (Jim on line 6). Molly's concern is focused on the home ('they' line 3) not taking Tom out of the home. Jim's response on line 6 ('that gee pee does go out there a lot'), focuses on Molly's mention of the GP (line 3), and disregards the mention of the home ('they', line 3). On line 7, Molly's response to Jim demonstrates that their issue hasn't been heard, using a contrastive 'but' and expressing grievance with the provider through a number of pitch shifts (lines 7 and 8). Molly closes this concern using a stock phrase,

‘they need to get out really’ (lines 8 and 9). The team members respond to Molly by focusing on her subjective experience with the provider (‘I bet you loved that’ line 10), rather than the content of the concern. 40 seconds later the chair moves on to the next client. In comparison to speaker owned concerns early in the discussion, other team members do not respond to the concern construction as an opportunity to collaboratively assess the potential risk. Thus, the collaborative impact of speaker owned concerns seems to be linked to the early positioning of the concern construction in the client discussion.

Third party concern constructions also open talk in a meeting to collaborative input from the team. There were two of these in the collection, and they were characterised by a subjective assessment of a client situation by someone who was not present in the meeting. However, unlike speaker owned concern constructions that lead to an uninterrupted telling sequence, team members would collaborate in the telling of the concern. This would then be followed by team members taking turns to contribute to assessing the potential risk, similar to speaker owned concerns.

Extract 3 is an example of a third party concern construction found in the data. David is presenting a concern previously discussed by Linda who is not present at the meeting. However, unlike speaker owned concerns, interactants do not allow David to complete telling the story of the concern in an un-interrupted way. Instead, two interlocutors also become involved in telling the team about Linda’s concerns (Julie at Line 6 and Clyde at Line 10).

Extract 3: Third Party Concerns: SE5:1hr49.

Dav: David; Cly: Clyde; Jul: Julie

```
1   Dav: Linda I remember in this room we've had °integrated
2        meetings° Li:nda was sat somewhere around the:re and
3        Linda was concerned about this one because she
4        felt >everytime a provider went in< (.) they would
5        s:[abotage it,]
6   Jul:   [sabotage it] yeah
7   Dav: so it would be like maybe it was all fa- and it was also
8        weird why he was moved back home in the first place he
9        was in an autism provider down at pen-
10  Cly: and and he was really settled where he was
```

In this extract, the construction of a concern of a non-present third party gains affiliative contributions to the concern construction. David recruits other team members in lines 1 and 2, drawing on their potentially shared memory of a previous memory, ('I remember in this room we've had integrated meetings'). The consequence of this recruitment may allow other team members to also contribute to the shared memory of Linda's concerns (as per Julie's and Clyde's responses on line 6 and 10 respectively).

Presenting a concern as belonging to a third party, rather than David's own, may also work to bolster the claim of the concern (e.g. it is not just David's concern, it is another professional's). Clayman (1992) discussed how shifts in footing of an evaluation, from belonging to the speaker to belonging to another person, can help pursue neutrality in news interviews. In an I(L)D MDT meeting, it might help to persuade other team members of the veracity of the claim. However, once the concerns are collaboratively constructed with other team members, there is a lack of

affiliation. Extract 4 occurs 18 lines after Extract 3 and shows the response to the concern (in the intervening period the client's background and issues with the family are discussed).

Extract 4: Third Party Concern Continued: SE5:1hr49

```
1  Cly: -so that (0.5) he could be (David's) paid (.) carer
2       ↓didn't he so °they got the money°
3       (1.6)
4  Rob: °°I think it's: it's °° (0.3) >as I said (it's sort of)
5       there is this life events< which are going o:n behind
6       the scene
```

In Extract 4 the concern construction audibly finishes at line 2, with an upshot of the story by Clyde stating 'so they got the money', suggesting there may be a risk that the family are not providing the best care but instead are motivated by potential income. Rather than an immediate affiliative evaluation by a recipient, there is a gap in the interaction at line 3, predicating some trouble in the next turn. In the next turn, Rob at line 4, an alternative explanation is sensitively provided by Rob; that other circumstances in the service user's background may help explain their parents' behaviour. The team continue to discuss and assess if there is a potential risk for another 4 minutes.

Both speaker owned and third party concerns, construct a subjective position on the potential risk to the client. They both can lead to collaborative input from the other team members to assess the potential risk, and in third party concerns to also explain the concern. Speaker owned concerns have this impact when presented early in a client discussion. Third party concerns may not have this boundary condition: Extract 3 started almost two thirds into a client discussion (~ 8 minutes in). The practice of discussing potential risk to the client as a subjective concern thus has the potential to get collaborative input from the team to help assess the risk.

Non-openers

The non-openers in the collection will now be briefly explained. These do not work as a collaborative practice in the same way as the openers, as they do not have the action of opening up discussion in the meeting around potential risk. However, they do highlight how 'concern' is used in I(L)D MDT meetings as a synonym for potential risk.

When discussing service user issues at times team members would state that there was 'no concern' (see Extract 5). There were three examples of no concerns in the corpus.

Extract 5: No concern: SE7.1: 29.28

Sal: Sally

```
1  Sal: it seems quite safe (.) quite a positive
2       relationship and um but and I think you know s:afe
3       now also 'cus she s:tabbed him °I think was ° 1997
4       but there's been no sort of recent to our knowledge
5       (.) u:m concerns, (.) I think she hears voices
6       around hurting herself >but you know< that there
7       (is an) [issues around that
```

By stating 'there's been no ….. concerns' in relation to a specific issue, as in line 4 and 5 in Extract 5, Sally is preventing the recipients from focusing on the issue of the potential for the client to put another person at risk of harm. Although the no concern is marked by a disclaimer that is inserted to make a specific epistemic claim (that they have not been notified of a current risk, 'recent to our knowledge' line 4), it still closes the concern. There is no change in speaker at the end of the TCU on line 5 after 'concerns', and Sally transitions to discussing a health issue that the client has. Mentioning the potential concern conforms to an organisational requirement to acknowledge the potential of risk, but offsets the development of a concern construction by revising and tightening the potential problem. This is almost a step-wise entry into the problem, which can be similarly found in advice sequences provided

by healthcare visitors (Heritage & Sefi, 1992). Thus, the action of stating that this is objectively 'no concern', highlights this is not a concern for the team to collaboratively discuss and assess, moving the interaction to focus on another health issue.

In comparison to concern constructions which open up discussion to determine if a concern is a risk issue, the use of 'there's a concern' presents an issue as objective and definitive. Interactions in the team then focus on other issues related to the concern, rather than if it is a concern. Extract 6 provides an example of a definitive concern. Prior to the extract the team are discussing if a letter has been sent to query the quality of a handover.

Extract 6: Definitive concern: SE3: 16.21

Mol: Molly; Ma: Mark

1	Molly:	**there's lots of conce:rns here**
2	Mark:	yeah
3	Molly:	not lea:st that- [mum's]
4	Mark:	[mum's] ↑ye↓ah

At line 1 Molly mentions an objective concern about the client. The use of objective concern by Molly in line 1 takes a knowing epistemic stance on behalf of the team (Heritage, 2010), which invites affiliation by the team (seen by Mark in line 2; Lambertz, 2011). A lack of explanation and the immediate affiliation to this point suggests that the 'concerns' have already been discussed by the team. Rather than trying to invite discussion, it acts to formulate and summarise the case as an upshot of what has previously been discussed. As such, the team already have shared knowledge and agreement on the concern. Thus, the use of a definitive concern construction seems to prevent further interaction on whether this is a risk issue for team consideration.

Hypothetical concerns highlight the use of concern constructions to open discussion in the team meetings about the potential for risk. They are usually used in reference to whether a service user needs to be discussed in later meetings. For an example of this see Extract 7.

Extract 7: Hypothetical concern: SE1:7.17

Mar: Mark

```
1  Mar: >do you need to bring that back after you've done the
2          quomid? or will that go into< the dementi:a
3  Dee: (I don'think I'll need to bring it back)
4  Mar: okay
5  Dee: >u- unless there's anything, <concerning
6  Mar:    okay
```

Extract 7 comes at the end of a service user discussion by the team. Mark in line 1 questions whether the service user will need to be 'brought back' to a future meeting after an assessment has been completed (a 'quomid' on line 2). The question is designed to elicit a response that fits with the organisation's (here the I(L)D team) goals. To 'go in to the dementia' (line 2) means that the patient will be referred to a different team. The option for this patient to go to another team has been placed as the second option in Mar's question. There is a hierarchy of preference in either or questions (Antaki & O'Reilly, 2014), with the second option being the preferred option. Positioning the less preferable option first means that interactants have to do more work to state that as their preference. The initial answer by Dee seems to be oriented to the second option (although it is hard to hear on the recording) as she states that she shouldn't need to bring it back. However, Dee does go on to state at line 5 that bringing it back (the first option) would only be necessary if there was anything 'concerning' as a result of the assessment. This demonstrates how the use of 'concern' can be used to validate choosing the

less preferred option. The way a 'hypothetical' concern has been used by Dee also demonstrates a norm in the team that orients to concerns being a valid reason for a collaborative discussion.

In summary, concern constructions that are non-openers are not designed to start a collaborative discussion and input from the team about a potential risk to a client. They tend to be more objective constructions of a concern (e.g. there's a concern), unlike the openers. However, they show that I(L)D MDTs use the term 'concern' in relation to potential risk to a client, most often around abuse (12/15 in the collection). Safeguarding discussions were the only other time in the meetings when risk of abuse was discussed and it was termed 'risk', as the risk had already formally been raised. No concern, hypothetical concerns and definitive concern constructions also demonstrate the normative institutional practice in teams to orient to the potential risk of abuse.

Discussion: The nature of a concern

Concern constructions can at times be used as a clinical collaborative practice by I(L)D MDT members that leads to input from other team members to assess the potential risk of abuse to a client. Assessing potential risk of abuse to a client is an important clinical activity for I(L)D MDT members. As explained in the analysis, if speakers use the term 'concern' as a subjective assessment it can signal to recipients that there is a 'story' being told by the speaker, and thus recipients provide the necessary space for the full story to be told before taking a turn. However, this can be dependent on when in a discussion the concern is raised (e.g. for speaker owned concerns, they need raising early in the client discussion). Team members can then respond to the concern with interrogatives (e.g. extract 1), or with alternative assessments (e.g. extract 3). Thus, it seems the action of a concern construction is that they provide an opportunity for team members to bring an undecided issue to the MDT (at least for opening concern constructions). The I(L)D MDT can then work collaboratively to determine if this issue is an actual issue or not, using the range of professional knowledge the team members hold. This function is

demonstrated by the recipients' responses to the concern constructions focusing on whether this issue is an actual issue, rather than suggesting potential solutions to the concern.

The analysis highlighted the potential importance of when a subjective concern is raised. As detailed in this chapter's introduction (cf. p.118), previous conversation analytic research by Seuren et al. (2019) explained the structure of MDT meetings in emergency departments (EDs). Relevant here is their discussion around the beginning half of the client discussion, which starts with openers, then case presentations, then sharing information. Early concern constructions were receipted with engagement by other team members in the I(L)D meetings. This may also link to the fact that it is in a parallel position as case presentations in ED MDT meetings (Seuren et al., 2019). The next phase of an ED MDT meeting is where the case is further discussed, with professionals asking questions or adding contributions. Thus, the I(L)D teams' responses also 'fit' with what happens next in ED MDT meetings. Late speaker owned concern constructions are not oriented to in I(L)D meetings as additions, instead seem to be receipted as trying to bring a different focus, or 'story', on the case. This is problematic late in a client discussion, when the team may be orienting to progressivity in the meeting to move along to the next client on the agenda. Thus, the potential boundary condition, that speaker owned concerns must occur early in the case presentation, parallels the ED MDT meeting structure, where there are specific places for information to be presented. Although emergency departments in hospitals may have different institutional constraints and aims compared to I(L)D MDT meetings, the meeting focus on specific client cases with goals to make decisions around care is comparable to the allocation meetings analysed for this chapter.

The issues that are presented in concern constructions all relate to potential risk. Often this is with regards to the potential risk of abuse to the client. For example, in extract seven the third party concern relates to whether family members are only taking care of a service user to gain money, rather than having the service user's best interest at heart. There are three dilemmas

that healthcare professionals may have to balance when raising a potential risk. First, if it meets the threshold for state intervention to a person's personal life, which at times is a difficult decision to make. Second, I(L)D teams work in conjunction with providers and family members. If a risk is raised that ends up as unfounded, this may damage the relationship between the service and the purveyors of potential risk. Finally, at an individual level, a team member's professional judgement may be questioned if it is found that a concern is not actually a risk to a service user. When team members use a concern construction they can defer the rights of assessment of the risk to the team, rather than being the sole person accountable for the judgement. The deferral of assessment is similar to what was observed by Potter and Hepburn (2003) in their analysis of calls to a child protection helpline. Callers would use concern constructions to defer the right of assessment of the risk to the organization. Consequently, the use of concern constructions allow the individual professional to be comfortable that they have done something with a 'concern', and that the burden of this 'concern' is no longer held by them as an individual, instead it is shared with the team.

The ability for team members to share a potential risk to a service user and gain input to assess this risk is a clinical collaboration practice between I(L)D team members. One of the clinical benefits of bringing multiple professionals together in MDTs is to make joint decisions on key clinical areas, such as the potential risk of abuse. The analysis shows collaboration is not as simplistic as putting different professionals in a team; instead team members must perform actions to gain collaborative input from other team members, which can be contingent on when the actions are performed. Not only do the actions move accountability off the individual to the team, but it also ensures that decisions – even if something is a concern or not - become made through team consensus and thus become more robust decisions. This robustness comes from the different perspectives that the various team members can bring to decision making. Bringing a range of perspectives to make collaborative clinical decisions is key to I(L)D MDTs

and thus any way that professionals can capitalize on gaining this variety of perspectives, from using a concern construction for example, helps a MDT achieve this aim. Thus, concern constructions are one, of the potential many, clinical collaborative practices in I(L)D MDTs.

Reflection box 5: Concerns

When I initially began analysis, I started by listening to recordings of the MDT meetings with an 'open ear' to what seemed intriguing in the conversations. During this 'open' listening I noticed that there seemed to be an interactional pattern when the term concern was used. However, it is interesting to think about how much of an 'open ear' I had, and equally if 'unmotivated looking' is actually possible. For me, an 'open ear' meant not having any decision in mind about where I was going to focus on listening – for example I did not think I would listen specifically to the first question that team members asked about a client (although this may have been a fruitful approach to ananlysis). Although the aim is to be data led when 'open' listening, there is always going to be an element of wanting to find something of interest, and finding a phenomena that could be helpful to understand. In part, the focus on concerns may have been influenced by my own socialisation and education in psychology. In psychology, terms such as 'concern' and 'worry' are often highlighted as being telling about a situation. There are other potential clinically relevant areas that could have been looked at. These other areas may have been pursued via participant's feedback or suggestions, by for example asking participants what clinical work they do that relies on MDT interactions to gain collaborative input on a client. Equally, I could have focused on areas that were highlighted in the results of the literature review that related to tricky areas of clinical practice for teams.

Chapter 6. Relational Collaboration: Laughter in the MDT

This chapter focuses on the role of laughter in I(L)D MDTs as a relational collaborative practice. The ethnography found that I(L)D team members orient to their relationships with other team members as key to a positive work life and important 'oil' for them to work and collaborate together (cf. caring team p.98, need to get to know team p.102). In a joint analysis (cf. p.111) one of the teams reflected that humour was used in meetings to maintain and protect good working relationships. I(L)D team meetings contain potentially distressing client information, and disagreements between team members, which can be contained with humour. Humour is often drawn on as a coping mechanism in a range of settings (for paramedics, Christopher, 2015; sex workers, Sanders, 2004; managing racism, Dokis, 2011). However, humour is subjective and hard to define. Thus, to understand participants' reflections on humour, and link to collaboration, laughter was used as a tractable phenomenon to analyse what action it might have for collaboration in the relational domain.

This chapter will first demonstrate that the behavioural phenomenon of laughter has a range of potential meaning for teams' collaboration, beyond a person's mood or state. Purely relating laughter to the mood or state of an individual can overlook the collaborative action between people it may have, which is of interest from a DP/CA approach. It will go on to explain the benefit of examining the minutiae of laughter and the need for a systematic CA approach to understanding its role in collaboration The analysis section then uses some previous CA findings to understand the relational collaborative action of laughter in I(L)D MDT meetings. A tentative finding in the analysis is the role of embedded laughter, which may be an important collaborative practice to manage and maintain relationships between team members. By focusing on a small area of interaction (laughter), this chapter demonstrates the multiple and nuanced ways that I(L)D MDTs do collaboration.

Laughter and collaboration: Beyond humour

A number of broad concepts have been related to laughter in meetings and healthcare settings that are significant to collaboration. Although often not explicitly linked to collaboration, some researchers have focused on how concepts related to collaboration, such as power and hierarchy (cf. Chapter 2) can be managed with laughter. For example, Griffiths (1998) related laughter to resistance within professional hierarchies in MDT meetings. Griffiths (1998) discussed the data in terms of humour, however in their examples the team members use laughter to respond to a narrative they disagree with and to demonstrate resistance. Griffiths' findings show how laughter could be a technique that enables different professionals to collaborate across their multiple perspectives on a client, which is a key driver for MDTs. Watson and Drew (2017) related humour to exerting influence in shared decision making meetings, however the data they presented shows laughter to be key in what they describe to be influence in interactions. Equally, laughter can be used as a softener that might manage trouble in relationships, and maintain the ability of people to collaborate together. Archer, Azios and Moody (2019) draw explicitly on laughter in their analysis of practitioner-patient interactions, stating it is used to soften power imbalances. These researchers have examined the action of laughter beyond humour in meetings and healthcare settings, but they have not presented a micro-level analysis of the interactions. For example, Watson and Drew (2017) do not transcribe the laughter. As different types of laughter have been associated with different consequences (Potter & Hepburn, 2010), the importance of this micro-analysis needs consideration for understanding laughter's role in collaboration.

Microanalysis of laughter for collaboration

Microanalysis is important to understand the potential collaborative action laughter might have, so that it is clear what the laughter is in response to and what action it goes on to have. Conversation analysts developed a method of transcribing laughter, providing the tool for a

precise micro-analysis of the timing and consequence of laughter in conversation. Jefferson (1985) first developed the method for representing laughter in transcriptions of talk and this method allows its sequential placement, including any overlaps, to be represented. Jefferson (1985) argued that instead of being random and overwhelming, laughter is an interactional resource that is orderly and systematic. Transcription needs to be quite precise to capture the orderly nature of laughter and its varied production, e.g. through combining the 'h' sound with different vowels (huh/hah/heh/hih/hah), how it is interspersed in speech (goo(h)dness, Potter & Hepburn, 2010). In general for prolonged laughter breaths, there should be one 'h' to represent every beat (0.1-0.2 seconds; Hepburn & Varney, 2011), e.g. for 0.5 seconds of laughter 'hhhhh'. The precise measurement of the timing and production of laughter allows analysts to see who laughed first. The ability to analyse interactions at the detail of who laughs first, led to the discovery that often a person making a humorous statement will end with laughter to invite laughter from others, rather than laughter being initiated as a response from another speaker (Jefferson, 1981). Thus, laughter can be used to frame talk to demonstrate how a statement is meant to be interpreted, which may have a range of collaborative actions (e.g. allowing criticisms whilst maintaining relationships).

Conversation analysts have demonstrated that laughter is associated with a wide range of interactional projects that may be relevant for understanding its collaborative role in maintaining I(L)D teams' relationships. Closely related to humour, laughter has been associated with playfulness (Haakana & Sorjonen, 2011) and people entering a playframe in talk (Holt, 2016). Playful talk in MDTs may help to alleviate troubled talk and help team members get to know each other, which is important for collaboration. It also has been shown to make displays of intimacy (Jefferson, Sacks & Schegloff, 1987) and affiliation (Clayman, 1992; Ekstrom, 2009). This may help to do collaboration by demonstrating being part of a supportive team. In contrast, laughter can also be related to trouble (Jefferson, 1984; Arminen

& Halonen, 2007; Potter & Hepburn, 2010), orient to a tense situation (Ovaldsson, 2004) and manage complaints (Holt, 2012). This is important for I(L)D teams' collaboration as they are meant to bring together different opinions, whilst maintaining the ability to work together. Thus, laughter can be associated with both positive (e.g. affiliation) to negative (e.g. trouble) actions in interaction. The range of actions that laughter has demonstrates the need for a careful and systematic analysis to understand how it might relate to collaboration.

I(L)D MDT meetings are specific institutional settings for examining the collaborative role of laughter. Key features of the meetings, for example their multi party nature and agenda focus, further emphasise the need for careful analysis, as the action of laughter has been found to change based on a range of factors. Investigations have found there to be differences between solo and shared laughter (Tanaka, 2018), which is relevant for examining the collaborative role in laughter in MDTs, where there may be places in the agenda where shared laughter becomes more appropriate. Equally, there is a change in the action of laughter between multiparty vs. dyadic interactions (Glenn, 2003), so the multiparty nature of MDTs may mean that there is a specific collaborative impact of laughter. The specific collaborative action of laughter in I(L)D meetings, due to their size and multiparty nature, may differ when compared to traditional CA research which often focuses on interactions between 2-3 people.

