2018-11

What a discursive understanding of interprofessional team meetings might reveal: an exploration of intellectual (learning) disability managers' performances.

Smart, C

10.1080/13561820.2018.1500450
Journal of Interprofessional Care
Taylor & Francis

What a discursive understanding of interprofessional team meetings might reveal: An exploration of intellectual (learning) disability managers' performances

Abstract

Clinical and academic understandings of interprofessional working are focused mainly on individual factors such as knowledge about different professional roles, and organisational opportunities for interprofessional working (IPW). Less research has examined what happens between people at an interactional level, that is, how interprofessional working is conducted in everyday face-to-face interactions in clinical practice. The current paper proposes a discursive framework for understanding what constitutes IPW in interprofessional meetings at this interactional level. Clinical effectiveness meetings held in intellectual (learning) disability services were used as an example site for IPW. The analysis explored how agenda change points were negotiated, appropriate as agenda change points require collaboration (or agreement) between practitioners to progress to the next point The study found changes in agenda points were accomplished by practitioners conjointly through using discursive strategies including closing questions, and resources such as professional identity and laughter. The agenda provided a frame for the institutional order of the meetings, invoking a trajectory towards timely completion. However, this institutional order was at times subordinated to an 'order of concern', which seemed to enable challenges by managers to the meeting Chair and the agenda that demonstrated adherence not only to the procedural nature of the meetings, but also to the needs of service users and the services discussed. We suggest discursive strategies, resources, and both institutional orders, and order of concerns might provide a

framework for developing future training and research, that is able to illuminate how IPW might be enacted in face-to-face team meetings.

Keywords: Interprofessional working, Healthcare teams, Discursive psychology, Meeting agendas; Intellectual (Learning) Disability

Introduction

This article reports a study which takes a discursive psychology approach to understanding how those who participate in interprofessional team meetings jointly constitute these meetings as occasions for collaborationThe data for this study was taken from team meetings of I(L)D (intellectual (learning) disability[i]) managers. This setting provides a canonical instance of an everyday interprofessional working context. The aim of the study was to add to the growing body of work which examines how team meetings actually function (e.g. Angell & Boden, 2016; Arber, 2008; Pullon, Morgan, Macdonald, McKinlay, & Gray, 2016) through a detailed examination of the interaction between team participants and thus begin to identify the practices constitutive of interprofessional team working.

This study specifically focuses on those points in multidisciplinary team meetings where there was a move from one agenda item to another. The rationale for this focus was twofold. First, they represent the end point of collaborative engagement where, in principle, agreement on a course of action has been reached. Secondly, they potentially are the point where the different and possibly competing professional concerns of the team members are displayed, managed and resolved.

Interprofessional practice

As the recognition of the importance of interprofessional practice for improved health and social care has grown, so has the complexity of our understanding of how interprofessional practice is implemented. Rather than a singular linear dimension from poor to good implementation, different types of interprofessional practice have been proposed (Reeves, Xyrichis & Zwarenstein, 2018). The effectiveness of interprofessional practice is contingent on multiple interacting factors such as influence of professional roles, and the nature and extent of communication between professionals (Brown, et al., 2011; Morgan, Pullon & Mckinlay, 2015; O'Carroll, McSwiggan & Campbell, 2016; Xyrichis, & Lowton, 2008; Reeves, Pelone, Harrison, Goldman and Zwarenstein, 2017). Based upon an analysis of six main factors influencing the delivery of patient care, Reeves et al. (2018) proposed that there are different types of interprofessional practice: teamworking, collaboration and networking. These different types reflect different combinations of the six factors. Each type also is differentially suited to different health and social care needs. In the study reported here, the I(L)D teams tended to fall under the collaborative type of practice. This type of practice emphasises shared accountability and interdependence between individuals; however there is less emphasis on shared identity and integration of individuals (Reeves et al., 2018)

.

The development of interprofessional teamwork has been one approach to enhancing collaboration across professions. These teams are normally composed of individuals from multiple professions. However, although the literature provides helpful insight into a range of factors that are relevant for enhancing interprofessional practice, such as the ways that spaces are designed (Belanger et al., 2014) or enhancing knowledge of different people's roles

(Mosser & Begun, 2013; Weaver, Dy & Rosen, 2014), it does not detail the effects of this on how professionals speak to each other in their everyday settings – the 'between' people level. The focus on the interaction between those engaged in interprofessional practice needs to examine directly how collaborative practice is enacted, and in particular how participants' discourse shapes and is shaped by an orientation to interprofessional working (see for example Belanger & Rodriguez, 2008; Bokhour, 2008; Lewin & Reeves, 2011; Morgan et al., 2015; Mosser & Begun, 2013).

Background

A discursive psychology approach

A growing body of work has examined IPW in multiple health and social care contexts at the face-to-face level. This study falls within this body of work and specifically adopts a discursive psychology methodology. Discursive psychology focuses on the situated use of naturalistic discourse in all kinds of informal and institutional interactions. It has three main principles (Potter, 2003; Tileaga & Stokoe, 2015): that discourse is action-oriented, that particular moments of talk are situated in orderly sequences of discourse and that discourse is both constructed and constructive. These principles entail a methodology requiring close analysis of discourse via detailed transcripts of relevant extracts of talk. This allows understanding of how participants themselves orient to and display their ongoing concerns. For example, in Arber's (2008) work on questioning in IPW, the focus on how nurses used questions, in contrast to the doctors use of declaratives revealed both how the nurses oriented to the organisational hierarchy in which they were working and the rights and obligations that they held relative to doctors.

A discursive psychology approach allows us to go some way toward capturing the complexity of face-to-face interprofessional working in team meetings. This complexity not only requires an understanding of interactional practices, but also how participants incorporate and display their concerns drawn from wider moral and political contexts. The intersection of the local management of interaction with other moral and political concerns creates an underlying 'argumentative texture' of the meetings which participants navigate in order to accomplish effective collaboration.

