

Achieving teamwork: a grounded theory investigation in selected stroke units in the north of England.

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Submitted in accordance with the requirements for the degree of Doctor of Philosophy

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April 2007

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## Acknowledgements

I would like to express my sincere thanks to the following:

The patients and their families in both stroke units who so willingly allowed me to observe and participate in their care and treatment.

All members of the stroke unit teams for encouraging and supporting my participation in their work and for their patience with my efforts to make sense of their teamwork. I greatly appreciated their honesty and openness in our discussions.

My supervisors Geof Mercer and Anne Forster for challenging my thinking and for their support and encouragement to develop my work. I have benefited greatly from sharing their experience and I thank them for their invaluable contribution to my intellectual and professional development.

Bernard Rhodes, for stimulating my early interest in research and helping me to see the importance of scholarship in healthcare practice.

Julie Pryor for her interest in my research and for sharing her enthusiasm for rehabilitation, for nursing and for grounded theory.

My colleagues in the School of Healthcare for their support and for allowing me to work flexibly to undertake and write up this research; and in particular to Janet Holt and Joan Maclean for their continued support and encouragement.

My son Sam for understanding why my work was important to me and for tolerating my absences with a smile, and the rest of my family for their continued interest and support.

My wife Anne for her love and belief in me, and for encouraging all of my efforts.

## Abstract

The development of collaborative interdisciplinary working is a key element of contemporary health policy. Future healthcare workers will need to work, individually, collaboratively and in teams if they are to meet the complex and changing needs of the patients they serve. The literature related to health professional team working identifies many barriers and sources of potential conflict, but there is also evidence that effective interdisciplinary teamwork can be achieved and is associated with improved health outcomes. The specialised and co-ordinated multidisciplinary team care provided in stroke units was considered to contribute directly to the improved patient outcomes seen in these units. However, the ways in which stroke unit team members co-ordinate their work was not clearly understood.

This study utilised a grounded theory approach to develop an explanation of the ways in which health professionals in two stroke rehabilitation units in the North of England achieved teamwork. Data were generated through over 200 hours of participant observation and thirty four semi-structured interviews with a range of team members.

The findings of the study identified a basic social process which was common to team working in both stroke units; this process was termed 'opportunistic dialogue'. This represented an interactional process through which the division of labour in respect of specific rehabilitation activities was worked out and agreed by team members on a day-to-day basis. Co-location of most team members in both units led to repeated engagement in sharing and validating patient information and in exploring different perspectives. Opportunistic dialoguing contributed to mutual learning in the stroke unit teams and explained the shift in thinking and team culture which occurred as team members moved from concern with discrete disciplinary actions to dialogue and negotiations focused on collaboration to meet the needs of stroke patients.

Negotiations played a major role in opportunistic dialogue and coming to agreement on the teams' rehabilitation work. The study findings emphasised the interrelatedness and interdependence of these concepts as core interactional processes contributing to the achievement of teamwork in stroke units. The study confirmed the utility of the negotiated order perspective in understanding and explaining workplace interactions, but identified that whilst negotiations were a key feature of opportunistic dialogue, other processes also contributed to achieving and maintaining teamwork. Focussing on dialogue demonstrated that patterned talk-in-interaction processes maximised the contribution of opportunistic dialogue to coordinating the skills and knowledge of the different disciplines participating in stroke rehabilitation. The achievement of teamwork in these units occurred through access to and participation in opportunistic dialogue.

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## Abbreviations

BMA	British Medical Association
CHI	Commission for Health Improvement
DoH	Department of Health
GP	General Practitioner
HCA	Healthcare Assistant
ICN	International Council of Nurses
MDT	Multidisciplinary Team
NAO	National Audit Office
NHS	National Health Service
NSF	National Service Framework
OPD	Outpatients Department
OT	Occupational Therapist
PCT	Primary Care Trust
PT	Physiotherapist
RN	Registered Nurse
RA	Rehabilitation Assistant
RCP	Royal College of Physicians
SN	Staff Nurse
SALT	Speech and Language Therapist
SHO	Senior House Officer
SW	Social Worker
WTE	Whole time equivalent

Colebrook and Holton are fictitious names given to the two stroke units in this study.

## Transcription conventions

*Tape recorded interview extracts and field notes appear in italics.*

All tape recorded materials and documents are verbatim transcriptions.

.... indicates a pause in speech

[...] words, phrases or sentences of the extract have been omitted

[explanatory or descriptive material added by the researcher in order to make the meaning or context clear]

Data have been edited in order to preserve anonymity

All real names of people and places have been omitted from data extracts.



## Chapter 1:

Introduction: Why study teamwork in stroke units?

## Introduction

This study arose from a longstanding interest in understanding the process of team working in healthcare. As a registered nurse I worked in medical-surgical and mental health teams for over ten years. Those in the medical-surgical setting were mainly medically led and the working relationships can most accurately be described as loose groupings of professionals carrying out their own disciplinary work. Communication between team members was achieved through ward rounds or team meetings. In contrast, team meetings in mental health settings were markedly different as they involved a wider range of health professionals, included greater discussion between members and were not always medically led. Subsequently, I began working with health professionals undertaking continuing professional development programmes in higher education settings who described very different experiences of team working. Some were convinced of the effectiveness of teamwork and stressed its contribution to patient care and working relationships, whereas others felt that the concept was largely rhetoric, and rarely evident. These differences intrigued me and I became determined to understand how teamwork was achieved in practice. I aimed to develop this understanding in the context of teamwork in stroke units.

## The policy and professional context

The use of multidisciplinary healthcare teams to deliver services has attracted growing support over the last 30 years (Department of Health and Social Services (DHSS), 1978; World Health Organisation (WHO), 1988; Department of Health (DoH), 2000a). The issues driving calls for teamwork included increasingly complex healthcare problems, technological advances, increased specialisation in health professional work, rapidly escalating costs of providing healthcare and demand for effective use of scarce human resources (Audit Commission, 1986; Schofield & Amodeo, 1999; Borrill et al, 2003). However, despite the commonsense appeal of collaborative arrangements, policymakers and professionals found its achievement was complex and challenging.

Contemporary definitions of teamwork are discussed in chapter 2; the WHO (1988:3) statement is provided here in order to inform the discussion in this chapter. Teamwork involves:

*Co-ordinated action carried out by two or more individuals jointly, concurrently or sequentially. It implies common agreed goals, clear awareness of, and respect for others' roles and functions. On the part of each member of the team (it requires), adequate human and material resources, supportive co-operative relationships and mutual trust, effective leadership, open, honest and sensitive communications and provision for evaluations.*

The statement identifies the wide range of factors considered to be important when working with others, as part of a team. Structural elements identified include adequate human and material resources and agreed goals. However, the definition also indicates that interactional processes are key components of teamwork.

The reform of the National Health Service (NHS), begun in the late 1990s by the Labour government, explicitly identified the need for healthcare professionals to work together to improve the quality of healthcare for patients in the United Kingdom (UK). One of the six principles guiding the reform of the NHS was '*getting the NHS to work in partnership*'; an example given was teams of GPs and community nurses working together in new primary care groups (DoH, 1997:2). Later, in the NHS Plan (DoH, 2000a:7), one of the core values identified was the ability to '*work together with others to ensure seamless services for patients*'. Skills required included the ability to '*work effectively in teams, appreciating the roles of the staff and agencies involved in the care of patients*'. Improving patient care was linked by policy makers with health professionals working in teams; this was a central element of the NHS clinical governance and modernisation agenda (Scholes & Vaughan, 2002). The importance placed on the development of effective team working was evidenced by the establishment of a Team Resource Management programme in 2002 as part of the Clinical Governance Support Team of the NHS Modernisation Agency. This applied learning from organisational research to facilitate and improve team working: specialist coaches were made available to work with poorly performing or dysfunctional teams. A specific resource to support stroke services was introduced in October 2003.

Policymakers have drawn attention to the importance of teamwork previously. For approaching thirty years, healthcare policy documents have directly or indirectly called for health professionals to work together in teams (DHSS, 1978; Audit Commission, 1986; 1992; DoH, 1989; 1997; 2000a, 2000b). The primary care sector was the focus of much initial enthusiasm for team working, driven by the desire of policymakers to bring about partnership working between formerly separate organisations providing health and social services. These services were perceived to be fragmented and ineffective; integration was designed to reduce costly overlaps and duplication in provision (DHSS, 1978). Proponents highlighted empirical evidence from organisational research demonstrating that effective teamwork improved the quantity and quality of goods and services in industry (Guzzo & Shea, 1992; Mohrman et al, 1995).

However, by the late 1970s the accumulated health services research evidence was not encouraging. Research in primary and secondary care identified the complex dynamics of healthcare teams. McIntosh & Dingwall (1978) reported that in the primary care teams they studied, health visitors and district nurses made significant contributions to achieving the objectives of the teams, but had clearly defined and subordinate relationships with general practitioners who were perceived as the head of the team. Such relationships did not match the rhetoric of equality and respect inherent in policy makers' or managers' visions of team working. Evers (1982) examined multidisciplinary teamwork in inpatient elderly care settings and reported that the majority of health professionals participating in the research accepted that they were part of a multidisciplinary team, but the consultant physician was set apart from other team members. She noted that this was in direct contrast to the philosophy of teamwork found in textbooks of the time which emphasised interprofessional collaboration. These studies highlighted the sharp difference between policymakers' rhetoric, and the reality of healthcare professionals' working relationships. The Audit Commission (1986) reported that inter-agency and cross boundary working in health and social care was being impaired by rigid professional boundaries, stemming from primary education and

socialisation in quite different professional cultures. Many studies have since reported problems in establishing team working in primary and secondary care (see Chapters 2 &3).

Research evidence also indicates that developing effective teamwork can be problematic. Gulliver et al (2002) examined the development of integrated mental health and social care services in the southwest of England, highlighting the influence and importance of team and professional boundary activities as integration progressed. Newly established teams took time to make connections and create commitment within their team before they were able to collaborate effectively with other teams. In this study co-location, commitment to integrated care planning and a unified management structure all contributed to successful integration. Protecting professional differences was an important part of the transition to more collaborative working arrangements, but was not perceived to be a barrier to integration. Multidisciplinary team working is evident in secondary care, for example in stroke units. A growing body of evidence overwhelmingly demonstrates the effectiveness of the care and management provided in such units (Langhorne et al, 1993; Stroke Unit Trialist's Collaboration (SUTC), 1997; Indredavik et al, 1999; Langhorne & Duncan, 2001).

### The intellectual context

Griffiths (2003:156) drew attention to the large volume of sociological work which examined the complex division of labour between healthcare professionals and how this contributed '*to our understanding of the way that health care is delivered, and the 'organisation' that underlies that delivery*'. Interactions between health professionals have interested sociologists, since the 1960s (Freidson, 1963; Strauss et al, 1963; Olesen & Whittaker, 1968; Dingwall, 1976). Freidson's (1970a, 1970b, 1976) research on professional dominance was particularly influential in theorising the relationship between medicine and other healthcare workers. He outlined the way in which the medical profession attempted to control the activities of other professionals in order to maintain its own power, status and prestige. Freidson (1970a, 1970b, 1976), and later Larkin (1983) reflect a

conflict derived perspective on the division of labour, although Larkin (1983) argued that to understand the relative positions of professionals in the division of labour, it was necessary to focus on the ways in which they negotiated role boundaries and managed their relationships with other, sometimes higher status professionals. Abbott (1988) extended this work in his influential study in which he drew attention to the ways in which professions achieved and maintained jurisdiction over their work. He argued that strategies used by professionals to maintain recognition, power and influence in society in general were different to those used in the workplace. However, while there is an extensive literature on teamwork in a variety of organisational settings, only a small proportion of this examines the day-to-day interactions between team members, and how these influence the achievement of teamwork.

Recent studies have examined the impact of health service reforms on interactions and working practices between doctors and nurses, between dentists and dental hygienists, and nurses and operating theatre department practitioners (Mackay, 1993; Walby & Greenwell et al, 1994; Svensson, 1996; Adams, 1999; Allen, 2001; Timmons & Tanner, 2004). This research has focused on the accomplishment of professional boundaries and jurisdictions and how professionals attach meaning to their interactions with each other in day-to-day work. Despite the large body of sociological work, Opie (2000) and Borrill et al (2003) argued that much research into health professional team working had been under theorised. Griffiths (2003) suggested that there was a need to build on earlier workplace studies examining the division of labour in healthcare, and to re-examine Strauss's (1978) theory of negotiated order. This focuses on the day-to-day workplace interactions occurring between health professionals and how these are negotiated and impacted upon by internal and external professional and policy drivers (Allen & Pilnick, 2005). This study seeks to respond to these challenges in the context of teamwork in stroke units.

### Teamwork in stroke units:

Given the evidence that stroke units were effective in improving patient outcomes, recommendations relating to specialist stroke services were included in the National Service Framework (NSF) for Older People (DoH, 2001a). Standard 5 of the NSF required that all patients be treated by specialist co-ordinated multidisciplinary teams within dedicated stroke units. In 2001 this occurred for only about 26% of stroke patients; and every general hospital which cared for stroke patients was required to have plans to introduce a specialised stroke service by 2004. The NHS Changing Workforce Programme (DoH, 2002a: 2) highlighted a series of initiatives on new ways of working in stroke care and noted that '*traditional roles do not always fit the needs of patients*'. The report suggested that new roles would probably alter traditional demarcations between health professionals.

Research on how health professionals carry out their work in hospital settings was examined. This was characterised by a broadly ethnographic approach with a focus on direct engagement with professionals in their working practice. The examination of stroke unit research stressed one recurring theme: that co-ordinated multidisciplinary teamwork was a key factor in achieving improved patient outcomes in stroke units. However, existing research has not examined the ways in which co-ordinated teamwork may be achieved and maintained in these units. Given the strong evidence for the effectiveness of stroke units and the policy requirement that they should be implemented throughout the UK, these represented an ideal location for research into team working. As stroke units, like coronary care units are likely to be a key component of health services for many years to come, the research would have national and potentially international relevance. The current study adopted a grounded theory approach (Glaser & Strauss, 1967; Strauss and Corbin, 1998) in order to develop understanding of day-to-day interprofessional working and to explain the process of teamwork in selected stroke units.

### The thesis

The thesis will develop as follows: Chapter 2 discusses the inclusion and exclusion of particular bodies of literature and reviews literature on teams and teamwork. Conceptual definitions of teamwork and findings from research on team working are examined prior to discussion of research related to stroke unit teams; the rationale for this study is presented. In chapter 3, sociological perspectives on professions and the division of labour as these contribute to understanding and analysing team working in healthcare settings are considered, and then research examining the division of labour in practice is reviewed. The central research question and the aims and purpose of the study are presented.

The rationale for using a grounded theory approach in the study is discussed in chapter 4. Debates surrounding qualitative research and on conducting grounded theory studies are critically examined. The research design and sites selected for the study are discussed and the work contexts and social characteristics of the research participants described. The discussion then turns to the sampling strategy, gaining access and ethical approval. Chapter 5 explores my research practice and considers the interrelationship of fieldwork experiences, engaging with data and theory in practice and developing theoretical explanations. In chapter 6, the process of data analysis is traced from initial immersion in the settings through to development of explanations drawing on the coding paradigm developed by Strauss & Corbin (1998). Extracts from fieldnotes, interviews and memos are used to illustrate the way in which theoretical categories were developed.

The research findings are presented in chapters 7 & 8, major categories are explained and their relationship to the core theoretical category explored. The discussion draws directly on study data to establish the properties and dimensions of categories and their interrelationship. A grounded theory of *opportunistic dialogue* is developed; this identifies and explains the basic social process which underpins the achievement and maintenance of teamwork in these units.



In chapter 9, the concept of opportunistic dialogue and the negotiated order perspective are critically reviewed in so far as they inform analysis of the discursive and negotiated features of teamwork in these settings. The contribution of this study in terms of developing teamwork practice in other stroke units and in advancing the literature related to these and other perspectives is established.