The institutional setting of I(L)D MDTs may also impact on the collaborative role of laughter in a meeting. For example, examinations of laughter in a range of institutional settings have highlighted the specific relationship of the action of laughter to that setting, including TV debates (Ekstrom, 2009; Clayman, 1992; Clift, 2016), therapy sessions (Arminen & Halonen, 2007), telephone surveys (Lavin & Maynard, 2001) and business meetings (Markaki, Merlino, Mondado & Oloff, 2010). There is a wealth of research on doctor-patient interactions, where patients often use laughter when they are discussing a delicate or difficult issue (that potentially places blame on them) (Beach & Prickett, 2016; Zayt & Schnurr, 2011; Haakana, 2002, 2001).

Shared laughter also has a specific action for business meetings (Kanagasharju & Nikko, 2009), and laughter has a specific role for social worker assessments (Ovaldsson, 2004), classroom interactions (Petitjean & Gonzalez-Martinez, 2015) and supervision for mental health professionals (Hutchby & Dart, 2018). Thus, the specific context when laughter occurs has an implication for what collaborative action it might have.

The aim of this chapter was to understand how laughter might be a collaborative practice for managing and maintaining relationships in I(L)D MDTs (e.g. how it might fit in the relational domain, cf. p.28). Previously laughter has been associated with managing power imbalances and hierarchy, which have been regularly related to collaboration (cf. Chapter 2). A CA analysis makes it possible to begin to unpick what the collaborative actions of laughter actually are, and how it is done. The previous literature demonstrates the need to consider analysis of laughter systematically as its action can vary due to a range of factors. A systematic focus guided the analysis approach that looked at all instances of laughter in meetings to interpret them in terms of what collaborative action they might have.

The data

All instances of laughter from the meetings across the second phase of data collection were extracted, transcribed and analysed (60 extracts in total). The decision of when extracts began and ended was often dependent on the extracts themselves, but as a rough guide the extracts began a few lines prior to the laughter and ended a few lines after the laughter. During analysis, regular reference was made to the wider context of the extract in the meeting, via the orthographic transcription of the meetings and the meeting recordings. This ensured that the meaning of the extract was interpreted accurately. The extracts were categorised into collections iteratively, with consideration to the sequential placement of the laughter, and the action of the laughter in terms of collaboration. The collections often reflected similar actions that had been highlighted in the CA literature on laughter (see the first three collections on end

of turn, playfulness and troubles laughter). The final collection focuses on embedded laughter, a novel laughter analysis, and details how this type of laughter is a collaborative practice.

The sub-headings indicate the number of instances of laughter that were categorised to have a certain action in the corpus. These numbers need cautious consideration, as often laughter will not have a single action. The numbers purely provide an idea of how regularly these types of actions occurred. All names of people and places in the extracts are pseudonyms.

End of turn laugh (29 instances)

Laughter at the end of a turn of talk was common in MDT meetings and could be helpful to maintain collaborative relationships by softening criticisms and disagreements between team members. Laughter at the end of a person's turn at talk, also known as a 'post completion action modifier' (PCAM, Schegloff, 1996; Auburn & Pollock, 2013), is regularly found in a range of interactional projects. Schegloff (1996) named it PCAM, as laughter in this position retroactively modifies the action of someone's turn, post-delivery. For example, Shaw, Hepburn & Potter (2013) argue that laughter at the end of a dispreferred turn can work to soften, but not repair the turn, potentially aiding progressivity. In the extract from Raymond and Heritage (2006) below, Shaw et al. (2013) explain that the laugh at the end of Jenny's turn prevents the negative assessment of James to be interpreted as a criticism or complaint.

Shortened extract from Raymond and Heritage (2006): Rahman B.2.IV; 1.10, P2

9 Jen: Yeh James's a little divil ihhh ↑heh ↑heh

Extract 1 below is an example of a laugh at the end of the turn that prevents a rejection of an idea to be interpreted as a criticism or complaint. A primary care liaison nurse (PCN) ends their turn with laughter particles interspersed within the final word (dentist) and finishes their turn with two beats of laughter. The other participants in this extract are the chair of the meeting (Cha) and a clinical psychologist (CPY).

Extract 1: End of Turn: L15:Ref25.6.18-:39.3.94

CPy: Clinical Psychologist; PCN: Primary Care Liaison Nurse; Cha: Chair

```
1  CPy: yeah something along with (Joan) joint maybe a
2       joint visit and seeing [°how things are°
3  PCN:                        [well it might not be
4       (Joan) seen as he sees (Joan) and ↑I as the
5       people that insisted that he went to the
6       den(h)tis(h)t=
7  CPy: oh right
8  PCN: =heh heh ↑but we> we'll look at that within
9       our: within our team as to who it> who it will
10      be:
11 Cha: mmhm
```

Prior to the Primary Care Liaison Nurse's (PCN) turn, which begins in line 3, the clinical psychologist (CPy) suggests a non-present PCN visits the client under discussion (lines 1 & 2). The PCN's response is marked as dispreferred, beginning with 'well' (Pomerantz & Heritage, 2013) and continuing with an account for why that isn't a good plan. The laughter occurs at the end of this dispreferred response. Finishing their turn with laughter particles attends to the turn's delicacy in rejecting the CPy's suggestion and softens the response.

Softening a rejection with PCAM laughter is helpful in I(L)D MDT meetings, as disagreement can be done without causing friction in the conversation. Within Extract 1, after the disagreement + PCAM there is acceptance. Although there is no joint laughter, the CPy states 'oh right' (line 6) as a change of state (CoS) token (Heritage, 1985). The CoS token

demonstrates that the clinical psychologist did not have this knowledge, but accepts the new knowledge with no active disagreement. The PCAM allows this to happen delicately, and on line 8 leads to the PCN taking ownership of the issue from the CPy, transforming the issue into the nurses' jurisdiction.

I(L)D MDT meetings are designed to bring professionals from different backgrounds together, with varying ideas of the best course of action. This may lead to professionals disagreeing and rejecting each other's ideas. The use of the end of turn laugh allows for rejection to be done delicately, potentially maintaining collegiality in teams of differently graded professionals. Laughter throughout the collections often tended to do this work to maintain good working relationships.

Playframe (9 instances)

Laughter can occur when there is playfulness in interaction (defined in contrast to speakers being serious), which may also work to maintain collaborative working relationships. Building on Coates' (2007) definition of playframe in interaction, Holt (2016) used CA to examine playfulness in talk. Holt (2016) states that elements of a turn can suggest playfulness, for example exaggeration, overstatement, formal language, aggrandisement and unreal claims (cf. Holt, 2011). Interlocutors can then either play along and/or make an appropriate response (e.g. laughing). In Holt's corpus, the instigator of the playful turn would then often laugh in the third turn, whether the interlocutor had responded with an appropriate turn or not. If the interlocutor had responded appropriately, the laughter by the instigator would be aligning. However, if the interlocutor hadn't recognised the move to the playframe, the laughter by the instigator would frame their previous turn as a playful turn.

Playful talk occurred within the I(L)D MDT meetings, providing a short diversion in the talk that might do some relational work. Extract 2 below is an example. In this extract the team are discussing whether a clock shows the right time. The Clinical Psychologist (CPy) uses

exaggeration to move into a playframe at line 3 and the Chair (Cha) plays along by claiming they are able to manipulate time (an unreal claim; lines 5 and 6). Other team members also play along, for example by suggesting the Chair is behaving differently because the researcher is present (Line 8). The CPy laughs on line 11, marking the end of the playframe. The sequence of interaction here reflects Holt's (2011) findings. The team here jointly accomplish the playframe, reinforcing social solidarity between participants. After the closing laughter at line 11, the interaction returns to business, transitioning to the next client to be discussed in the meeting (line 12).

Extract 2: Playframe:L14:R25.6.18:33.55.51

CPy: Clinical Psychologist; PCN: Primary Care Liaison Nurse; CNu: Community Nurse; Cha: Chair; OTh: Occupational Therapist; BSu: Business Support.

```
1  CPy: that clocks not right is it
2  PCN: £no I w(h)as just tryin to work it out£
3  CPy: oh [you're quick today (Chair)
4  CNu:    [it's in be[tween ten and quarter past
5  Cha:               [no look at me I'm dynamic I can
6       make, [I can make              time]
7  OTh:       [it's quarter past ten already]
8  PCN: that's cus Maddie's [here
9  Cha:                     [twelve minutes past
10 PCN: he's doing it extra [fast
11 CPy:                     [p-hih heh
12 Cha: eryeah absolutely (name)
13 OTh: (BSu) did we have any information (.) around
14      (name) in terms of the best practice
15 BSu: no
16 OTh: paperwork
17 BSu: we never do to be fair
```

1

Trouble (14 instances)

Laughter is commonly used to manage trouble in conversations, whether that trouble relates to criticisms, errors in talk and talking about a troubling situation. This is equally important to maintaining collaborative relationships between I(L)D MDT members when these types of conversations are likely to occur in MDTs. Edwards (2005) has discussed how laughter can be present throughout an indirect complaint sequence (from preface to receipt). When laughter is within the complaint, Edwards (2005) argues it manages the complaint's reception. Voge (2010) expanded on this in business meeting talk, arguing that laughing when complaining crosses differences in hierarchy between the complainer and the recipient. Recipients can use laughter in an attempt to moderate a complaint, preventing any further complaining whilst maintaining relations with the complainer (Holt, 2012). Edwards (2005) also suggests that laughter can be used in complaining to manage attitude and the speaker's accountability by signalling that the item is not something that they will be moaning about, also managing recipiency.

Outside of complaints, telling a troubling story can also be managed with laughter, although it is an inappropriate response to someone discussing troubles (Jefferson, 1984). However, in institutional settings it has most often been linked to the negotiation of trouble (Hutchby & Dart, 2018; Arminen & Holonen, 2007). Laughter has also been examined in multiparty talk and is argued to manage disagreements and interactional trouble (Ovalsson, 2004). The link between laughter, trouble, criticisms and disagreements is of relevance when looking at laughter in I(L)D MDT meetings that relates to potentially troubling interactions. Laughter tends to be used in these interactions to maintain good collaborative relationships. Extract 3 is an example of laughter in MDT meetings that manages the trouble of making a statement that might be heard as a criticism.

Extract 3- Troubles - L31 Ref3.12.18-:30:59:48

Psy: Psychiatrist; Man: Manager; NA1: unknown; NA2: unknown.

Psy: I wonder whether outside this meeting maybe
     CQUAL or something we should talk about
     formalising a role so that there is: clear
     communi↑cation
Man: m:m
Psy: because I'm £missing that and I'm feeling a
     bit uncomfortable here
Man: mm
Psy: just so we know everything that is going on
     maybe it wasn't his £job but (heh)he still
     k(h)new every(h)thing that was(h) going on£
Man: >I think with (name2)< I think when (cl9) was
     admitted (name2) was there and then he went on
     leave for a week
NA1: mm
Man: so then it was ↑talking to the other two:
NA2: mm
Man: um:
Psy: °(so that's the other thing)°
Man: but we were in contact with (cl9) we were in
     constant contact with each other

In lines 1 to 3 the Psychiatrist (Psy) is suggesting to the Manager (Man, also chair) that a problem needs addressing due to a change of staffing in another team. In line 5 Man does a minimal acknowledgement, failing to take up this suggestion, allowing Psy to continue with their turn. In response, Psy explains their rationale, using a trouble narrative (that they feel 'a bit uncomfortable', lines 6-7). The laughter particles and smiley talk that occur in the Psy's talk (lines 10-11) work to soften the complaint or accusation implicit in their 'uncomfortableness', that things should be managed differently. The laughter particles works to both manage the Psy's face in being the 'complainer', and also the face of the manager who may also have ultimate responsibility in this area. The Man responds here, not with laughter, but by trying to account for why things have changed. This shows that they have receipted the Psy's turn as a problem that requires an account, for why things have changed, but the Man's turn is not marked by anything that would convey offence with what the Psy has said. This extract shows how laughter is used in troubles/complaints in MDT meetings, allowing people to raise issues and get a response, whilst maintaining good collaborative working relationships in smooth interactions with other members of the team.

So far, the analysis has focused on how laughter at the end of a turn, laughter during troubles talk and laughter during a playframe all have an action for maintaining collaborative working relationships. Laughter at the end of a turn can soften a potential rejection, maintaining collegiality between team members. Laughter in a playframe can provide a short diversion in meetings, which can be of benefit to other team members when the meetings can be around two hours long. Laughter during troubling interactions, such as making a criticism, can save the face of both the complainer and recipient, and maintain smooth interactions between team members. All of these types of laughter have been found to have similar actions in different settings in the CA literature. They also often overlap – although discussed here in terms of troubles and playframe as separate

entities, participants may move to a playframe to manage troubles telling. The next analysis collection, embedded laughter, was different to what is often discussed in CA literature, but is a potentially important way for collaboration to be displayed and reaffirmed.

Embedded Laughter (9 instances)

Following detailed analysis of laughter within I(L)D MDT meetings, some laughter particles were found and have been described here as 'embedded'. These were identified as cases when short laughter particles occurred and talk in progress continued. The laughter particles were categorised as embedded due to the following similar features: participants did not orient to these stand-alone laughter particles, and there was no associated account of the laughter. These features made it particularly difficult to understand the actions of these laughter particles. As argued by Shaw et al. (p.94, 2013), laughter is already a challenge for analysis due to its "nonpropositional and somewhat off the record nature". Embedded laughter may be considered even more challenging, as it is not directly referred to by speakers in interaction. This section elaborates on how these laughter particles have been characterised as embedded in the I(L)D MDT meetings to clarify the concept under analysis. The characteristics are compared and contrasted with other practices to explore the action of embedded laughter. Examples of embedded laughter in I(L)D MDTs are then provided and its possible action discussed.

These cases were termed 'embedded' laughter as they did not affect the progressivity of talk. The term 'embedded' was adopted from Jefferson's (1987) description of 'embedded corrections'. Jefferson explains that when 'exposed corrections' occur, someone may correct another person's talk, and the progressivity of talk is diverted to attend to the correction. In comparison, embedded corrections may function to change the ongoing talk of the person who is being

corrected; however there is no account for the mistake or correction, and the progressivity of the original talk is unaffected. Embedded laughter is similar to embedded corrections, in that it does not seem to divert the progressivity of the talk and is 'embedded' into the ongoing talk. Equally there is no account for the laughter. However, unlike embedded corrections which change the ongoing talk, we cannot see any change to the continuing talk in response to embedded laughter.

One of the difficulties of understanding the action of embedded laughter is that it does not seem to have any clear impact on the ongoing talk and is not accounted for in interaction. The CA method relies on the next turn proof procedure (Hutchby & Wooffitt, 1998), where the action of the first turn at talk is understood on the basis of the second turn at talk. Thus, although 'do you have any butter?' may grammatically be understood as an information seeking question, it is analysable as a request when the recipient states 'would you like salted or unsalted?'. As embedded laughter is not responded to in talk, we cannot be clear what action the laughter has. However, as embedded laughter does seem to come in response to a prior speaker's turn, it may mark something relevant about the information in the first speaker's turn.

The rational for describing embedded laughter as having a marking action comes in its relationship to the work of Goffman (1978) on 'response cries' and Wilkinson and Kitzinger (2006) on response tokens. Goffman (1978) argued that response cries (e.g. urg, gulp, tsk) are not just outward expressions of a speaker's inner state, but as having interactional import. Response cries were described by Goffman as short, often non-lexical utterances, like embedded laughter (which is normally one or two beats). Wilkinson and Kitzinger (2006) expanded this work to also consider the local context of when response tokens happen. In their

analysis of 'surprise tokens', which included non-lexical items such as heavy out-breaths and non-news mark 'oh's', Wilkinson and Kitzinger noted these tokens were regularly produced in response to turns that are designed to be heard as containing something surprising to the recipient. Their analysis suggests that tokens can 'mark' the prior turn, identifying something as important, and in the case of surprise tokens, achieving the performance of surprise. If embedded laughter is treated in the same way, given that it is a short token produced by an overhearing party and not the first speaker, it may be suggested that the action is similarly to 'mark' the prior speaker's talk in some way. Following Wilkinson and Kitzinger's analysis, analysing the local context of when embedded laughter happens may expose what it might be briefly marking.

A further consideration for embedded laughter is who initiates the marking action, and how it is responded to. Embedded laughter is initiated by an overhearing party in response to a prior turn at talk, with no associated account. Other participants do not comment on the embedded laughter particles. Similarities may be drawn here to what Schegloff (1996) and Shaw et al. (2013) described as PCAM's, which were discussed earlier in the chapter (cf. p.145). PCAM's are laughter particles at the end of a speaker's turn at talk, which often are not explicitly commented on by recipients and do not affect progressivity. However, as they are produced by the first speaker at the end of their turn at talk, Shaw et al. argue that they retroactively modify how the speaker's turn should be heard (e.g. to soften potential trouble in their turn). Embedded laughter is different as the laughter particles are produced by someone other than the first speaker, so instead of the laughter particle working to retroactively modify the prior talk, it seems to mark the prior speaker's turn at talk.

The action of marking a prior speaker's turn may have many functions. For example, it may be a method of acknowledging that something complex is under discussion, without diverting the meeting's talk too far from the focal topic. Next, this section will turn to some examples of embedded laughter and tentatively discuss what action it may have.

Examples of embedded laughter

Extract 4 is the first example of embedded laughter. The embedded laughter comes at line 11. Here, the discussion will describe the turns leading to the embedded laughter, draw out the characteristics of embedded laughter, and suggest what action this embedded laughter has.

Extract 4 - Embedded Laughter. L16 : Ref 25.6.18:42.06.63

OTh: Occupational therapist; PCN: Primary care liaison nurse; CPy: Clinical psychologist; CNu: Community nurse.

```
1  OTh: what what's his capacity around you know his
2       medical int [interventions
3  PCN:             [it's re:ally difficult because
4       (cl6) doesn't want anything to do with it [so
5  CPy:                                           [he
6       won't talk about it will (h)he [heh
7  PCN:                                [he won't talk>,
8       ↑when we went to talk about the dentist he said
9       (other PCN) °those° pictures make me feel sick
10      um=
11 CNu: ↑.h:nh.
12 PCN: =and he didn't want to talk about it
13 CNu: tck
```

14 PCN: and (0.5) he'll↑(0.5) he'll um he'll say if he's in pain if
15 he's in pain with a headache he'll tell staff↓ because he
16 knows the solution is parace↑tamol

At the start of extract 4 the occupational therapist (OTh) is querying a client's capacity (lines 1 and 2). The primary care liaison nurse (PCN) takes the floor to explain difficulties working with the client which impact on their ability to accurately assess their capacity. On lines 5 and 6 the clinical psychologist (CPy) aligns with the PCN's narrative, with an account to show their knowledge of the client ('he won't talk about it will he heh'). This first laughter particle at the end of CPy's turn is a PCAM. This PCAM orients to the trouble in the CPy's and PCN's accounts which means that they are not straightforwardly answering what the client's capacity is for medical interventions.

The embedded laughter comes after the next turn by the PCN. On lines 7 to 9, the PCN furthers their account and upgrades the assessment of the client's capacity using a specific example (by stating that dentist pictures reportedly make him feel sick). At line 11 the community nurse (CNu) does an embedded laugh ('↑.h:nh.', line 11). This laugh is a short laugh, sharing the first characteristic of an embedded laughter. It is not a jolly laugh, but is breathy and, similarly to PCAMs (Shaw et al., 2013), is fitted to the valence of the prior speaker's troubled account of their attempts to assess the client's capacity. Although the laugh comes at a place which might be considered a TRP (after sick), the 'um' on line 10 by the PCN works to retain the turn at talk. The laughter particles at line 11 do not affect the progressivity of the talk. Instead, the PCN continues (line 12) to explain the trouble with the client.

The action of the embedded laughter in extract 4 can be understood by looking to the prior turn at talk. On lines 7-9 the PCN constructs their stance and assessment of the client. Although the CNu's embedded laughter could be understood as a continuer due to its placement in ongoing talk, a continuer is more commonly found as 'mm'. The laughter has an action that is more than an 'mm'. Instead it seems to be marking and responding to the PCN's stance and assessment of the client. In this instance, the embedded laughter may have an affiliative action, in the same way that nodding has been highlighted as affiliative in storytelling (Stivers, 2008). Similarly to nods, it may be an affiliative marker due to the sequential proximity of the embedded laughter to when the speaker has displayed their stance. As such, using laughter particles to display affiliation to other team members' talk may be a collaborative practice that orients to the time restrictions of an I(L)D meeting due to the fact that they are short and do not distract from the agenda of the meeting.

Extract 5 is another example of embedded laughter, which is short, is not explicitly oriented to by the speaker or recipients, and does not affect the progressivity of talk. As in extract 4, this example of embedded laughter seems to mark the prior talk in an affiliative way. The embedded laughter happens on line 3 in extract 5.

Extract 5 – Embedded Laughter. L8 :Ref25.6.18:18.13.6

CPy: Clinical psychologist; PCN: Primary care liaison nurse; CNu: Community nurse; Cha: Chair

```
1  CPy: I thought it might turn out to be a bit more
2       complex when I saw the referral
3  PCN: hn(.)↑hn
4  CNu: huh
5  PCN: is she refusing t- is she another one refusing
6       to eat or drink
```

```
CPy: it was something a bit ↑it wasn't it
     straightforward dysphasia when I read it but it
     already said (SLT) [was picked  it up]
Cha:                     [no no it that that]
     says it's absolutely it's not very
     [straight=
CPy: [no
Cha: =forward but [I I agree
CPy:              [I assumed (SLT) knew something
     about  it
```

At the start of extract 5, the team are discussing a referral that has come in for a client that had been marked as non-urgent. The clinical psychologist (CPy) on the team suggests there are reasons that the label of non-urgent might not be appropriate (lines 1-2). Earlier on in the meeting the business support member of staff reported that they took the telephone call that referred this client to the team. Whilst doing observations of the team it was noted that when referrals come in, the staff member who receives the referral 'triages' it and more urgent cases are dealt with immediately, rather than discussed at a meeting (cf. p. 95). The CPy's emphasis on 'might' (line 1) works to be slightly sensitive to the fact that they are disagreeing with the administrative staff who had labelled it as non-urgent.