Focusing on IPW in intellectual disabilities service manager meetings

This section outlines the broad argumentative context relevant to the focal I(L)D manager meetings. An indication of the wider moral and political concerns which I(L)D managers are likely to orient to are contained in a number of recent reports highlighting poor services and increased mortality (e.g. the Winterbourne and Francis reports (Department of Health, 2015, Francis, 2013)). This has led to staff management of services being increasingly scrutinised (Baxter, 2013), and increasing emphasis on individual professional accountability (Care Quality Commission, 2012) and critique (Anning, Cottrell, Frost, Green & Robinson, 2006). These national concerns intersect with local service needs and priorities. Local service organisation is particularly important for the promotion of good interprofessional relationships and dissemination of values based care (Clark, 1997).

Drawing on the work of Goffman, Lewin and Reeves (2011) conceptualised MDT meetings as one form of 'stage' on which IPW takes place. Using this analogy, we suggest that the 'argumentative texture' may be negotiated within the formal meeting on this meeting 'stage', and that to better understand how meetings work, this needs to be further explored. Work in other areas examining meetings emphasises how meetings can create particular roles

for people. Halvorsen and Sarangi (2015) distinguished these as action (related to formal meeting roles, such as the Chair) and discursive roles (relating to social relationships). The action roles are part of the institutional order, and include the 'Chair', responsible for moving from one agenda point to the next and maintaining the timely conduct of the meeting. Svennig (2012a; 2012b) suggests that the Chair occupies the senior, leadership, position within the room, which might be unrelated to hierarchies and professional relationships outside of the meeting environment. It is likely that these roles might punctuate how the I(L)D meetings operate, as the argumentative context is negotiated.

At issue here is not only how managers negotiate the argumentative context on the stage, but how they achieve this collaboratively. At an interactional level, collaboration can be defined as working together to achieve the conversation itself. Depperman, Schmitt and Mondada (2010) argued that the transition between agenda points is a central juncture in meetings for collaboration between speakers, as there must be at least implicit agreement on the prior point before transition to the subsequent point. These moments seem particularly difficult for teams generally to manage (Beach, 1993; Deppermann et al., 2010; Jefferson, 1984; Mondada, 2006; Robinson and Stivers, 2001). Further, in healthcare meetings there can be discrepancies between the institutional order and the concerns of the participants (Bokhour, 2006). This raises questions around how these moments are managed in I(L)D meetings.

The current paper aimed to develop the foundations for a discursive framework for understanding I(L)D team interactions in interprofessional meetings that is able to:

a) accommodate the specific concerns of I(L)D meeting contexts;

b) facilitate understandings of the ways in which meetings are performed;

c) be used to develop new questions about team working; and

d) offer recommendations for improving interprofessional working in meetings.

In order to study collaboration in face-to-face team meetings attended by intellectual disability managers, the specific objectives of this study were to: examine how the agenda was treated in the meeting; identify and discursively interrogate the accomplishment of agenda change points in meetings, and explore how political, local service, professional and interpersonal concerns are negotiated at agenda change points.

Methods

Naturalistic recordings were collected of I(L)D service planning manager meetings and analysed using a discursive psychology approach.

Participants

The data presented here are from three audio recorded meetings each lasting 3-4 hours (11 hours in total). These meetings involved managers from different local I(L)D services discussing service design and clinical effectiveness across an NHS trust. Topics included reviewing risk assessment processes, service design, the development of new processes for ensuring patient safety and medication checking processes. Participants were staff managers from different areas of practice (Doctors, Occupational Therapists, Nurses, Speech and Language Therapists and Clinical Psychologists). Seven people were present at each meeting, though they were not always the same people.

The region represented by managers was a large, mostly rural area of the UK. The meetings occurred monthly, and were chaired by the same manager during the recording period, which the service had opted for to maintain stability.

Data collection

An initial request was made to the Clinical Psychologist working in the team for interest in the research project. CS and NF presented the research to the team, and additional information was sent to all potential participants. The team met separately to discuss participation, and emailed the researchers with their response. CS and NF then met the team again and consented participants individually before recording meetings. Audio rather than video recordings were obtained as staff felt this was less intrusive. The researchers were absent during meetings. Digital devices were transferred immediately following meetings to a secure site. Subsequently, the audio recordings were anonymised and transcribed orthographically.

Data analysis

Analysis was mainly informed by Conversation Analysis (CA), though we also viewed the data from a critical discursive psychology perspective, reflecting a focus on how different moral and political concerns were managed within interactions. This approach, we have termed 'synthetic', as it combines CA with a consideration of the personal, social, or other work related concerns which participants brought to the meetings (cf. Wetherell, 2007). We wanted to incorporate into our analysis not only how speakers responded immediately to each other within their talk, but also how team members oriented to and managed concerns particularly relevant to managers in I(L)D services.

Through repeated listening of the meeting recordings, 33 instances were identified where agenda points were closed and a new point opened, 12 where agenda change was resisted, and 7 where the agenda was orientated to. These instances constituted our collection

of agenda change points. Each instance was transcribed using standard Jeffersonian (1984) conventions (Table 1).

INSERT TABLE 1 ABOUT HERE

The analysis was developed inductively from these extracts. The extracts in the collection were categorised according to distinctive practices which could be identified at these agenda change points. The categorization was an iterative process, in which all the authors participated. As well as categorization, the analysis considers how these practices are sequentially organized and the action(s) to which they are oriented, and were collaboratively produced. Some extracts illustrated more than one of these practices. The categorization of practices is considered in detail in the next section alongside exemplar extracts. These extracts have been simplified for ease of reading.