## Chapter 2:

Literature review: Teams and team working in healthcare practice

This chapter begins with discussion of the approach taken to searching health and social sciences literature and explains the rationale for selection of the literature reviewed, and the importance of ongoing review of literature in grounded theory studies. Key concepts including team, team-care, multidisciplinary and interdisciplinary teams are then examined. Research on health professional team working in general and specific to team working in stroke units is critically reviewed. The chapter concludes that existing research does not provide an adequate explanation of team working processes in stroke units and develops a rationale for the current study.

### Search strategy

The initial literature search used Medline, Cinahl, PsychInfo, Web of Science, Assia, BIDS IBSS and Sociological Abstracts databases. Search terms included teams, teamwork, team-care, team working, multidisciplinary, interdisciplinary, interprofessional, collaboration and grounded theory. These terms were searched separately and in combination with healthcare, effectiveness, stroke, stroke rehabilitation and stroke units. No exclusion criteria other than that publications should be in English were adopted. The University library catalogue, the Cochrane Library, Department of Health (UK), Department of Health and Human Services (USA), and the National Library for Medicine (USA) were searched for relevant texts. Theses and dissertations were searched via the Index to Theses and British Library Theses Service. The search provided in excess of 600 potentially useful references. These were separated into four groups: general and specific team working literature, stroke specific resources, literature related to the division of labour and interprofessional relations. Reference lists were also reviewed to find relevant papers not identified through electronic or hand searching. Following a review of abstracts, 145 of the original 600 papers were accessed.

Papers that focused on teams, team development and team management strategies in sports and leisure, primary or secondary education and industrial settings were excluded. The focus of some

of these papers on team dynamics, interaction and roles was relevant to a broad understanding of teamwork. However, the nature of the work and its settings, the origin and purpose of these teams and the research methodology (mainly survey and intervention studies) differed markedly from the current study's focus. The initial search did identify the work of key authors on teams in organisations, including Adair (1986), Belbin (1981, 1993), Galbraith & Lawler (1993) and Mohrman et al (1995), in organisational psychology, for example West (1994, 1996) and in the sociology of work, Hall (1994) and Grint (1998). These texts were accessed before and during the current study as part of comparison of healthcare and sociological literature on teams. Studies focussing on the experiences of single professions, including nurses, occupational therapists or physiotherapists in healthcare teams were identified (Gibbon, 1991; O'Connor, 1997; Long et al, 2001; Atwal, 2002; Booth & Hewison, 2002). These were excluded from the initial literature review because of their single discipline focus, but were retained for review in analysis of data generated in the current study.

The literature reviewed in this and the next chapter focuses on team working and interprofessional relations in healthcare settings, and on the healthcare division of labour. It provided a range of perspectives, which were used in two ways: firstly to understand professional and sociological debates surrounding the division of labour and interprofessional relations; and secondly, to provide evidence against which concepts and categories identified in the current study could be critically examined.

Approaches to literature review in grounded theory studies have differed in respect of its purpose, necessity and extent (Dey, 1999). Positions expressed include; not reviewing literature prior to fieldwork (Chenitz & Swanson, 1986; Glaser, 1992), to completing a thoroughgoing review prior to fieldwork (Strauss & Corbin, 1998; McCallin, 2003b). The position adopted in the current study lay between these extremes. It aimed to ensure the study design and central research question were

informed by relevant literature while remaining open to concepts generated by the data (Strauss & Corbin, 1998). Additionally, an ongoing search for relevant literature was an essential resource in supporting data analysis.

Registration with the Zetoc system (the British Library's Electronic Table of Contents) ensured items related to the original search terms were identified as they were published, and abstracts were reviewed to determine their relevance to data analysis. Twenty three journals and twelve search terms were used in the alerts listing. Concepts generated in data analysis, for example, negotiation and dialogue, prompted searches to identify published work in these areas; search terms including negotiated order were then added to the alert listing. Thus, existing and contemporary literature were used as devices to aid development and critical examination of concepts and theoretical categories emerging from the data (Dey, 1999).

#### Literature review

The literature on teams and team working is substantial and draws upon commentary from medicine, psychology, nursing, social science and organisational studies. Two main types of literature were identified. Firstly, that concerned with definition, description and theoretical modelling of teams and roles within teams; and secondly that focused on examining team working in health services including primary care, mental health, child development, stroke care and care of older adults.

The literature which defines and theoretically models teams was typified by descriptions of how individuals function within teams and contribute to team working (Tuckman & Jensen, 1977; Adair, 1986; Belbin 1993, 2000). Much of this literature examined teams in industrial or large organisational settings and was concerned with improving product quality and performance of individuals within teams. Tuckman's (1965), and Tuckman & Jensen's (1977) discussion of stages

of group development provided a sound basis for understanding the ways in which newly formed groups interact and how interactional processes can influence individual and group activity over time. Similarly, Belbin's (1993) team role theory, developed from nine years of research with managers at Henley Management College, describes team members' behaviour in facilitating the work and progress of management teams. This theory is influential, but the team roles identified and validated were not derived from observing and interviewing managers in their workplaces, but as a result of engaging them in a range of complex management exercises, and psychometric testing.

The development and effectiveness of team working in primary care in the UK has been investigated by Anderson & West (1994) Poulton & West, (1993, 1994) West & Poulton (1997), and Ovretveit (1993; 1997a, 1997b). The contribution of this research, located within organisational psychology and organisational studies, lies in the empirical development and testing of measurement tools such as the Team Climate Inventory (Anderson & West, 1994) which identifies and quantifies factors affecting team role and function. This tool has been used in assessment of healthcare teams in the USA and the UK (Strasser et al, 1994, 2005a, 2005b; Gibbon et al, 2002). This literature has also identified theoretical models and tools for assessing, measuring and developing team performance and functioning. Nevertheless, it does not directly focus on team member interaction in healthcare settings.

The literature examining team working in primary care, mental health, child development, stroke care and care of older adults was more limited. It was concerned with the effectiveness of healthcare teams, and health professionals' perceptions of team working, and provided some in-depth case studies of team working in NHS settings. Studies examining team working in stroke units are relatively few in number and are reviewed later in this chapter following analysis of commonly used descriptors for teams and teamwork.

### Defining team and teamwork

Halstead (1976: 508) defined teams as *'a group of two or more health professionals from different disciplines who share common values and work towards common objectives'*. A similar definition was found in the National Clinical Guidelines for Stroke (RCP, 2000: 23) where 'team' was defined as *'a group of individuals working together towards a single goal or set of goals'*. These definitions are imprecise; Rothberg (1981) suggested that in reality most teams were small units who focused on individuals or groups of patients and he used the terms 'core' and 'adjunctive' to suggest a narrow or broad focus of attention. A core team could include professionals based on a stroke unit, their primary function being assessment and treatment of patients following a stroke. The adjunctive team would include neurologists, radiologists, discharge planners and intermediate care services; they would advise, support and implement care agreed with the core team. Ovretveit (1993) used the terms 'core' and 'extended' and Miller et al (2001) used 'core' and 'peripheral' to describe the same concepts. There is evidence that satisfaction with teamwork is related to whether individuals perceive themselves as members of core or peripheral teams (Cott, 1997; Miller et al, 2001). Some authors argue that teams also include patients and their family, this view has attracted increasing attention as the NHS attempts to develop patient-centred services. However, at present there is limited evidence of inclusion of patients in goal setting or decision-making (DoH, 2001a; Drinka & Clark, 2000; Coulter, 2002).

Halstead (1976: 508) defined team-care as *'co-ordinated comprehensive care provided by persons who integrate their observations, expertise, and decisions'*. Key words here are co-ordination and integration; whilst it is common to find these identified as essential to effective teamwork, few publications explore how these processes are realised. What is not evident is how the make up of the team should be decided upon or how common goals are agreed and communicated to the team members. Again, how is work allocated to prevent duplication and overlap, or who is responsible

for the activities undertaken by the team on a collective and individual basis? In short, these definitions leave open how teamwork is achieved and maintained in practice.

Team-care requires professionals who were often socialised to work independently, within well established hierarchies, to overcome professional boundaries and work in collaborative ways for which they often receive no preparation (Opie, 2000; Scholes & Vaughan, 2002). This observation is not new and has often been made over the last 20-30 years (Halstead, 1976; Rothberg, 1981; Keith 1991). What is more novel is an interest in understanding how some health professionals collaborate and develop ways of working which overcome potential barriers to teamwork. The concepts of team, team-care and teamwork are so ingrained in the consciousness of most health professionals that they rarely question what they mean or ask whether team working is necessary or effective in improving patient care (Schofield & Amodeo, 1999; Payne, 2000). Common terms used in the literature include; multidisciplinary, interdisciplinary, interprofessional, collaboration, and transdisciplinary. These are rarely defined, often used interchangeably, and sometimes used inconsistently within documents (Ryan, 1996; Schofield & Amodeo, 1999; Leathard, 2003). Defining these concepts is important in understanding how health professionals and policy makers represent team working in published documents and in practice.

### Multidisciplinary teams

A multidisciplinary team brings together professionals from different disciplines who share a common area of working practice (Payne, 2000). For some teams this is defined by disease or disability such as stroke or heart failure, conditions resulting in complex clinical situations, requiring expert knowledge and skills from a range of professionals. However, bringing individual professionals together does not mean they will automatically function co-operatively (Payne, 2000). Rothberg (1981) argued that whilst there was an organised division of labour in multidisciplinary teams, with members sharing responsibility and accountability for patients' well being, they each



made and implemented decisions independently. This can mean the energies of individual team members are focused on separate tasks and may result in a simple aggregate of individuals '*doing their own thing*' (Rothberg, 1981: 408). Wilson (2000) argued that despite the rhetoric suggesting something more co-ordinated, many primary healthcare teams in the UK operate in this way; as a result the potential benefits of integrated team action are not realised.

Opie (2000), Miller et al (2001) and Borrill et al (2003) studied a wide range of healthcare teams, and each provided evidence that a mismatch between policy rhetoric and professional practice reality was also evident in secondary care where multidisciplinary approaches predominated. A more integrated and effective approach to working together is claimed for interdisciplinary teams (Mickan & Rodger, 2000).

#### Interdisciplinary teams

According to Melvin (1980: 379) interdisciplinary teamwork implies that not only do team members perform activities towards a common goal, they also accept the added responsibility of group effort on behalf of patients:

*This effort requires the skills necessary for effective group interaction and the knowledge of how to transfer integrated group activities into a result which is greater than the simple sum of the activities of each individual discipline. The group activity of an interdisciplinary programme is synergistic, producing more than each could accomplish individually and separately.*

It is claimed that interdisciplinary teams are more likely to be effective when team members function as equals, with respect for the skills and knowledge brought by each (Mickan & Rodger, 2000; Borrill et al, 2003). Interdisciplinary team members contribute different professional perspectives but goal setting, care planning and decision making are collaborative activities, rather than led by an individual such as a physician (McClelland & Sands, 1993; McCallin, 2001). Team members must communicate regularly and co-ordinate their activities in the scheduling and delivery of care. Collaboration occurs in team meetings, in team rounds or case conferences and in providing

direct care. These events are not unique to interdisciplinary teams but it is through these that individual team members come to accept responsibility for team successes and failures as well as for their own professional activity. The commitment to working collaboratively as opposed to individually, together with respect and acceptance of equal status differentiates interdisciplinary from multidisciplinary teams. Miller et al (2001) and Borrill et al (2003) reported that in their studies interdisciplinary teamwork provided regular interpersonal support and increased satisfaction with team working.

In addition to the above attributes, Mandy (1996) identified the importance of disciplinary articulation; here team members develop understanding of each other's roles and recognise where overlap occurs. She also identified conflict resolution as important in understanding differences in perspective between team members, although she did not clearly articulate how this occurred in teams. Interdisciplinary working attempts to make effective use of professional skills; however this is more difficult to achieve than to proclaim its benefits (Mickan & Rodger, 2000; Miller et al, 2001). The term interdisciplinary has become common in health policy documents in the UK in the last five years (DoH, 2000b, 2001b; RCP, 2002) but is still used interchangeably with the term multidisciplinary without apparent appreciation of the differences between these concepts. The term 'interprofessional' has the same meaning for many authors, as both emphasise the interaction between professionals as they work together (Farrell et al, 2001). Nevertheless, Leathard (2003) argued cogently that researchers should focus on actual interactions between health professionals rather than on semantics.

#### Transdisciplinary teams

The term transdisciplinary is less commonly used, but is not a new concept. Garner & Orelove (1994) suggested the term was introduced by Dorothy Hutchinson, a nurse responsible for national collaborative projects to provide comprehensive services for children with problems such as

cerebral palsy. Hutchinson defined transdisciplinary as being '*of, or relating to a transfer of information, knowledge, or skills across disciplinary boundaries*' (United Cerebral Palsy, 1976: 1, cited in Garner & Orelove, 1994). The difference between this and the interdisciplinary approaches is the emphasis on shared knowledge and skills. Transdisciplinary teams share implementation of the whole treatment plan and do not rely upon specific disciplines to deliver particular elements. This requires team members to function as equals, transcending professional boundaries and carrying out the activities and prescriptions of other disciplines as part of patients' treatment. There are few examples of transdisciplinary approaches in the healthcare literature and limited evidence that transdisciplinary teamwork is likely to become widely implemented in the short term (Leathard, 2003; D'Amour et al, 2005). However, current UK health policies (DoH, 2000b; 2001b, 2004; NAO, 2001) support joint education of health professionals in order that they can develop not only an understanding of each others' work, but also generic skills which transcend existing professional boundaries. As part of the Changing Workforce Programme in the NHS, there is encouragement to blur professional boundaries and develop shared skills and knowledge to improve outcome for stroke patients (DoH, 2002a). These developments may require greater attention to transdisciplinary approaches.

Collaborative care and collaborative teams are other terms used interchangeably with multidisciplinary and interdisciplinary teams in the healthcare literature. Collaboration means to labour together or to act jointly and gained a high profile following health and social care reforms in the 1970s and 1980s (Hornby, 1993; Ovretveit, 1997b). Hornby (1993:7) described collaboration as '*a relationship between two or more people, groups or organisations working together to define and achieve a common purpose*'. Sullivan (1998) argued that in addition to working together, collaboration was about sharing power or authority for determining and carrying out practice activity. Henneman (1995, cited in Sullivan, 1998: 6) noted that sharing of power was '*based in knowledge and expertise, rather than role or title*'. These comments emphasise the importance of

respect and equality for team working. Some degree of collaboration will occur in all teams but the definitions reviewed suggest that sharing of power and authority is more likely to be evident in interdisciplinary and transdisciplinary teams. In terms of the existing literature, no claims are made that any of these definitions apply specifically to stroke units. This section has identified overall differences in the way that the work of team members might be structured and organised and has highlighted some of the interactional processes which are prominent as teams move from working separately to collaboratively. Further issues are team 'effectiveness' and the impact of teamwork on improving patient outcomes.

### Characteristics of effective teams

In an industrial context, team effectiveness normally refers to capacity to produce high quality 'goods' at a cost which maintains competitiveness in the market. In health services, effectiveness is concerned with delivering services which result in improved health outcomes for individuals or communities. This involves balancing patient need, clinical expertise, research evidence and costs to provide care and interventions which work (Muir-Gray, 2001). This principle of clinical effectiveness is widely supported, but as with teamwork, its realisation depends on a range of factors including organisational infrastructure and resources, and interpersonal processes.

Belbin (1981, 2000) argued that effective teams share a common purpose, a clear understanding and respect for team members' roles and responsibilities for outcome, and include individuals who are able to work in autonomous groups. Larson & LaFasto (1989) in their three year study conducted in-depth interviews with teams from healthcare, sport and geographical expeditions, consistently finding features which distinguished effective from ineffective teams. Eight characteristics were described including: a clear elevating goal, results driven structure, competent members, unified commitment, a collaborative climate, standards of excellence, external support and recognition and principled leadership. Guzzo & Shea (1992) observed team member interactions and team

performance in a variety of organisational settings and identified four characteristics of effective teams: team members sharing a common goal, clear understanding of the roles and contributions of others, pooling of knowledge and taking responsibility for outcomes, and the capacity to self manage and become independent.