The embedded laughter comes in response to the CPy's suggestion that things might be a little more complex, when on line 3 the Primary Care Liaison Nurse (PCN) does two short bursts of laughter particles. Again, these laughter particles are not jolly or raucous (Shaw et al., 2013), but are produced like two nasal outbreaths with an upward change in pitch on the second particle. As in extract 4, these laughter particles match the valence of the prior speaker's turn at talk, which is negatively assessing the labelling of the referral. The community nurse (CNu) joins in with a single beat of laughter on line 4 ('huh'). Although the first laughter by the PCN is perhaps responded to

by the CNu's laughter, neither of these laughter particles are explicitly accounted for or responded to by other members of the team. As such they do not affect the progressivity of the talk.

In extract 5 the embedded laughter particles may also have an affiliative action. The placement of the embedded laughter suggests it is a responsive marker to the CPy's turn, which has provided access to the CPy's stance on the situation. Again, this marker could be affiliative, in the same way that nods can be affiliative in storytelling when they happen after the speaker provides access to their stance (Stivers, 2008). Further support that this embedded laughter is potentially affiliative can be found in the PCN's question on line 5. This question, containing a candidate answer (Pomerantz, 1988), asks if the client is refusing to eat or drink. The inclusion of a candidate answer works to demonstrate the PCN's potential familiarity with this issue. If a client is not able to eat or drink then it is clear that the case is more complicated and more urgent than it has been classed as. Therefore, this question affiliates with the CPy's stance that this may be a more complex case.

Another example of embedded laughter is in Extract 6 below, on line 13. Again, the embedded laughter is short, there is no account for the laugh, and it does not affect the progressivity of talk. However, in this example the embedded laughter may be marking trouble in the prior turn, rather than affiliation to the prior turn. In this extract, a social worker is visiting the team meeting and is looking for support from the team to help a client. The social worker has previously worked through the different areas of the team (psychology, occupational health) to see if they are able to offer assistance, and now in line 12 is asking about the Continuing Healthcare (CHC) team.

Extract 6 – Embedded laughter. L12:Ref25.6.18: 30.45.62

OTh: Occupational therapist; CPy: Clinical psychologist; SWo: Social worker; CHC: Continuing healthcare nurse; Cha: Chair.

OTh: if he's open to IAT and there's an OT need and
OT works with him and we would follow up on some
of those equipment needs but
SWo: yeah
OTh: if if he's not open then that would go through
the normal
CPY: yeah
OTh: social care channels
SWo: ↑okay
OTh: yeah
CPy: yeah
SWo: and in ↑terms of CHC then
CPy: [hu:: heh
SWo: [do you just work with] CHC assessments who are
in> are within the team=
CHC: =no
SWo: or .hh ye:ah
Cha: no you do CHC separate to
CHC: CHC is separate
SWo: mm
Cha: so
CHC: it's anyone with a learning disability

The embedded laughter happens on line 13, at the end of a turn construction unit in the SWo's talk and in response to their implied question in line 12. The embedded laughter is short. Again, it is not a jolly laugh, but has a flat prosody, and can be heard as having a negative valance. The embedded laughter here does not affect the progressivity of the talk, as the SWo's talk is ongoing with seemingly no disruption (lines 14 and 15).

The embedded laughter in extract 6 seems to mark trouble in the social worker's interactional project. The laughter is clearly coming from someone other than the intended recipient of the talk (the CHC nurse). The self-selection to laugh, along with the negative prosody of the laugh, displays a potentially negative assessment of the SWo's project to request help from another member of the team. Clift (2016) demonstrated that the self-selection to laugh can do identity work (as a co-parent), so this embedded laugh may have a similar action and mark the CPy as sharing a team identity with the CHC nurse, rather than sharing an identity with the SWo.

Embedded versus exposed laughter

This section will now turn to an example of laughter that looks like embedded laughter, but to use Jefferson's (1987) terminology, becomes 'exposed' laughter. When it becomes 'exposed' laughter the action of the laughter changes, as instead of purely 'marking' something, it creates a response from another party. This is potentially problematic, as it affects the progressivity of talk in I(L)D meetings. We join extract 7 when the team is discussing a client, and the physiotherapist (Ps2) is discussing some work they would like the senior occupational therapist (SOT) to do with the client on lines 4 and 5. In explaining the work, the physiotherapist uses a three-part list to account for changes in the client's motivation, finishing the list with a change to the football team that the client supports (lines 10-14). The laughter of interest comes at line 15.

Extract 7 - Embedded Laughter. L30 : 3.12.18:25.28.22

Ps2: Physiotherapist 2; SOT: Senior occupational therapist;

```
1  Ps2: >my letter hasn't gone out yet but the letter I've just< that
2       I've that will be going out this week I did actually mention
```

SOT: okay
PS2: a referral to yourself we were hoping to do >a
bit of a kinda like graduated<
SOT: yep
Ps2: activity plan=
SOT: yep
PS2: =with him because I think with his carer (name)
he's starting to do some bits like he's really
into Eastenders and he's started like looking at
the characters and he's just started supporting
West Ham football team I think he was a
previously a Man U supporter
SOT: °ha:[::↑heh°
PS2: [I don't know why he's changed
SOT: [it's a good move [↑huh huh
Py2: [um: [yeah but he was looking to
buy the kit so he is showing some
SOT: pockets of moti[vation
Py2: [yeah but then the rest

On line 15 the SOT softly laughs after the physiotherapist has explained that the client has changed to support West Ham football team. The short laugh comes in at a place where it is hearable that the Py2 has not quite finished accounting for the need for an activity plan, as they have yet to reach the upshot of their account (that they are showing some motivation, but still need some help, transcript not shown). Therefore, the sequential placement, along with the fact that the laughter is short and quiet, suggests it was not designed to get a response. For these reasons, the laughter has similar characteristics to embedded laughter.

However, there are two clear differences in the design and placement of this laugh, compared to the previous examples of embedded laughter. First, this laughter is more plosive than the laughter in extracts 4, 5 and 6. The plosion of the laughter may orient to something playful in the way that a change of football team has been used to account for the client's motivation. Equally, it could be orienting to something playful in the change of football team itself. Second, the laughter is sequentially placed after the PS2 has reported on a client's behaviour, rather than a request they have, or stance that they might be taking themselves. Therefore, the laugh may mark alignment and affiliation to the client's behaviour (rather than a stance the PS2 is taking).

Unlike embedded laughter, the laughter in extract 7 is responded to by other participants in the interaction. After the first beat of the SOT's laughter particles, the PS2 responds to the laugh by stating 'I don't know why he's changed' (line 16). The action of PS2's turn is ambiguous. Its placement suggests that this turn could be a request for an account of why the SOT laughed (similar to an other-initiated repair, cf. p. 73), or a request for information of why the client changed football team. The SOT responds to the PS2 by explaining that it is a 'good move' before laughing again. Although the SOT's turn in line 17 may not fully account for why they were laughing or why the client changed football team, the positive assessment of the change (as 'good', line 17), works to further affiliate with the client and their reported behaviour. On line 21, the PS2 mitigates the change in interactional focus to the client's football team, stating 'yeah but' to move the focus back to the meeting's agenda, which at that point is to assess the client's capacity and motivation.

The laugh in extract 7 disrupts the progressivity of the talk as it is attended to by a recipient. This means that despite having similar features, it does not seem to have the same action of just marking the prior talk as embedded laughter does. A key feature of embedded laughter in I(L)D team

meetings is not disrupting the progressivity of talk. This may reflect the institutional focus of these meetings, as they are time limited and agenda focused. Although the laughter in extract 7 is not the same as embedded laughter, it also is not similar to the other laughter discussed in this chapter. For example, the laughter is not a PCAM, as it is not produced by the speaker at the end of their turn at talk, it is produced by a recipient. Equally, it is not responding to trouble in the interaction. Instead, it is most similar to laughter that is seen in playframe (cf. p.146). Yet the design of the laugh, as both short and soft, suggests it is not designed for a response, which is similar to embedded laughter. Despite this design feature, the laugh initiates a new sequence of turns and interrupts the progressivity of the interaction. As such, the laughter becomes 'exposed' within the interaction.

A feature of the laughter in extract 7, which marks it as similar to embedded laughter, is that the laughter is not obviously responsive to a turn that has been designed to elicit laughter. For example, in extracts 4 and 7 the laughter comes in at the end of a TCU, but mid-way through the speakers turn, suggesting the speaker had not anticipated any response at these points. This is unlike many examples of laughter, which are often prompted by the speaker laughing, or by the speaker moving into a playframe. The next section examines how this feature may relate to the multi-party setting of I(L)D MDT meetings.

Embedded laughter and multi-party talk

The multi-party setting of I(L)D MDT meetings may be part of the reason that laughter is found in response to a turn that is not obviously designed for laughter. Clift (2016) also examined laughter particles that occur in response to a turn that was not obviously designed to elicit laughter. In some cases, they found potentially non-elicited laughter in multi-party settings could have

multiple actions and work to disaffiliate to one person, whilst at the same time affiliate to another. In Clift's extract below, Simon's laugh on line 6 disaffiliates with his daughter Emily, but affiliates with his wife Joan.

Clift (2016) extract. J(oan) and S(imon) parents of E(mily). Gaze and movement notes removed from extract.

```
1  J: [An' - (.) An' the other thing, what's happening on S-
2     unday, Simon¿
3     (0.2)
4  E: I'm working
5     (0.4)
6  S: heh heh heh heh heh heh heh heh.hhh
7  J: It's my fortieth birthday [and mother's day
8  E:                           [I tried to get it ↑off
```

As embedded laughter in the I(L)D teams is occurring in a multi-party setting, there are instances where embedded laughter may equally be having multiple actions. An example of this can be seen in extract 8, line 9 below.

Extract 8- Embedded Laughter. L22 : Ref3.12.18: 03.33.81

Py2: Psychiatrist 2; OTh: occupational therapist

```
1  Py2: she was ↑due a dental review↓ this: week or last
2       week
3  OTh: tck she's had yeah
4       [°she's had the dental review°]
5  Py2: [yeah and with     the outcome]    of that we=
6  OTh: =the outcome was all good
7       [(didn't move)
8  Py2: [a↑rh da](h)mn eh↑he
9  ???: [ar(h) ]          [eh:h huh >hahaha<     ]
```

10 Py2: [cus I was ↑really] hoping
11 that she'd need dental work
12 Py2: [(because that)]
13 ???: [(cough)]
14 Py2: would be a great opportunity
15 [t(h)o get bloods]
16 OTh: [to get every]thing done yeah

We join extract 8 as the team is discussing a client's dental review. In lines 1 and 2 the Py2's shifts the topic to the client's upcoming dental review. When the OTh states that this has already been done (lines 3 and 4), the Py2 enquires about the outcome (line 5). In response the OTh states things are 'all good' (line 6). The embedded laughter of interest (line 9) occurs at the same time as the Py2's laugh on line 8. This laugh is short, not oriented to by the other members of the team, and does not seem to impact on the progressivity of the talk. However, the laughter here ('ar(h)') has a negative valance and may be marking some problem with the OTh's response. Therefore the embedded laugh may work to disaffiliate with the OTh. At the same time, it may mark affiliation with the recipient of what has become the 'laughable', Py2. The affiliative nature of the laugh is reflected in Py2's laugh at the same time (line 8). Self-selection to laugh by someone other than the main recipient of an unintended laughable was noted by Clift (2016) and related to having this dual action of affiliation and disaffiliation. The Py2 at line 10 then accounts for the reason they were asking about the outcome of the client's dental review, which also works to account for their laughter (and potentially the other laughter on line 9).

Clift (2016) mentioned that laughter that displays affiliation can do identity work. In their example reproduced above, this idea was related to co-parenting – i.e. a laugh that disaffiliates with a child but affiliates with the other parent had the action of emphasising their co-identity as a parent. In

I(L)D MDTs the use of a laugh may also have a similar role. For example, in extract 8 the laugh at line 9 could be tentatively suggested as marking some access to the Py2's stance. Therefore, the embedded laughter in this instance might also be a way for I(L)D MDT members to mark some affiliation which may be identity based.

To summarise, embedded laughter is ambiguous for the analyst because it is not explained by the speaker or attended to by recipients. However, examining the sequential placement of the laughter suggests that it seems to mark something relevant in the prior speaker's talk. In some examples shown, embedded laughter seems to have an affiliative action. Therefore, embedded laughter might be important for I(L)D MDT members to display and affirm collaborative working relationships with other team members. I(L)D MDT teams are under time constraints in large team meetings with multiple clients to discuss. The minimal nature of embedded laughter, and the lack of response to it by other team members, may orient to the time restrictions in MDT meetings. Collaborative working relationships within the team will be flexible and managed locally within talk. Embedded laughter may help manage these relationships within talk, whilst orienting to the institutional requirements of the meeting. MDT members constructing positive working relationships is relevant to their ability to work well and collaborate together towards shared goals of client care (cf. p. 100).

Discussion

Laughter can be used as a relational collaborative practice by I(L)D teams and has a range of different actions in meeting talk. The analysis of laughter in MDTs has demonstrated its role in relational aspects of collaborative working. For example, when laughter is used during trouble, where criticisms are made or mistakes are highlighted, laughter manages face between team members, maintaining collegiality and enabling continued smooth interactions. Laughter is also

found during light relief when the team move (briefly) into a playframe. Demonstrating engagement with moments of 'play' in talk through a laugh might be important during long meetings to give other members of the team a short break. Embedded laughter could be a minimal way to mark talk, display affiliation and maintain a collaborative working relationship. In sum, although often short and unobtrusive in interaction, laughter can be an important way that I(L)D MDT members perform relational aspects of collaborative working.

The knowledge about the teams gained from the ethnography was key to understanding the collaborative role that laughter may have for I(L)D team members' working relationships. Understanding which team members the embedded laughter may be affiliating with, and why laughter might have occurred, was partially informed from understanding gained in the ethnography. This was particularly important for embedded laughter as it is often not oriented to by other team members. The analysis of embedded laughter shows the benefit of combining CA with ethnography, as it may be hard to suggest embedded laughter's function without this information. Using knowledge about the participants is comparable to Clift's (2016) analysis which relied on knowing who are the parents and who are the children, to understand the affiliative action of the laughter. I(L)D services are a specialist setting, so gaining background on how the team work and applying it to the analysis, is key to understanding the collaborative function.

Each of the actions laughter achieves can be linked to the wider issues of collaboration in I(L)D MDTs. Laughter is a delicate way to deal with trouble and mistakes/criticisms, which may save face and maintain collegiate relationships. Junior staff in healthcare MDTs often find it hard to communicate openly for fear of making mistakes, which may lead to valuable information about clients being withheld (Sutcliffe, Lewton & Rosenthal, 2004; Williams et al., 2007). Laughter therefore can be helpful to manage mistakes, negotiating hierarchy and power which is a relational

construct highlighted in Chapter 2's literature review on collaboration (cf. Pratto, 2015). Epistemic order (speakers' rights and access to knowledge) is something that is constructed in the moment through speakers' interactional projects, so laughter can help maintain collegiate relationships in negotiating epistemics and preserves smooth interactions between team members. The analysis of laughter and its link to managing trouble provides a new way of understanding the relational practice of collaboration. Instead of viewing power and hierarchies as barriers to collaboration (cf. Chapter 2), team members can use laughter as a collaborative practice to negotiate power/hierarchy and maintain working relationships.

Moving into a playframe demonstrates a collaborative practice that can provide a 'light' break in meetings, which team members experienced as important to their working relationship (cf. joint analysis p.110). Humour and light relief can be important in I(L)D MDT meetings when managing stressful and difficult situations. Burnout is common in healthcare services in the UK (Aikmann, 2018), with 40% of staff reporting feeling unwell due to stress (NHS, 2017). Therefore, it is important for team members to support each other's wellbeing. Wanzer, Booth-Butterfield & Booth-Butterfield (2006) found that nurses who reported using humour as a coping strategy had a higher job satisfaction score and greater perceived self-coping. Although Wanzer et al. (2006) looked at individual self-report, the ability for team members to introduce a playframe and use laughter is a relational collaborative practice that may support their fellow team members to cope in stressful situations.

Demonstrating affiliation through laughter allows team members to display and maintain a collaborative working relationship. Policy documents (e.g. NHS England, 2014) regularly emphasise that healthcare professionals should work as part of a team to provide the best care for clients. Laughter might be one way for professionals to demonstrate in the moment that they are

part of the same team that work collaboratively together. Furthermore, as well having benefits for clients, strong team relationships also protect professionals from burnout, which means that they will say engaged and be efficacious (Abu-Bader, 2000).

Whilst laughter may display a collaborative working relationship and affiliate to other team members, the analysis highlighted that doing this display may also work to disaffiliate with certain people or groups. This is an important caveat for the relational collaborative action of laughter. As Glenn (2003) argued "Be aware of the ecology of laughter. … Be aware that each time you laugh at the expense of another person or group, you may be contributing in some way to perpetuating a system of domination" (p.170). Although embedded laughter is perhaps not laughing at the expense of another person or group, it may exclude some team members from being included in the display of a collaborative working relationship, for example if they do not understand the reason for the embedded laughter and others do. Although beyond the scope of the current chapter which began investigation into this type of analysis, one future way to investigate this might be to focus on embedded laughter only, and see if it has consequences for who remains engaged in the meeting's interaction.

Systematically looking at instance of laughter in I(L)D MDTs has demonstrated how it can be a collaborative practice and do relational work for team members. Additionally, laughter is a minimal action which tends to not distract from the progressivity of talk, important for the agenda focus of I(L)D MDT meetings. This chapter shows that taking an inductive discursive approach to understanding a feature that participants find important (humour), we can begin to see the multiple and nuanced collaborative practices of healthcare professionals. Thus, rather than collaboration being the end result of lots of inputs into a I(L)D team (cf. Chapter 2), it is something that team members regularly do and orient to. Relational collaboration, which focuses on the ways

participants foster good working relationships, is an important domain for healthcare professionals. Thus, this analysis can help I(L)D members understand how they do relational collaboration, which may be useful for their working practice.

Reflection box 6: Laughter in the MDT

I chose to focus on laughter due to a joint analysis session where team members said humour was important to their collaborative practice. Focusing on what the participants thought was of interest seemed important. I thought it was important as it overcame some worries I held about the 'researcher' vs. the 'researched' where I as a 'researcher' imposed a focus of analysis that the teams did not see as important. However, there is a tension I think in being participant led, when approaching research from a CA/DP/ethnographic perspective. The aim is to understand the normal, by seeing it as curious. If team members are leaning on their normative sense-making frameworks, what is meant by humour? Would what they mean as humour be the same as what I meant? This tension was resolved through discussions with my supervision team, where we focused on laughter, rather than trying to define what humour is. However, there is a danger here that I have still taken the role of a 'researcher' imposing analytic foci that makes sense to the perspective this thesis has taken. My own agenda was to complete a coherent thesis. Equally I think this tension between what is seen as important by participants and researchers may often be present, as even when both parties are interested the same thing, the way they understand a phenomenon may be through different lenses. The clearest way to resolve these tensions is to try to explain the reasons for making the decisions in the research process.

Through examination of the thesis and subsequent reflection I have changed elements of the embedded laughter analysis section. I had originally thought that this was related to inexplicit displays of understanding. Unfortunately, this was very difficult to demonstrate in the write up and due to the methods of CA, which fundamentally rely on the next turn proof procedure. Embedded practices that are not attended to, are difficult to demonstrate by the next turn proof procedure. Perhaps if there was a bigger corpus, or accompanying video recordings, this could have been further unpicked. I was quite attached to this analysis, and possibly was

influenced by noticing it as a cultural ‘member’ where I can understand the action it may have had, but could not ground it sufficiently in CA. This is an interesting point to consider when thinking about the things we may attend to in CA, as we are always going to be members that also use language and may understand an utterance as doing something colloquially, without it being ever present in analysis. I am grateful to have had a chance to reflect and amend this section.

Chapter 7. Organisational collaboration: Orienting to job role in the MDT

This chapter addresses a core organisational concern of collaboration in MDTs: how individuals with different professional backgrounds collaboratively decide courses of action and allocate tasks. In comparison to other teams, it is a core concern for I(L)D MDTs because there are multiple professional identities in a team that team members might orient to when allocating tasks, as well as their team and individual identities. Therefore individual team members may orient to their professional identity, above their team identity, in situations that emphasise differences, such as in I(L)D MDTs where their individual expertise is key. It is likely to be especially evident in meetings where a challenge for these teams is to decide, out of the multiple professionals in the team, who *can* do a piece of work as well as who *should* do a piece of work. The collaborative negotiation of what should be done for a client and by which team member is explored in the findings of this chapter, with a focus on orientation to professional identity and jurisdiction. The introduction will provide the background importance of identity for collaborative teamwork in I(L)D services, a concept drawn on as a barrier to collaboration in research that was included in Chapter 2's literature review. It will define professional identity and describe the historical development of professional identities in healthcare, as the basis for understanding what professionals can do. It provides a brief review of the healthcare literature on the impact of professional identity on collaborative working, and how identity has been argued to be helpful or restrictive for collaborative working. Understanding what professionals should do, based on their identity, is discussed in terms of professional jurisdiction. The key issue with the previous research on professional jurisdiction and identity is that it has not explained *how* these concepts impact collaboration. CA provides a way to examine how they impact collaboration in the moment. The introduction finishes on an explanation of how the CA concepts of deontics and epistemics are helpful for

understanding the impact of professional identity and jurisdiction on collaborative working, before moving through the analysis.