The objectives of the analysis were to interrogate how the agenda was treated in meetings, how change points were managed, and how political, local service, professional and interprofessional concerns were managed at these junctures. We use the analogy of the 'stage' to characterise the meeting context. We consider managers as 'performing' on this stage using a range of discursive strategies and resources to manage competing interprofessional, interpersonal, political and local service concerns.

Ethical considerations

Ethical approval was received from the University and local NHS research and development departments (UK). The NHS Research Ethics Committee also reviewed the study. Two service receiver consultant groups and a steering group involving two clinicians and a service receiver contributed to the direction and governance of the project. Advice from service receivers and NHS Ethics committees was that asking consent of named clients

would place additional stress on them and be unethical. All names, locations and identifiable information was obscured within 72 hours of obtaining the recordings. Pseudonyms were used in transcripts and extracts for publication selected to maintain anonymity.

Results

The results suggest what collaboration between clinicians in interpofessional meetings can look like in the details of conversation. We illustrate what we considered as an institutional order, discursive strategies and resources available for professionals to collaboratively achieve agenda change points, and strategies for invoking orders of concern, which might not fit with the institutional or procedural order of the meeting, but are important for ensuring that clinical concerns are addressed.

How the agenda was treated – establishing and using an institutional order

The agenda was used to establish and maintain the 'institutional order' of the meeting, that is, it guided how the business was conducted. It provided a resource for team members collaboratively to move out of 'small talk' (Maynard, 2008) and initiate 'meeting talk'. This move is illustrated in extract 1:

1.			(4.1) ((Giving out cake))
2.	Claire:		>thank you very< mu:::ch happy
3.			↓birthday::y
4.	Sandra:		↑yeah↓ >happy birthday melovely<
5.			(1.6)
6.	Sandra:	→	Right. are services <u>safe</u>.
7.	Kat:		Oh the next agenda point yea

(Extract 1: Moving back from break-time small-talk to 'meeting talk'

using the agenda - C1:33.10-34.45)

In this extract, the group are sharing birthday cake (lines 1-5). In line 6, Sandra (the Chair) switches from an informal mode of celebrating a birthday, to the formal mode of introducing the first agenda item (safe services). Sandra's change of footing is not challenged, and consequently can be read as institutionally appropriate. Further, it contrasts with the normative stepwise transition (Jefferson 1984) of changes of topic in every day conversation, suggesting that in this context she is afforded normative rights, through her role as Chair, which permit this change of topic. We tentatively suggest that this may illustrate a switch back from small talk to the particular institutional 'stage' of the MDT meeting. The transition was prototypical of the 4 such transition effects captured.

The 'power' of the agenda itself within the meeting is further suggested in Extract 2, where a breach of the agenda or meeting order is made. Breaches to the order of the agenda were rare and we captured only 3 such instances. Sue raises a topic prior to its place on the agenda, and this breach requires negotiation with the Chair, Sandra.

1.	Sue:		˚rather than developing several reports.˚
2.	Sandra:		Yeap. uhm.
3.	Sue:	→	I <u>know</u> >it is on the< agenda but it's just the kind
4.			of the the <u>fo</u>cus of that ˚slightly˚↓
5.	Sandra:		and do we know <u>gen</u>erally what the feedback was?
6.	Sue:	→	>We can pick it up on the< ↑agend:a

(Extract 2: Prioritising the agenda - C1:1:50-2:22)

In Extract 2, line 1, Sue is completing her turn discussing an issue that has not yet been raised on the agenda. In line 1, Sue completes her turn about the challenges of

pulling together feedback about the services. This is receipted by Sandra in line 2 using minimal acknowledgement tokens with a downward intonation that seems to close the sequence. However Sue continues on line 3, with a recognition that her item is on the agenda later and an account for mentioning it out of sequence. This explicit acknowledgement of the breach in institutional order seems to be treated favourably, as Sandra then offers a continuing conjunctive 'and' (line 5), seemingly displaying an affiliative stance toward this issue and to invite further discussion of it. Sue's response seems slightly anomalous in line 6. Instead of answering Sandra's query, she advocates a return to the agenda. However, she appears to have achieved using the agenda as a discursive resource to mark out a matter for concern. This extract illustrates two issues for the agenda in these meetings. Firstly, the importance of the agenda is shown in managing information flow – without referring to the agenda, the issue was not taken up. Secondly, it illustrates how the agenda can be used as a discursive resource to mark out delicate matters. Furthermore, reference to the agenda seems to provide Sue with 'institutional' power, in line 6, which seems to be prioritised above that of Sandra in her role as Chair.

How changes in agenda change points were accomplished – discursive strategies and resources

Staff used resources including: closing questions, professional identity and group affiliation, to close down agenda points and open up the floor for the next agenda point.

Closing questions. (Present in 22 of 33 agenda change point extracts). A clear transitional sequence was identified that closed the preceding topic and opened a new point, normative in agenda point transitions (Depperman et al., 2010). This process seemed to be

collaboratively accomplished through a format of a high grade assessment (HGA, Antaki, Houtkoop-Steenstra & Rapley, 2000) of the prior point+ Okay+ a move on statement. This is illustrated in Extract 3, line 5, where Sandra moves the meeting on from checking the minutes of the prior meeting.