There are distinct similarities in the characteristics identified by these studies, including shared goals, understanding the roles and contributions of others and shared responsibility for outcome. This replication lends some validity to these empirically derived characteristics. There are also differences, with Larson & LaFasto (1989) including principled leadership and both Belbin (1981, 2000) and Guzzo & Shea (1992) highlighting the capacity to self manage or work within autonomous groups. These differences may be attributed to the differing reasons the teams were formed or result from the different research methods used in these studies. However, understanding the factors which contribute to effective team functioning does not automatically transfer to team working in practice. In the context of health professional practice, Soothill et al (1995) and Wilson (2000) suggested that focusing on the presence or absence of these characteristics represented an over simplification of the processes involved in health professional work. They argued that because of the complexity and changing nature of contemporary health services and interprofessional relationships, such lists of characteristics did not take sufficient account of the health, professional, social and political contexts which had a significant bearing on the ways in which individual professionals and healthcare teams developed and operated at a local level.

This section has identified important differences in the way teamwork is defined, and reported on characteristics consistently associated with teams considered to be effective. In order to establish the necessity for and specific focus of the current study, the discussion will now turn to review of the research evidence on health professional team working.

### The evidence for effectiveness of healthcare teams

There has been limited systematic examination of effectiveness in healthcare teams. The majority of studies identified have taken a quantitative approach to investigation of team effectiveness and health professional perceptions of team working. There are a small number of qualitative studies and only a few of these have examined interpersonal team processes. The strengths and limitations of these studies will be considered.

Halstead's (1976) review of 25 years of literature relating to team-care in chronic illness indicated that effectiveness was a neglected area of research. He identified three categories of published work: opinion based, descriptive based and empirical. The publications categorised as opinion or descriptive based focused on statements of belief regarding the merits of team-care, expert (medical) views on the benefits of team-care in chronic illness, or descriptions of programmes designed to develop team approaches. These represented the majority of publications in the review but the programmes described were rarely subjected to objective evaluation of outcomes. Halstead (1976) located only ten quantitative studies, which examined the effect that co-ordinated team-care had on patients with chronic illness, spanning heart disease, hypertension, stroke, hip fracture, rheumatoid arthritis, diabetes, and groups of patients referred for comprehensive rehabilitation. Six studies indicated co-ordinated team-care was more effective than other approaches (including one conducted with stroke patients, Benton, 1959 cited in Halstead, 1976). Halstead (1976: 507) suggested that *'although these studies served as a useful guide, the extent to which these findings can be generalised is open to serious question'*. This was due to methodological weaknesses including small sample sizes, incomplete information regarding research designs and interventions, procedures for allocation of subjects to treatment or control groups, and the lack of comparability of measurement of outcome variables in the studies reviewed. He recommended the development and testing of objective outcome measures and larger scale prospective studies designed to compare the

effectiveness of different team based interventions. None of the studies reviewed by Halstead examined the process of teamwork or its possible relationship to team effectiveness.

This paucity of empirical evidence was still apparent in a later review of 2,200 abstracts from medical and social sciences literature relating to the effectiveness of interdisciplinary teams in healthcare (Schofield & Amodeo, 1999). They examined 224 articles (of the 2,200 originally identified) and found 138 included substantive discussion of interdisciplinary teams. These were spread across four categories of publication as follows: descriptive (55), process focused (51), empirical (21) and outcome (11). The predominance of descriptive articles was similar to that seen by Halstead (1976) and is typical of much of the contemporary literature in nursing, medicine and the allied health professions, and represents attempts to share information on developments in practice. While Schofield & Amodeo (1999) differentiate 'descriptive' and 'process focused' articles, the latter term appears a misnomer as these publications concentrated on how teams should work rather than examined team member interaction or work processes. Of the 21 empirical research articles examined, the majority utilised survey methods to investigate the relationship of team dynamics, collaboration, and perceptions of team functioning to team effectiveness. This reliance on survey methods to examine interactional processes provides only a partial representation of team working. However, one study (Cooley, 1994) described a team training intervention designed to overcome identified barriers to effective teamwork. Team meetings were observed to determine the effectiveness of training, and although the intervention was deemed unsuccessful, the study highlighted the difficulty of identifying and measuring the impact of training on team performance. A longitudinal study using interviews and observations of team practice, as well as before and after measures, would have provided more detailed information on the ways in which the team members perceived and responded to the training intervention and how this affected team working.

The outcome focused articles reviewed by Schofield & Amodeo (1999) all demonstrated attempts to determine whether team interventions were associated with improved outcomes in specific patient groups. Sample sizes ranged from six to ninety-eight (team members) to 2353 patients. The methodological rigour of these studies can be criticised in that there was inconsistent use or absence of pre-and post-test measures (Case & Leavitt, 1986; Hennessy & Shen, 1986; Reuben et al, 1995) and a lack of comparability between control and intervention groups, (Case & Leavitt, 1986; Erickson & Perkins, 1994). Accepting these limitations, none of the studies found empirical evidence that interdisciplinary teamwork was more effective than usual care. Only two outcome studies examined the contribution of team processes to team effectiveness. Vinokur-Kaplan (1995) used Hackman's (1990) model of group effectiveness in a study of 15 interdisciplinary treatment teams in three psychiatric hospitals. She demonstrated that initial and enabling conditions, including group structure, supportive organisational context, conducive physical environment, expert coaching and process assistance were positive, but not statistically significant, predictors of overall team effectiveness. Crepeau's (1994) grounded theory study focused on development of integrated care plans using direct observations of team meetings to explain team interactive processes. A focus on team meetings as units of study in relation to team functioning and process is common (Sands, et al, 1990, Sands, 1993; Griffiths, 1997; Cott, 1997; Gibbon, 1999; Opie, 2000) and yet the majority of team interactions take place outside of and in addition to those which occur in formal, planned team meetings. The lack of comprehensive investigation of the process of team working is both surprising and significant given the contemporary policy demands for collaboration between health professionals and confirms the relevance of the current study in stroke units. A further key element of teamwork research concerns views held by team members.

#### Health professionals' perceptions of team working

In one of the few studies examining health professionals' understanding of teams and teamwork, Temkin-Greener (1983) challenged the standard assumption that the concepts of team and team



working were well understood by doctors and nurses. She interviewed 12 heads of departments of nursing and medicine in a large US medical centre and concluded they had quite different perceptions of these concepts. Interviews focused on two areas, firstly an abstract discussion relating to the purpose, structure and function of teams; and secondly on interviewees' experiences of working within teams. For many respondents, interdisciplinary teams were an administrative construct rather than a practice reality. Groups of staff came together on a functional basis to complete funded programmes of work, rather than as a deliberate strategy to harness the proposed benefits of interdisciplinary team working. The findings demonstrated that nurse managers viewed interdisciplinary team working as complementary to their aspirations for professional recognition and autonomy over their work, emphasising equality and collaboration as key to teamwork. In contrast, most medical staff regarded teams as a form of shared activity promoted and desired by nurses, whereas they tended to reinforce the traditional hierarchical view of interprofessional relations where power and authority rested with the doctor. Hence, professional hierarchy proved stronger than allegiance to a group or team.

Despite the small sample, Temkin-Greener's (1983) findings were broadly consistent with the pre-eminent sociological critique of medical dominance which is discussed in chapter 3 (Freidson, 1970b, 1976; Johnson, 1972; Larkin, 1983). A weakness of Temkin-Greener's (1983) study was that reliance on interviews alone provided only a limited view of the day-to-day reality of interprofessional relations in this setting. The views and beliefs expressed by participants may have differed from their actions in practice and also from other, less senior groups of nurses and doctors. However, the study demonstrated the importance of in-depth examination of perceptions of health professionals through qualitative interviews, and provided a clear indication of differences between the ideology expressed by policymakers and the reality of day-to-day practice as understood by doctors and nurses. Temkin-Greener (1983) provided some insight into the differences in

perceptions between disciplines, but further research comparing the perceptions of a wider group of staff was required to determine the generalisability of her findings.

In the USA, health professionals from ten different disciplines (n=113, response rate =77%) participated in a survey of perceptions of the interdisciplinary team environment and interprofessional relations within three teams caring for patients following stroke and spinal cord injury, orthopaedic conditions and Parkinsonism (Strasser et al, 1994). The survey instruments utilised were validated measures of factors affecting interdisciplinary rehabilitation, and included the ward atmosphere scale, and the group environment scale (Moos, 1986) and the interprofessional perceptions scale (Golin & Ducanis, 1981). Data supporting claims for construct validity and test-retest reliability of these instruments were provided. Statistical analysis was described in detail and was consistent with the levels and complexity of data generated. Findings indicated that more than 89% of the respondents were positive about team approaches to rehabilitation, and perceived fellow team members to be ethical, competent, and concerned for patients. Nevertheless, the survey also demonstrated that 20% of the respondents felt team members were very defensive about their professional judgement and expected too much of others. In addition, half of the respondents reported that team members could sometimes encroach on their professional territory.

This study provided empirical evidence of the contribution of interprofessional relations and professional boundaries as sources of discord in rehabilitation teams. Strasser et al (1994) suggested that this discord may reflect the tensions which exist between one's professional identity and other reference groups such as the multidisciplinary team, particularly when overlapping and conflicting authority exists. In common with Temkin-Greener (1983), these findings demonstrated that whilst rehabilitation team members supported the philosophy of interprofessional working, they identified primarily with their own professional group and interpreted the actions of other health professionals from that standpoint.

Despite the use of validated instruments to ascertain and compare perceptions, the reasons why team members felt defensive about professional judgments and were concerned about encroachment on their professional territory can only be surmised. Comparison of these findings with interview and observational data gained in the settings would have enabled further exploration of these differences. This study was part of an ongoing programme of research examining interdisciplinary teamwork in rehabilitation (Strasser & Falconer, 1997; Strasser et al, 2005a, 2005b) the focus of which remained mainly on interventions such as training and education and the use of quantitative outcome measures. As a result, the interactional components of team process and the meaning which team members attribute to these remain unexplored.

Findings similar to those of Strasser et al (1994) were reported following a survey of health professionals working with stroke patients in England (n = 64) in a general medical ward, elderly care unit and a stroke unit (Pound & Ebrahim, 1997). Although the survey questions did not expressly seek to elicit perceptions of team working, participants commented on conflict between team members, particularly where a medical as opposed to a rehabilitation model of care was dominant. Team members also described frustration with the lack of understanding of their professional role and skills demonstrated by some team members; again the research methods did not allow for exploration of the reasons for team member frustration or dissatisfaction with the model of rehabilitation.

These studies demonstrate that despite positive perceptions about the value of teamwork, barriers to integrated working remain. These include differing professional ideology, concern with encroachment into professional territory and traditional hierarchical relationships with medicine. However, survey research alone cannot comprehensively illuminate the ways health professionals understand and respond to the requirement to work together in the practice setting, nor can reliance on this methodology establish what factors help or hinder development of teamwork over time. This

highlights the importance of studies that incorporate qualitative methods and a wider range of teams. One such example is Miller et al's (1999) three year study of multiprofessional working and shared learning. It examined the preparation of health and social care professionals to work in teams and how well they did this in reality. Data were generated through non-participant observation, documentary analysis and interviews of six teams in hospital and community settings. Representatives of several professional bodies also participated in interviews and all UK universities offering health and social care programmes were surveyed (n= 74). In general, higher education institutions (HEIs) endorsed the principle of multiprofessional learning. However in practice, as a response to the need to manage increasing student numbers without a significant increase in resources, there was very limited evidence of effective preparation of students for future multiprofessional practice, despite the widespread use of a shared teaching/learning model.

Miller et al (1999) found a mismatch between policy makers' directives for health and social care professionals to work together and the reality of most professional work. Interviews conducted with 12 nurse managers and 2 physiotherapy managers identified similar sentiments to staff in HEIs in that there was general agreement with policy intentions and a recognition that teamwork should contribute to improved patient outcomes. However, improved team working was only one policy directive faced by these managers who reported that such requirements were compromised by financial restrictions, inadequate workforce planning, variable commitment to role expansion and differing professional perspectives on service redesign and multiprofessional working. Despite overall support for the principle, only a limited number of initiatives to bring about improvements in team working were identified. One example, the development of integrated care pathways, highlighted some initial collaborative activity between nurses and allied health professions but several managers noted that it had been difficult to engage medical colleagues in multiprofessional training and development activities. findings which echo those of Temkin-Greener (1983).

Miller et al's (1999) in-depth case studies with six teams identified three types of multiprofessional working. Integrated collaborative working was seen only in a neuro-rehabilitation setting, core and periphery working was identified in a specialist diabetes team and a child development assessment team, and fragmented working was seen in a medical ward, a primary healthcare team and community mental health team. In the integrated team, several benefits to patients and team members were noted, including consistency and continuity in care, a high level of team knowledge and role understanding, a more holistic basis for decision making and referral, and increased satisfaction with care. In contrast, in fragmented teams, interprofessional conflicts and active protection of disciplinary boundaries predominated along with a lack of team knowledge and less satisfaction with teamwork. Miller et al's (1999) case studies indicated that neuro-rehabilitation team working was not associated with concerns related to professional boundaries and professional judgements. Sharing the same work base, frequency and type of contact between team members and the degree of joint working with patients, all influenced team working in that setting.

Data were generated from a large number of stakeholders in primary and secondary care using observations, telephone and face-to-face interviews, surveys and documentary analysis. This combination of approaches provided opportunities to explore and develop an in-depth understanding of team working in action. Contextual features impacting on health and social care professionals were included in the analysis, for example, health policy directives and their interpretation and implementation in differently organised NHS and Primary Care Trusts. Analysis of qualitative data adopted a grounded theory approach and was detailed and rigorous. Findings were supported by data extracts which illuminated the complexity of team working in the case study sites. The findings in respect of the neuro-rehabilitation team are consistent with those from small-scale studies examining teamwork in rehabilitation and elderly care settings (Halstead et al, 1986; Pound et al, 1999; McCallin, 2001; Molyneux, 2001). However, the other teams studied identified problems arising from different perceptions of the division of labour, mistrust and protection of

professional boundaries and lack of understanding of the roles of other health professionals, features noted in earlier studies (McIntosh & Dingwall, 1978; Evers, 1982; Sands et al, 1990; Strasser et al, 1994; Griffiths, 1997). In an attempt to move beyond problem identification, the multiprofessional education model developed by Miller et al (2001) was derived directly from data generated in their 1999 study. This model aims to promote factors associated with integrated team working, whilst explicitly addressing and working through factors which were consistently associated with fragmented and core and periphery working.

In a similar study of educational preparation for mental health nursing within multiprofessional and multi-agency teams, Stark et al (2000) also found differences between teamwork rhetoric and practice. Drawing on grounded theory methodology to generate and analyse data, they concluded that skills and knowledge for teamwork were more likely to be 'caught than taught' and that the turbulence brought about by rapid and continuing change in policy, education and practice led to disjunctions and tensions in practice settings. This study highlighted that teamwork was imposed on some workgroups without adequate preparation which in turn led to dissatisfaction, fragmentation and some interprofessional conflict. Stark et al (2000) drew attention to the need to recognise and understand the impact of power, status, authority and competition between team members if attempts to develop collaborative or partnership working were to have any prospect of success. The strength of these studies is in their methodological rigour and their attempt to include all health and social care professionals involved in teamwork in the study settings.

In a major study led by the Aston Centre for Health Service Organisation Research, Borrill et al (2003) examined team working and effectiveness across the NHS. This represents the largest review of team working in the NHS. Data were gathered over a period of three years by a quantitative survey of over 400 teams including more than 7000 NHS personnel. Participants included 100 primary healthcare teams, 113 community mental health teams and 193 secondary

healthcare teams. The survey data were added to by in-depth qualitative interviews and observations in twelve primary care and community mental health teams. Participants were recruited from NHS Trusts and PCTs representing city, urban and rural centres across the UK. Levels of deprivation in different centres (Jarman scores) were reported and were correlated with team composition; these indicated the diversity of patient populations that teams worked with. Description of the characteristics of each sample in terms of gender, age, and professional background suggests that the participants were representative of those routinely involved in team working in the NHS, and that the study findings have broad generalisability.