Professional identity and jurisdiction in healthcare collaboration

Professional identity is defined by which profession a healthcare worker affiliates to, based on their training and socialisation. Healthcare professions have a history of creating, maintaining and establishing themselves into recognised occupations (see Chapter 1 for further details on the development of professional identities). For example, medical doctors established their profession over several campaigns to create laws that protect their status as the only people who can provide certain services, which were previously diffused to different professions (e.g. barbers as surgeons, Ehrenrich & English, 1972). The creation of separate professional bodies for different healthcare professions that are regulated by law, clearly defines which professions can do certain tasks. For example psychiatrists are able to prescribe medication treatment to clients, whereas clinical psychologists are only able to provide psychotherapeutic treatment. This developmental history impacts collaborative working in an MDT as task territories that healthcare professionals can work within have already been defined. Thus, when allocating work in I(L)D MDTs there are predefined tasks that professions can do, and these tasks may get owned and defended by professionals. The result for I(L)D MDTs is that not all members of the team can complete certain tasks.

Professional identity is a factor that has been argued as both helpful and restrictive to team collaboration in healthcare. Interview studies of healthcare professionals have stressed that clear professional identities are helpful for MDT working (Pullon, 2008; Stewart, Betts, Chee & Ingamells, 2015; Stewart, Crozier & Wheeler, 2016). Pullon (2008) argued professional identity encompasses more than just professional role (e.g. task) but also a professional conduct (e.g. behaviour). Developing a clear professional identity (alongside clear professional roles) has been found important for teamwork in MDT support for student mental health (Stewart et

al., 2015), as well as for healthcare students working in MDTs (Stewart, Crozier & Wheeler, 2016). All these studies have been based on interviews, reflecting participants' views, which omit an explanation of how professional identities are helpful for collaboration.

Professional identity has also been argued to be a restrictive factor to collaboration. Leach & Hall (2011) argue, based on interviews, that professional identity is restrictive to collaboration; however, they do not explain why it is restrictive. Miller (2004) provides more detail, correlating strong professional identities in nurse participants, with a negative perception of how nurses think other professionals view them and poor ratings on collaboration measures. Caraciti et al. (2015) provided a more nuanced view on how identity impacts collaboration. They compared team and professional identity, in both nurses and doctors. Professional identity was more problematic for doctors than nurses, as nurses were argued to think 'good collaborator' is a behaviour that is part of their professional identity. In summary, although there is contrasting evidence on the impact of professional identity on collaboration, which suggests it is not exclusively a positive or negative factor, researchers are yet to explain how professional identity becomes positive or negative for collaboration.

Organisational and social theories may go some way to understand both views on how professional identities impact on collaboration. Caraciti et al.'s (2015) paper reflects organisational theory on teamwork, such as Salas, Rosen and Cooke's (2008) theory that suggests team members have to work to both individual and team-based tasks, so nurses may orient to team tasks, whereas doctors may not. Social Identity Theory (SIT; Tajfel & Turner, 1979) adds the role of identity to understanding professionals' behaviour. For example, Lloyd, Schneider, Scales, Bailey & Jones (2011) completed ethnographic observations of healthcare assistants (HCA) in dementia MDTs. They found that a strong commitment to the HCA group identity linked to limited communication with other professionals and lost opportunities to work with the wider team (Lloyd et al., 2011). The authors explain the findings are likely

context specific, as the low social status of HCA in dementia MDTs emphasises their group identity (cf. SIT). The limited generalisability of Lloyd et al.'s (2011) study and the previous conflicting findings on the impact of professional identity, suggests there is a limit to focusing on rules to explain/predict professionals' collaboration based on identity. A more useful focus is exploring how identity is enacted between professionals to achieve certain aims, such as deciding who should do what task.

Determining who should do what task, above who can do what task, moves from professional identity towards professional jurisdiction. Professional identity categorises what work is relevant to which professional, and their jurisdiction is defined here by what authority they might have to make decisions about care. Jurisdiction is implicitly understood in teams, and breeches in jurisdiction may be the underlying reason that professional identity is attributed for difficulties in teamwork. Problems establishing MDTs have been related to concerns about breeching jurisdiction (Kvarnstrom, 2008). Healthcare professionals have reported that experiencing threats to professional jurisdiction have led to conflicts in MDTs (Cain, Frazer & Kilaberia, 2019). Medical doctors in both educational and clinical settings struggle with threats to their jurisdiction (e.g. challenges to their decision making authority) when working with nurses and midwives (Bradley, Cooper & Duncan, 2009; Hunter & Segrott, 2014). The concept of professional jurisdiction is similar to the concept of psychological contracts. Psychological contracts are the implicit expectations people have of the organisation that employs them. Similarly, professional jurisdiction is the implicit understanding between team members of who has authority over certain areas of work. Breeches for both are expected to have a negative impact for collaboration. An exploration of psychological contracts in medical settings found that strongly identifying with your profession attenuates the impact of a breech, more so than a strong identification to the organisation (Deng et al., 2018). A breech in professional jurisdiction may be another team member trying to make decisions in someone else's area of

work. Based on Deng et al. (2018), it could be proposed that strong identification with the team or organisation may attenuate a breech in professional jurisdiction. However, how potential breeches to jurisdiction can be seen and managed in collaborative working has not been explored.

CA, Professional Jurisdiction and Identity, and Collaboration

CA can be applied to understanding, in the moment, how professional identity and professional jurisdiction are negotiated in interaction as a collaborative practice. The general benefit of conversation analysis, and examining talk between professionals whilst they are collaborating, is explained in Chapter 3. Here, two key CA concepts are explained as they are particularly relevant for understanding the impact of who *can* do something and who *should* do something in conversation. These two concepts are epistemics and deontics (cf. p.73).

There are three main areas of epistemics that help reveal professional identity and the negotiation of professional jurisdiction in interaction. First, epistemics relates to the knowledge claims that people make in conversation. The claims can relate to a range of different domains, including the professional knowledge domain. A person's professional knowledge is defined by their professional identity, so talk that makes professional knowledge claims draws on an individual's professional identity. Second, a claim to knowledge is also a display of authority over that knowledge. It is vulnerable to challenge as it is achieved in interaction (Mondada, 2013). Therefore, a professional's authority over their profession related knowledge must be achieved in interaction. The third area relates to epistemic stance and status. A person's status relates to the positioning of their right to know relative to others. In a team people may be knowing (K+) or not knowing (K-) in relation to certain domains of knowledge (Heritage, 2012). Epistemic stance is the display of epistemic status in turns at talk and conversational actions. Incongruent positioning of stance, compared to status, can be used to negotiate and change epistemic status. Thus, in I(L)D MDTs, different professionals can manipulate their

status in turns at talk to achieve aims, such as emphasising their professional authority above other team members based on their professional identity. A key point here for understanding collaboration is that their professional identity must be made locally relevant in interaction, rather than imposed by the researcher as important a-priori (Mondada, 2013).

CA research has tended to focus on understanding epistemic displays in contexts where there is a clear a-priori understanding of authority. For example, in guided tours between the guide and the guided (Mondada, 2013), and healthcare interactions between the patient and doctor (Lindstrom & Weatherall, 2015; Maynard & Heritage, 2005). Using the common sense understanding of the power hierarchy as a framework to the interactions has provided understanding of how epistemic authority is achieved. Team based explorations of epistemics in a multiparty setting have been related to professional identity, as displays of epistemic access to certain information were found often to be role based (Wahlin-Jacobsen & Abilgaard, 2019). However, Wahlin-Jacobsen and Abilgaard's (2019) study involved a traditional team with a clear manager-employee hierarchy. I(L)D MDTs tend to have a clear overall manager/chair of meetings, but the hierarchy between the rest of the team members is not always overt. The understanding of epistemics from research with a clear notion of hierarchical structures can be applied to the ambiguous hierarchies within I(L)D MDTs, demonstrating how professional identity can be used in interaction as a practice for collaborative working to assert, or gain, epistemic authority on who can do a piece of work.

Alongside who can do a piece of work, this chapter is interested in how professionals might need to assert or defend their professional jurisdiction to determine who should do a piece of work. Deontics is a CA concept that can be applied to interaction to help unpick jurisdiction, as it relates to who has the right to determine future actions (Stevanovic, 2013). Stevanovic & Perakyla (2012) state that deontic rights and responsibilities define what should or should not be done. Thus, professionals can draw on not only what they can do, but also what they should

do – e.g. two professionals could do the same assessment, but who should do it is what may be negotiated in meetings. Deontics is seen in interaction through how participants design talk about their own and others' actions, events and decisions- often exerting power and authority (Stevanovic & Svennivig, 2015). Deontic authority is often paralleled to epistemics, with deontic claims, deontic status and deontic stance all being drawn on as concepts to explain how turns at talk are sequentially understood (Stevanovic & Svennivig, 2015). Like epistemics, who has deontic authority is not predetermined, and professional based jurisdiction must be made locally relevant in interaction.

Akin to epistemics, most CA studies that have drawn on the concept of deontic authority are situated in fields where there might be a clear hierarchy of moral authority. For example, between a pastor and a cantor (Stevanovic & Perakyla, 2012) and doctors and patients (Kawashima, 2017). The overlap between deontics and epistemics results in many studies assessing both at the same time, as can be seen in the workplace study by Wahlin-Jacobsen and Abilgaard (2019) and again in medical interactions (Lindstrom & Weatherall, 2015). Differences between the two domains have been suggested evident in talk by the use of 'I think' (epistemics) versus 'we should' (deontics), and participants' overt deference to a speaker's decision by Lindstrom & Weatherall (2015). Examining how people orient to both domains in talk allows analysts to understand how people achieve making decisions. The knowledge gained from studies in situations with overt power structures and knowledge asymmetries may help to understand how professional jurisdiction is negotiated and claimed as a collaborative practice for I(L)D MDTs, where it is not always clear in advance who might hold the jurisdiction.

This chapter focuses on the negotiation of future courses of action and task allocation to understand collaboration as a practice between different professionals. Thus, this chapter focuses on the organisational domain. Drawing on the concepts of deontics and epistemics, the

findings show how professional identity is used and jurisdiction is drawn upon in these negotiations.

The data

All the team meetings recorded in phase two of the data collection were examined for this analysis. These meetings contained discussions of over 140 clients. Most of the meetings were allocation meetings, where discussion is around referrals into the team. Two of the meetings were not referrals; one was a supervision meeting for a programme Team B were delivering, and one was an in depth discussion of a single complex client case (Team C). The team meetings were examined for moments where there was resistance and disagreement between team members around a proposed future course of action and/or task allocation. Determining who should do what was raised as a delicate issue for the teams (cf. p.102). Determining what happens next and who will do the task, is a core organisational activity that I(L)D MDTs have to collaborate on. Overall, after repeated listening, 22 extracts were analysed that fit this criteria. The extracts were categorised into two collections iteratively with reference to their sequential organisation, as well as the content and the action of the talk in the extracts. The extracts were started around the point in the meeting that a proposal or task allocation had been made and ended when talk moved on. All names of people and places in the extracts are pseudonyms.

Deontics and epistemics are a regular part of everyday talk that clearly link to both professional identity and jurisdiction. They are likely apparent in most I(L)D meeting talk, particularly as a focus of these meetings is to provide updates of information about clients (that will, for example, draw on their epistemic knowledge of the client) and to make decisions on task allocation (that will, for example, draw on a person's authority to make future proposals). The analytic decision here was to draw on extracts where there is resistance to proposed courses of action or task allocation, to see if and how epistemics and deontics are used by professionals

in these moments. If professionals were to listen back to these extracts, they may hear some points of friction in the interactions. Thus, it may be helpful for healthcare professionals to understand the collaboration practices in these moments, where things might be more difficult than smoother interactions.

The analysis that follows relies on epistemic constructs discussed in Chapter 3 (cf. p.73) and the notion presented by Stevanovic (2018) of a deontic gradient in talk. Stevanovic discusses two areas of deontic gradient; asking others to do something and determining your own right to do things. These two areas clearly map on to task allocation, and professional jurisdiction in I(L)D MDTs. Table 6 is a reproduction of Stevanovic's examples of deontic gradient in these domains, which show strong vs. weak claims.

Table 6.

Deontic gradient (Reproduced from Stevanovic, 2018)

Deontic Gradient	Asking others to do something	Determining the right to do your own thing
STRONG	Shut up	I'll submit my dissertation now
	Would you please be quiet?	Do you think I could submit my dissertation now?
WEAK	I'm sorry, I can't hear the weather report.	When do you think I could submit my dissertation?

Table 6 shows that in terms of task allocation, when you may be asking someone to do something, strong claims are designed in a blunt manner to be receipted with acceptance. In contrast, weak claims are mitigated and provide room for recipients to not take up the directive within the speaker's turn. When proposing future actions, strong claims are declarative and weaker claims are designed to be more contingent on the recipient. Understanding the strength of a deontic claim is contingent on the context (Stevanovic, 2018). The issue in I(L)D MDTs is that it may not always be obvious who has the authority over decisions– the individual professional has to negotiate with other professionals, who could orient to their own or the

team's authority to make decisions. This is important for collaboration in I(L)D MDTs so that decisions about future courses of action are made, which orient to the organisational purpose of the meeting. The following analysis show the impact of strong and weak deontic claims, and how these are used differently dependent on whether the aim is to claim ownership over the right to determine future actions, or to tell other people what to do. In both analyses, consideration is given to the impact of the deontic claims design and the use of claims to knowledge (epistemics). Strong deontic claim designs may maintain the progressivity of talk – key in lengthy meetings that need to discuss a number of clients. However, the weaker claims may work to maintain collegiate relationships (cf. Chapter 6).

Resistance to proposed course of action: Orientation to your professional jurisdiction

Professionals need to be able to say no to other team members' propositions. Saying no is one way they can retain autonomy and a way that they can reach an agreed consensus on a decision- an important way teams collaborate to meet the organisational aims of a meeting. When other team members make propositions that relate to their own professional role, and what they should do, team members follow a pattern to say no to and resist the proposition. The pattern was identified in ten of the extracts. The following steps describe the pattern:

1. Take the next turn at talk
2. Separate yourself from the team
3. Propose a future role-relevant task
4. [Use listing]

Step four has been put into brackets as this tactic seems to be used when there is not acceptance of the attempt to say no after step 3.

Both deontics and epistemics are used in these steps to say no. Clear claims to the right to say no and propose a future action demonstrates a high deontic status. The more knowledge about the area (epistemics) that is drawn on to support the deontic claim, weakens the deontic authority and provides an opportunity for resistance from other team members (reflecting findings by Stevanovic & Perakyla, 2012). Here four extracts (of the 10 that demonstrate this pattern) will be used to illustrate the pattern to say no, starting with a very clear example when saying no is accepted in the team early in the interaction, leading to extracts where the acceptance of someone saying no takes more turns in interaction (and therefore more time). There is a preference for early acceptance, to allow the conversation to continue, which is important to MDTs when there are many clients to discuss and limited time available. Extract 1 below demonstrates a clear acceptance of a strong claim to deontic authority by an occupational therapist, who proposes more work needs to be done with a client's carers. This claim to authority comes after a turn in which another member of the team (the community nurse) proposes there is no need for further work with the family.

Extract 1: Saying no: PB- TC- E19

CN3: Community nurse; OTh: Occupational Therapist

```
1  CN3: yeah: [I ↑went through the]
2  ???:       [(missed)          ]
3  CN3: communication profile with mum a:nd .hh (name)
4  ???: [mmm]
5  CN3: [and] everybody's happy with it↑
6  OTh: okay↓ thank you so much I'll I'll I'll still want
7       to do some sort of: f::eedback with the team I
8       think but >thank you for doing that<
9  Psy: don't the safeguard the social care need to come
10      up with a plan:
```

Prior to this extract the community nurse (CN3) has been providing the team with a client update. In response to the occupational therapist (OTh) making a general comment on the

situation (not shown), the CN3 provides feedback on a communication profile (see line 1 and 3). The CN3 completes their turn, making a declarative knowing statement stating 'everybody is happy' (line 5; Heritage, 2012). The CN3's statement suggests no further work is needed, with the claim that 'everybody' is okay with the explanation of the assessment. Although the statement itself on line 5 is structured as an assertion, the upward intonation at the end of the turn brings an element of questioning, lowering the CN3's deontic claim in this area. The OTh's response features three of the four steps to saying no, orienting to their professional jurisdiction and high levels of deontic rights to achieve acceptance of their no. First, they take the next turn at talk, which highlights the relevance of an occupational therapist taking a turn. The CN3's turn makes the OTh's professional role relevant, as they are making a comment regarding the 'communication profile'. In addition, there are also two instances of thanking (line 6 and line 8) in the OTh's turn, which draws on the OTh's deontic authority to thank other members of staff in relation to communication profiles, because communication profiles are within their professional jurisdiction. Secondly, on line 6 the 'I'll' separates the OTh from the rest of the team, emphasising that they are speaking as an OT, rather than a team member. Finally, the OTh proposes a role relevant task on lines 6 and 7, stating they will do some feedback with the team. This proposal is declarative ('I'll still want to do some feedback with the team'), and does not require approval by other team members (Stevanovic, 2018). These three steps are successful as there is no opposition received in the conversation – instead acceptance is shown by the conversation moving into a different area (line 9).

Extract 1 demonstrates an early acceptance of a claim to deontic authority, as the OTh draws on their professional jurisdiction, making clear deontic claims in the conversation with little resistance, and there is quick resolution to the discussion, with conversation moving on in line 9. Extract 2 is another example of an accepted claim to deontic authority using the three steps

to saying no. In this extract an occupational therapist (OTh) is suggesting that they complete some standardised mental health assessments on a client, but the consultant psychiatrist (CPs) says no to this suggestion.

Extract 2: Saying no: PB-TA-E12

(OTh: occupational therapist, Cha: Chair/manager, CPs: Consultant psychiatrist)

OTh: >↑what ↑are ↑the ↑assess↓ments on the mental
health pa- pathway as part of the initi:al
Cha: (.) s:o kinda [things like]
OTh: [°assessment°]
Cha: mini PASAD [or]
OTh: [yeah]
Cha: Glasgow anxiety scale or the
[Glasgow depression scale]
OTh: [sounds like it would be really helpf-]
(.)
Cha: [it might be worth]
OTh: [doing those] as an initial.
CPs: I think I'll go and see her actually and go from
th:ere (.) and the problem with all the: (.) with
all the the the: um (tck) things like MDRAS and
everything else is that it's a very blunt to:ol
°er particularly° if you've got somebody who
potentially has got things like borderline PD
thrown [in]
OTh: [mm]
CPs: for good measure
OTh: yeah
CPs: they're really <not that helpful> I'd ra:ther go
and see her clinically and ↑then go from ↑there=
CN3: =I think she's had a lot of changes in her (.)
review

From lines 1 to 12 the OTh and chair (Cha) are discussing the different tools that could be used to assess the client. At line 13, the CPs begins to claim deontic authority in this domain using the three steps. They take the next turn at talk (step 1), separate themselves from the rest of the team ('I'll', step 2), and then suggest a role relevant future action ('go and see her actually' step 3). The statement is declarative, which may suggest a strong deontic claim. However, there is no immediate affiliation to this initial deontic claim, as no other team member begins to speak at the first pause in line 14. This is likely because the CPs begins their turn from a low deontic stance, using 'I think' on line 13 (Stevanovic, 2017), which mitigates their proposal for a different course of action (which if from a high deontic stance would not be present). The CPs then moves to use epistemic authority, providing their professional knowledge about why the assessments are not adequate (lines 14-18). A stronger deontic claim using the 3 steps is made by the CPs on lines 22 and 23('I'd rather go and see her clinically and go from there') that is strong as it is not contingent on recipients (Stevanovic, 2017). The strength of the declarative claim is accepted by the team, with the community nurse moving the conversation on, providing further information on the client. Extract 2 demonstrates that it helps to make a strong deontic claim, designing turns from a high deontic status, for it to be accepted by the team.

Extract 3 demonstrates another use of the three steps to resisting an idea which may affect the proposed course of action. In this extract, a speech and language therapist (SLT) and nurse practitioner (NPr) are discussing the client's stammer. The two professionals are discussing if the client has a stammer, drawing on different epistemic domains, the NPr drawing on their knowledge from experience of working with the client, and the SLT drawing on their professional knowledge of stammers. The three steps come at the end of the extract and the speech and language therapist's turns are designed to assert their deontic rights to provide resolution in the conversation.