1.	Sandra:	→	>Are you <u>happy</u> with the< accuracy::↑=
2.	Caroline:		=Yep. Fine.
3.	Sandra:	→	>Any further amendment:s (.) ↑then
4.			<apart from Jon Taylor:s↑
5.		→	Good Oka:y↓ ºlet's move <u>onº</u>

(Extract 3: Institutional agenda change: through closing questions -

C2: 0:01:52:21 - 0:02:01:52)

In line 1, extract 3, Sandra offers a check that people are in agreement, which is receipted with a 'yep' acknowledgement token in line 2. This could be termed a closing initiation question, designed for alignment with a no problem stance from others, and seeming to display a collaborative approach as a request was made for agreement. It is immediately followed by a negatively valenced question in lines 3 and 4 where Sandra asks whether there are 'any' more comments, which prefers a 'no' response (Heritage, Robinson, Elliott, Beckett & Wilkes, 2007). This question design sequence appears to provide the necessary level of agreement (Depperman et al., 2009) for Sandra to progress the meeting. She provides a positive upshot - 'good' in line 5, followed by 'Okay', and then 'let's move on'. This 3 part transition, HGA + Okay + a move on statement, was repeatedly used to close an agenda point and prepare the ground for the next. This was seen in 27 of our 33 agenda change extracts. It appears to construct a level of agreement for the meeting members that permits the Chair to move the meeting to the next agenda point. These transition practices

were generally proceeded by a pre-sequence (Scheglof, 2007), seen here in the closing initiation question in line 1.

This transition is particularly rapid compared with other CA studies of agenda orientated talk, such as Depperman et al. (2010). Noticeably, staff repeatedly commented on the time pressures on these meetings, the costs of so many high level staff meeting together, and their pride in achieving the organisational task requirements in a timely fashion. Thus the design of these closings and openings seemed attuned to local service priorities, concerns with time management, and could be considered collaborative in the sense that they were not resisted by participants in these examples.

Use of professional affiliation to offer a solution. A second practice was for professional identity to be used as a resource to close down a prior agenda point, seen in 5 of the 33 agenda change extracts. This is illustrated in Extract 4, appearing at the end of a discussion of a newly implemented medication review policy to ensure that I(L)D clients did not remain on unnecessary medication for long periods. Bob's status as a medical doctor enables him to voice an assurance 'for all doctors'. This perhaps illustrates how professional status can be orientated to.

1.	Bob:	→	I I'm <u>sure</u> Richard will make sure it:'s
2.		→	>discussed< with <u>all</u> doctors
3.	Sandra:		<u>fab</u> that's ↓great >okay< fifte:en PIM:S↑
4.			Sue's gonna ↑y:eah↓ a [ring I still think that's
5.	Sue:		[I <u>a:m</u> ↓yea

(<u>Extract 4</u>: Institutional agenda change through professional validation - C2:33:15.3 – 33:26.3)

In extract 4, lines 1 and 2, Bob seems to offer a solution to whether the medical review will be implemented – he reassures the team that medication review will be raised

with ‘all doctors’. This appears to be a downgraded epistemic claim that attends to his accountability for the action. Bob displays a degree of access to Richard’s mind and actions, predicated on their common professional practice, as Richard was not present. He asserts that the issue will be discussed with ‘*all* doctors’, an extreme case formulation, which can both be persuasive, and ‘softly’ done (Edwards, 2000). Bob’s persuasive strategies ‘I’m sure Richard will’, and his epistemic stance claiming knowledge of this, combined with his epistemic status (Heritage, 2012) as a doctor himself appears to enable the closure of the prior agenda point. Thus in line 3, Sandra then again moves through the transition sequence: high grade assessment (fab that’s great) + okay + move on (fifteen PIMS, the next agenda point). This illustrates how professional identity can be used as a resource to achieve social actions (in this case to progress the meeting), rather than identity necessarily determining how people act within meetings. Identity then becomes a useful resource to achieve activities within the meeting, such as in this case, moving on.

Alignment through laughter. Laughter was also used to close the prior agenda point in 6 of the 33 agenda change extracts. Where laughter was used there were no closing questions, nor professional claims. Instead there appeared to be ‘spontaneous’ agreement within the room, with the prior agenda point being transformed into a laughable and ‘yea’ agreement tokens seemingly completing the institutional requirement for agreement. Further, laughter appeared to replace the requirement for an HGA from the Chair, illustrated in Extract 5.

1.	Sue:		the rest of us wi:ll >↑but not the £new manager£
2.	Bob:		yea [yes
3.	Sue:	→	[↑he he hu ↓hu
4.			(0.8)
5.	Sandra:		oka:y let’s move <u>on</u>↓ six point tw:o↓

6. sequins[ii]

(Extract 5: Institutional agenda change through laughter -

C2:1:38:50.1 - 1:39:06.4)

Extract 5, line 1 comes at the end of a discussion of how things might change with the new manager, where Sue begins to transform the prior agenda point into a laughable by speaking with a smiley voice 'not the £new manager£'. Agreement tokens are then presented by Bob in line 2 appears to affiliate with Sue's smiley voice, potentially qualifying this as laughable. Affirming laughter follows in line 3, the downward intonation of which appears to indicate a closing of the prior agenda point. This is followed by a lapse in the conversation, line 4, potentially reflecting the challenges presented in transitions and re-establishing the working context following a pause (Deppermann et al., 2010). This appears to enact collaboration and agreement from the group, allowing Sandra to self-select and initiate a transition in line 5: Okay + move on. The HGA is not included here, but instead seems provided through the laughter sequence. Indeed, laughter can imply interpersonal collaboration (Glenn, 2003), and has been considered as important for interprofessional working (Griffiths, 1998). Therefore it could tentatively be argued that interpersonal concerns (to be friendly) were attended to here, and used as a resource for progressing meetings.

In summary, discursive strategies such as closing questions and laughter, and resources, such as professional identity and interpersonal relationships, were used to achieve the collaboration required to perform completion of the meeting within the institutional order.

Managing political, local service, professional and interpersonal concerns at agenda change points

At some agenda change points, the institutional order was not adhered to. Instead, managers appeared to prioritise ordering (or organising) their talk around other political, moral, local service, or professional concerns. For clarity, we have termed these 'orders of concern', that is, where talk was ordered around manager concerns specifically related to the needs of ensuring a high quality I(L)D service. Here we illustrate some ways that these orders of concern were performed.