The study had a sound theoretical basis in the input, process, and output model of team effectiveness (West, Borrill & Unsworth, 1998). This identifies a range of validated factors, which influence team working, including for example, the healthcare environment and organisational context, leadership and clarity of objectives, team member mental health and team member turnover. The three domains of the model provided the basis for data collection. A range of valid and reliable data collection instruments were used including the Team Climate Inventory (Anderson & West, 1994), the Organisational Climate Questionnaire (Hill, 1998) and the General Health Questionnaire (GHQ-12). Semi-structured approaches to telephone and face-to-face interviews, and the means of recording, transcribing, and analysing observed team meetings were clearly identified.

Whilst the focus of this research on effectiveness, differed from the current study, some of the findings, particularly those arising from the observation of team meetings and interviews, provided important evidence regarding the process of teamwork. The research identified a clear positive relationship between team working and the effectiveness of healthcare teams which in turn was associated with improved quality and outcomes of patient care:

*Good team processes means clear, shared objectives amongst team members; high levels of participation including frequency of interaction, quality of information sharing and shared influence over decision making; emphasis on high quality care within teams and a*

*preparedness to encourage constructive controversy but to discourage interpersonal conflict; and practical support for ideas for new and improved ways for providing healthcare.* (Borrill et al, 2003: 216)

These factors were strongly correlated with greater innovation in teams, improved mental health of team members, and better staff retention. Borrill et al (2003) reported a reduction in patient mortality 30 days after emergency surgery and after hip fracture where staff worked predominantly in teams. They also noted increased team effectiveness where there was shared leadership and team members perceived they were involved in the team. The study recommendations identified the need for major reform if the NHS was to develop team based organisations. Suggested reforms included reconsideration of NHS management and education structures, which Borrill et al (2003) argued were traditional, hierarchical and inconsistent with effective team based organisations. Creating a culture of team based working and educating, resourcing and supporting staff to work within such a culture would be a major undertaking for an organisation the size and complexity of the NHS; Borrill et al (2003) concluded that without such fundamental change the benefits of effective team working would not be realised.

These large scale studies (Miller et al, 1999; Stark et al, 2000; Borrill et al, 2003) generated data directly from the workplace and progressed beyond identification of problems associated with teamwork, to explanation of ways in which team members respond when required to collaborate. These studies recognised that health professionals must respond to external policy drivers, local organisational demands and attempt to reconcile these with professional obligations and practice. A range of factors which can contribute to or militate against accomplishing teamwork were identified and explored. These factors require detailed consideration by policymakers, educators, managers and health professionals if we are to understand and to realise the potential benefits associated with effective team working. However, in terms of the current study, only the neuro-rehabilitation team



in Miller et al's (1999) study provides any evidence of the process of teamwork in a unit similar to stroke units.

### Stroke unit team working

The notion that rehabilitation, '*the restoration of the individual to his (or her) fullest physical, mental and social capability*' (Mair, 1972: 3), should be provided by a team is a long established one, pre-dating the formation of the NHS (Warren, 1946). The necessity for team working is widely accepted in many clinical areas, including cardiac care, orthopaedics, elderly care and stroke. Strasser et al (1994: 177) maintained that in some areas of healthcare, co-ordinated teamwork is considered to be fundamental. They stated that:

*Team-care is a cornerstone of modern rehabilitation philosophy and practice. The need to co-ordinate the activities of the different rehabilitation professionals in addressing the comprehensive needs of individuals with disabilities, distinguishes the rehabilitation model from the medical model*

Stroke units are a relatively recent development but they endorse the concept of co-ordinated multidisciplinary teamwork (O'Connor, 1994; 1997; Langhorne & Dennis, 1998, Gibbon, 2003). The first stroke unit in the UK was set up in Glasgow in 1968 as a comprehensive stroke unit (Stevens & Isaacs, 1984). The continued development of stroke units occurred in geriatric units. Currently, there are three main types of unit in the UK, the first takes stroke patients soon after onset and provides acute care. These are medical units with a clear emphasis on early and accurate diagnosis, physiological stabilisation and interventions to prevent further strokes, aspiration pneumonia, dehydration and nutritional deficits (DoH, 2001a; RCP, 2004). Whilst multidisciplinary assessment of rehabilitation requirements begins in these units, after a short period of time, normally less than ten days, the patient is transferred to a rehabilitation unit. These units provide intensive rehabilitation aimed at restoring functional and cognitive abilities and must also recognise and respond to the social and emotional consequences of stroke (Langhorne & Dennis, 1998; Gibbon, 2003). A small number of units combine acute care and continuing rehabilitation. Each of

these units brings together many different health professionals with expertise in caring for stroke patients but it is in rehabilitation units where the complexity of stroke illness and the associated (often extended) length of stay challenges health professionals to develop integrated approaches to meet the complex needs of patients and their families. Stroke rehabilitation units are normally staffed by a wide range of therapists, nurses, physicians and support workers. Co-ordination of the interventions of these professionals is important if patients are to benefit from the skills and knowledge of the team members. There is substantial overlap in the focus of care and interventions, with the consequent potential for conflict and tension as well as positive approaches to blurring of occupational boundaries (Kumar, 2000; Audit Commission, 2002; Gibbon, 2003). There is currently very little research on how health professionals work with others in rehabilitation stroke unit teams. The ways in which these teams plan and manage the requirement to work jointly with other professionals and address complex health problems, or how they co-ordinate programmes of stroke care are not well understood.

It had long been speculated that stroke units may deliver improved outcomes similar to those reported in coronary care units. However it was only when all previous randomised trial comparisons of differences in outcomes when patients received care in stroke units, care of the elderly units or general medical wards were reviewed that definitive evidence became available (SUTC, 1997). This systematic review provided unequivocal evidence of improved outcomes where patients had been treated in a stroke unit by a multidisciplinary team. When compared with conventional care, organised inpatient stroke care resulted in long term reduction in death, dependency and the need for institutional care. The size of the treatment effect reported was surprisingly large, with numbers needed to treat (a measure of absolute benefit) of 33, 20 and 20 respectively. Thus, for example only 20 patients need to be treated on a stroke unit to save one patient unnecessarily dying or requiring institutional care; this is a powerful treatment effect. The systematic review drew attention to the contribution of team working to the effectiveness of stroke

units and called for further research to understand this important area of practice by investigating team processes or team members' interactions (SUTC, 1997; Young & Forster, 2007).

Other research has focused on the daily activities and treatment of stroke patients as means to determine which aspects of specialist rehabilitation contribute to improved patient outcome (Keith, 1980; Keith & Cowell, 1987; Lincoln et al, 1996; Newell et al, 1997, Pound & Ebrahim, 1997; Pound et al, 1999). These studies, in common with others of rehabilitation settings adopted non participant observational methods to gather data regarding stroke patient activity (Clark & Bowling, 1990; Ellul et al, 1993; Newton et al, 1993). Indirectly they identified fragmented team working in that therapeutic activity was described as being carried out away from the wards or units by separate professions, particularly physiotherapy and occupational therapy. An absence of rehabilitation activity during the time patients were on wards or units was identified. These studies provided little evidence of interprofessional teamwork and criticised the low level of rehabilitation activity undertaken by patients. This research generated data from direct observation in rehabilitation settings, however, these data are quantitative and focus on frequency of occurrence of patient activity as opposed to the nature and kind of interactions of patients with team members, or between team members.

Gibbon (1999) focused more directly on team working in stroke units and investigated interprofessional collaboration in five stroke rehabilitation team conferences, using a quantitative observational tool, the Team Observation Protocol (TOP) (Ducanis & Golin, 1979). This categorises the major statements of team members and allows for summation and quantification of the responses. Gibbon (1999) noted that team conferences provided an opportunity to collaborate in the planning and management of stroke patient care. but that the small number of conferences observed functioned primarily to disseminate decisions made by key professionals rather than to collaborate in arriving at those decisions. He found that physiotherapists spoke most frequently and

proposed decisions which were supported or seconded by occupational therapists. Whilst nurses chaired and co-ordinated the conferences, their main role was in actioning decisions made. Interestingly, physicians did not attend the conferences but 'sanctioned' the decisions made; although the mechanism by which this occurred outside of team meetings was unclear.

Gibbon (1999) noted some positive features of team conferences including the opportunity for team members to share their views. He reported that a shared language had developed which facilitated discussions between team members and implied a degree of group cohesion. He suggested team conferences provided some tangible evidence of collaboration and were regarded as important events by team members. Nonetheless, despite the cohesion and shared language, the apparent differentiation in roles of professions in these conferences and the absence of physicians suggested that there was a need to study the ways in which these team members interacted outside of team conferences. Gibbon (1999) noted that the TOP instrument did not capture qualitative data and suggested that to develop more detailed understanding of team processes, qualitative observations should also be used.

In an attempt to explain the improved outcomes associated with stroke unit care, Pound et al (1999) and Pound & Ebrahim (2000) reported on a non participant observational study which compared the process of care in an established stroke unit, an elderly care unit and a general medical ward. Their quantitative observations focused on 12 patients in each unit and recorded information about activities experienced by them, for example, in interaction with different team members as part of therapeutic interventions. The unstructured qualitative observations in this study focused on ward rounds, team meetings, therapy sessions, assessments and general activity such as meal times, but not directly on interaction between team members.

Few examples of teamwork were observed on the medical ward, where therapists rarely visited. Relationships between team members on the medical ward and the stroke unit were observed to be based on therapists giving instructions which they expected nurses to carry out. The medical team was separated from nursing and therapy teams in the medical ward, and was allied with therapists on the stroke units. In the medical ward, therapists worked separately from each other and other team members and there were no weekly team meetings. Communication between team members on this ward was reported as poor. Stroke unit team meetings and ward rounds were more participative, although the description of the meetings is very similar to those witnessed by Gibbon (1999) with physiotherapists contributing most and nurses least to decision making. Relationships were more collaborative on the elderly care unit where a rehabilitation philosophy was shared by the nursing and therapy team. However, Pound & Ebrahim (2000) again noted that medical teams were separated from these groups on this unit. Physiotherapists and occupational therapists worked together with patients but not routinely with other team members. The therapists reported that team meetings and ward rounds were not useful and suggested tensions related to differences between a medical and rehabilitation model of care.

Pound & Ebrahim (2000) were able to confirm some beneficial aspects of stroke unit care including an increased number of timetabled activities for patients, good communication between therapists, a less institutional atmosphere, attempts to meet the needs of carers and a consultant physician who was respected by the team members. However, almost all of these features, except for work with carers and the style of medical leadership, were also seen in the elderly care unit. Pound & Ebrahim (2000) found more collaborative integrated teamwork and mutually respectful relationships between nurses and therapists in the elderly care unit: they associated this with greater carryover of therapy by nurses (which they termed 'rehabilitation nursing'). In contrast, the stroke unit and medical ward teams can be described as fragmented, carrying out their work separately with the possible

consequence that care of stroke patients in both settings was less effective. The apparent absence of medical involvement is not explained.

This was a well designed study with clear evidence of reliability and consistency in observations; however, the conclusions of the study are disappointing. Pound & Ebrahim (2000) identified a number of factors which may influence patient outcomes including type of team contact, participation in team conferences, interaction and relationships between team members, and differences in contribution to decision making. Despite this, they focused only on the training of nurses and their engagement in the teams studied, concluding that nursing processes may be central to high quality stroke care. The study identified these as factors which could explain the more limited evidence of 'emotional labour' and 'rehabilitation nursing' in the stroke units. However, the focus on nurses and the absence of analysis of the evolution and contribution of the different models of team working in these units mean that Pound & Ebrahim's (2000) conclusions do not accurately reflect the study findings as a whole. In fact, the study pointed towards the contribution of organisation and location of rehabilitation practice and team interactional processes but did not fully explicate the possible role of these issues.

Gibbon et al (2002) took a different approach to studying team working within stroke care. Their quasi-experimental research attempted to evaluate the effect of introducing two team based interventions on staff attitudes to team working in five stroke units. Integrated care pathways (ICP) for stroke were introduced to 3 units (one acute and two rehabilitation) and unified team notes (TN) were introduced to 2 units (a rehabilitation unit and a 29 bedded stroke unit, based on a medical ward). The interventions are not directly comparable although both called for team members to work together with researchers in their design and implementation. The Team Climate Inventory (TCI) was used to measure staff attitudes before and after the interventions were introduced. The TCI has been shown to be reliable in a range of settings with scale reliability ranging from 0.84 and

0.94 (Anderson & West, 1994) and is considered a valid measure of workgroup climate suitable for measuring team development and changes in group climate over time. The use of the TCI in this study was not a direct measurement of the effectiveness of the interventions, but a measurement of changes in staff attitudes following the introduction of ICP or TN.

The findings demonstrated little change in TCI for four of the five units studied. The fifth unit initially scored highly but scores deteriorated by the post-test measure. Gibbon et al (2002) noted that in the units where scores remained stable, all but one had been set up more than three years previously. In the remaining unit which was just over 12 months old, while scores were stable in the pre-and post-test, they were the least positive of the four units. The unit which demonstrated deteriorating scores was less than 12 months old and subject to considerable organisational change during the course of the study. These findings suggest that cohesion and a positive team climate may take some time to develop, and that significant organisational change, together with the introduction of new staff into teams can be disruptive to team working, even when staff demonstrate a high degree of enthusiasm for the new development.

These interventions were externally imposed rather than sought by the teams participating in the study. This could have affected the level of commitment to the interventions and may actually have disrupted established patterns of team working rather than enhanced them as the authors anticipated. Gibbon et al (2002) accepted that data generated from observing how the teams responded to the interventions over time and by exploration of team members' perceptions and reactions to the interventions could have provided important information in relation to the way teams work with innovation and change. In an earlier paper discussing the design and implementation of this study, Watkins et al (2001) identified the importance of working with potential research participants prior to studies to address practical problems in designing intervention studies. An alternative to introducing researcher led interventions such as these could have involved using the TCI as a

diagnostic tool with teams to determine the areas where they perceived development would enhance their team working practice.

In a study focussing on multi-agency rehabilitative care for people who had suffered a stroke, Allen et al (2004) reported on case studies of eight patients which illustrated the complex networks of care through which health and social care providers delivered care. The authors traced the impact of policy directives on the work of these providers and on the experiences of stroke patients and their carers. The study highlighted that despite considerable and continuing change in the context of health and social care provision, integrated and flexible working for and with stroke patients was regularly evident in the two study sites. This is one of very few workplace based studies in stroke care, but it clearly identified the willingness of health and social care providers to manage complex care requirements by working at interagency boundaries and interpreting health and social care policy at a local level. In an earlier report on this study, Allen et al (2002) argued that the in-depth ethnographic research methods used were necessary to develop detailed understanding of interaction between providers and patients in health and social care settings and exhorted researchers to conduct more studies of this kind (see chapter 3).

### Summary

Services for older people have been closely monitored since the introduction of the NSF for Older People (DoH, 2001a). In addition, since 1998 a National Sentinel Stroke Audit has been conducted bi-annually by the Intercollegiate Stroke Working Party and published by the Royal College of Physicians. The purpose of this is to improve the quality of care provided for stroke patients by involving NHS trusts across the country in an audit that enables them to compare their results with national data (RCP, 2006). Co-ordinated interdisciplinary services for stroke units are one of the five key standards measured by the sentinel audit, but neither the audit standard nor the National Clinical Guidelines for Stroke (RCP, 2004) define what is actually meant by co-ordinated



interdisciplinary team working or how this can be achieved in practice. Domain 8 of the audit indicates that team meetings have been identified as a significant factor in co-ordination stroke services, but teamwork outside of meetings is not considered.