Extract 3: Saying no: PB-TA-E7

SLT: speech and language therapist, NPr: Nurse practitioner, OTh: Occupational therapist, Cha: Chair/manager

SLT: he's also got a bit of a s:tammer which could be linked to his dyspraxia
NPr: no I ↑didn't notice the stammer
SLT: he
NPr: [at all]
SLT: [he did have] when he was telling me
NPr: yeah
SLT: he told me that he stutters a bit and as he did he was stuttering hih if you see what [it was quite interesting]
???: [awwww]
OTh: [(it's often the hardest)]
SLT: [but he ↑answered the phone] unlike any other stutterer I know he actually picked the
???: (lots of overlap)
SLT: phone up and answered it so
NPr: yeah but [I didn't notice that at all so]
SLT: [I mean it's v:: it's perfectly] functional he's able to
NPr: .hhh yeah
SLT: have a conversation with m
Cha: okay [so
SLT: [↑I'll go meet him next week
Cha: okay
SLT: and um bring that back
Cha: okay >okay (SLT) bring that back<

The disagreement based on epistemic authority begins at line 1, when the SLT states the client has a stammer, possibly linked to dyspraxia (line 2). The SLT produces the turn without hesitation, claiming the epistemic authority to diagnose the client as someone who has a stammer. The NPr immediately disagrees with the diagnosis (line 3), with no hesitation. The NPr is claiming high epistemic (K+) authority from their experience of working with the client. The NPr's experience contrasts with the SLT's professional knowledge. On line 4 the SLT begins to resist the NPr's assessment 'he', prior to the NPr upgrading their assessment to 'at all' (line 5). In line 6 the SLT also starts to draw on experiential knowledge of the client, which they continue on lines 8 and 9. The SLT then adds their professional knowledge to their experiential knowledge on lines 13 and 14. The statement 'unlike any other stutterer I know' constructs the SLT as having wider authoritative knowledge due to their professional identity. However, the NPr still resists the SLT as their experience doesn't support the assessment ('yeah but' line 19). Before the NPr completes their disagreement, the SLT overlaps with an upgraded technical assessment ('it's perfectly functional' lines 20-21). To this point, the epistemic based disagreement is not getting resolved, with both participants presenting their K+ epistemic authority, from different domains.

On line 25 the SLT moves from asserting epistemic authority to using the three steps to assert their deontic authority. The SLT moves to speak again (step one, line 25), before the chair can complete a potential proposition for future action (line 24). They separate themselves from the rest of the team (step two, 'I'll' line 25), and they state they will meet the client and bring information back to the team (step three, lines 25 and 27). The SLT uses these steps to make a declarative claim to deontic authority. The claim is accepted in the interaction (the conversation moves on from line 28). However, in terms of the progressivity of the talk, compared to Extract 1 a number of turns occur before the use of this deontic claim, and the strategy is only implemented after an unresolved disagreement based on epistemics. Progressivity in the

meeting may have been maintained if deontic authority was claimed using the three steps earlier in the conversation.

Extract 4 is also an example of a weaker claim to deontic authority using the three steps. Unlike Extract 3 where delay in using the three steps hinders progressivity, the problem in Extract 4 is that there is hesitancy when using the steps. The hesitancy highlights a potential incongruence between the deontic stance being claimed and the professional's deontic status, designing the speaker as having a weaker right to claim authority over the future actions. Prior to the extract, this team is discussing a group therapy programme they deliver, and a clinical psychologist (CPy) proposes having another team meeting to go through the training manual. A community nurse (CLD) attempts to say no to this extra meeting, as they only work with the team when delivering the programme.

Extract 4: Saying no: PB-TB-E18

CLD: community learning disability nurse, CPy: Clinical Psychologist, CP2: clinical psychologist

```
1  CPy: would >that feel okay with< ↑you guys↑ to:
2  CLD: well ↑I'm the the thing is
3  CPy: <I don't want to use [up the time we      have  ]
4  CLD:                      [ you've             you've]
5       I feel as if I'm more, I'm more happy to be le:d
6  CP2: [mmhmm            ]
7  CLD: [because it's it's] I'm only: I'm suppose to be
8       helping you so the group can run
9  ???: yeah
10 CLD: >else it won't be able to< ↑run
11 CPy:  su[re  ]
12 CLD:   >[so I] don't take< ow:nership of it I come an-
13      my view ↑of it I'm guided by you about what needs
14      to be done I don't understand the whole concept
15      >though because I've not done the< t↑raining and
```

16 it's: not going ↑to happen for: me .hh so but for
17 you guys as the fa[cilitator]
18 CPy: [yeah yeah]
19 CLD: I'm ↑co [facilitating]

The three steps to saying no occur in lines two, four and five. After the CPy queries if it will be okay to have more meetings, the CLD takes the floor to respond (step 1, line 2). However, they are making a dispreferred response and start their turn with a 'well' preface which forecasts their no response (Pomerantz & Heritage, 2013). The CLD then continues their turn to say no, separating themselves from the team (step 2, 'I'm' line 2). After stating 'I'm' there is further hesitancy in saying no, demonstrated in repetition of 'the' and another forecasting statement to a dispreferred response ('the thing is', line 2). Forecasting the bad news gives the CPy an opportunity to respond on line 3. A left push demonstrates the CPy's readiness to respond and repair the CLD's disagreement. The CLD gets to step 3 on lines 4 and 5, overlapping the CPy's talk and stating they are 'more happy to be led', claiming their deontic authority to propose what they will do in the future. Although there are other turns at talk, this attempt at the 3 steps does not get acceptance (e.g. 'okay'), but acknowledgement tokens (Stivers, 2013; 'mmm' line 6, 'yeah' line 9, 'sure' line 11). A lack of acceptance leads to the CLD using step 4: listing their reasons between lines 12 and 16, that orient to, and display their epistemic authority over their professional jurisdiction. The CLD present declarative statements on what they can do (repeated use of 'I'; they are there to be 'guided' line 13; they 'don't take ownership' line 12), building a clear case of knowing about what their role is (Heritage, 2012). Finally, they draw on their knowledge over the other professionals' role ('you guys as facilitator' line 17). The move to epistemic authority is comparable to Extract 2, when the CPs had to resort to epistemics when their first deontic claim was unsuccessful. However, this extract does not finish on a clear deontic claim, instead the CLD clearly states their role

('I'm co-facilitating', line 19), rather than something like 'I won't attend any further meetings'. The extract only shows part of the discussion, and the CLD continues to explain why it is not their job to attend more meetings for another 35 lines, before the conversation moves on.

The analysis of these four extracts has demonstrated how professionals can claim the right to determine future courses of action through orientation to their professional jurisdiction and knowledge about their role where necessary. Claims to determine a future course of action are most successfully accepted when they are presented with a strong deontic authority (D+). Features of strong deontic authority are evident in Extract 1, 2 and 3. Clear and direct declarative statements that follow the 3 steps are accepted by the team. However, if the deontic claims are presented with weak deontic authority (D-) there is less acceptance, partially seen in Extract 2, and clearly seen in Extract 4. A D- claim is not accepted by the team and leads to an extended period of listing, which requires speakers to orient to a higher epistemic status about their professional role rather than deontic status. This is an important collaborative practice as it shows how professionals negotiate potential disagreements and reach a resolution, which continues the progressivity of the meeting and ensures that future work is organised.

<u>Allocating tasks to another professional: Orientation to another professional's jurisdiction.</u>

Professionals can make deontic claims over another professional's jurisdiction to get the other professional to do a piece of work. This is generally done when the other professional is not forthcoming in offering support in a client issue. This is an important collaborative practice, which orients to the organisation of the I(L)D teams, which are (in part) multidisciplinary so that they can draw on each other's expertise and skills.

There are two techniques that are drawn on when making these deontic claims to get others to do something, identified in 13 of the 22 extracts. First, professionals use epistemic knowledge about the other professional's domain to build a case that they should do a piece of work. Second, they make a future proposal for what the other professional should do from a D- (low

deontic authority) position. These proposals tend to be neutral and non-personal in their construction, which may also help with their acceptance in this context, where it is also important to maintain working relationships (cf. Chapter 6). The two techniques help team members manage a delicate situation of telling another team member what to do, particularly when they have already said 'no'. Extract 5 is an example of an Occupational Therapist (OT1) saying no, and a Clinical Psychologist (CPy) using the two techniques to challenge the no, claiming deontic authority over the OT1's professional jurisdiction.

Extract 5: Allocating tasks: PB-TA-E1

SLT: speech and language therapist, Cha: Chair, NPr: nurse practitioner, CPy: clinical psychologist, OT1/2: occupational therapist

CPy: so is there any OT [involvement at the moment
OT2: [another core group meeting
OT1: ↓no
CPy: right
OT1: he's supposed to be having community enablers (.)
going in as well
SLT: o↑h
NPr: yeah: it's taken a long time: I think <and mum is
also strugg↑ling to get hold of (name)
Cha: okay=
NPr: =she was saying (.) so
OT1: but ↑these are social care issues
???: yeah
OT1: so you know I'm not- I don't think that as a te:am
we need to rush in to deal with the situation
that's to do with primarily right now
???: mmm
OT1: social care needs
CPy: but in terms of his ↑functional skills like mu:m I
was ↑thinking↓ about like her not appreciating why
he might need the

NA1: mm
CPy: visual sequencing=
Cha: =yeah
NPr: you know
OT1: (name)'s involved though in terms of like the
visual sequencing stuff
CPy: yeah but in terms of ta:sk sequencing and things
to ha- have an understanding of how he: approaches
tasks how he is best going to learn new tasks I
↑think that might be a ↑role
Cha: ye:ah
SLT: ye↑ah↓ does↑ when↑ did↑ you ↑ask mum about autism
where do they un- do they what do they understand
about it and do they think he's got it

Between lines 1 and 18, the OT1 claims that there are no tasks for an occupational therapist to do with the client. On line 5 the occupational therapist draws on knowledge of what should be happening for the client, then on line 12 clearly states that the problems the client has should be addressed by social care. On lines 14 to 16, the OT1 almost uses the 3 steps to saying no, initially separating themselves from team (step 2), but then repairs their turn – repairing 'I'm not', to 'I don't think as a team', and they finish with a future proposed action for the team (step 3, not rushing in, line 15). Rather than making a deontic claim about the issue being situated within their own professional jurisdiction, they are making a deontic claim to have authority over what the team should be doing. The deontic claim is not accepted by the team. Instead the CPy begins to build an argument for why the OT1 should work with the client.

The deontic claim made by the CPy over what the OT1 should do begins with the CPy using epistemic knowledge about the OT1's professional domain. In line 19, the CPy resists the OT1's suggestion that it should be social care, starting their turn at talk with 'but' which is marked with emphasis. The CPy then mentions two technical aspects of the client's care that

relate to the OT1's profession - 'functional skills' (line 19) and 'visual sequencing' (line 23). The CPy does this in a delicate manner – stating 'I was thinking' (line 19-20). The chair agrees with this suggestion, latching on to the TRP at the end of the CPy's turn at line 24. The OT1 resists the proposition, stating that another person is involved with the client's visual skills. The CPy persists, taking a knowing epistemic stance of the OT1's profession (Heritage, 2012), this time with regards to task sequencing (lines 28 to 31). After the CPy has used this epistemic knowledge of the OT1's professional domain, they make a proposal of what the OT1 should do from a weak deontic authority position. The phrase 'I think that might be a role' contains two items that constructs the CPy as having a weak deontic authority - 'I think' and 'might be' (Stevanovic, 2017). The proposal neither directly names the OT1, nor does it name their role, which keeps the proposal relatively neutral, although it is still clear from the way the turn is constructed that the CPy is suggesting that 'it might be a role' for the OT1 specifically. A strong deontic claim would be reflected by a statement such as 'That is a role (for you)'. The CPy's turn (lines 28 to 31) is receipted with agreement in the meeting from the team, with both the chair and the speech and language therapist (SLT) agreeing (line 32 and 33). After the SLT agrees on line 33 the conversation moves to a different area.

The two techniques, using knowledge about another professional's domain, along with a D-proposal for what the other professional should do, can also be seen in Extract 6. Here the Clinical Psychologist (CPy) uses epistemic knowledge about a client to propose that a speech and language therapist should do an assessment. They list information that makes an autism assessment something that is relevant for the speech and language therapist (SLT) to do. In this extract, the CPy begins with the future proposal, then lists the information, before making the future proposal.

Extract six: Task allocation: PB-TA-E4

CPy: Clinical psychologist, SLT: Speech and language therapist; NA1: Unknown

CPy: she has- ↑well we ↑said un↑us:ually we thought
it would be helpful for her to have an autism
assessment because she's °got° lots of classic
features but has never had any assessments
missed kinda missed seems to have missed out on
all that stuff so um: she seems to e- she's
she's e- very hypersensitive very hyper acoustic
sensitive so w- will °at° times wear ear
defenders seeks out kinda stuff to try and make
sense of stuff that might be distressing for her
.hh has fixed routi:nes doesn't like change
won't go on holiday she went on holiday had to
come back in two days cus it just threw her °she
has° routines like if it's bedtime and she
already got her pyjamas on she'll have to go in
her bedroom and pretend to take> like go
physically as if she is tak- undressing and
putting her pyjamas back on keep the routine the
same .hh dad has to do things a certain wa:y
NA1: mm
CPy: um and we we just feel like it might be helpful
y'know [in terms of (missed)]
SLT: [so how would you]propose we do that
CPy: pardon
SLT: how would you see us doing that
CPy: well we thought as a starter you could do your
(.) >all your< all your training
[won't go to waste]
SLT:[heh heh]
CPy: cus you could do your

31 SLT: well I'll have to find someone to lend us an
32 ADOS first
33 CPy: [right]
34 SLT: [but]I could a- I could ask my contacts
35 CPy: yep that would be perfect
36 SLT: in other other organisations
37 CPy: that would be per↑fect um

Just before Extract 6, the CPy is summarising a previous meeting about the client and the outcome of the meeting was that SLT should be involved. The extract starts with the CPy proposing the SLTs future action, from a low deontic status 'we thought it would be helpful' (lines 1 & 2). The proposal is again neutral, and does not start by directly naming the clinician who they are proposing should be involved. Rather the epistemic knowledge CPy presents about the client makes the SLT and the assessment relevant. On lines 3 to 16 the CPy moves to explain why a speech and language assessment is needed, drawing on their domain of knowledge about the client. This extended explanation provides evidence to support relevant diagnosis features, e.g. 'hyper acoustic sensitive' (lines 7 and 8) is supported by wearing 'ear defenders' (lines 8 and 9); 'fixed routine' (line 11) is supported by 'won't go on holiday' (line 12). The listing has no obvious TRPs where it would be appropriate for another team member to take a turn and the design of the talk builds a case that would be hard for a recipient to disagree with. The CPy's turn at talk is finished by another proposal, again from a low deontic status 'we just feel like it might be helpful' (line 21). The CPy proposes this future action not as their own idea, but as part of a team of people. Feeling something might be helpful is not a strong argument to tell someone what to do (cf. Stevanovic, 2018). The SLT responds with a question, asking how the CPy thinks the SLT should do this – they do not argue with the epistemics of why an autism assessment is relevant, they argue with the deontics of the proposal that they should do it. To counter the SLTs resistance, the CPy constructs the SLT as separate to the team (we vs. you, line 26), however they never get as far as explicitly stating what they

should do. Instead, they draw on knowledge of the SLTs professional training ('all your training won't go to waste' lines 27 and 28). The SLT's receipts this suggestion as laughable, suggesting they do not find this statement problematic. Thus, the CPy's orientation to the SLT's professional training is not resisted, and leads to action: the SLT states they will find an ADOS (the assessment tool, line 32).

The analysis of these two extracts has demonstrated how deontic claims can be made by team members to tell other professionals what to do, based on knowledge of their professional jurisdiction and role. Telling another professional what to do is treated with sensitivity – deontic claims are made from a D- position shortly after or before the speaker's explanation (building a K+ position) of why the other profession is relevant to a client's care. The deontic claims are not explicitly accepted – but neither are they resisted. The talk moves forward. In terms of deontic gradient (Stevanovic, 2017), professionals don't explicitly direct another professional what to do - e.g. 'you have to complete an assessment', either a general statement is made e.g. 'we thought it would be helpful … to have an autism assessment' (lines 1-2, Extract 6) or what could become an explicit direction is never completed 'cus you could do your' (line 30, Extract 6), 'I think that might be a role' (line 31, Extract 5). This is an important collaborative practice for I(L)D MDTs, as they need to be able to recruit the other members of the team to help with clients, whilst maintaining collegiate relationships.

Discussion

This chapter has demonstrated a collaborative practice in the organisational domain that allows professionals to negotiate who is going to do what (and thus orients to the organisational purpose of the meeting). Two difficulties in negotiations have been used as exemplars of how orienting to what you should do (your professional jurisdiction) and what you can do (your professional identity) can resolve the negotiation. The first difficulty was saying no to what another person states they will do with a client, as what they have proposed oversteps into what

you want to do with a client. The second difficulty was convincing another professional to do something that you think they should do. Saying no to another person's proposal can be achieved by making a clear claim to deontic authority, which constructs the speaker as having a high deontic status (D+). Less direct claims to deontic authority (D-) resort to epistemic knowledge to support the deontic claim. Convincing another professional that they should do something can be achieved by making deontic claims from a low deontic status (D-), orienting to epistemic domain of what the other professional can do. Saying no to a proposal has a strong orientation to deontics (and professional jurisdiction; Stevanovic, 2018), whereas telling another what to do orients more to epistemics (and what other professionals can do based on their identity; Heritage, 2012).

In contrast to previous research on collaboration, rather than causing problems, when I(L)D MDT members orient to professional identity and professional jurisdiction they can help to resolve negotiations. Professional identity was suggested as a both a problem and helpful for collaboration in previous research (e.g. Pullon, 2008; Miller, 2004)) and breeches to professional jurisdiction were classed as a major concern in MDT collaboration (Kvarnstrom, 2008). The previous research was mostly based on interviews and potentially only discussed identity/jurisdiction as barriers or facilitators to collaboration as they were conceptualised as objective 'things' that input into a 'black box' of collaboration. The benefit of examining how these 'things' are oriented to is that the examination demonstrates that instead of being fixed 'things', professional identity and jurisdiction are flexible resources that professionals can use during negotiations. These resources are a helpful part of the professionals' collaboration practices that allows I(L)D MDT members to work out who is going to do what.

One of the studies in the literature review (cf. p.49) also commented on the role of professionals' identity in interaction and how it can affect collaboration. Rovio-Johannson and Liff (2012) examined interactions between professionals and argued that the treatment methods

professionals advocate for are intertwined to their professional identity, which is discursively constructed. Overall they suggested that the participants' interpretation and misinterpretation of talk based on their own professional roles was damaging to the collaborative ideal of the team. Rovio-Johannson and Liff's (2012) study did not utilise CA and so did not explain exactly how this played out in interaction. If they had used CA, and the concepts of epistemics and deontics, they perhaps may have also seen how negotiations on future courses of action are delicately managed and nuanced. Thus, instead of being a barrier, professional identity may have also been understood as a resource in an MDT's collaborative practice.

Professionals designed turns that separated themselves from the team when they were saying no to a proposal or being told what to do. The separation of the individual professional reflects Salas et al.'s (2008) discussion of individual and team-based tasks. This division between different types of tasks is important in terms of professional jurisdiction as the individual professional has power over their own actions, but team tasks require team consensus. In decision making meetings, professionals separate themselves from the team in their turn design to claim authority. The fact that turns can be designed to claim authority flexibly, demonstrates that power is achieved in interaction rather than being fixed in pre-existing hierarchies. Therefore, a support worker who might traditionally be seen to have a low level of power could make a high status deontic claim in a meeting, which if accepted in interaction, means that the traditional hierarchical structures do not hold the same levels of importance as often assumed in many investigations into collaboration (cf. Chapter 2).

There are some caveats to the claim that power is flexible and professional identity/jurisdiction can be used flexibly by any team member to claim authority in interaction. The ethos of MDT working – to collaborate and work with a range of professionals to get the best care for patients – may foster an environment where any team members' claims of authority are more accepted by the team. As Stevanovic and Perakyla (2012) make clear, a claim to deontic authority is

deemed successful from its receipt. In other healthcare environments, strong deontic claims to authority may not be accepted by other team members. Equally, it may not be common for professionals to take a low deontic stance to get someone to do something – they may do so from a high deontic stance. For example, UK GP practices have a very pronounced hierarchy due to the management structure and investment into the practice made by partners. It may be accepted in these environments for people to directly tell each other what to do or say no to doing something. Nonetheless, previous research has assumed that professional identity and hierarchy is problematic for collaboration, so it would be interesting to see if claims to authority were as flexible in other less collaborative healthcare environments.

This chapter brings understanding of collaboration practices that negotiate the organisational purpose of the I(L)D MDT; that different professionals, with different professional identities, work together and make decisions about what needs to be done for clients. The focus has been on when there is some disagreement and negotiation of what to do. Rather than view the multiple different professional identities as a problem for collaboration, there is new insight in how orientation to the individual professionals' tasks, in comparison to team tasks, benefits decision making. Professional jurisdiction (deontics) and profession related knowledge (epistemics) become tools in negotiating these decisions, instead of barriers or facilitators.

Reflection box 7: Orienting to job role

Initially I had aimed for this chapter to examine the mentions of social care in MDT meetings. This interest was bound by my own assumptions that there were difficulties in the working relationship between social care and healthcare teams. These assumptions were based on reading lots of policy documents highlighting that there was a need for joined up care between health and social care professionals in I(L)D services. It was difficult to break out of my understanding of groups, and that there would be difficulties based on different professionals being associated to different services (health vs. social care). Again, this was likely due to being embedded in a psychology culture where thoughts about social identity, and the impact of social groups on behaviour (e.g. Tajfel & Turner, 1979), are dominant. I initially focused on all mentions of social care in the data, but there was not a clear interactional phenomenon to explore. The methodological perspective of the thesis, that relies on participants own orientation in interaction, challenged my assumptions. However, the examination of social care began the exploration of task allocation that is discussed in this chapter. At times, I had related the findings to the term 'persuasion', but this started to use terms that were exogenous to the data. Again, I think the focus on persuasion was because I was embedded in a psychology culture where ideas such as persuasion are dominant. My own repertoires drew on the common concepts of psychology, which started to become potentially distant from the meanings and sense making used by participants. Despite a change from examining mentions of social care to focus on task allocation, where there is what I have termed some 'conflict' and may be better described as negotiation, I have still potentially been biased to look at what I saw occurring in the data as due to different professional roles. My underpinning agenda for the thesis was to understand how different professionals work together, and what their collaborative practices are. Alternate lens on the data may have approached this differently, for example if certain tasks were constructed as 'feminine' roles, and what a 'feminine' role was understood as.