Orientating to an 'order of concern': checking questions. Professionals retained their ethical accountability for the topics being discussed throughout the meetings, at times requiring resistance to changing agenda points. 7 extracts were identified where checking questions were used from our collection of 12 extracts where agenda change was resisted. For example, in Extract 6 Sally challenges Sandra's attempt to move the meeting on.

1.	Sandra:		>okay↓ lovely↓<right now< MRI
2.			↓scans procedures<right we we
3.			>can take that< off now
4.	Sally:	→	is that sorted
5.	Sandra:		I thi:nk, Richard was going<to go
6.			go awa<do you know anything ↑about th:at,

(Extract 6: Orientating to orders of concern through checking questions -C1:32.43.3-33:28.3)

In Extract 6, line one, Sandra makes a transition to a new topic 'okay lovely right', and immediately goes on to remove the prior item from discussion in lines 2-3 (we can take that off now). However, the assumed implicit team agreement is challenged by Sally at line 4

where she asks: ‘is that sorted’. As the agreement has been challenged, the institutional condition for moving on is not met. Sally appears to be orientating to a concern about whether the issue has actually been resolved, rather than prioritising the institutional order of following the meeting Chair and the agenda. This questioning by Sally imposes a concern around service provision of MRI procedures for people with I(L)D, opening the floor for discussion. This question could be heard as conflictual, as it challenges the authority of the Chair and the agenda. However, by re-framing our understanding of the question as imposing an order of concern about service provision, it can be heard as legitimate. Indeed, the question is not treated as problematic here. It is not dismissed and does not cause any lapses. Instead it seems that an order of concern is temporarily prioritised in the interaction.

Collaborative management of orders of concern. At some points, team members would temporarily shift their roles, from manager in a meeting to clinician, prioritising professional concerns (in 5 of our 12 cases of agenda change resistance). In one instance, the Chair herself prioritised an order of concern. In this instance the team collaboratively managed the competing orders of concern through a temporary change of roles from the action roles of the meeting to their professional roles. This is seen in extract 7. Here, when discussing feedback from staff on the service reorganisation related to psychology, her professional group, Sandra moves from her action role as the meeting Chair, to her professional role as a psychology manager under evaluation. She prioritises discussion of feedback as an ‘order of concern’, above the institutional order of the meeting.

1.	Kay:	and <u>act</u>ually >you know< ah=I didn’t expect to ↑<u>keep</u>
2.		people on board in this <u>pr</u>ocess↑ (.)
3.		[I ˚think˚ I guess you ˚ca:n’t˚ really can you but-
4.	Sandra:	[Mmmm↑mmmm↓
5.	Kay:	.hhh >but you< there is:s carrier balance [()

6.	Sandra:		mmm .hh::h hhh. [Yep hh. [ok:ay↓
7.	Kay:		[()
8.	Sue:		↑well that's not as bad as >I thought<
9.			it would be↓
10.	Sandra:		↑no I mean it's impr::oved by nearly ten percent
11.			so I think we (should be) be heartened by that
12.	Claire:	→	o::ky then harassment how's that done
13.	Sandra:		it was one of ou:r
14.			(.) yea it was still one of our
15.			three lowest

(Extract 7: Orientating to orders of concern through foregrounding professional over meeting/action roles - C2:2:15:52.9 – 2:16:06.1)

In extract 7 lines 1-3, Kay appears to offer an expectation that people might not be happy. Sandra's receipts in lines 4 and 6 appear to align, but not affiliate with this approach. In line 6 particularly, she offers a clear dispreferred stance, taking a breath and delaying before offering an agreement token and 'OK'. We can read this as reluctant given the prior hesitation. This does not conform to the normative practice of 'HGA + OK + move on' that the action role of the Chair might require. Instead, Sue attempts a more positive upshot on line 8, possibly taking a more 'discursive' or interpersonal role, and rescuing Sandra's displayed disappointment. Sandra then attempts to reframe her disappointment more positively, with the term 'heartened' (line 11). Though this upgrades Sue's assessment (lines 8 and 9), it is considerably more measured than those HGAs that she offers elsewhere (e.g. good, fabulous, lovely), and does not lend to meeting progression. Instead, Claire (Senior Nurse Manager) comes in in line 12 and treats the prior 'heartened' statement as the agenda point upshot, and offers the 'okay' that enables the meeting to progress to discussion of harassment (new topic), taking on the role of the Chair by moving the meeting on. This role-shift is not treated as problematic within the conversation, and Sandra continues by

responding to the new topic point. Claire is the senior manager in the room outside of the meeting, despite Sandra chairing the meeting. The group appear to use their professional and organisational roles and status as resources here, enabling Sandra to invoke an 'order of concern', but policing this by temporarily substituting the Chair. This flexibility in the fulfilment of the chairing role might illustrate how a collaborative approach to leadership can successfully work in teams. It shows how individual members can attend emotionally and professionally to orders of service concern, yet the business of the meeting can still be accomplished by other team members.

Discussion

This study examined the details of interaction between professionals in an interprofessional meeting to explore how a discursive framework might increase understanding of IPW in team meetings. Using the analogy of the stage, it is possible to characterise meetings as particular forms of performance, following (Lewin and Reeves, 2011). We suggest that this stage has a particular institutional order incorporating the use of the meeting agenda, which was mostly prioritised in the accomplishment of the meeting, and meeting roles such as the 'Chair'. Agenda point changes required some form of agreed closure of the prior agenda point. This was achieved through discursive strategies including using closing questions, or the establishment of affiliative laughter. Managers also illustrated how discursive resources including professional identity as a resource for reassurance, and the agenda itself, can be used to achieve the institutional order. Central at agenda change points was a concern for the timely completion of the meeting, but this was not prescriptive of the meeting. Managers flexibly used changes of meeting role and questioning strategies to prioritise service concerns, temporarily imposing an 'order of concern' over the institutional

order. We suggest that this analysis could be used as a framework for a discursive approach to IPW. Issues raised for IPW include those related to defining orders of concern, collaboration and power.