Stroke unit teams established in the last five years work in a health service where policy makers explicitly claim that interdisciplinary teamwork will lead to more flexible working and breakdown traditional hierarchical barriers (DoH, 1997; 2000). Interdisciplinary team working is expressly linked by policy makers with improved patient outcomes despite only limited research evidence that this is the case (Zwarenstein & Reeves, 2000; Schmitt, 2001; Borrill et al, 2003). The Audit Commission (2002: 36) identified the need for integrated teams as a key component of whole systems working in older adult care, but recognised that *'team working highlights differences in approach or culture'* which can lead to tensions between professionals in health and social care; and even in teams which were working well *'this required a great deal of managed discussion, negotiation and working together to resolve'*. The NHS Changing Workforce Programme, (DoH, 2002) suggested 'new ways of working' including employment and development of assistants with generic skills, were essential to combat staff shortages in most professional groups and to respond the time pressures and challenges brought about by the European Working Time Directive including the reduction in junior doctors hours from August 2004 (Council of the European Union (93/104/EC, 1993; DoH, 2004). Pilot sites, including one in stroke care, were set up to examine options for job redesign and skills acquisition across traditional professional boundaries. The Department of Health (2002: 56) also identified the need for more integrated and more flexible working if critical skill shortages were to be overcome and services were to meet the complex needs of older people. They noted that whilst there was no single best model for team working in older adult services:

*'the spirit of the single assessment process and person centred care in the NSF Older People would seem to favour the inter and transdisciplinary models rather than existing professionally based MDTs'*

These were held to be less likely to experience the problems inherent in multidisciplinary team working where protection of professional boundaries could become a source of conflict and require time and energy which should more properly be spent with patients (Kumar, 2000).

Policy makers continue to position teamwork as a core element of flexible working practices which can meet the complex healthcare needs of NHS patients. However, calls for team solutions are not always supported by clarity in defining the kinds of teamwork required, or by adequate recognition of the factors which facilitate or compromise teamwork in the NHS. This chapter has identified the different ways in which teamwork is described in the health professional literature. Whilst these definitions provide conceptual clarity, their impact on the thinking and interactions of health professionals is unclear. Characteristics of effective teams were reviewed. These included interpersonal processes which appear to be key contributors to co-ordinating, integrating and maximising individual health professionals' efforts to improve patient outcomes. A small number of studies indicated that health professionals can and do develop integrated collaborative working; this was particularly evident in neurological rehabilitation settings. However, the majority of studies reviewed also reported factors which inhibited team effectiveness. These included tensions related to differing professional ideologies, lack of understanding the roles of other team members and problems in interprofessional relationships resulting from differences in status and power. Research examining the relationship between teamwork and improved patient outcomes was very limited. Only one study provides robust evidence of a positive relationship between teamwork and increased effectiveness (Borrill et al, 2003).

The majority of studies reviewed relied on survey and quantitative observational methods to report on dynamic interactional processes; this has provided only a partial picture and explanation. With a few exceptions, there has been very little in-depth examination of the process of teamwork in stroke units in the UK (Pound & Ebrahim, 1997, 2000; Gibbon et al, 2002). Allen et al's (2002, 2004)

study of multi-agency rehabilitative care provided insights into how health and social care providers collaborated in managing resources and providing services to meet the complex needs of stroke patients. However, to date there has been no in-depth study specifically focusing on how teamwork is achieved on a day-to-day basis in stroke units in the UK. The research reviewed in this chapter indicates that prolonged engagement with stroke unit teams would generate data which would add to our understanding of how healthcare professionals work individually and collectively to provide specialist stroke care. Such research would contribute a further, qualitative dimension to the existing body of knowledge related to stroke units. Miller et al (1999) and Stark et al (2000) demonstrated the utility of grounded theory methods in analysing qualitative data from their research with healthcare teams; this approach is appropriate for developing explanations of teamwork in stroke units and is discussed in chapter 4.

The discussion in chapter 3 will focus on sociological perspectives on professions and their respective positions in the healthcare division of labour. These provide a related but different set of insights into factors which may influence and help to explain team interactional processes in stroke units.

## Chapter 3:

Literature review: Professions and the division of labour

## Introduction

This chapter will outline key sociological positions on professions and the division of labour, before reviewing empirical studies of teamwork in healthcare settings. This literature provides important theoretical and empirical perspectives which constitute a basis for analysing and understanding factors which influence individuals in teams. The strengths and limitations of the sociological literature are assessed. In particular, the importance of focusing research on interactions between health professionals in the workplace is established. The chapter will conclude by identifying the central research question which underpinned the design and conduct of the research presented in this thesis.

## Professions and the division of labour

Organised occupational groups including the ‘professions’ have interested sociologists for more than a century, but in the 1950s they became the subject of more critical examination (Annandale, 1998). Freidson (1994: 13) noted that until the early 1950s sociologists represented professions as:

*‘Honoured servants of public need, conceiving of them as occupations especially distinguished from others by their orientation to serving the needs of the public, through the schooled application of their unusually esoteric knowledge and complex skill’*

He argued that early writing on professions was characterised by its concern with establishing particular traits, definitions and typologies which often directly reflected the ways in which powerful occupational groups defined and organised themselves. These typologies were used to determine whether particular occupational groups such as social work or nursing could be classified as professions, but did not challenge the claims of established professions to define and control their work and entry to the profession. Critical examination of the relationships between professions and other occupational groups, and with the state was not a central priority. However, a more critical stance had been taken by economists concerned with labour market monopoly, and policymakers concerned with developing a broad vision of the needs of the public as opposed to one dominated

by professional perspectives (Freidson, 1994). In a novel contribution, Parsons (1952, 1964) focused on medicine and the law in the context of his functionalist analysis of the interrelationship between social institutions and the social system. His work on the sick role and medicine's contribution to defining and legitimating illness in society provided an early indication of the legitimate authority medicine had over its work with patients and other healthcare workers.

Other role theory research focused on professional socialisation in medicine and the means by which the power of medicine to control its work and its members could be maintained (Hughes, 1956, Becker et al, 1961). A division of labour in which high status professionals kept control over desirable aspects of their work and delegated unpleasant, routine or less desirable work to lower status occupational groups was identified (Hughes, 1958). Becker et al (1961) focused on the way that medical students made sense of the medical education process and negotiated a role for themselves within that process. Olesen & Whittaker's (1968) study explored nurses' socialisation, but also commented on nursing's dependent and subordinate relationship with medicine. These studies moved away from defining the characteristics of professions, towards understanding of the production and maintenance of medical authority and medical knowledge. The research confirmed the powerful position held by medicine in the healthcare division of labour and illustrated how doctors interacted with patients, with other healthcare professionals and the state.

A more critical examination of the influence of professions in society was exemplified by Freidson's (1970a, 1970b) critique of medicine, and Johnson's (1972) analysis of professions and the state. Rather than altruistic servants responding to public need by providing specialist knowledge and skill, Johnson (1972) argued that professions were able to impose their own definitions of need and specify the kind of service that would be provided. He focused on the power of professions in controlling their work. Sociological writings on the professions became preoccupied with struggles for power and control between professions and the state, defining powerful professions such as law

and medicine as being motivated primarily by self interest, status and reward, rather than service (Macdonald, 1995). Freidson (1970a, 1970b) argued that autonomy and dominance underpinned professional power and control and that the medical profession had achieved a dominant position in the division of labour because it not only exerted control over its own work, but also over the work of occupational groups such as nursing and the allied health professions.

McKinlay (1975) suggested medical dominance was already being eroded as doctors became absorbed into increasingly complex healthcare organisations and lost their privileged status as providers of unique services, a process he termed proletarianisation. His claims were based on the view that as doctors needed to rely upon organisations (hospitals) to fund the technology for their increasingly specialist practice, they became employees in large bureaucracies with a consequent loss of autonomy over their work. In contrast, most research reports the continuing authority of medicine, and particularly its control over diagnosis and treatment of disease, with medicine pre-eminent in comparison to other healthcare professions. However, the healthcare division of labour was becoming increasingly complex and as a result doctors were only one interdependent part of a larger whole; but interdependence is not the same as equality (Freidson, 1976). There was some agreement that medicine's autonomy and dominance was being challenged not just by other aspiring professions but also by managerialism and the marketisation of healthcare (Annandale, 1998; Fournier, 2000). Yet, disagreements remain about where this will lead; Freidson (1994) predicted that medicine would have little difficulty maintaining its powerful position. Similarly, Fournier (2000) argued that despite becoming employees in complex healthcare bureaucracies, doctors found ways to turn dependent employment into authority and privilege. She suggested this was due in large part to the importance of intellectual capital and 'credentialed or licensed specialist skills' which are in demand in modern healthcare organisations. In her view, medicine had traded off some of its traditional control over its work but gained other benefits as knowledge boundaries continued to shift and medicine continued to claim unique and specialist expertise.

*'The prediction of the demise of professions underestimates the power of professional knowledge to remake itself and to reconstruct its boundaries'* (Fournier, 2000: 84).

Stacey (1977: 13) argued that *'the social organisation of health is never fixed, but remains fluid and open'*. This was reiterated more recently in Annandale et al's (2004) review of medical work and medical knowledge, which identified unprecedented changes in the organisation and delivery of healthcare, and challenged sociologists to reconceptualise and re-examine the healthcare division of labour. Working in complex organisations may have reduced autonomy and control for doctors as demands for increased flexibility in working practices and the recognition that other professionals, such as nurses and physiotherapists, are working in what were once exclusively medical areas. The rival claims to knowledge and expertise made by allied health professions may also directly influence the division of labour and the relationships between these professions (Annandale, 1998; Griffiths, 2003). The focus on medical dominance was not able to fully explain the complex reality of workplace interaction in healthcare. The working practices which emerge when different professionals are called upon to work collaboratively became an important area of sociological concern.

The professionalising strategies of occupational groups such as nursing, social work and physiotherapy, whilst aimed primarily at improving their status and rewards, were also concerned with establishing a unique body of knowledge and gaining control over their work (Abbott & Meerabeau, 1998). These strategies involve identifying and defining occupational boundaries which mark out the territory or jurisdiction of professional groups (Larson, 1977; Macdonald, 1995). Strategies of occupational closure were conceptualised as mechanisms to exclude other groups from this territory and as a means to maintain power and control over it, and over other occupational groups contributing to that area of practice (Parkin, 1979; Larkin, 1983; Witz, 1992; Freidson, 1994). Occupational boundaries can be sites for dispute and competing claims, particularly when established professions perceive that other groups are attempting to gain the recognition, rewards.



power and control associated with the state mandated licence to practice in a particular area (Larkin, 1983; Walby & Greenwell et al, 1994). Disputes of this kind have been seen recently between dentists and dental hygienists in Canada (Adams, 1999, 2004) and between nurses and operating department practitioners in the UK (Timmons & Tanner, 2004). Studies examining interactions between professions at occupational boundaries have mostly focused on the relationship between two groups such as nursing and medicine (Mackay, 1993; Walby & Greenwell et al. 1994; Svensson, 1996; Allen, 1997). Research with a wider range of professionals indicates that studying interactions at the occupational boundary can highlight factors which can enhance or compromise the integration of services for patients demanded by contemporary health policies (Griffiths, 1997; Allen et al, 2002, 2004; McCallin, 2004).[The findings of these studies are reviewed later.]

An important contribution to the debate surrounding interaction at occupational boundaries was advanced by Abbott (1988) who, following the work of Hughes (1958, 1963) and other Chicago sociologists including Strauss et al (1963; 1985), argued for a shift in the study of professions away from their characteristics or traits onto their work, their tasks and functions and interactions with other professionals. He saw professions not as fixed entities but as subject to change and flux, influenced both by the way they defined, redefined and carried out the minutiae of their daily practice, and by wider social, cultural and political beliefs and debates relating to their practice. Abbott's (1988) central argument related to the concept of jurisdiction and he showed how interprofessional competition and claims for jurisdiction could provide an explanation of the ways in which professions develop and maintain control over their work and that of others.

At the core of claims for jurisdiction in healthcare is the capacity to diagnose and to treat problems defined by the professional; underpinning this capacity is specialist, often abstract academic knowledge. These jurisdictional claims cannot escape the requirement for legitimation by the state or a professional regulatory body in a particular social and cultural setting, but focusing on the day-

to-day processes of professional work can illuminate the ways in which interprofessional competition is managed in the workplace. Strauss et al (1985) argued that whilst organisations have rules and job descriptions which specify and frame the expected division of labour, these may have little impact on day-to-day work. These authors conceptualised the workplace as an 'arena' where the complex reality of professional life was worked out, negotiated and renegotiated over time as the organisation and the demands upon it altered in response to social, political and local change. In some workplaces assimilation occurs, that is, knowledge and skills are shared with other professionals and with lower status workers so that a division of labour evolves which can get the required work done (Abbott, 1988). Interprofessional relations in the workplace therefore may not reflect clear cut objective legal and social definitions of jurisdiction and occupational boundaries. Indeed whilst professions frequently seek to maintain the public image of jurisdiction, Abbott (1988) argued that assimilation was common in healthcare settings.

This concern to focus on interactions in the workplace was supported by Walby & Greenwell et al (1994) in their large scale study of the relations between nursing and medicine in five hospitals across the UK. Data were generated from in-depth interviews with 127 doctors and 135 nurses and a number of other key informants including general managers. They acknowledged the importance of theoretical perspectives on professions and occupational closure but suggested they were not adequate for analysis of interprofessional relations in the workplace. They proposed that these perspectives had more direct relevance to understanding larger structural debates between professions and the state, and professionals and their employers, than they had for the day-to-day interaction between professionals. Their findings demonstrated some conflict and tension at the boundaries between nursing and medicine. However they also found that other factors such as the seniority of the professionals concerned and the time-space geography of hospitals, reflected in sometimes separate working areas and limits on contact between doctors and nurses, were important in understanding interprofessional working. Contrary to theoretical perspectives on the inevitability

of competition and conflict, their study demonstrated that doctors and nurses frequently found ways to co-operate and that senior doctors sometimes supported rather than prevented nurses increasing their technical-medical skills. Walby & Greenwell et al (1994: 89) reported that doctors and nurse co-operated in forming alliances:

*'against intrusion from either senior nursing staff or other consultants; between doctors and nurses in opposition to the programmes of general managers; and between general managers and doctors'*

They argued for a focus on how professionals who were required to work in teams actually dealt with a shift from vertically structured occupations to horizontally structured groups, and they concurred with Abbott (1998) in arguing for a focus on interaction at work.

Similarly, Allen et al (2002: 298) reporting on a series of ethnographic case studies conducted to explore the ways in which health and social care practitioners worked together to provide rehabilitation post stroke, argued that that interactionist perspectives such as those of Strauss et al (1985) and Abbott (1988) conceptualise:

*'the division of labour in dynamic terms and makes social interaction between 'workers' central to its concerns. In this view occupational boundaries are not self evident but have to be actively established and re-established in response to the work situation'*

These authors acknowledge the importance of broader sociological perspectives on the healthcare division of labour, but maintain that to understand the challenges and complexities faced by health professionals working together to deliver care in hospitals or at the interface between health and social care, researchers must explore and develop explanations of day-to-day, patient focused interactions occurring in the workplace. The interactionist perspective will be briefly reviewed before more detailed examination of relevant research related to health professional work.

### Interactionist perspectives

Interactionists are not a single entity, but share a rejection of the rational-bureaucratic view of organisations, with its emphasis on the formal structure of the organisation and rationally defined goals as determinants of individual behaviour. The interactionist perspective and the underpinning theoretical perspective of symbolic interactionism provide a theoretical basis for the examination of teamwork in healthcare settings. Symbolic interactionism has its origins in the concept of self developed by Mead (1934) who suggested that whilst there was a biological base underlying experience selves were essentially social products which developed out of interaction with others. Annandale (1998: 21) suggested that *'the self develops through role taking, its legitimacy dependent on the attitudes of others'*. Self-reflection enables individuals to interpret and give meaning to their interactions with others. However, others may not see us as we see ourselves, or may not act towards us in the ways we expect, and their actions may act as barriers to us, so we have to engage in a process of *'negotiation, impression management and meaning creation'* (Fine, 1993: 64).