Chapter 8. Discussion

The overall aim of this thesis was to understand the collaborative practice of MDTs in I(L)D services. Focusing on the collaborative practices of these teams was a novel approach compared to previous research that has focused on input-output models of collaboration or has had an emphasis on outcome measures. Three collaboration practices were identified after recording multiparty interactions between healthcare professionals and analysing them inductively, prioritising emic perspectives when developing the analysis focus. The three practices can be conceptualised as sitting at different domains that are important for healthcare professionals; the clinical, relational and organisational. Using a different methodological lens to understand collaboration has provided an understanding of what professionals do in practice when collaborating. Here, this chapter will first provide an overview of the findings and discuss their overarching message. It will then detail how the aims and objectives of the thesis have been met, followed by a section on how the findings contrast with other bodies of work, drawing on the literature review in Chapter 2. The discussion then moves to focus on the application of the findings to healthcare practice, followed by a reflection on the role of ethnography in applied CA research. Finally, the chapter finishes on a statement of the importance of this research and how beginning to unpick the collaboration puzzle (cf. p.10) can help teams in I(L)D services, and beyond.

The findings: Three collaboration practices

The three collaboration practices focused on in the analysis chapters can be conceptualised and situated within three key healthcare domains: the clinical, the relational, and the organisational. To recap, the clinical domain relates to the clinical work that teams need to do to support people with I(L)D, the relational domain relates to the interpersonal relationships between team members and the organisational domain relates to the organisational structures that teams have to work within (cf. p.28). These domains are a relevant way to understand collaboration, as

these are key areas of interest for healthcare professionals, service users and researchers (Smart, Reed, Storcz, et al., 2018). They also relate to some of the main areas of barriers/facilitators associated with collaboration other researchers have focused on when collaboration is conceptualised as a result of different factors (e.g. relational domain can map onto the team level of factors, organisational domain can map onto the context level, cf. p.44). However, framing the analysis in these domains shows that rather than a result of inputs, collaboration is achieved through practices in interaction.

In the clinical domain, the practice of constructing a potential risk issue as a concern has two main functions. If speakers use the term 'concern' as a subjective assessment it can signal to recipients that there is a 'story' being told by the speaker, and thus recipients provide the necessary space for the full story to be told before taking a turn. This function can be contingent on when in the client discussion the concern is raised; for example with speaker owned concerns it can be important that the concern is raised early in a client discussion for the speaker to be given space to tell the story and gain collaborative input around the potential risk to a client. This is important as team members will then tend to provide advice and share the decision making burden on the risk issue (see Chapter 5).

In the relational domain, laughter was examined for its action in meetings. Laughter can be used by I(L)D team members to manage trouble and mistakes/criticisms, which may save face and maintain collegiate relationships. Laughter is also found during light relief when the team move (briefly) into a playframe. Embedded laughter is also found in I(L)D team meetings and was tentatively explored for its potential to demonstrate affiliation. This is important for I(L)D teams' collaboration, as the team meetings are agenda focused, so there is little space to build relationships and share experiences, but a small laugh can do some of the work to bring the team members together.

Finally, in the organisational domain, Chapter 7 details how professionals draw on their job role and jurisdiction in negotiations about proposed courses of action. Using the CA notions of deontics and epistemics in conversation, the analysis highlighted the delicate ways that healthcare professionals can ask another person to do something. It also showed the impact of both weak and strong claims to authority that healthcare professionals use to resist a proposed course of action. This is key for the organisational distribution of work, and for professionals to be able to collaborate and get work done. The three practices that have been related to the three domains help to show collaboration as an interactive process between individuals, rather than a black box concept into which a range of other concepts input.

As a body of work, these findings show collaboration as a range of practices that evolve in the moment. Collaboration is achieved between people by negotiating, persuading, laughing and seeking input from one another to solve problems. As such, rather than focusing on collaboration as a single thing, it is more helpful to focus on the range of collaborative practices that I(L)D teams use. Team members working together towards a common goal is part of the standard definition of collaboration, but examining the moment-to-moment interactions of teams demonstrates in practice they are working towards more than one goal. Interactions are layered with multiple, potentially competing, goals; for example in a meeting there is a goal to get through all the clients on an agenda, whilst at the same time a goal to ensure that individual clients have been discussed in sufficient depth to make clinically sound decisions. The attempt to try to apply a single descriptive word (e.g. collaboration) to understand what professionals do when working together towards a common goal is inadequate. As a result, this thesis has focused on 'collaborative practices' to provide a more nuanced understanding of what professionals actually do.

The collaboration practices have been conceptualised as situated within different domains, but this does not mean that the practices are only relevant for those domains. For example, the

collaborative practice discussed as important for the relational domain in Chapter 6 focused on the different ways laughter is used in team meetings. Embedded laughter was discussed in terms potentially demonstrating affiliation and showing agreement to what a person had stated, helping team members to feel part of the same group. Yet, although it may be doing relational work, it is also is designed to meet the organisational requirements of the meetings, where talk must be agenda oriented and progressive. Equally, in relation to the organisational domain, Chapter 7 discussed how job role is oriented to, to assert authority over future courses of action. The orientation to the different professional roles makes links to the organisation of the team, but the practice used to orient to the different roles is delicate and maintains working relationships; thus could also be related to the relational domain. Chapter 5 was related to the clinical domain, but almost all that is done in a team meeting is clinical, how it is done also orients to the organisation of the teams (gaining space in a meeting agenda) and how team members relate to one other. The important learning point throughout these findings is that collaboration requires a nuanced understanding that embraces the complexity of institutional interactions.

Revisiting the aims and objectives

The introduction laid out the aims and objectives of the thesis. The table below details how the aims and objectives have been met.

Aim	To take an inductive discursive approach to explore collaboration in a healthcare context and consider how this may change the current understanding of collaboration	Using CA and ethnography interactions have been examined between healthcare professionals in I(L)D teams (see Chapter 3 and 4).

	Use an approach to conversation analysis that gives primacy to participant concerns	Most clearly seen in the second analytic chapter, providing participants an opportunity to look at the data and raise what they think is important, allows a systematic and scientific analysis of the phenomenon to understand the action and purpose of the experience people have (Chapter 5, 6 and 7).
	Contribute an understanding of collaborative practice for healthcare professionals	The analysis chapters clearly demonstrate examples of what collaborative practices can look like (Chapters 5, 6 and 7).
Objective	Examine literature about collaboration in healthcare	The literature review, along with the discursive methods chapter, provides the critique of prior approaches to collaboration and why a different approach is needed for the purposes of the research question (Chapter 2 and 3).
	Examine how a different approach to collaboration can highlight I(L)D MDTs practices of collaboration	The analysis chapters in 5, 6 and 7 show how the approach developed in Chapter 3 can uncover new understanding of collaboration practices in I(L)D MDTs .
	Use ethnographic methods to understand the context under examination and develop the analysis focus	Although not always explicit, the research question and subsequent focus for all the analyses have developed from working with and around the teams involved in this research. Subsequent visits to the teams to feedback progress has always been helpful in both checking findings relevance and help develop the ongoing research process.

The table demonstrates that the aims and objective of the thesis have predominantly been met and are evidenced in the previous chapters. The final objective 'Use ethnographic methods to understand the context under examination and develop the analysis focus' will be discussed

here to expand on how this worked across the thesis as a whole. Chapter 5's analysis began when the focus was more broadly on 'How do MDTs function'. The research question developed to focus on collaboration, as this is a core driver of how I(L)D MDTs function. The concentration on concerns was developed inductively, from listening to how professionals in team meetings discussed clients and noticing a common pattern that emerged as relevant to the ways team members collaborated on the clinical issue of the potential risk of abuse. Although the team members did not have an active role in choosing this focus, the focus developed from what they were actually doing in their daily life as a collaborative practice. In that way, the actions that clinicians take in the meetings work to highlight the areas that are relevant to their collaborative practice. Chapter 6's focus on laughter was explicitly developed from running a CPD session with Team A. How this developed is discussed briefly in Chapter 6, and more detail on the joint analysis is on p.111 and p.213. Finally, Chapter 7's focus on professional jurisdiction took inspiration from policy documents, a wider concern reported in literature on professionals' worry about their jurisdiction and professional boundaries, the interviews I held with the professionals and also from listening to the recordings. Thus, for this thesis the ethnographic component of the methodology influenced the research process, rather than developing the focus by sitting with participants as is done in Reflective Interventionist Conversation Analysis (O'Reilly et al., 2020).

There are two reasons why sitting with the team to get them to highlight areas of collaborative practice did not always happen, and perhaps should not always be relied upon. First, it was not always possible as teams would not have the time to take part in such an activity. Although feedback sessions happened with all of the teams, often they were encompassed within one of the standard team meetings. There would be 20 minutes as a maximum to discuss some of the thesis progress, and this is insufficient time to explore joint analysis. Although Team A managed to arrange joint analysis in a continual professional development slot, Team B and C

experienced more difficulty getting the team together for team building sessions, and understandably this research was not a priority. The joint analysis with Team A highlights the difficultly with using a single joint analysis session to direct analysis foci. The team members focused on the use of humour in the team, drawing on the common discourse that humour manages difficulties. Approaching the research from a discursive perspective meant that laughter was used as the tractable foci for analysis. Across the meeting recordings there were roughly 60 instances of laughter, which may make it less common than team members anticipated, and laughter related to a range of different actions. Thus, in short analysis sessions it may be common that team members draw on their reflective experiences, rather than what happens in the data. This makes the rationale for choosing certain practices susceptible to the issues raised in Chapter 3 on running interviews to understand collaboration; e.g. not based on the reality of the process. On the other hand, due to the teams being only comfortable with audio recording, there may be embodied versions of embedded laughter (e.g. smiles), which could have been missed due to the data collection method. Nevertheless, the use of real data from team meetings means that the conclusions are still rigorous and based on systematic analysis of the actual practices of healthcare professionals that are evidenced for all to see.

The findings: A new way of understanding collaboration?

This thesis provides a different way to understand collaboration as a process, moving beyond previous research on collaboration in I(L)D services that focused on concepts as inputs to collaboration (see Chapter 2). Belanger and Rodriguez (2008) made a call for a discursive approach (the use of discourse analysis specifically) to move researchers from examining different concepts that impact MDTs, to begin to look at team interactions and how they affect team formation. Although Belanger and Rodriguez (2008) were focused on primary care teams, and the creation of a team identity, rather than collaboration, their notion of co-operative practice in multidisciplinary teams is applicable to the findings in this thesis. The analysis

chapters detail three collaboration practices based on what participants co-operatively do together, rather than what a single participant brings to the team. Furthermore the collaboration practices go further than labelling separate concepts, such as knowledge sharing (Liberati, Gorli & Scaratti, 2016), clear roles (Janssen, Snoeren, Van Regenmortel, & Abma, 2015), mutual trust (Fay, Borrill, Amir, Haward & West, 2006), and relating them to how they might be good or bad to a team collaborating. Instead, the practices show how team members navigate, negotiate and do collaboration together – which provides a more nuanced understanding than just focusing on the individual concepts that might be associated with collaboration. Reducing the understanding of collaboration in healthcare teams to a range of concepts, misses what has been shown in this thesis: that collaboration is achieved collectively by team members moment by moment, through practices in interaction. As such it is a process, rather than a thing that passively receives good or bad inputs.

The seventh chapter, that discussed job role and professional jurisdiction, is a clear example of how the discursive approach taken by this thesis provides a different theoretical understanding to collaboration. Researchers who have previously explored collaboration have discussed that factors relating to job role can be both a barrier to, and facilitator of, collaboration. For example, Janssen, Snoren, Van Regenmortal and Abma (2015) found for geriatric teams, having insight into other team members' professional role was beneficial to collaboration. Equally in multiagency teams a lack of clarity on other team members' roles has been reported as a barrier to collaboration (Robinson & Cottrell, 2005). Liberati, Gorli and Scaratti (2016) argued having multiple disciplines in a team as problematic, as they would stick to their professional silos and this prevented collaborative working. These three studies were all based on unreported observations and interviews with participants. The discursive approach taken in Chapter 7 means that it was possible to examine how participants orient to job role. The findings in Chapter 7 highlight that rather than being a barrier or facilitator, job role is a tool that

professionals use to negotiate, persuade and manage conflict when working together in meetings. Job role can therefore be reconceptualised as a tool, rather than a static 'thing', that professionals jointly orient to in interaction to perform collaboration.

Beyond just collaboration, this thesis develops the conversation analytic work completed by the MDTs In Action group and Seuren et al.'s work on multidisciplinary meetings. Seuren et al. (2019) explained the structure of decision making in emergency department MDT meetings. Although their focus was to explain the interactional organisation of decision making, Chapter 5's discussion of concerns adds knowledge from a different healthcare setting on how team members can bring different information into a case discussion, a key driver for the use of MDTs to make client care decisions. The MDTs In Action group released a body of work (Smart & Auburn, 2018) that has discussed a range of different practices related to MDT meetings. Chapter 5's analysis is part of the MDTs In Action book, and Chapters 6 and 7 add to the work the research group has already completed. Aikman (2018) discussed how team members can perform explicit compassion to other team members, and Smart & Auburn (2018) discuss the use of 'we' to demonstrate team membership. Chapter 6 adds to this work to show that team members potentially demonstrate affiliation what other professionals state, with just a minimal laugh. Thus, even in the smallest actions, MDT members can work to build their group relationships. Smart, Pollock, Aikman & Willoughby (2018) unpicked professionals' deontic and epistemic orientation to service user needs to claim authority on proposing future courses of action. Chapter 7 adds to this by demonstrating how professionals can also claim deontic authority based on their professional identity and maintain their professional jurisdiction. In sum, the findings from exploring I(L)D team meetings in depth can be applied to a range of conversation analytic settings and expand the knowledge base on multidisciplinary interactions.

Application of the findings

Alongside adding to the body of healthcare literature on collaboration, an aim of this thesis was to run research in a way that would be meaningful to healthcare professionals. The research design gave primacy to healthcare professionals, through observing how the teams work, interviewing the clinicians and examining what they actually do in detail. This thesis provides one of the most in-depth analyses of how I(L)D teams work together and collaborate that is available. Aside from just understanding collaboration in these teams, this section of the discussion will examine the learning points from this thesis that healthcare professionals can apply to their own practice.

Translating the findings to recommendations for clinicians requires careful consideration. The findings chapters demonstrate there are different ways that professionals talk, which have different actions. For example, stating 'I'm concerned about..' prior to discussing a client risk issue presents ownership over the concern, and other team members provide meeting space for the clinician to talk. If it is stated too late in a client discussion, the space is not provided, and it may be more likely to be queried as legitimate (see Chapter 5). Thus, the recommendations for team members would be to raise any concerns they might have earlier in the discussion, constructing them as self-owned concerns. This is similar to the sort of recommendation from Heritage et al.'s (2007) paper, which advised doctors to ask patients if they have 'some' other issues to discuss, rather than 'any' (cf. p.58). However, Heritage et al.'s recommendations may be relatively easy for doctors to implement – e.g. at the end of every patient consultation they should ask if patients have some others issues to discuss. In I(L)D MDTs, the interactions are multiparty and complex, and the potential risk of abuse is not relevant to every client. Thus, recommendations on how to discuss concerns may be something healthcare professionals could reflect on, but it is unknown how professionals can draw on the idea in the moment.

There are multiple different approaches within applied CA to use research findings to make recommendations (Antaki, 2011). One way to overcome the reliance on staff remembering feedback on findings has been highlighted by Stokoe's (2014) Conversation Analytic Role-play Model (CARM), and Real-Talk communication skills training (Parry et al., 2020). In CARM, a team of researchers record service encounters, and use conversation analysis to unpick the interactions. The training consists of listening back to real conversations, then pausing the interaction, role playing what might come next, and discussing the benefits of the different responses that are used. Examining what happened in actual conversations; the training develops and is situated in the 'real' world, rather than an idealised version of interactions that happen in traditional role-play. Real-Talk communication skills training follows a similar pattern, with a focus on end of life conversations. The Real-Talk training package shows healthcare professionals actual clinician-patient interactions that focus on areas such as broaching dying and unpicking ambiguity (Parry et al., 2020). The focus in the training is on what is more or less helpful about the way the talk is designed and the responses the talk receives. Both the CARM and Real-Talk training methods focus on two or three person interactions, in a more service level environment, where one person is providing advice or solutions to another person (e.g. Dr-patient, mediator-person with a problem). The training methods demonstrate the value of using real talk, yet this may need a different application to multi-party interactions.

The MDTs In Action group developed a method for helping teams to focus on the way that they communicate in team meetings. Similar to Real-Talk (Parry et al., 2020) and CARM (Stokoe, 2014), the focus was presenting healthcare professionals actual recordings of team meetings. Smart, Reed, Sztorc, et al., (2018) ran training sessions with healthcare professionals, highlighting a range of interactional practices that are used in MDT meetings and the action that the practices have. Although in the early stages, this type of training had good feedback

from those attending as a reflective tool to consider how they talk and the impact that may have, as well as to learn about different qualitative methods. Future recommendations for developing this type of training emphasises the time needed with teams to develop their understanding of the method, to try to include some recordings of their team meetings and to focus the analysis on areas that are relevant to the team attending.

The MDTs In Action group's approach is similar to the reflective interventionist conversation analysis (RICA) recently described by O'Reilly et al., (2020). The RICA approach also reflects the overall approach of this thesis. It is not based on fixing a pre-defined problem, begins with unmotivated looking and the researchers work together with the people working in the area under investigation. The method section (cf. Chapter 4) explained how this thesis began with a general interest in collaboration, rather than a predefined problem to investigate. A key focus in RICA is providing data sessions to practitioners, so that through the process of analysis they can reflect on their own practice. As part of this thesis, a joint analysis session was run with Team A in one of their CPD slots, in a similar vein to the reflective element of RICA. Although the joint analysis is discussed elsewhere in terms of developing the focus of analysis, it can tentatively be suggested as a form of training. All the extracts presented in the joint analysis session were taken from recordings of Team A. The joint analysis session provided an opportunity for the team to hear themselves at work for the first time. Using a CA approach, healthcare professionals were encouraged to listen without judgement and to focus on the action of what was said. This is a different approach for many healthcare professionals, and provides an opportunity for reflection, a core component of clinical practice (Stedmon & Dallos, 2009). Although it is common in hospital settings for video recordings to be used for reflection (Iedema, 2010), there is a call for healthcare teams to also share reflections on their teamwork (Schmutz & Eppich, 2017). It is unfortunate that the other teams who took part in the research were unable to accommodate joint analysis sessions, but the teams' response to

feedback on the research project was also helpful for them to reflect on their practice. Smart, Reed, Tremblett & Froomberg (2018) further discuss joint analysis, and how joint analysis enables teams to learn about the role of communication practices in teamwork. The use of joint analysis in training would require planning a string of sessions with teams, to cover the basics of CA and give sufficient time to examine data. Securing the necessary time with NHS teams could be difficult in overburdened services, so the team's management would need to be convinced of the benefit of this training.

The role of ethnography in applied CA research

Ethnography was used in this thesis for both providing a background to the research area and for helping inform the focus of analysis. It is common for applied CA to use ethnography to provide background to a study area (see p.79, Chapter 3), but in the course of this research no papers were encountered that explicitly used ethnography to inform the focus of analysis. This is likely due to researchers having a strictly defined research focus at the beginning of their research. For example, Finlay, Walton and Antaki (2011) were interested in how choice was given to people with intellectual disabilities by staff members. Collaboration in healthcare teams is a broader concept that had yet to be unpicked discursively. Although the RICA approach to applied CA involves participants early in the research project, it does not use ethnography or observations of participants in the research process (O'Reilly et al., 2020). Instead it relies on the co-production of research with participants to help inform the focus of analysis. The RICA approach gives primacy to what participants are interested in, however requires a high time investment from participants. In healthcare settings in the NHS, it can be difficult for healthcare professionals to find time outside of their core role. Thus, as well as helping to understand the institutional actions of practices and acronyms used by team members, the focus of the analysis was inductively informed in part from the ethnography (cf. Chapter 6 and 7).

There are two key learning points that can be drawn out from the attempt to use ethnography to inform analysis. First, it is unlikely that the analysis focus will develop from ethnography alone. Interviews, policy documents and the meeting recordings all contributed to this thesis' chosen analyses focus. Second, the in-depth knowledge of the teams developed through ethnography can become embedded in the conversation analysis. This emphasises the importance of demonstrating the findings clearly in the presented data, with less embellishments from the wider knowledge gained from the ethnography. The use of team information to help explain analysis was critiqued in joint analysis sessions (in the Conversation Analytic Research Plymouth group). The analysis is still defendable from the data, but it is easy for analysts to fall back on their wider knowledge of institutions when discussing the findings. It is important to maintain the focus on data to highlight that the analysis is rigorous and valid. In this way, ethnography can be used in a more advanced way than just providing understanding of the background and how meanings are made in certain groups, whilst maintaining the epistemological position of CA and enhancing inductive research projects.