A major tennet of IPW is the assumption that the engagement of multiple professionals can enable higher quality, more scrutinised services. One way that this seemed emergent in our analysis was through the notion of 'orders of concern'. This concept is particularly important for this approach, as it allows team meetings to be understood in relationship to the priorities of the specific healthcare context being considered, which can be overlooked when generalising knowledge gained from multiple healthcare fields. For I(L)D, operating within an argumentative texture where staff and services have received considerable critique, giving value to raising concerns or questioning was perhaps a heightened priority. Imposing an order of concern and temporarily 'pausing' the meeting seemed to provide space for self-critique, and for having that critical awareness of services heard within the team. We had anticipated greater resistance to issues being raised at the point of agenda change in time pressured services, particularly as clinicians and service users and carers had raised anxieties that manager meetings often were too procedural and did not consider service need. This research illustrated how concerns can be raised in manager meetings talk, which may facilitate a better understanding of the ways in which the broader political and service contexts impact on the interactions of professionals in their everyday practice. Future research might examine how raising knowledge of these practices might enhance opportunities to identify concerns in meetings. Further it might help communication with other practitioners to understand that concerns are raised in manager meetings and how this happens. The effects of this might be evaluated.

A second principle arising is the way that collaboration is understood within IPW in MDT team meetings. In both policy and academic literatures the term collaboration is considered as essential for IPW. For example, D'Amour et al (2008) argue collaboration is a complex concept operating at multiple levels within an organisation, defined by constructs such as trust and shared goals. Reeves et al (2010) argued that interprofessional meetings can also have similar multiple dimensions, and can be theorised at relational, processual, organisational and contextual levels. In our analysis we focused on the relational aspects of team meetings, but also illustrated the effects of these broader organisational and contextual features as evident in this level of analysis.

. We tentatively suggest that this observation of collaboration in the detail of interactions could be helpful for teams to understand their own functioning. So, in additional to training around use of space and knowledge of professional roles, it might be appropriate to consider the conversations that clinicians have between each other as places where people can work on developing interprofessional working. For example, recognising the different reasons that people might have for offering a checking question and preventing a meeting from moving on, could help to improve team function, so that the rational for this is not attributed to conflict. There are a wider range of current training methods in teams, for example based on simulated experiences (Boet et al 2014), which have been found to be really helpful approaches to training. However, this discursive approach offers a further possible training intervention. Clinicians might learn not just from simulations, but from watching videos of their own interactions, or of others holding team meetings. Stokoe (2014) details the benefit of using naturally occurring scenarios above role play in training, including because these enable discussion of what happens in real contexts. Our research approach, of recording meeting interactions, provides an opportunity for teams to listen to team meetings

which might be a used as the basis of a future intervention to promote thinking about, and improve team working.

Negotiating power differentials is another key IPW issue. The current study illustrated that professionals may draw on different resources to assert different forms of power, where power is considered as having a voice heard within the meeting. Within these formal meetings, the power of the institutional order was most apparent, proffering certain rights to the Chair and embedding the agenda as a central and powerful resource. However, similar to Arber (2008), who illustrated how nurses could gain power beyond their status through use of particular question types, invoking orders of concern also appeared to be a method through which those other than the Chair could carry heavy influence. Imposing an order of concern also seemed to change the footing and power roles in the meeting, drawn from wider political and moral discourses.

We hope that this framework offers an approach for practitioners to reflect on how to engage in IPW within team meetings. As Reeves et al (2011) have suggested, communication in teams is an essential part of team working. The organisational context and enhanced knowledge of each other's roles is essential for developing IPA (Brown, et al., 2011; Morgan, Pullon & Mckinlay, 2015; O'Carroll, McSwiggan & Campbell, 2016; Xyrichis, & Lowton, 2008; Reeves, Pelone, Harrison, Goldman and Zwarenstein, 2017). However, we extend this to emphasise that how a person 'displays' collaboration is also important. We encourage clinicians and trainers to view different interactional contexts as specific stages, based on Lewin and Reeves (2011). We suggest they consider what resources and strategies might be available to help them to interact on those stages. For example, to have a point heard in a formal meeting it might be helpful to refer to the agenda.

Consideration of professional identity as a resource, rather than as a status, and exploring how it can be used as such also begins to 're-frame' some of the differences between practitioners, which might enable practitioners to re-think differences and similarities. Future research might examine the effects of this re-frame. Hopefully the framework also initiates a way of linking together everyday clinical practice and the broader argumentative textures that practitioners are situated in, so that practitioners are able to consider how IPW can be developed in the most relevant way to their own contexts.

This study was exploratory. Only a small number of a particular type of meetings were studied within a specific service. Generalisation of the specific findings may therefore not be possible. Nevertheless, careful analysis was conducted on the data set, drawing on the now considerable set of established normative practices in conversation analysis. The study focused on formal meetings between managers. Other meetings types, including greater power differentiation of practitioners should also be studied in their own right, to explore whether this discursive approach is helpful for developing IPW in different contexts. The study was designed for illustrative purposes, to explore how a discursive framework might work. Future research is needed to refine the framework, and to explore further the emergent 'orders of concern'. The study did not consider interactions outside of the meeting space, which as Lewin and Reeves (2011) have pointed out, can be very different, and might reflect yet another set of collaboration types. Thus more questions are raised than answered, but we hope that a new research agenda is set, potentially enabling practitioners to understand how the spaces 'between' practitioners can constitute IPW.