Early interactionist studies of hospitals indicated that whilst institutions have rules, especially modern institutions, as social contexts they were also open ended and problematic (Strauss et al 1963, 1985; Bucher & Schatzman, 1964; Glaser & Strauss, 1965, 1968). The rules, rituals and ceremonies surrounding healthcare, (for example ward rounds and multidisciplinary team meetings) were viewed as inherently precarious because they are built on the less than stable foundation of a negotiated consensus between the health professionals who make up the teams. Strauss et al (1963: 150) suggested that the hospital acted as a container in which *'persons from different professions come together to carry out their respective purposes'*. Rules were not the key to understanding how professionals carried out their work with and for patients; indeed they said hardly anyone knew the rules. In their place, negotiation, give and take and bargaining characterised organisational life. Abbott (1988) echoed these claims, arguing that the practical realities of work settings mean that professions may have to suspend jurisdictional claims and come to some accommodation to ensure

that the work required gets done. An important perspective on the social organisation of work developed within the interactionist tradition is that of negotiated order.

### Negotiated order

This perspective developed in response to dissatisfaction with rational bureaucratic models of organisations and provided a way of understanding and explaining how social order was maintained in the face of inevitable change (Maines & Charlton, 1985; Allen, 1997). Strauss et al (1963) argued that earlier organisational theorists overemphasised stable structures and rules and had not attended sufficiently to the internal flux and change occurring in organisations. A more useful approach they argued would be to conceptualise social order as continually reconstituted through processes of negotiation. Strauss et al (1963) accepted that hospitals had rules and that the established division of labour was related to recognised hierarchies of authority where, for example, high status doctors gave orders to lower status nurses and other staff members. An understanding of the rules, and the expectations of individuals within these hierarchies, formed part of the structure of the organisation and framed the context in which work with other professionals and patients occurred. However, research at two psychiatric hospitals pointed out the uncertainties and ambiguities which confronted healthcare workers as they worked with patients, and how medical orders could be subverted or ignored by subordinate workers seeking to control the content and conditions of their work (Strauss et al, 1963). Recognising that individuals had to interact and come to some collective agreement about how the work to improve patients' conditions could be achieved, Strauss et al (1963: 162), argued that the healthcare workers had to negotiate with each other to get things done, and in so doing:

*'They give and take, make bargains, stake claims, make counter demands. The negotiations may be explicit or implicit, but through them the participants reach understanding about how the work will be done'*

These negotiations were framed, but not necessarily limited, by the wider social context and the local organisational context and rules. It was also evident that the outcomes of negotiations themselves impacted on the existing rules and procedures, confirming the interplay between structure and process in the day-to-day work of organisations (Maines & Charlton, 1985).

#### Studies of health professional work

Bucher & Schatzman (1964) reported on a case study examining the division of labour among professionals working on five wards in a psychiatric hospital. Officially each ward was led by a psychiatrist who was defined as the team leader, but in practice each ward functioned quite differently. The study took place against a background of considerable change in that the psychiatrists were all newly appointed, and four out of five were inexperienced. They were expected to introduce modern psychiatric care principles into the hospital, but had to do so initially with existing ward teams. The study detailed how newly formed teams came together and organised themselves in determining a pattern of work aimed at achieving the hospital's goal of therapeutic psychiatric care. Negotiations were central to getting the day-to-day work done, but these were wide-ranging and influenced by factors such as professional ideologies, specialist training, and perceptions of roles and power within the hierarchy of professions. Not all negotiations were successful, complete or to the satisfaction of those involved. They were also not one-off events, as agreements were continually revised and renegotiated as patients, team members and the organisation changed over time. Bucher and Schatzman's (1964) fine-grained analysis of interaction processes in these wards illustrated the complexity of work organisation and demonstrated that negotiation processes were central to determining who would take responsibility for a given area of work, or in some cases what work would be defined as legitimate for individuals or teams as a whole.

In a later commentary on hospitals as professional organisations Stelling & Bucher (1972) rejected traditional rational bureaucratic models of organisational authority. They argued that whilst traditional professional hierarchies were clearly evident in the hospitals studied, they did not necessarily determine whether those most senior in hierarchical terms, had authority over workers lower down the hierarchy. Stelling & Bucher (1972: 432) proposed that autonomy, that is. the capacity of individuals to control their participation in a course of action involving others was *'neither fixed nor inherent in any given position'*. Their argument was that the control over work was not necessarily dependent upon hierarchical authority, but could be determined by negotiations between participants engaged in day-to-day work in wards.

The negotiated order perspective influenced a number of studies of organisations including: Goldie's (1977) study of interprofessional relationships between psychiatrists, clinical psychologists and social workers; Busch's (1980) examination of the organisation of American agricultural sciences; and Hall & Spencer-Hall's (1982) study of the organisation of two district school systems. These studies built on earlier research, highlighting how organisations and working groups within them could rarely be regarded as homogenous but more often were characterised by heterogeneity and diversity. Despite occupying similar positions in the social structure, for example, being funded by government and being established to deliver specific government objectives such as agricultural improvements, health or education, organisations are influenced at a local as well as national level by particular priorities and support for particular projects and areas of interest. These studies demonstrated that local contextual factors such as the degree and frequency of contact between individuals in organisations, and the perceptions and characteristics of the individuals themselves, could limit opportunities for and expectations of negotiations (Goldie, 1977; Hall & Spencer-Hall, 1982). Not everything is negotiable or continually in flux: routine and sometimes repetitive activity is also a feature of work in a range of organisations. Hence:

*'one of the researcher's main tasks, as it is that of the negotiating parties themselves, is to discover just what is negotiable at any given time'* (Strauss, 1978: 252)

Critics argued that negotiated order theorists, concentrated too narrowly on micro or local contexts, ignoring or not taking sufficient account of the ways in which larger (macro) structural features such as power and inequality, influence and predetermine the limits of the interaction under investigation (Day & Day, 1977). In response, Strauss (1978) argued that whilst politics, power and gender were important concepts which may have an impact in interprofessional relations, they should be no more analytically privileged than other potentially relevant concepts such as autonomy, motivation or negotiation. The negotiated order perspective draws on three major concepts: *negotiations* which refer to the interactions and strategies engaged in by social actors; the *negotiation context* which refers to features of the social setting which directly affect the course and content of negotiations; and the *structural context* which refers to larger transcending conditions such as social, political and economic factors which directly or indirectly influence actors in social settings. These concepts take account of macro as well as micro influences on interactions in organisations (Maines & Charlton, 1985).

Healthcare research drawing on this perspective has mainly concentrated on examining interactions at the boundary between two professions, for example between pharmacists and medicine (Mesler, 1989), paramedics and nurses (Mellinger, 1994), and nursing and medicine (Svensson, 1996; Allen, 1997, 2001). Mesler (1989) reported on a study utilising participant observation and interviews to examine the changing relationship between clinical pharmacists and physicians in two teaching hospitals in the USA. Responding to criticisms of the micro level focus of the negotiated order perspective, he showed that day-to-day interactions provided evidence of how negotiations between these clinicians were shaped by the wider hospital and healthcare context. Mesler (1989) noted the analytical importance of examining structural factors to understand change and development in interprofessional relations and boundaries in general terms. He conceptualised the gradual shift in



the work of pharmacists from making and dispensing drugs to the development of a patient focused clinical function as an occupational redefinition and survival strategy. This in turn impacted on established medical teams and in particular the physicians. In response to the rapid proliferation of drug therapy in hospitals, doctors recognised that despite their undisputed autonomy over prescription of drugs they required pharmacists' specialist technical knowledge to enable them to prescribe safely.

Mesler (1989) argued that the negotiated order perspective revealed how established and entrenched elements of the wider social structure including medical dominance and resistance of some pharmacists to expand their occupational boundary, restricted and constrained the possibilities for negotiations and limited the changes which were perceived to be necessary responses to managing complex drug therapies. Negotiations were serial and repeated events and were resisted by both main players at different times, but over time led to a shift in thinking about the role and function of pharmacists. This view gradually became institutionalised in both hospitals and a new social order was established. The clinical role of the pharmacist in turn influenced the socialisation of new and existing medical team members towards a view that pharmacists were an integral part of effective clinical teams. Other factors limited or facilitated negotiations; these included temporal-spatial factors, such as the time and opportunity pharmacists had to access certain clinical teams or to physicians. Pharmacists at one hospital concentrated on influencing nurses' perceptions of their clinical role as a means of furthering their negotiations with physicians. At the other hospital, pharmacists were deliberately placed on wards to increase their visibility and thus opportunities for access to physicians. These strategies do not represent negotiations in themselves but are features of the negotiation context which Mesler (1989) highlighted as being integral to the clinical pharmacists negotiations.

In a study of working relationships between nurses and doctors, Svensson (1996) interviewed 45 nurses from medical and surgical wards in five Swedish hospitals. He also acknowledged the influence of the structural context, tracing historical and contemporary changes in healthcare organisation and delivery, and argued that these resulted in dramatic changes in the traditional hierarchical superior and subordinate relationship between medicine and nursing. He noted changes including a greater concern with social and emotional components of care, educational socialisation of nurses as independent and autonomous professionals, and reorganisation of nursing and medical work along collaborative team lines. Svensson (1996) argued these changes resulted in a social context where relationships between medicine and nursing were no longer dominated by hierarchical and status based interactions but provided opportunities for nurses to negotiate for '*stronger influence upon the ward's rule and norm system*' (Svensson, 1996: 386).

Nurses interviewed reported that they could question and challenge doctors, express their opinions and perspectives and influence decision making in respect of proposed medical treatments and discharge arrangements. Svensson (1996) also presented some evidence of nurses monitoring the work of doctors and attempting to negotiate for changes in medical practice where it was perceived as detrimental to patient care. However, he only interviewed nurses and the lack of a comparative medical perspective or observation of practice raises obvious questions about the claim to identify a negotiated order in doctor-nurse relationships.

In a more comprehensive ethnographic study focussing on negotiations at the occupational boundary with medicine, Allen (1997) examined nurses working relationships with doctors and reported on the ways in which they accomplished occupational jurisdiction. This study addressed some of the methodological weaknesses of Svensson's (1996) study in utilising participant observation, interviews and documentary analysis. Features of the wider structural context were again highlighted as influencing local working. Reforms aimed at professionalising nursing

(UKCC, 1987) and also a reduction in junior doctors working hours (NHSME, 1991) were identified as creating turbulence and uncertainty in hospitals and in turn contributed to a redefinition and expansion of nurses roles and working practices. Allen (1997) anticipated that these circumstances would increase tensions at the occupational boundary and increase the need for negotiations between nurses and doctors. Interview data indicated conflicts and disagreements about the division of labour. However, field observations revealed that whilst changes in the division of labour between nurses and doctors were being accomplished and there was blurring of the nursing and medical occupational boundary, there was minimal face to face negotiation and little obvious conflict. Allen (1997) suggested the nurse-doctor boundary in this study could be regarded as a non negotiated order; that is there was a relative absence of open discussion between nurses and doctors relating to tasks and functions traditionally considered to be medical work. Instead, she highlighted the ways in which nurses managed changes at the occupational boundary with medicine without negotiation. To support this position she drew on a detailed analysis of the turbulent work context which regularly restricted nurses' accomplishment of occupational jurisdiction. Three key features of the work context impacting on the nursing-medical boundary and thus on the possibilities for negotiation of jurisdictions were:

*'the respective transience and permanence of nursing and medical staff, the fragmented temporal-spatial organisation of medical work, and the disjuncture arising out of status hierarchies and the flow of work' (Allen, 1997:507)*

The contribution of the relative permanence of nurses in increasing their influence in respect of the work of transient doctors has been identified in other studies (Bucher & Stelling, 1969; Hughes, 1988); this was directly linked by Allen (1997) to temporal-spatial features of the work context including different shift patterns worked by nurses and doctors. These differing patterns, particularly at night, reduced the contact of nurses with doctors and contributed to differing perspectives on what was the most important concern in their work. Nurses were narrowly focused on needs of individual patients, whereas junior doctors worked across many wards. Tensions arose

between nurses who initiated most medical work at night and doctors trying to manage competing demands for their services. Allen (1997) argued these features led to two main types of non negotiated boundary blurring; 'de facto' and 'purposive' (with five sub types). In de facto boundary blurring for example, in the absence of doctors, nurses' monitoring of patients led them to make diagnostic decisions about patients' need for medical intervention or treatments, although in terms of the occupational hierarchy, diagnosis is regarded as a medical concern. In purposive boundary blurring, nurses essentially *'did doctors' work in order to maintain continuity of treatment'* (Allen, 1997: 511). These forms of non negotiated boundary blurring increased nurses' control and autonomy over their work at ward level. At the same time, standards of patient care were maintained whilst potential conflict with doctors was minimised by reducing requests for them to carry out what could be regarded as low status tasks, within nurses' scope of practice. Interestingly when they were present by day, this work was then expected of doctors.

Allen (1997) identified a lack of conceptual clarity in the negotiated order perspective and questioned whether negotiations alone could be regarded as the determining feature of social processes and social order. She noted that the perspective may not deal sufficiently with constraints on negotiation in every day life. Allen (1997: 516) suggested it may be more useful to consider *'negotiation as one of a number of processes through which social order is accomplished'* and challenged sociologists to address the limitations inherent in the concept of negotiations in order to determine its analytical contribution to understanding workplace interaction.

Thus, whilst the negotiated order perspective has made an important theoretical contribution to understanding interactions between healthcare workers in organisations, the positioning of negotiations as central to developing and maintaining social orders has been challenged (Day & Day, 1977; Farberman & Perinbanayagam, 1985). In addition, empirical studies have identified the importance of recognising and analysing and constraints on negotiations and highlighted the

absence of negotiations between professionals in some organisational settings (Goldie, 1977; Hall & Spencer-Hall, 1982; Allen, 1997). These authors argued for a broader conceptualisation of negotiations as an important, but not necessarily defining element of social orders.

#### Studies of interprofessional teamwork

In an ethnographic study of the social organisation of two newly formed community mental health teams, Griffiths (1997) examined the division of labour and power relations between two psychiatrists and teams they worked with. Data were generated through observation and recording of weekly team meetings and interviews. The analysis focused on team members' talk in team meetings as this framed the different ways in which they attempted to control the division of labour. In addition to different perceptions of teamwork, there were contrasting conceptualisations of mental illness which impacted on teamwork and led to competing categorisations of patients. Psychiatrists exerted control over the work of nurses and social workers by either attending or not attending the weekly team meetings and by their definition of the purpose of the meetings. In one team the meeting was defined as being about allocation of patients (psychiatrist did not attend) and in the other team, as patient review (psychiatrist did attend). In both teams the psychiatrists controlled which patients were initially accepted for care. Authority for decision making was retained by the psychiatrists despite the appearance of collaboration and participation by the one psychiatrist who attended team meetings.

Griffiths (1997) noted that in the team where the psychiatrist did not attend weekly meetings, members often challenged the psychiatrist's assessment and diagnosis of patients. These team members attempted to control their workload by collaboratively redefining some patients' symptoms as 'not mental illness', and presented an agreed 'team' view which challenged the need for intervention. This was partly explained by the different conception of mental health held by team members and the psychiatrist. Nurses and social workers espoused a shared and inclusive

psycho-social perspective whereas the psychiatrist's views were consistent with a biomedical model of mental illness. Nurses and social workers did not consider the psychiatrist as part of the team, were unhappy with many of the patients allocated to them and actively tried to find reasons not to process the patients allocated, but were careful not to directly challenge the psychiatrist's clinical judgement.