Transferability and the I(L)D context

Collaboration is particularly important to I(L)D services (cf. p.19), but it is also important across healthcare teams working in the NHS and globally (World Health Organisation, 2010). This thesis' aim was to focus on collaborative practices in I(L)D services, but there may be similarities that make the findings relevant to other settings. Taking each chapter in turn, Chapter 5's focus on the term concern, reflects the way 'concern' was used on child protection hotline: associated with a potential risk of abuse. Thus, for other settings where risk of potential abuse is relevant both in healthcare services (e.g. geriatric services) and outside of healthcare (e.g. school meetings) the findings may be relevant. However, the impact of when the concern is raised may not be the same dependent on the role of an agenda in meetings. Chapter 6 focused

on the way laughter is used in I(L)D teams and its relational role. The way laughter was used, during trouble for example, was similar to the action laughter has had in a range of settings. Embedded laughter seemed to have a specific function for I(L)D teams' relationships, in the context of multiparty and time limited meetings. Thus, in other settings where there are multiparty and time limited interactions, this type of laughter may also be found. Chapter 7's focus on how professional identity and jurisdiction is oriented when tasks are negotiated also could be relevant for a range of other settings, where multiple professionals from different backgrounds are collaborating to make decisions on future action. Thus, there is potential for the findings to have some relevance to other settings.

Although the findings may have some relevance to other settings, the focus of this thesis was not on the transferability of the findings. Similar to the RICA approach (O'Reilly et al., 2020), the aim was to provide some understanding of I(L)D teams' collaborative practices that may have some impact on the teams that participated. The research was designed to give primacy to the participants' actual practices from an emic approach, using ethnography and meeting recordings to understand the specific setting that participants work in. The findings are likely to be relevant to other I(L)D MDTs who work in a similar way. However, to make the most impact in other settings, research would need to be done in those specific settings to see if similar collaborative practices are found for teams outside I(L)D services. The combination of DP, CA and ethnography used in this thesis helped to provide new insights to collaboration. This research approach is transferrable to different settings, and may gain other researchers an understanding of collaboration that starts from the inside out.

Limitations

There are a number of ways that future research on collaboration could advance this work and build on the limitations of this thesis. The reflection boxes throughout the thesis add some understanding of the researcher's role in the decision making and interpretation of the research.

Some of these ideas were prompted from the discussions held in the viva voce. The reflections have some clear threads, which allow a consideration of how this research could have been approached differently and improved.

Alongside reflections, there has been some reflexivity incorporated into the thesis in the reflection boxes. This is common in qualitative research, but it is rarely explicitly discussed in CA research. O'Reilly et al. (2020) developed the notion of Reflective Interventionist CA, but that is not so much about reflexivity, but rather describes a process of doing CA that allows for reflection on participants' practice. Reflexivity in qualitative research aims to consider how the researcher's experience, assumptions and agenda have shaped the research (Rolls & Relf, 2006). There is a danger that researchers use CA as a 'neutral' method, which hinges on describing things as they were, using clear evidence to support conclusions. Yet, researchers still go through a process of transcribing data, and choosing something to focus on. Group data sessions help to overcome potential bias, but they still involve people, and those that take data to data sessions may still influence others in a group to focus on elements in a data extract. Reflexivity can be seen as more important in clinical settings, due to the hope to effect some change or have an impact on clinical practice. The role of reflexivity in CA, particularly in applied CA, could be developed by future researchers, to find a way to incorporate reflexivity within the theoretical boundaries of a CA analysis.

The overall approach of this thesis was to build research in a way that privileged an emic orientation. Future research could advance this understanding of collaboration by using a framework to direct analysis. For example, the framework of the different factors that influence collaboration in the literature review may provide some analytic direction. Thus, although laughter was focused on as a relational collaborative practice in Chapter 6, other relational collaborative factors (such as trust) could have been explored based on their presence of a finding in the literature review. Equally, I discuss a number of policy documents in the

introduction that have been important in emphasising the role of collaboration for I(L)D teams. A systematic policy review could also help develop an analytic framework for future researchers.

Future researchers could also consider more creative ways to work with the participants to enhance the understanding of collaboration. For example, instead of holding interviews with participants, recordings of the meetings could have been played back to team members. After listening to the meetings, the team members could have been asked to reflect on what they thought they were trying to achieve in the recorded meetings (e.g. data prompted interviews, Kwasnicka et al., 2015). The reflections by the team members could have been used to help determine which areas to focus on in the recorded meetings for analysis. CA could have been applied to unpick these specific areas to understand what structurally was happening in the interactions and why, with consideration for patterns of when the interaction was 'smoother' or not. Furthermore, recent methodological developments have demonstrated ways in which interview data can be combined with recordings to enhance understanding. For example, Stevenson et al. (2021) examined the way participants describe in interviews their use of information from the internet in doctor-patient consultations, compared to a conversation analysis of what actually happened in the consultations. This led to an understanding of the skilled ways in which patients present their problems as 'doctorable'. Thus, for understanding collaboration practices, the ways in which participants discuss collaboration after a meeting could be compared to what happens within the meeting. For collaboration, it would likely be helpful to focus in on specific factors relating to collaboration (e.g. the 'flattened hierarchy' discussed in the interviews, pg. 99). Combining these two types of evidence would potentially enhance understanding of participants' methods of collaboration.

Corrections

A number of corrections have been made to the thesis post examination. This section will briefly discuss the ways the thesis has been amended and reflect on how the changes have strengthened the work.

Reflection boxes have been added to the thesis at the end of every chapter. These boxes have a dual role: they help to demonstrate the thought processes that underpin the decisions made over the project along with explaining some of the changes made after examination. These boxes are helpful for others to understand the perspective that I came from, which may have led to specific choices (Tong, Sainsbury & Craig, 2007). Considering these choices has allowed for some reflection on how the research could be changed in the future to develop the understanding of collaboration.

The analysis of embedded laughter in Chapter 7 was the most significant area changed in the thesis. The value of CA is that other researchers are able to develop and strengthen the analysis by examining the evidence for themselves. The reflection box at the end of Chapter 7 also discusses the changes made for the analysis. Overall, the main change has been to reflect on the function of embedded laughter. Instead of focusing on the function of the laughter as something that is demonstrating shared understanding, I have commented on how it seems to be an observable practice, that could have a number of interpersonal functions in I(L)D team meetings. Overall, I have concluded that more instances of the same practice would be needed to see if there is a way to clearly understand what the function is, based on the next turn proof procedure.

The other corrections made to the thesis were additions that have helped to strengthen the rationale for examining collaboration in I(L)D teams, and the methods chosen to do so. The first chapter has added in more information about I(L)D services, and how they are organised. This addition has provided a more rounded background to the research area. Chapter 4 has also

added in some more on the theoretical basis of ethnography, CA and DP, and the benefit of combining these three methods. This helps to demonstrate to readers why all three were chosen when the project was developed.

Conclusion

This thesis provides an in-depth exploration of collaboration practices in I(L)D MDTs and demonstrates that collaboration is a discursive achievement between team members. It has developed the understanding of collaboration away from concepts that input into a team and affect collaboration, towards a nuanced understanding of what team members actually do when engaging in the process of collaboration. Vital here has been the different epistemological stance afforded by discursive psychology, and in particular conversation analysis. The focus on how talk has action in the moment, that creates collaborative spaces and co-constructs practices of collaboration, is a radical departure from listing concepts that might feed in to collaboration. Instead, this thesis provides something tangible that healthcare professionals can relate to their own practice.

Although this thesis has focused on I(L)D services, the tangible nature of the findings could be applied to a range of different healthcare settings. MDTs are standard features of healthcare services, and seem to be born out of institutional requirements for different healthcare professionals to collaborate for better patient care. As explained in Chapter 1, the need for collaboration in I(L)D services is more heightened, but there is little explanation of how collaboration is done in any setting. Returning to the quote from a participant shown in the introduction:

> "*… we are part of a jigsaw for you know, … we're never going to be one thing to everybody, but everybody needs to put their little bit in*."

This thesis has demonstrated that constructing risk issues as concerns to get advice from colleagues, using laughter to soften critique and orienting to job role to claim authority on

certain care issues are all practices that professionals employ to ‘put their little bit in’. Although these are just some of the practices of collaboration, it is hoped that this thesis provides a new and useful framework for healthcare professionals both inside and outside of I(L)D services to understand the process of collaboration.

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Appendix A

CASP questions and table of assessment.

Screening Questions

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?

Table of assessment for studies included

Y = Yes, N= No, '-'= Can't tell.

Number	Ref.	CASP 1	CASP2	CASP3	CASP4	CASP5	CASP6	CASP7	CASP8	CASP9	CASP10
1	Columbo, bendelow, fulford & williams (2003)	Y	Y	Y	Y	Y	_	N	Y	Y	Y
2	Farima et al. (2016)	Y	Y	Y	Y	Y	N	_	Y	Y	Y
3	Fitzgerald & Tea (2004)	Y	Y	Y	Y	Y	N	_	_	_	Y
4	McKean et al. (2016)	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
5	McDougall, Goldsmidt, Kinsella, Smith & Lingard (2016)	Y	Y	Y	N	_	_	_	_	Y	Y
6	Nugus, Greenfield, Travaglia, Westbrook & Braithwait (2010)	Y	Y	Y	Y	_	_	Y	N	_	Y
7	Robinson & Cottrell (2005)	Y	Y	Y	Y	Y	_	Y	Y	N	Y
8	Liberati, Gorli & Scaratti (2016)	Y	Y	Y	Y	Y	_	Y	_	Y	Y
9	Korner et al., (2016)	Y	N	N	Y	Y	N	Y	Y	Y	Y
10	Rovio-Johansson & Liff (2012)	Y	Y	Y & N	Y	Y & N	Y	Y	N	Y	Y
11	Clark (2014)	Y	Y	Y	Y	_	_	_	_	Y	Y
12	Hunt, Spence & Mcbride (2016)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
13	Caricati et al. (2016)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
14	Janssen, Snoeren, Van Regenmortal & Abma (2015)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
15	Belanger & Rodgriguez (2008)	Y	Y	Y	-	Y	-	Y	Y	Y	Y
16	Fay, Borrill, Amir, Haward & West (2006)	Y	Y	Y	Y	N	N	Y	Y	Y	N

17	Gum, Prideaux, Sweet & Greenhill (2012)	Y	Y	Y	Y	Y	Y	Y	Y	Y	_
18	Hudson (2007)	Y	Y	Y	N	Y	N	N	N	Y	Y
19	Jones (2007)	Y	Y	N	N	N	N	N	N	N	Y
20	Lee et al. (2012)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
21	Sousa & Costa (2010)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y

Appendix B

Information sheets for participants
Participant Information Sheet

(Component: Ethnographic study)

Project Title: Collaboration in Intellectual (Learning) Disability Services

Researcher: Madeleine Tremblett

Invitation

I would like to invite you to take part in a research project that is looking at collaboration in learning disability services. Before you decide to take part you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or you would like more information. Take time to decide whether or not to take part. Thank you.

Purpose of the study

Recent government recommendations emphasise the need for learning disability service staff to work collaboratively. However, little is known about how professionals in the NHS collaborate or the process of collaboration in a multi-disciplinary team. Current understandings of collaboration are mostly based on asking staff to retrospectively reflect on their experiences, which doesn't allow an understanding of how the process of collaboration is achieved in the moment by staff members. Thus, by observing a few instances of teams that work collaboratively daily to provide care, this research will be able to describe how these teams work together and how collaboration is achieved in these instances. The research is being undertaken by Madeleine Tremblett as part of a PhD project with the University of Plymouth.

This research is part of a larger research project that is looking at collaboration in Intellectual (Learning) Disability (I(L)D) Services. The ethnographic study aims to provide some contextual information about how teams in I(L)D services are organised to enable collaboration and how staff themselves construct the meaning of collaboration. Alongside the observations, interviews with three professionals from each team will be held to gain a more in-depth depiction of how collaboration is understood by staff. In addition, another strand of the research will be recording team meetings to identify communication practices that demonstrate collaboration.

Why have I been invited to take part?

You are being approached to take part as this research is specifically interested in collaboration in community adult learning disability service teams. It is important that we gain consent from all members of a potential team, although we are not interested in individual members' conduct, but how the team functions as a collective body. We are aiming to recruit 3 teams in total.

Do I have to take part?

No, participation in the study is entirely voluntary, and you are free to withdraw participation at any time. This information sheet and one of the consent forms are to keep for your records, and contain the contact details for the research team if you need to notify us of your wish to withdraw.

What will happen to me if I take part?

There is no requirement to take part, but if you choose to participate you will be one of three I(L)D teams that will take part in a one week observation period. It is hoped that this quantity of data will capture the diverse ways that different I(L)D services operate collaboratively and mean that individual teams will remain anonymous. After all team members agree to take part the researcher will observe the day to day practice of the team, situating themselves in the team's base office where day to day interactions and planning take place. The researcher will take field notes of observations pertinent to the collaboration process. A 'team map' will be sought to help us understand who makes up the team. You do not have to spend any time in addition to your normal working day if you do not want to. Three team members from each team will be sought to provide some additional detail to the collaboration after the observation week, however this will be on a voluntary basis and there is no requirement for you to take part in this.

Field notes will be made anonymous in situ. In practice, this will mean that notes will not identify team members by name, but by role only. If your role is unique and may provide identification, you will be labelled by a similar generic role to prevent identification. Any confidential client information will not be recorded in the field notes. Each team will be allocated a unique study number for the records, anonymising the team. Field notes will be stored securely on an encrypted USB device, an encrypted data storage service and held in a locked cabinet in the University of Plymouth. You will have the opportunity to review the field notes and request for any part of the field notes to be removed from the data set prior to analysis. Consent forms and the data in anonymised form will be retained for ten years in line with Plymouth University's retention policy.

It is important to remember that this research is focused on the team process of collaboration – it is not designed to identify or focus on individual contributions to the collaboration, but rather to explore different dimensions of how teams operate.

What are the possible disadvantages and risks of taking part?

It might be that there are difficult team dynamics that are currently going on within the team, and that therefore you do not wish to take part. It is hoped that even in these cases it might be possible to identify more positive practices than anticipated and we are open to all views, however we would not like to cause any further difficulties.

We recognise that having your day to day practice observed could feel a bit uncomfortable. To minimise the potential for discomfort, we would reiterate that individual performance is not being studied, rather how *teams* operate and that *multiple* teams are being recruited from each service area to reduce the feeling of being in the 'spotlight'. All field notes used in analysis will be brief and anonymous.

In the unlikely event that poor practice were to be identified during observations the researcher has a duty of care to take the appropriate steps accepted within the NHS. As participants deliver NHS services, the researchers will follow protocols recommended for

NHS staff, which can be found at www.wbhelpline.org.uk. We will advise the relevant teams of this in advance and discuss any concerns raised with the relevant staff members.

It is notable that the team interactions are likely to involve the discussion of clients. Clients confidentiality must take priority and will be maintained at all times, and their identifiable data removed from the field notes in situ. We have discussed this issue extensively with service user groups who have commented that they would rather not be informed of the research, as they have other concerns to consider. They have, however, suggested that research examining how teams operate would be valuable.

In past research of this nature run by the University we have found that these anxieties have been overcome, and that in fact the focus on good practice in team working has been very helpful.

What are the possible benefits of taking part?

Participation within the research will give you and your team the opportunity to reflect on how the team works, and to have first access to new and innovative findings around team working. It would also enable you to contribute to a project that is likely to have positive benefits for the development of staff teams both nationally and internationally. We will aim to disseminate the findings at local, national and international conferences. As participants you will also have the opportunity to ask any questions that you might have about this research, and perhaps to consider how it might influence you to developing your own research projects subsequently.

Further questions

- *What if there is a problem?*

If you are finding the research upsetting at all, you should contact in the first instance Cordet Smart (cordet.smart@plymouth.ac.uk), who is the research supervisor. If you are upset in any way with how the research is being conducted, or have any concerns or wish to complain, then please get in touch with Prof. Judy Edworthy, Psychology Ethics Committee Lead, Plymouth University (j.edworthy@plymouth.ac.uk).

- *How will my information be kept confidential?*

The transcripts and analysis will only reference team roles, rather than individual names. Study information will be collated using unique study numbers. Careful selection will be made of excerpts that do not refer to any easily recognisable information about any individual or team.

- *What will happen if I don't want to carry on with the study?*

Participation in the study is entirely voluntary, and you are free to withdraw participation at any time and without giving a reason, without it affecting your legal rights.

- *What will happen to the results of this study?*

The results will be fed back to each team through a report made available to the teams and seminar presentations. In addition, it is expected that 3 international publications will be produced from the research project in order to publicise the usefulness of this approach.

- *Who is organising and funding this study?*

The study is being sponsored by Plymouth University. The primary researcher is a PhD student at the University of Plymouth. The research supervisor, Cordet Smart is a lecturer in Clinical Psychology and is involved in wider research on MDTs in Action.

- *How have patients and the public been involved in this study?*

Two different service user groups have been contacted to discuss the development of the research. They welcomed the idea of examining how staff teams work.

- *Who has reviewed this study?*

The study has been reviewed by Dr. T. Auburn, Dr. J. Stedmon, and Prof. J. Edworthy from Plymouth University for academic content. It has also been reviewed by the Health Research Authority (HRA) Assessment team to obtain HRA Approval and has been ethically reviewed by the University Faculty Research Ethics Committee. The study has also received approval through the HRA Capacity & Capability process with Cornwall Partnership Trust.

For further information, and to take part, please contact:

If you would like further information, please contact:
Madeleine Tremblett at madeleine.tremblett@plymouth.ac.uk
Or Dr. Cordet Smart at Cordet.smart@plymouth.ac.uk

Thank you for your interest in taking part

HEALTH & HUMAN SCIENCES WITH PLYMOUTH UNIVERSITY

Participant Information Sheet

(Component: Ethnographic study- Interviews)

Project Title: Collaboration in Intellectual (Learning) Disability Services

Researcher: Madeleine Tremblett

Invitation

I would like to invite you to take part in a research project that is looking at collaboration in learning disability services. Before you decide to take part you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or you would like more information. Take time to decide whether or not to take part. Thank you.

Purpose of the study

Recent government recommendations emphasise the need for learning disability service staff to work collaboratively. However, little is known about how professionals in the NHS collaborate or the process of collaboration in a multi-disciplinary team. Current understandings of collaboration are mostly based on asking staff to retrospectively reflect on their experiences, which doesn't allow an understanding of how the process of collaboration is achieved in the moment by staff members. Thus, by observing a few instances of teams that work collaboratively daily to provide care, the research will be able to describe how these teams work together and how collaboration is achieved in these instances. The research is being undertaken by Madeleine Tremblett as part of a PhD project with the University of Plymouth.

This research is part of a larger research project that is looking at collaboration in Intellectual (Learning) Disability (I(L)D) Services. The ethnographic study aims to provide some contextual information about how teams in I(L)D services are organised to enable collaboration and how staff themselves construct the meaning of collaboration. Alongside the observations, interviews with three professionals from each team will be held to gain a more in-depth depiction of how collaboration is understood by staff. In addition, another strand of the research will be recording team meetings to identify communication practices that demonstrate collaboration.

Why have I been invited to take part?

You are being approached to take part as this research is specifically interested in collaboration in community adult learning disability service teams. You are being approached to take part in an interview for the researcher to gain more information on your perspective of what collaboration is in learning disability services. Three people from each team involved in the research (3 teams in total) are being approached to take part in these interviews. Each interview aims to be held with a professional from a different role, to gain a variety of perspectives.

Do I have to take part?

No, participation in the study is entirely voluntary, and you are free to withdraw participation at any time. This information sheet and one of the consent forms are for you to keep for your records, and contain the contact details for the research team if you need to notify us of your wish to withdraw.

What will happen to me if I take part?

There is no requirement to take part, but if you choose to participate then we would like to interview you about your experiences of collaboration and the organisation of your I(L)D service. The interview will provide an opportunity for you to discuss collaboration in your role. It is expected the interview will take about 1 hour and will be held in a private room at a time that is convenient to you.

To ensure accuracy we would like the interviews to be audio recorded so that the researcher can listen to your view about collaboration. The interview recording will be transcribed as soon as possible and you will be allocated a unique study number to protect your confidentiality. The transcriptions will be anonymised, with any identifying information removed and volunteers will only be referred to by their role and study number. If your role is unique and may provide identification, you will be labelled by a similar generic role to prevent identification. You will have an opportunity to review the transcript prior to analysis and request any portion to be removed. The audio recording and transcripts will be kept on an encrypted USB stick in a locked in the University of Plymouth, and on an encrypted secure online storage service. Consent forms and the data in anonymised form will be retained for ten years in line with Plymouth University's retention policy.

It is important to remember that this research is focused on the team process of collaboration – it is not designed to identify or focus on individual contributions to the collaboration, but rather to explore different dimensions of how teams operate.

What are the possible disadvantages and risks of taking part?

It might be that there are difficult team dynamics that are currently going on within the team, and that therefore you may decide not to take part. It is hoped that even in these cases it might be possible to identify more positive practices than anticipated and we are open to all views, however we would not like to cause any further difficulties.

We recognise that discussing collaboration in your team may highlight some areas of difficulty. However, throughout the interview you have the right to withdraw at any time or to not answer questions without giving a reason. To minimise the potential for discomfort, we would reiterate that individual performance is not being studied, rather how *teams* operate and that *multiple* teams are being recruited from each service area to reduce the feeling of being in the 'spotlight'. All excerpts from the transcripts used in analysis will be brief and anonymous to protect your confidentiality.

In the unlikely event that poor practice is to be identified during the interview the researcher has a duty of care to take the appropriate steps accepted within the NHS. As participants taking part in the research deliver NHS services, the researchers will

follow protocols recommended for NHS staff, which can be found at www.wbhelpline.org.uk. We will advise the relevant teams of this in advance and discuss any concerns raised with the relevant staff members.