Concluding comments

This study sought to examine how understanding the details of face to face interaction might hep professionals to work in interprofessional teams. For example, to understand how collaboration can be constituted in the details of face to face interaction, and to explore some strategies that clinicians might use to facilitate this. Strategies included using checking questions or different roles in order to support or challenge points being made in the meeting. At some level, the interprofessional meeting might be considered as a microcosm for interprofessional working, and as a key environment in which relationships are played out. This study adds to the literature by revealing strategies that clinicians might use in face to face interactions to gain agreement, or to challenge, but also provides a method to encourage clinicians to stand back and reflect on the words they use, and how these might influence interprofessional working.

Declaration of interest: Nil to make.

Acknowledgements: We would like to acknowledge the contribution of the participants in this study, kindly giving up their time and enabling the conduct of the research.

Funding information: No funding was received for this project.

References

Angell, B. & Bolden, G. (2016). Team work in action: Building grounds for psychiatric medication decisions in assertive community treatment. In M. O'Reilly and J. Lester (Eds.), *Handbook of adult mental health: Discourse and conversation studies.* London: Palgrave Macmillan.

Anning, A., Cottrell, D., Frost, N., Green, J. & Robinson, M. (2006). *Developing Multi-professional Teamwork for Integrated Children's Services.* Milton Keynes: Open University Press.

Antaki, C., Houtkoop-Steenstra, H. & Rapley, M. (2000). "Brilliant. Next Question…": High Grade Assessment sequences in the completion of interactional units. *Language and Social Interaction, 33*(3) 235-262.

Arber, A. (2008). Team meetings in specialist palliative care: Asking questions as a strategy within interprofessional interaction. *Qualitative Health Research, 18*, 1323-1335.

Baxter, P. (2013). Service provision for people with learning disability. *Developmental Medicine & Child Neurology*, *55*(11), 972-972. Doi: 10.1111/dmcn.12279.

Beach, W. (1993). Transitional regularities for 'Casual' ''Okay'' usages. *Journal of Pragmatics 19* (4), 325–352.

Belanger, E. & Rodriguez, C. (2008). More than the sum of its parts? A qualitative research synthesis on multi-disciplinary primary care teams. *Journal of Interprofessional Care, 22*(6), 587-597.

Belanger, E., Rodriguez, C. Groleau, D. Legare, F., Macdonald, M. E. & Marchand, R. (2014). Initiating decision-making conversations in palliative care: an ethnographic discourse analysis. *BMC Palliative Care, 13,* 63. Doi: 10.1186/1472-684X-13-63.

Boet, S., Bould, M. D., Burn, L., & Reeves, S. (2014)Twelve tips for a successful interprofessional team-based high-fidelity simulation education session. *Medical teacher*, 36(10), 853-857, doi: 10.3109/0142159X.2014.923558

Bokhour, B. G. (2006). Communication in interdisciplinary team meetings: What are we talking about? *Journal of Interprofessional Care, 20*(4), 349-363.

Borrill, C. S., Carletta, J., Carter, A. J., Dawson, J. F., Garrod, S. Rees, A., Richards, A., Shapiro, D. & West, M. A. (2001). *The effectiveness of health care teams in the National Health Service.* Aston University. Retrieved 0n. 10/05/2016 from: http://homepages.inf.ed.ac.uk/jeanc/DOH-final-report.pdf.

Brown, J., Lewis, L. Ellis, Stewart, M., Freeman, T. R. and Kaperski, M. J. (2011). Conflict on interprofessional primary healthcare teams – can it be resolved?, *25(1)* 4-10. Doi: 10.3109/13561820.2010.497750.Epub2010

Care Quality Commission (CQC) (2012). *Learning disability services inspection programme: National overview.* Retrieved on November 24th 2015 from: http://www.cqc.org.uk/sites/default/files/documents/cqc_ld_review_national_overview.pdf

Clark, P. (1997). Values in health care professional socialization: Implications for geriatric education in interdisciplinary team work. *Gerontologist, 37,* 441-451.

D'Amour, D., Goulet, L., Labadie, J., Martin-Rodriguez, L. S., & Pineault, R. (2008). A model and typology of collaboration between professionals in healthcare organisations. *BMC Health Services Research, 8*, 188. Doi:10.1186/1472-6963-8-188.

Department of Health (2015). *Winterbourne View: Transforming Care Two Years on.* Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/399755/Winterbourne_View.pdf

Deppermann, A., Schmitt, R., & Mondada, L. (2010). Agenda and emergence: Contingent and planned activities in a meeting. *Journal of Pragmatics, 42,* 1700-1718.

Duner, A. (2013). Care planning and decision-making in teams in Swedish elderly care: A study of interprofessional collaboration and professional boundaries. *Journal of Interprofessional Care, 27*, 246-253.

Edwards, D. (2000). Extreme Case Formulations: Softeners, Investment, and Doing Nonliteral. *Research on Language and Social Interaction, 33*(4), 347–373.

Farringdon, C., Clare, C. H., Holland, A. J., Barrett, M. & Oborn, E. (2015). Knowledge exchange and integrated services: experiences from an integrated community intellectual (learning) disability service for adults. *Journal of Intellectual Disability Research, 59(3),* 238-247. Doi:10.1111/jir.12131.

Francis, R. (February 2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Retrieved from http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

Glenn, P. J. (2003). *Laughter in interaction*. New York: Cambridge University Press.

Griffiths, L. (1998). Humour as resistance to professional dominance in community mental health teams. *Sociology of Health and Illness, 20*(6), 874-895.