In the other team whilst contrasting conceptualisations about mental illness were evident and some tensions and conflict existed, the key difference was that contrasting conceptualisations were addressed by team members in meetings with the psychiatrist present. These meetings were characterised by '*negotiating between divergent perspectives, face to face and reaching a practical accommodation*' (Griffiths, 1997: 70). There was some evidence of shared team definitions and of jointly constructed explanations of patients' behaviour. This team developed a more participative system where the psychiatrist chaired the meeting but each team member had space to speak and present their views. Griffiths (1997) argued nevertheless, that teamwork was only surface deep, noting that team members participated in discussions about treatment options and were encouraged to believe that they had influenced the decision making, but the psychiatrist held and exercised the most power to determine the course of action in each case.

Griffiths (1997: 60) did not expressly consider the negotiated order perspective but did stress '*the negotiated and contested nature of the working arrangements that develop*'. The extended transcripts presented clearly indicated limitations on the power and control of the team members to negotiate their workload, and also identified how the presence or absence of psychiatrists at meetings could deny team members access to negotiations. She traced the influence of features of the structural context, highlighting factors such as psychiatrists' perceptions of the need for these newly formed teams to operate in a market orientated NHS where the success of the service may be measured by the size and kind of caseload managed. This was contrasted with social workers' and

nurses' apparently long standing scepticism of the medical model in classifying mental illness. This study highlighted the complexity of interactions in team meetings and provided important insights into how those who are required to participate in team working may accomplish this as a practical and continuous process of working with competing ideologies and micro-political struggles.

In Canada, drawing on a social network analysis approach, Cott (1997, 1998) surveyed (n=153) and interviewed (n=26) team members from five multidisciplinary older adult care teams in order to describe the structure and pattern of relationships and the meaning attributed to team working. Poor response rates from two teams resulted in their exclusion from the analysis of the survey data. The majority of the sample was nurses although small numbers of therapists, physicians and social workers were included in the analysis of data from the three remaining teams. Social network theorists identify the importance of proximity (defined as regularity and closeness of contact) in understanding the nature and function of informal social relationships. Cott (1997, 1998) found perceptions of the meaning and value of the multidisciplinary team varied according to the professional background and status of the health professional, and their level of contact with other team members. Nurses and unqualified carers who were the main direct care givers had low status in terms of the ward hierarchy, had little involvement in team decision making and minimal contact with non nurse members of the teams. In contrast, higher status nurses (ward sisters), therapists, physicians and social workers formed the 'core' multidisciplinary team and made decisions regarding the care required by patients which would be carried out by others. Team members who met regularly and constituted the core decision making team felt part of and held positive views about the multidisciplinary team, whereas direct care givers felt alienated from the core team and did not share the positive views of their higher status colleagues.

Cott (1998) argued that her findings challenged the view that teams in older adult settings remove or flatten the hierarchical division of labour. She maintained that when only a few high status

professionals benefit from changes in the division of labour, other healthcare workers become alienated, with the consequence that teamwork can be fragmented, uncoordinated and ultimately dysfunctional. She drew attention to the importance of examining the social relations between team members and highlighted the contribution that access to informal as well as formal relationships with other team members had on the pattern of work which developed. Low status team members had very limited physical and professional proximity with high status members. In contrast, core team members' relationships were underpinned by formal organisational proximity, for example in team meetings, which led to physical and professional proximity and explained their greater satisfaction with team working. Proximity, although expressed slightly differently as opportunity for regular face to face contact and co-location, was also highlighted as a positive factor in team working by McCallin (1999) and Molyneux (2001). However, other studies of interprofessional relations concluded that proximity was limited or compromised (Allen, 1997; Griffiths, 1997; Opie, 2000). In common with these researchers, Cott (1998) stressed the impact of temporal-spatial features on patterns of work organisation. Core team members largely worked office hours by day, whereas direct care givers rotated through three day shifts and worked nights and weekends. She argued that these structural determinants impacting on proximity could explain the different meanings that participants attached to team working.

In a parallel vein, Opie (2000) studied professional and team discourses to undertake a reading of teamwork. Over a period of two years, she carried out research with six healthcare teams providing care for people with physical disabilities, the elderly and those with psychiatric illness in New Zealand. Fieldwork involved observation and audio-taping of a large number of team meetings, case conferences and family meetings, over fifty interviews with team members and extensive documentary analysis. Her analysis led to development of a conceptual model of teamwork as 'knowledge work' which should occur in the spaces where team members come together to engage in discussion about clients. Opie (2000) argued that this discussion must be more than team



members telling each other about their clients and the work they have done with or to them. Instead, 'knowledge work' requires team members to articulate their disciplinary perspectives, to listen to and interrogate those of other team members and find the points where they can connect these perspectives to develop team goals. She argued that for this type of teamwork to develop, relationships between team members must shift from being hierarchically ordered to a situation where team members can engage in discussion which does not privilege one (disciplinary) view over another.

Opie (2000) acknowledged that this is not what she actually saw or heard occurring in her research; rather it was her conceptualisation of the way in which team members could bring about two important outcomes. Firstly, to discuss, debate and come to agreement on approaches which will bring about beneficial outcomes for the client. Secondly, to recognise and discuss the *'different discipline-specific and professional issues that are raised by work with this client'* (Opie, 2000: 148). She argued that knowledge based teams must determine how the team will work with the different perspectives that disciplines bring to discussion of clients and teamwork. These are the product of different disciplinary knowledges and experiences, yet no one perspective despite its origins can claim privileged or dominant status over that of other team members.

In another study conducted in New Zealand, McCallin (1999) presented a grounded theory of interdisciplinary practice in which she argued that a process of 'pluralistic dialogue' was the means by which team members continually discussed competing disciplinary perspectives and found ways of working collaboratively to meet the needs of clients. The study was based on over eighty hours of participant observation and in depth interviews with team members (n=44) in four specialist teams working in acute care hospitals. McCallin (1999) identified two complementary phases of pluralistic dialogue; 'rethinking professional responsibilities' and 'reframing team responsibilities'. These represented the ways in which team members challenged stereotypical representations of

different disciplines and came to terms with different perspectives on patients' needs. This directly influenced the development of a system of dialogue in which team members discussed new forms of interdisciplinary service provision. Once again, tensions, competition and conflict occurred as teams were required to work together; but the process of pluralistic dialogue enabled these challenges to be worked through. These findings provided some empirical evidence to support Opie's (2000) conceptual model of teamwork as 'knowledge work', including the claim that an effective team would be one that:

*Attends to and works with the different knowledges of clients and their situations that are made available to it through discipline specific accounts of clients and families (which may also differ from each other). The work of the team requires engagement with such differences (rather than marginalising them or suppressing them) to ensure, as clients' circumstances evolve, the continued elaboration and revision of team goals and care plans. (Opie, 2000: 6)*

McCallin (1999) also highlighted the importance of temporal-spatial features of the hospitals noting how these contributed to information exchange and the process of pluralistic dialogue. However, her findings contrasted with some studies considered in this review in that opportunities for regular face to face dialogue and informal networking were frequent and common. Tensions seen in other studies related to a lack of access to and reliance on other professionals, particularly junior doctors, to complete specific tasks, were not evident. The seniority and experience of participants also contributed to their apparent lack of concern with traditional hierarchical systems of authority and their primary focus on meeting the needs of patients. McCallin (1999) concluded that concerns with conflict at professional boundaries may dominate the literature, but were not evident her research.

In a smaller study based on interviews with six members of an interdisciplinary team supporting early discharge for stroke patients, Molyneux (2001) reported that experienced team members were regarded as being of equal status, flexible in their thinking about patients' needs and willing to reflect on and share their views on different cases. As in McCallin's (1999) study, frequency of face to face communication between team members was high, the small team and its location at the same

work base led to regular team member interaction. Participants compared this team with others they had worked in, noting in particular the difference that the absence of medical staff made to the direction and leadership of the team and in reducing interdisciplinary competition. Molyneux (2001) claimed this was related to team members' clinical experience and confidence in their own professional role, arguing this meant they were more willing to blur professional boundaries, share control over their work and take on skills and practices traditionally associated with other disciplines. She used the concept of 'professional adulthood' (Laidler, 1991) to explain the willingness of these team members to blur boundaries and develop an interdisciplinary approach to their teamwork. However, she was a member of the team under study and her insider status may have directly influenced the responses of her colleagues in interviews, and her interpretation of the data. Nonetheless, these findings provide some support for McCallin's (1999) claim that interdisciplinary teams can manage changes at the occupational boundary through regular and pluralistic dialogue.

Another recent study also completed in the field of stroke care further indicated the capacity of team members to manage care across professional and agency boundaries. Reporting on eight ethnographic case studies examining multi-agency care for adults who had suffered a first stroke, Allen et al (2002) highlighted the complexity of co-ordinating care, particularly as patients moved from hospital to a community facility or home. The study took place in a policy context which requires integrated working between health and social care agencies in order to provide seamless patient focused services. The authors argued that it was necessary to study interactions between workers as they interpreted and worked with these policy intentions at the point of service delivery. They reported that in contrast to much of the existing literature, which highlights considerable problems in interprofessional working at the interface between health and social care, the case studies provided many examples of the:

*'Willingness of providers of health and social care to work together to manage intra and interprofessional and interagency boundaries and with family carers in order to secure integrated care packages (Allen et al, 2002:300)*

The case studies illustrated the importance of establishing trust and shared understanding between professionals who develop packages of care; without this, care provision could be disrupted or fail, particularly where elements of the provision were delivered by professionals who were not party to the original agreements and who may hold different views on care. Thus, the situated and local nature of agreements must be comprehended if we are to understand how professionals work together at the 'street level' of policy delivery. Two other findings of this study are important. Firstly, the study provided evidence of the importance of a single professional taking a lead role in ensuring appropriate elements of care were delivered. Secondly, the case studies identify the unique challenges presented by complex health problems such as stroke, where both patients and their family and care networks take time to adjust to the physical, psychological and social disruption brought about by the stroke. The study demonstrated that despite the commitment working together to arrange patient centred services, predicting and then meeting the medium and long terms needs of these complex cases sometimes resulted in care packages which could not respond sufficiently to the needs of patients and their carers.

In a more detailed report on a single case study from their research, Allen et al (2004: 1008) explored the development and use of a theoretical framework which they argued '*can assist in understanding of the linkages between individual trajectories of care and broader health and social care systems*'. The authors combined Strauss et al's (1985) concept of illness trajectory and Elias's (1978) game theory, and introduced the concept of a 'care trajectory game', (CTG) which they argued could facilitate understanding of the social processes which underpin complex care trajectories and also the relationships between those involved in providing or receiving care. The strength of this approach is the focus on the whole of the care trajectory (as opposed to only the in

hospital or community based elements) and the inclusion in the analysis of the actions and interactions of all of the actors, professional and lay, who engage with and across the course of the care trajectory.

In this case more tensions and problems were highlighted between professionals and the family network than in other cases in this study, but detailed analysis illustrated the complex and often unpredictable interactions which were prompted by the particular individual needs of the patient. Allen et al (2004) explored the development of alliances between some team members led by a speech and language therapist, who considered a home care package was required, and an alliance between a social worker and the patient's wife who considered care in a specialised nursing home to be in the best interest of the patient and his wife. The authors show how factors such as cultural norms and values, disagreement over patient goals within the team and between the team and family members, and the availability of specialist care facilities for younger stroke patients all impacted on the care trajectory. The CTG framework was utilised to explain anticipated and unanticipated consequences of actions of key players involved and also to question the assumptions of policy makers in terms of the perspective that interprofessional and interagency collaboration will result in seamless and patient focused services. Rather than increasing patient choice and service quality, increased collaboration between health and social services staff who have to work with limited resources to meet complex and ongoing needs could disadvantage patients and their families. Allen et al (2004) suggested for example, that health and social care staff may form alliances to press for a particular course of action such as nursing home care rather than the more complex care package required by discharge to the patient's home.

These authors highlighted the necessity to conduct research on the micro-organisation of healthcare work if we are to understand how health professionals respond to directives to work collaboratively within and between agencies. In developing the CTG concept Allen et al (2004) provide a

framework which expands Strauss et al's (1985) work on negotiated orders. They argued this could illuminate the relationship between the organisational context, interprofessional relationships, and the negotiation processes of the social actors involved in complex care trajectories such as those experienced by stroke patients. This framework appears to provide a structure for researchers to examine the reality of health professionals attempts at 'whole systems working' in health and social services.

### Summary

This chapter reviewed established theoretical perspectives relating to the healthcare division of labour. The powerful position of medicine and its complex relationship with the state, with employing organisations and with other health professionals was identified. The potential for conflict and disharmony in teams was related in part to attempts to establish control and autonomy over professional work and its boundaries. The review also identified the need for a shift from this macro level of analysis of interprofessional relations to a focus on the organisation of day-to-day work, to the workplace itself. Just as the concept of teamwork may be taken for granted, there is also evidence that the many and complex barriers to teamwork identified, may have assumed an inevitability in the minds of healthcare professionals and perhaps also researchers (Hudson, 2002). The evidence in the professional and sociological literature which points to deep rooted features of the social structure including the power and status of professions and the conflicts which may arise when this is challenged or threatened cannot be ignored. However, the research evidence reviewed in this chapter strongly indicates that contemporary explanations of health professional team working must also be grounded in the day-to-day experiences and practices of health professionals in particular social settings. The contribution of the interactionist perspective in focusing analysis on interprofessional interaction in the workplace was highlighted. The research reviewed consistently identified the importance of considering micro features of the workplace including

proximity, negotiations and temporal-spatial ordering of work flow. within the wider context of structural and organisational pressures.

Walby & Greenwell et al (1994), Allen (1997); McCallin (1999), Allen et al (2002, 2004) indicated that whilst tensions exist in health professional working they are not always unhealthy and competition at occupational boundaries is not inevitable. Hudson (2002:16) argued that whilst *'social science caution and caveat is understandable and necessary'*; the academic contribution of the disciplines must move beyond scepticism of collaboration and co-operation between professionals and be prepared to explore more optimistic explanations of interprofessional work. That is, to explore how barriers can be or are overcome as opposed to repeatedly focussing on their existence. Research reviewed in chapter 2 provided examples of the contribution this approach has made to understanding healthcare team working in general (Miller et al, 1999; Borrill et al, 2003). However, it remains clear that the factors which contribute to the achievement of teamwork in the specific setting of stroke units require further investigation if we are to increase our understanding of the co-ordinated collaborative action occurring in these units. Policy makers continue to identify standards and requirements for interdisciplinary collaboration and co-ordination of services between health professionals, but the research reviewed highlights that it is in the workplace where the complex reality of collaboration is managed. Overall, the review demonstrates the complex interplay of structural, organisational and within team factors which impact on interprofessional relations, the division of labour and teamwork. The findings of these studies provide important theoretical and empirical reference points for the design of this study of the social processes influencing achievement of teamwork in selected stroke units.

#### The study and central research question

As stroke units require large numbers of different health professionals to co-ordinate their specialist interventions, they represent theoretically rich cases for researching the process of team working.

The strong research evidence for the effectiveness of these units has consistently acknowledged the contribution of co-ordinated teamwork, but this remains an under researched feature of these units. The policy requirement for widespread introduction of stroke units in the UK (DoH, 2001a) confirmed the importance of in-depth examination of the ways in which stroke unit teams were responding to directives to work flexibly, share skills and knowledge and blur professional boundaries. A key area of interest was how stroke unit team members conceptualised and managed overlapping areas of jurisdiction; at present the ways in which this is understood and achieved by these teams is largely unknown. Drawing on the interactionist perspective with its concern with the dynamics and processes of professional work, this study aimed to develop an explanation of stroke unit teamwork which was grounded in day-to-day work in practice settings.