At times during the study interview you may feel it is necessary for clients to be discussed to illustrate a point about team collaboration and we ask you to refrain wherever possible from using the client's name. Clients confidentiality must take priority and will be maintained at all times, and their identifiable data will be removed from the transcripts and audio recordings in the event that they are referred to during the interview. We have discussed this issue extensively with service user groups who have commented that they would rather not be informed of the research, as they have other concerns to consider. They have, however, suggested that research examining how teams operate would be valuable.

In past research of this nature run by the University we have found that these anxieties have been overcome and that in fact the focus on good practice in team working has been very helpful.

What are the possible benefits of taking part?

Participation within the research will give you and your team the opportunity to reflect on how the team works, and to have first access to new and innovative findings around team working. It would also enable you to contribute to a project that is likely to have positive benefits for the development of staff teams both nationally and internationally. We will aim to disseminate the findings at local, national and international conferences. As participants, you will also have the opportunity to ask any questions that you might have about this research, and perhaps to consider how it might influence you to developing your own research projects subsequently.

Further questions

- *What if there is a problem?*

If you are finding the research upsetting at all, you should contact in the first instance Cordet Smart (cordet.smart@plymouth.ac.uk), who is the research supervisor. If you are upset in any way with how the research is being conducted, or have any concerns or wish to complain, then please get in touch with Prof. Judy Edworthy, Psychology Ethics Committee Lead, Plymouth University (j.edworthy@plymouth.ac.uk).

- *How will my information be kept confidential?*

The transcripts and analysis will only reference team roles, rather than individual names and all study information is collected using unique study numbers. Careful selection will be made of excerpts from the interviews that do not refer to any easily recognisable information about any individual.

- *What will happen if I don't want to carry on with the study?*

Participation in the study is entirely voluntary. You are free to withdraw participation at any time and without giving a reason, without it affecting your legal rights.

- *What will happen to the results of this study?*

The results will be fed back to each team through a report made available to the teams and seminar presentations. In addition, it is expected that 3 international publications will be produced from the research project in order to publicise the usefulness of this approach.

- *Who is organising and funding this study?*

The study is being sponsored by Plymouth University. The primary researcher is a PhD student at the University of Plymouth. The research supervisor, Cordet Smart is a lecturer in Clinical Psychology and is involved in wider research on MDTs in Action.

- *How have patients and the public been involved in this study?*

Two different service user groups were contacted to discuss the development of the research. They welcomed the idea of examining how staff teams work.

- *Who has reviewed this study?*

The study has been reviewed by Dr. T. Auburn, Dr. J. Stedmon, and Prof. J. Edworthy from Plymouth University for academic content. It has also been reviewed by the Health Research Authority (HRA) Assessment team to obtain HRA Approval and has been ethically reviewed by the University Faculty Research Ethics Committee. The study has also received approval through the HRA Capacity & Capability process with Cornwall Partnership Trust.

For further information, and to take part, please contact:

If you would like further information, please contact:
Madeleine Tremblett at madeleine.tremblett@plymouth.ac.uk

Or Dr. Cordet Smart at Cordet.smart@plymouth.ac.uk

Thank you for your interest in taking part

HEALTH & HUMAN SCIENCES WITH PLYMOUTH UNIVERSITY

Participant Information Sheet

(Component: Multi-disciplinary team meeting recordings)

Project Title: Collaboration in Intellectual (Learning) Disability Services

Researcher: Madeleine Tremblett

Invitation

I would like to invite you to take part in a research project that is looking at collaboration in learning disability services. Before you decide to take part you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or you would like more information. Take time to decide whether or not to take part. Thank you.

Purpose of the study

Recent government recommendations emphasise the need for learning disability service staff to work collaboratively. However, little is known about how professionals in the NHS collaborate or the process of collaboration in a multi-disciplinary team. Current understandings of collaboration are mostly based on asking staff to retrospectively reflect on their experiences, which doesn't allow an understanding of how the process of collaboration is achieved in the moment by staff members. Thus, by observing a few instances of teams that work collaboratively daily to provide care, this research will be able to describe how these teams work together and how collaboration is achieved in these instances. The research is being undertaken by Madeleine Tremblett as part of a PhD project with the University of Plymouth.

This research is part of a larger research project that is looking at collaboration in Intellectual (Learning) Disability (I(L)D) Services. The ethnographic study aims to provide some contextual information about how teams in I(L)D services are organised to enable collaboration and how staff themselves construct the meaning of collaboration. Alongside the observations, interviews with three professionals from each team will be held to gain a more in-depth depiction of how collaboration is understood by staff. In addition, another strand of the research will be recording team meetings to identify communication practices that demonstrate collaboration.

Why have I been invited to take part?

You are being approached to take part as this research is specifically interested in collaboration in community adult learning disability service teams. It is important that we gain consent from all members of a potential team, although we are not interested in individual members' conduct, but how the team functions as a collective body.

Do I have to take part?

No, participation in the study is entirely voluntary, and you are free to withdraw participation at any time. This information sheet and one of the consent forms are to keep for your records, and contain the contact details for the research team for withdrawal.

What will happen to me if I take part?

There is no requirement to take part, but if you choose to participate there will be minimal disruption to your normal practice. The team simply needs to record the meetings, and if any team members would like to make comments to the researchers about the meetings, these will also be collected to help make sense of the findings.

Three I(L)D teams will be approached to take part. It is hoped that these teams will take part in the ethnographic study along with allowing the opportunity to record their MDT meetings. We seek to record 5 hours of meetings from each team. It is hoped that this quantity of data will capture the diverse ways that different I(L)D services operate collaboratively and mean that individual teams will remain anonymous. If all team members agree to take part, the researcher will bring recording equipment and set this up to record the meetings. They will not stay for the meeting, but will collect the equipment and data afterwards. A 'team map' will be sought to help us understand who makes up the team. You do not have to spend any time in addition to your normal working day if you do not want to.

The video recording is particularly useful for the researcher to be able to clarify whether an utterance was made by, for example, the same speaker or a new speaker, which is important for analysis. It also allows additional detail such as eye gaze or note taking to be incorporated into analysis. To maintain confidentiality any snippets of the video recording that may be used in analysis will have a filter applied so that it is not possible to identify individuals. However, teams can just be audio recorded if they would prefer to not be filmed.

The data will be transferred securely using encrypted USB devices and stored on an encrypted secure online storage service. The USB will be kept in a locked cabinet in the University of Plymouth. All patient and staff identifiable information will be anonymised both on the recordings and in the transcriptions. You will have an opportunity to review the transcript prior to analysis and request any portion to be removed. Consent forms and the data in anonymised form will be retained for ten years in line with Plymouth University's retention policy.

It is important to remember that this research is focused on the team process of collaboration – it is not designed to identify or focus on individual contributions to the collaboration, but rather to explore different dimensions of how teams operate. The nature of the analysis, conversation analysis, focuses on how conversation works. It involves pulling out very short extracts and examples of interaction. Due to the short nature of these extracts, and careful ethical consideration, extracts can be managed in more anonymous ways to ensure that no clinician feels singled out in any way. This is particularly possible in this study as multiple teams will be involved.

The findings of the research will be fed back to each team, both in written form, and should the team wish, through aural presentation. As the data will be grouped and anonymised, feedback would include overarching conclusions and not individual team data. Interested participants are also welcome to be part of a consultative group for the research. If you would like to do this, please let the researchers know. We are working with a consultative group of clinicians and academics, and have asked service users to join in, so that we can ensure the ethical conduct of the research and to add additional comment.

What are the possible disadvantages and risks of taking part?

It might be that there are difficult team dynamics that are currently going on within the team, and that therefore you do not wish to take part. It is hoped that even in these cases it might be possible to identify more positive practices than anticipated and we are open to all views, however as a research team we would not like to cause any further difficulties.

We recognise that having a team meeting recorded could feel a bit uncomfortable. To minimise the potential for discomfort, we would reiterate that individual performance is not being studied, rather how *teams* operate and that *multiple* teams are being recruited from each service area to reduce the feeling of being in the 'spotlight'. All excerpts used in analysis will be brief and anonymous.

In the unlikely event that poor practice is to be identified in the recordings the researcher has a duty of care to take the appropriate steps accepted within the NHS. As participants taking part in the research deliver NHS services, the researchers will follow protocols recommended for NHS staff, which can be found at www.wbhelpline.org.uk. We will advise the relevant teams of this in advance and discuss any concerns raised with the relevant staff members.

It is notable that the team meetings are likely to involve the discussion of clients. . Clients confidentiality must take priority and will be maintained at all times, and their identifiable data removed from the transcripts and recordings. We have discussed this issue extensively with service user groups who have commented that they would rather not be informed of the research, as they have other concerns to consider. They have, however, suggested that research examining how teams communicate would be valuable.

In past research of this nature run by the University we have found that these anxieties have been overcome, and that in fact the focus on good practice in team working has been very helpful.

What are the possible benefits of taking part?

As we are recording meetings that already form part of a team's work, we hope this offers an opportunity to be involved in research without it creating any additional workload. The service-users and carers we have consulted gave their unanimous support for the aims of this research and thought it offered opportunities to improve service-user experience.

Participation within the research will give you and your team the opportunity to reflect on how the team works, and to have first access to new and innovative findings around team working. It would also enable you to contribute to a project that is likely to have positive benefits for the development of staff teams both nationally and internationally. We will aim to disseminate the findings at local, national and international conferences. As participants, you will also have the opportunity to ask any questions that you might have about this research, and perhaps to consider how it might influence you to developing your own research projects subsequently.

Further questions

- *What if there is a problem?*

If you are finding the research upsetting at all, you should contact in the first instance Cordet Smart (cordet.smart@plymouth.ac.uk), who is the research supervisor. If you are upset in any way with how the research is being conducted, or have any concerns or wish to complain, then please get in touch with Prof. Judy Edworthy, Psychology Ethics Committee Lead, Plymouth University (j.edworthy@plymouth.ac.uk).

- *How will my information be kept confidential?*

The transcripts and analysis will only reference team roles, rather than individual names and all study information is collected using unique study numbers. Careful selection will be made of excerpts that do not refer to easily recognisable information from any individual.

- *What will happen if I don't want to carry on with the study?*

Participation in the study is entirely voluntary, and you are free to withdraw participation from four weeks after data collection and without giving reason, without it affecting your legal rights. There is a time limit as after this point due to the anonymising procedure it will be impossible to identify individuals in the data.

- *What will happen to the results of this study?*

The results will be fed back to each team through a report made available to the teams and seminar presentations. In addition, it is expected that 3 international publications will be produced from the research project in order to publicise the usefulness of this approach.

- *Who is organising and funding this study?*

The study is being sponsored by Plymouth University. The primary researcher is a PhD student at the University of Plymouth. The research supervisor, Cordet Smart is a lecturer in Clinical Psychology and is involved in wider research on MDTs in Action.

- *How have patients and the public been involved in this study?*

Two different service user groups have been contacted to discuss the development of the research. They welcomed the idea of examining how staff teams work.

- *Who has reviewed this study?*

The study has been reviewed by Dr. T. Auburn, Dr. J. Stedmon, and Proff. J. Edworthy from Plymouth University for academic content. It has also been reviewed by the Health Research Authority (HRA) Assessment team to obtain HRA Approval and has been ethically reviewed by the University Faculty Research Ethics Committee. The study has also received approval through the HRA Capacity & Capability process with Cornwall Partnership Trust.

For further information, and to take part, please contact:

Madeleine Tremblett at madeleine.tremblett@plymouth.ac.uk

Or Dr. Cordet Smart at Cordet.smart@plymouth.ac.uk

Thank you for your interest in taking part

Appendix C

Consent Forms for participants

Consent Form

(Component: Team meeting recordings)

Title of Project: Collaboration in Intellectual (Learning) Disability Services

Name of Researchers: Madeleine Tremblett and Cordet Smart

Please initial each box and sign at the bottom.

1. I confirm that I have read and understand the information sheet (Version 2.0, 18.10.2017) for the above study and have had the opportunity to ask questions which have been answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw consent for four weeks after recording without giving any reason and without my legal rights being affected. ☐
3. I understand that data collected during the study, may be looked at by individuals from the University of Plymouth from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. ☐
4. I understand that taking part involves team meetings being audio, and or video, recorded and informal conversations with the researcher to be audio recorded with my knowledge and that I will not be able to be identified in any of the write up or publications to protect my confidentiality. ☐
5. I understand that I can review what I have said within the transcript and can request to withdraw my input in part or in its entirety for four weeks after recording. ☐
6. I understand consent forms and the data in anonymised form will be retained for ten years in line with Plymouth University's retention policy. ☐
7. I agree to take part in the above study. ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

When completed: 1 for participant; 1 for researcher site file (original)

Consent Form

(Component- Ethnographic interviews)

Title of Project: Collaboration in Intellectual (Learning) Disability Services

Name of Researchers: Madeleine Tremblett and Cordet Smart

Please initial each box and sign at the bottom.

1. I confirm that I have read and understand the information sheet (Version 2.0, 18.10.2017) for the above study and have had the opportunity to ask questions which have been answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. ☐
3. I understand that data collected during the study, may be looked at by individuals from the University of Plymouth from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. ☐
4. I understand that taking part involves an interview that will be audio recorded and that I will not be able to be identified in any of the write up or publications to protect my confidentiality. ☐
5. I understand that I can review the transcripts of my interview and can request to withdraw my input in part or in its entirety after the interviews have taken place. ☐
6. I understand consent forms and the data in anonymised form will be retained for ten years in line with Plymouth University's retention policy. ☐
7. I agree to take part in the above study. ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

When completed: 1 for participant; 1 for researcher site file (original)

Consent Form

(Component: Ethnographic study)

Title of Project: Collaboration in Intellectual (Learning) Disability Services

Name of Researchers: Madeleine Tremblett and Cordet Smart

Please initial each box and sign at the bottom.

1. I confirm that I have read and understand the information sheet (Version 2.0, 18.10.2017) for the above study and have had the opportunity to ask questions which have been answered satisfactorily. ☐

2. I understand that my participation is entirely voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. ☐

3. I understand that taking part involves the team being observed for one week and observations and informal conversations with the researcher to be recorded in field notes, but that I will not be able to be identified in any of the write up or publications to protect my confidentiality. ☐

4. I understand that data collected during the study, may be looked at by individuals from the University of Plymouth from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. ☐

5. I understand that I can review field notes and can request to withdraw my input in part or in its entirety for four weeks after the observation period. ☐

6. I understand consent forms and the data in anonymised form will be retained for ten years in line with Plymouth University's retention policy. ☐

7. I agree to take part in the above study. ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

When completed: 1 for participant; 1 for researcher site file (original)

Appendix D

Ethical approval

NHS
Health Research Authority

Miss Madeleine Tremblett
Psychology Office
University of Plymouth
Drakes Circus
PL4 8AA

Email: hra.approval@nhs.net

06 March 2018

Dear Miss Tremblett

Letter of HRA Approval

Study title:	**Exploring collaborative working in adult intellectual (learning) disability services**
IRAS project ID:	**224902**
Protocol number:	**FHHS-224902-MT-031**
REC reference:	**17/SW/0268**
Sponsor	**University of Plymouth**

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

RESEARCH WITH PLYMOUTH UNIVERSITY

16th March 2018

CONFIDENTIAL

Madeleine Tremblett
School of Psychology
University of Plymouth
Link 111, Portland Square
Drake Circus
Plymouth
PL4 8AA

Dear Madeleine

Application for Approval by Faculty Research Ethics and Integrity Committee

Reference Number: **17/18-909**
Application Title: **Exploring collaborative working in adult intellectual (learning) disability services**

I am pleased to inform you that the Committee has granted approval for you to conduct this research.

Please note that this approval is for the duration of your project as requested on your application form (1st April 2018 to 30th April 2020), after which you will be required to seek extension of existing approval.

Please note that should any MAJOR changes to your research design occur which effect the ethics of procedures involved you must inform the Committee. Please contact the committee administrator (email hssethics@plymouth.ac.uk).

Yours sincerely,

Professor Yaniv Hanoch
Chair, Faculty Psychology Ethics Committee

Appendix E

Example of observation notes

Monday morning

- Getting everyone to sign the consent forms
- A number of people have already arrived, about three
- Everyone helps with getting cups of tea

Poster on wall –
Safe: * Robust safeguarding processes

- Keeping service users and staff safe from harm
- Risk aware
- All staff up to date with training
- Safe staffing levels
    - Our strengths: RMS with safeguarding section on the form
    - Our challenges: CC safeguarding overwhelmed and don't feedback things on a regular basis

Well-led:

- Clear effective clinical leadership in the tea
- Structure for supervision and reflective practice
- Clear and well known governance structures
- Staff fully aware of personal roles and responsibilities
    - S: We have a very competent clinical team leader who is invested in his team
    - C: (blank)

Responsive:

- Service responsive to clinical need
- Timely access to assessment, treatment and review
- Flexible response to fluctuating referral levels
- Responsive needs are changing needs
- We listen to feedback
    - S: we don't have a referral list; referrals screened by a PA and urgency assessed at this time
    - C: (blank)

Effective

- Cohesive, supportive team
- Effective clinical supervision
- Outcome measures used
- Joint working with MDT
- Timely intervention
- Evidence based practice
    - S:
    - C:

Caring

- People and family centred

- Involving people, carers and family members in care planning and decisions
- The ward/clinic looks welcoming
- We show care in all we do
    - S:endeavour to include client and the circle of support in all we do
    - C:

Day one

- Everyone says hello to one another
- Hot desking, although regular seats
- General chit chat – weekend, food, diet, sharing food
- Ad hoc catch ups about clients
    - Can I grab you quickly, quick short discussions
- Contentious meetings – ability to check in, are you ok, don't seem ok today, issues ongoing
- Part time, and in and out; flux of staff
- All chat and know one another
- Discussion of staffing levels: T winding down, A leaving
- Cake Mondays – rota for who will bring cake
    - New member of staff (psychiatrist, can he bake, no, but he can make noodles)
    - Front given that to fit in with team cakes etc. are essential
- Jokes made about me
- KM stay until 6:30
- Predominantly nursing, then OT, then Drs
- Most eat lunch at their desk
- AB – spoke to everyone with full name
- DB in high demand, for requesting and having quick meetings
- Discussion – fraternising with same guy
- Mostly female – only 1 male
- Body language in meetings: KN use of circle gestures, DB leaning in, AC rolling eyes
- References to the tape – can't help but be seen looking
- AB – that was an interesting meeting wasn't it – contention between 3 occupational groups? Very siloed in what they will/won't do
- Pretty much the stem of the majority of issues in meetings relates to inadequate housing – not due to s/care, but no money – quite brazen about use of just checking as a stop gap- called out in professional way

Appendix F

Semi structure interview schedule

Collaboration in Intellectual (Learning) Disability services : Semi- structured interview schedule.

- In general, how do you characterise the way you work?
    - Thinking about other ways you have worked, perhaps in other teams, what is similar/different
- What sort of things do you think help this team work well?
    - Prompts:
        - Hierarchy
        - Resources
        - Location
        - Other people
        - Money
        - Gossip/informal chat
        - Casual team activities
- What sort of things do you think hinders this team working well together?
    - Prompts:
        - Hierarchy
        - Resources
        - Location
        - Other people
        - Money
        - Gossip/informal chat
        - Casual team activities
- What would you say the role of the MDT meetings is?
- How do the MDT meetings help or hinder what you want to achieve?
- Are there some other things about working in this team which you think are important that we haven't covered here?

Appendix G

Transcription conventions

((word))	Transcribers comments – i.e. ((ringing)) for a ringing phone.
(word)	Uncertain hearing is put into brackets
( )	Unrecoverable speech
(word1/word2)	Two possible hearings of a word
NA?	Uncertain speaker
(0.8)	Silence measured in seconds
(.)	Micropause
[	Overlap onset
]	Overlap end
=	Latching
>talk talk<	Speeded up talk
<talk talk>	Slowed down talk
:	Stretched sounds (e.g. no::, n::o)
–	Cut off sounds (for an unfinished word, e.g. ju-)
<talk	Jump started (‘left push’) talk
talk>	Suddenly stopped word (completed word, see ‘-‘ for part word)
talk	Emphasis, raise in volume
TALK	Loud or shouted talk
↑	Rise in intonation
↓	Drop in intonation
°talk°	Quiet talk
£talk£	‘Smiley voice’ – associated with suppressed laughter
.	Falling intonation at the end of a unit of talk
,	Continuing intonation at the end of a unit of talk
¿	Slight rise in intonation at the end of a unit of talk
?	Sharp rise in intonation at the end of a unit of talk
wo(h)rds	Within speech breath burst (aka laughter)
hah/hih/heh/huh	Different forms of laughter
#word#	Creaky or croaky voice
.pt	Lip smack
~word~	Upset voice
.hh	In-breath
hh	Out-breath
hhh or .hhh	Stretched aspiration
HH or .HH	Elevated volume of aspiration

Adapted from:
Stokoe.E. (2018) *‘Talk’: The science of conversation*. Robinson.

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H. Lerner (Ed.), *Conversation analysis* (pp. 13-31). John Benjamin's Publishing Company.

Hepburn, A., & Boden, G. B. (2013). The conversation analytic approach to transcription. In J. Sidnell & T. Stivers. *The handbook of conversational analysis* (pp. 57-76). Blackwell Publishing Ltd.

Hepburn, A., & Boden, G. B. (2017). *Transcribing for social research*. Sage Publications Ltd.