Halvorsen, K. & Sarangi, S. (2015). Team decision-making in workplace meetings: The interplay of activity roles and discourse roles. *Journal of Pragmatics, 76*, 1-14. Doi.org/10.1016/j.pragma.2014.11.002.

Kvarnstroem, S. (2008). Difficulties in collaboration: a critical incident study of interprofessional healthcare teamwork. *Journal of Interprofessional Care, 22,* 191-203. Heritage, J., Robinson, J., Elliott, M., Beckett, M. & Wilkes, M. (2007). Reducing patients' unmet concerns in primary care: the difference one word can make. *Journal of General Internal Medicine, 22*(10), 1429-1433.

Heritage, J. (2012). Epistemics in action: action formation and territories of knowledge. *Research on Language and Social Interaction, 45*(1). Doi: 10.1080/08351813.2012.646684.

Jefferson, G. (1984). Transcript notation. In J. M. Atkinson and J. Heritage (eds). *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press. Ix-xvi.

Lewin, S. & Reeves, S. (2011). Enacting 'team' and 'teamwork': Using Goffman's theory of impression management to illuminate interprofessional practice on hospital wards. *Social Science and Medicine, 72*, 1595-1602.

Maynard, D. W. & Hudak, P. L. (2008). Small talk, high stakes: Interactional disattentiveness in the context of prosocial doctor-patient interaction. *Language in Society, 37,* 661-688. Doi: 10.1017/S0047404508080986.

Mondada, L., (2006). Participants' online analysis and multimodal practices: projecting the end of the turn and the closing of the sequence. *Discourse Studies, 8*(1), 117–129.

Morgan, S., Pullon, S., & Mckinlay, E. (2015). Observation of interprofessional collaborative practice in primary care teams: An integrative literature review. International *Journal of Nursing Studies,* 52, 1217-1230.

Mosser, G. & Begun, J. W. (2013). *Understanding teamwork in healthcare*. New York: McGraw-Hill Education.

O'Carroll, V., McSwiggan, L., & Campbell, M. (2016). Health and social care professionals attitudes to interprofessional working and interprofessional education: A literature review. *Journal of Interprofessional Care,* 30:1, 42-49.

Potter, J. (2003) Discourse Analysis. In Hardy, M. & Bryman, A. (Eds.) *Handbook of Data Analysis*. London: Sage. (pp. 607-624)

Pullon, S., Morgan, S., Macdonald, L., McKinlay, E. and Gray, B. (2016). Observation of interprofessional collaboration in primary care practice: A multiple case study. *Journal of Interprofessional care, 30 (6),* 787-794.

Rice, K., Zwarenstein, M., Conn., L. G., Kenaszchuk, C., Russell, A. and Reeves, S. (2010). An intervention to improve interprofessional collaboration and communications: a comparative qualitative study. Journal of Interprofessional Care, 24(4), 350-61. Doi: 10.3109/13561820903550713

Reeves, S., Lewin, S., Espin, S., Zwarenstein. M. (2011). Interprofessional Teamwork for Health and Social Care. Wiley: NJ, US.

Robinson, J. D., & Stivers, T. (2001). Achieving activity transitions in primary-care encounters: from history taking to physical examination. *Human Communication Research 27*(2), 253–298.

Rowlands, S. and Callen, J. (2012). A qualitative analysis of communication between members of a hospital-based multidisciplinary lung cancer team. European Journal of Cancer Care, 22 (1), 20-31. Doi: 10.1111/ecc.12004

Schegloff, E. A. (2007). *Sequence Organisation in Interaction Vol. 1. A Primer in Conversation Analysis*. Cambridege: Cambridge University Press.

Sidnell, J. & Stivers, T. (2014). *A handbook of Conversation Analysis*. New Jersey: John Wiley and Sons.

Simpson, A. (2007). The impact of team processes on psychiatric case management. *Journal of Advanced Nursing*, *60(4)*, pp. 409-418.Svennevig, J. (2012a). The agenda as resource for topic introduction in workplace meetings. *Discourse Studies, (14)*1, pp. 53–66.

Stokoe, L. (2014). The Conversation Analytic Role-play Method (CARM): a method for training communication skills as an alternative to simulated role-play. *Research on Language and Social Interaction*, 47 (3), pp. 255-265. Svennevig, J. (2012b). Interaction in workplace meetings. *Discourse Studies, (14)*1, 3-12. Doi: 10.1177/1461445611427203.

Tileaga, C. & Stokoe, L. (Eds.) (2014). *Discursive Psychology: Classic and contemporary issues.* New York: Routledge.

Wetherell, M. (2007). A step too far: Discursive psychology, linguistic ethnography and questions of identity. *Journal of Sociolinguistics*, *11*(5), 661-681. doi:10.1111/j.1467-9841.2007.00345.x.

Weaver, S. J., Dy, S. M. & Rosen, M. A. (2014). Team-training in healthcare: a narrative synthesis of the literature. *BMJ Quality and Safety,* 23, 359-372. Doi:10.1136/bmjqs-2013-001848.

Xyrichis, A., & Lowton, K. (2008). What fosters or prevents interprofessional teamworking in primary and community care? A literature review. *International Journal of Nursing Studies,* 45, 140-153.

Zwarestein, M., Goldman, J., Reeves, S. (2009). Interprofessional Collaboration: effects of practice-based interventions on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews* 2009, 3. Doi: 10.1002/14651858.CD000072.pub2.

---

[i] There is current debate over the term 'learning disabilities', which although widely still used in NHS services in the UK, is often replaced with the term 'intellectual disabilities', considered more accurate. To avoid ambiguity we follow Farrington et al. (2010) and use the term Intellectual (Learning) Disability (I(L)D).

[ii] Sequins is the transcription as heard, referring to CQUINs, which are performance targets for services.