A critical part of any research project is progression from consideration of the general topic of interest, to a specific focus and direction for enquiry which identifies the research problem, the ways it might be explored and the knowledge that might be gained (Blaikie, 2000). Mason's (2002:18) concept of the '*intellectual puzzle*' was found useful in determining the central research question and designing this study. She defined four types of puzzle; developmental, mechanical, comparative and causal/predictive. Researching stroke unit team working focused attention on developmental and mechanical issues. Developmental concerns included understanding what happened when individual professionals came together as a stroke unit team and how teamwork evolved over time. In subsequent day-to-day working with each other and with patients and relatives, what kinds of interactions were they engaged in, and could these provide explanations of how interdisciplinary teamwork developed or failed to develop in these settings. However, the developmental focus was insufficient on its own in that the maintenance, or continued practice and performance of teamwork also required consideration if stroke unit team working was to be understood. Thinking about teamwork as a mechanical puzzle prompted questions regarding the social processes which underpinned day-to-day teamwork, and questioned how teams dealt with



change in team membership or in patterns of work. Mason's (2002) intellectual puzzles were valuable in clarifying the aims, purpose and central research question in this study. The literature review demonstrated that few studies involved observation of interactions between professionals as they planned and delivered care in stroke units. Recognising this, the current study aimed to combine participant observation and in-depth interviews in order to generate a rich and detailed account of the ways in which health professionals responded to these and other challenges as they worked in stroke unit teams.

*Study aims:* The aim of this study was to understand and explain the nature of stroke unit teamwork through:

- Generation and analysis of data from participant observation and interviews with team members
- Description and analysis of contextual factors influencing the work of stroke unit teams
- Development of a substantive theory of the achievement of teamwork in practice

*Study purpose:* The purpose of the study was to develop a grounded theory of the achievement of teamwork in selected stroke units in the North of England.

The research question was:

*What is the nature and process of health professional team working in selected stroke units?*

This provided direction for initial fieldwork and also prompted development of secondary research questions which contributed to a provisional semi-structured interview schedule (Appendix 7 & 8). The question was sufficiently broad to allow for literature derived concerns to be explored with research participants during the study; at the same time it remained open to and consistent with the interactionist concern to focus on the actual work and experiences of health professionals as they worked together in stroke unit settings. The following chapter will critically examine debates surrounding grounded theory and interactionist methodology; these influenced the decisions made in the design, conduct and analysis of data in this study.

## Chapter 4:

### Research design and grounded theory methodology

## Introduction

The review of research examining health professional team working demonstrated the contribution to knowledge which could be made by in-depth qualitative research focused on interactions between professionals in the workplace. Grounded theory methodology incorporates rigorous qualitative research methods and aims to develop theoretical explanations which are grounded in data; this approach was adopted in the design and conduct of this study of teamwork. The development of grounded theory methodology (Glaser & Strauss, 1967) will be critically examined; philosophical and theoretical principles which informed the design and conduct of this study will then be reviewed. The sites selected for the research will be discussed and the work contexts and social characteristics of the research participants described. The initial sampling strategy and ethical approval for the study are outlined; the chapter concludes by summarising the phases of the research design adopted.

## Grounded theory

Grounded theory approaches have been widely used by social science and health researchers. A key factor in the development of the grounded theory approach was to close what Glaser & Strauss perceived as *'the embarrassing gap between theory and empirical research'* (1967: vii). They argued that the functionalist and structuralist theories dominant in American sociology in the 1950s and 1960s (Parsons, 1952; Merton, 1957) did not accurately describe and explain the reality of the social world as it was understood by social actors. Glaser & Strauss (1967) claimed that pre-eminent social theories of the time were characterised by deductive reasoning leading to highly speculative grand theories, insufficiently grounded in the empirical world. The main role for empirical research in this approach was verification of theory through hypothesis testing (Dey, 1999). Glaser & Strauss (1967: 3) argued such theories did not demonstrate 'fit', i.e. *'the theory was not applicable to and indicated by the data under study'*. Nor did these theories 'work', i.e. they were not *'meaningfully relevant to and [be] able to explain the behaviour under study'*. They also sought to differentiate verification and generation in terms of

sociological theory, arguing that *'the dominance of the verification position assumed a point of closure had been reached in understanding social behaviour'* (Glaser & Strauss, 1967: 10).

Glaser & Strauss (1967) argued cogently that this assumption was invalid, and that grand theories should be regarded as flawed as they were not developed from systematic field research; they argued instead for inductive theory development. Emergent theoretical properties would be identified through systematic, continuous and rigorous interplay between empirical data and the developing conceptualisations of researchers as they engaged with social actors and analysed data. They did not deny the importance of verification of theory; but argued (1967: 2) that it should *'co-exist with theory generation'*; instead movement from verification towards *'canons more suited to the discovery of theory'* was required (Glaser & Strauss, 1967: vii). The primary intention was to develop theory which had a close and discernable relationship to the reality experienced by social actors.

In *The Discovery of Grounded Theory*, Glaser & Strauss (1967) were responding to criticism that qualitative methods were unscientific, unsystematic and impressionistic, and resulted in subjective descriptions of specific cases which were only useful when employed as a precursor to more rigorous quantitative methods (Charmaz, 1995; Denzin & Lincoln, 2000). This criticism was partly justified in that early fieldwork associated with sociologists at the University of Chicago produced rich and detailed descriptions of some social processes, but this work was not fully documented and did not present methods which could be learned or critically examined by other researchers (Hammersley, 1992). The original (1967) formulation outlined the logic and specifics of grounded theory arguing that if conducted systematically and rigorously its findings were capable of adequate verification by other researchers (Strauss & Corbin, 1998).

### Grounded theory literature

The literature relating to grounded theory methodology falls into two main categories. In the first are authors who predominantly describe and promote the claims made by Glaser & Strauss

(1967). Methodological contradictions in the original and subsequent formulations of grounded theory are either ignored or not explored. Although there are some exceptions, these publications tend to focus on presenting methods for researchers to follow (Chenitz & Swanson, 1986; Fain, 1999). These give the impression that if the 'right method' is followed then grounded theory will emerge. Other authors acknowledge the contribution of grounded theory methodology, but argue its claims regarding rigorous inductive theory development need critical scrutiny (for example, Cutcliffe, 2000; Hall & Callery, 2001; Priest et al, 2002). Only when directly engaged with grounded theory methods can researchers really understand how this impacts on their research practice (Woods et al, 2002; Dey, 2004; Heath & Cowley, 2004).

Publications in the second category analyse the 1967 formulation and the later revisions of Glaser (1978; 1992) and Strauss & Corbin (1990; 1998). These amend Glaser & Strauss's (1967) claims and identify the theoretical and practical problems faced by the researchers using grounded theory approaches. The reviews advanced by Wilson & Hutchinson (1996), Annells (1996, 1997a; 1997b), Dey (1999) and Charmaz (2000), and the views expressed by Glaser (1978; 1992; 2002) and Strauss & Corbin (1998) were drawn upon in designing and conducting the current study.

### Philosophical influences

The grounded theory approach was influenced by the philosophy of pragmatism, 'Chicago School' sociologists and the later symbolic interactionist perspective of Blumer (1969). Early pragmatists argued that it was not possible to gain direct access to the 'real truth' (that is, an accurate correspondence between belief and reality) and so we must accept plausible information adequate to the needs of practice. James (1907) and Dewey (1925) argued that subjective personal and varied individual views of social actors were central in forms of enquiry which sought to establish a plausible truth which corresponded to observed social reality. Strauss acknowledged the influence of pragmatism and symbolic interactionism on his thinking and research practice. However, many texts fail to recognise Glaser's background and

philosophical influences were different in that his training and experience had been in quantitative survey methods (Dey, 1999; Charmaz, 2000).

The influence of pragmatism is evident in Glaser & Strauss (1967), they adopted the principle that truth and meaning could not be directly apprehended, but argued that conducting fieldwork aimed at discovering 'what was really going on', enabled discovery of theory in data which could be judged to fit, work and have relevance. Another important influence was symbolic interactionism. This emphasises that social actors are thinking and purposive (not simply responding) organisms who construct meaning from their interactions with others (Mead, 1934; Blumer, 1969). According to Blumer (1969), symbolic interactionism rested on three premises: firstly that human beings act towards physical objects and other human beings in their environment on the basis of the meanings that these things have for them. Secondly, these meanings derive from the social interaction between and among individuals. This interaction is the context in which communication takes place through and in turn generating a combination of language and symbols. Thirdly, meanings are established through an interpretive process in which:

*'The actor selects, checks, suspends, regroups and transforms the meanings in the light of the situation in which he is placed and the direction of his action.....meanings are revised as instruments for the guidance and formation of action' (Blumer 1969: 5).*

This approach directs researchers to enter and closely observe the world of the individuals being studied in order that they can:

*'See the situation as it is seen by the actor, observing what the actor takes into account, observing how he interprets what is taken into account' (Blumer 1969: 56)*

It is not sufficient however simply to observe the behaviours of actors: their perspective, the social setting and interaction context should also be attended to. A key element of the symbolic interactionist approach to developing explanations of the social world is the interplay between researchers' observations in the field and their developing conceptual explanations of social processes. Glaser & Strauss's (1967) methodology emerged largely from their own fieldwork

using observation, informal and formal interviews and documentary analysis in their collaborative research in hospitals which culminated in the publication of the classic text 'Awareness of Dying' (Glaser & Strauss, 1965). Whilst pragmatism and symbolic interactionism were important influences, Glaser also brought to the collaboration the rigour associated with quantitative survey methods (Dey, 1999). This can be seen in the attempts to bring together the in-depth interpretive insights of qualitative research, with the systematic and rigorous approaches of the quantitative tradition. Glaser & Strauss (1967) attempted to outline qualitative research methods which could access the complexity of the social world, develop theory which explained that world and raise the academic standing of qualitative research.

The intention to take the best of both these research traditions was commendable, but the tensions inherent in finding ways to 'marry' them in grounded theory approaches is one of the enduring reasons for the divergence and dispute which occurred between Strauss and Glaser, after 1990 (Dey, 1999). Glaser & Strauss (1967) proposed a means for theory to be discovered without concepts being forced onto data during analysis, or imposed as a result of prior theoretical perspectives held by the researcher. However, trying to find ways to reconcile the discovery of theory in data and at the same time imposing structure and rigour on data analysis can be problematic (Dey, 1999). This issue became apparent when analysing data in the current study and will be discussed in chapter 6. The discussion will now turn to a review of philosophical perspectives as these impact on qualitative research in general and grounded theory specifically; this was a necessary part of determining the strengths and weaknesses of grounded theory as an established research approach.

#### Qualitative research: ontological and epistemological perspectives

Researchers cannot passively follow rules or instructions in research methods texts, but must actively engage with philosophy, theory and methods in the planning and conduct of research (Silverman, 2000; Mason, 2002). The way in which researchers view and understand the social world and engage with the theoretical and research literature, impacts on choices made and

conclusions drawn in the conduct of empirical research (Silverman, 2000). Denzin & Lincoln (1998b: xi) identify ontological and epistemological perspectives as the paradigm commitments of the researcher. These commitments inform and shape questions that direct research enquiry in a particular field, and also identify theoretical positions against which research findings can be examined.

Social enquiry cannot be atheoretical and whilst a preoccupation with philosophical and theoretical issues is not conducive to effective research practice, generating and interpreting data requires engagement with concerns about what knowledge is and how it might be justified:

*'In sum, acting and thinking, practice and theory are linked in a continuous process of critical reflection and transformation'. (Schwandt, 2000:190)*

The design and conduct of the current study benefited from such engagement with philosophical and theoretical debates. This included using Mason's (2002) intellectual puzzles as a mechanism to clarify my beliefs and concerns and to question how these could be explored and understood practically and theoretically. I combined this with critical review of qualitative research, the interpretative paradigm and grounded theory and also drew on the review of the existing research in this field. The integration of these elements is essential in designing studies capable of answering important research questions (Blaikie, 2000; Silverman, 2000).

There is no adequate single definition for qualitative research; the term encompasses different approaches to social enquiry which are drawn from a number of philosophical traditions (Flick, 2002; Holliday, 2002). However, I believe that qualitative research is concerned with finding ways to describe, understand and explain the nature and complexity of the social world in depth and in detail, and in ways which can illuminate the understanding and meanings people derive from their day-to-day experiences (Denzin & Lincoln, 1998a; Blaikie, 2000).



## Interpretivism

Interpretivism is a collective term for a range of approaches to social enquiry which share similar ontological assumptions and which include hermeneutics, phenomenology, symbolic interactionism, existential sociology and social constructivism (Denzin & Lincoln, 1998a). Interpretivism is based on the ontological assumptions that human action is meaningful, intentional and not merely reactive to external stimuli. Social actions can be understood by interpreting the meaning of the actions, but this must also be considered against the particular context or system of meanings to which the action belongs. In the current study this required that in order to develop understanding of the meaning of social actions of stroke unit team members, those actions had to be considered as part of the system of meanings developed through the actors' membership of a team drawn from distinct professional groups working within the healthcare system. The particular social context of rehabilitation stroke units and the intentions of the social actors are relevant factors in the interpretation and understanding of particular actions. To understand the social world, interpretivists argue that it is necessary to uncover and interpret the beliefs and practices which social actors may regard as everyday, ordinary and unremarkable, but which can provide a lens to view the intentions, motivations, symbols and rules of everyday life or work (Blaikie, 2000). Schwandt (1998: 222) suggested that:

*'To prepare an interpretation is itself to construct a reading of these meanings; it is to offer the enquirer's construction of the constructions of the actors one studies'.*

This does not mean developing a detached outsider's interpretation of data but rather one which attempts to closely approximate the understanding of those occupying a particular part of the social world. The problem remains however in how far we can claim to grasp the meaning of human social actions (Silverman, 2000; Mason, 2002). Research approaches which claim to uncover and represent insider perspectives face the difficulty of providing convincing accounts of how these perspectives are gained and how closely these match the beliefs, intentions and understanding of social actors (Denzin & Lincoln, 1998a).

This is a challenge faced by grounded theorists seeking to develop theory from data generated from interaction with and observation of social actors, and from analysis of social processes. It is managed through flexible use of methods including use of a three stage coding paradigm and development of theoretical and storyline memos. These are integral to the methodology and help researchers conceptualise and explain basic social processes evident in particular social settings (Strauss & Corbin, 1998; Dey, 2004). My intention was to develop explanations of basic social processes occurring as stroke unit team members interacted. Concentration on these processes can foreground the work of teamwork and explain the complex day-to-day reality of interactions as teams find ways to get the required work done. There are a number of approaches to developing grounded theory, including interpretivist and constructivist positions. Disputes have arisen regarding the way researchers work with and represent the data, and the prominence given to the perspectives of social actors (Glaser, 1992, 2002; Schwandt, 1998; 2000; Strauss & Corbin, 1998; Dey, 1999; Charmaz, 2000).

#### Interpretivist and constructivist grounded theory

Glaser & Strauss's (1967) and Strauss & Corbin's (1998) approaches reflect a modified interpretivist position; the researcher is regarded as an objective observer developing explanations in the form of middle range theories grounded in data (Dey, 1999; Glaser, 2002). These explanations, whilst prompted by the data, also incorporate factors influencing social settings and must stand scrutiny against existing practical and theoretical explanations of phenomena (Strauss & Corbin, 1998; Dey, 1999). This position has been criticised as naïve realist and objectivist by constructivists, who argue that this approach does not accurately represent the subjective meanings and understandings of participants (Annells, 1996).

Constructivists reject the concept of an objective observer discovering the 'facts' of social life and claiming to accurately represent the social world, arguing that *'knowledge and truth are created, not discovered by the mind'* (Schwandt, 1998: 236). An essential element of the social constructivist position is that social reality is not a fixed and enduring entity which can be

interpreted by skilled observers following correct procedures for knowledge production. Instead, they argue that social actors construct systems, concepts, and language for making sense of their experiences; these systems are built from the interactions or social exchanges between people in the social world (Schwandt, 1998). In this sense, meaning is generated not by individuals in isolation but by their social interactions with others, meaning is shaped by the conventions of shared language and social processes in particular social settings. Guba & Lincoln (1994) effectively summarised the differences between constructivist and interpretivist positions arguing that constructivists take the position that constructions are more or less informed or sophisticated, whereas interpretivists argue that their interpretations are more or less true and represent a reality which can be apprehended from interaction with social actors.

The consequence of this discussion for my research practice led to questioning of assumptions underpinning beliefs about reality, the ways in which it can be known and understood, the role of the researcher in interpreting data and the role of social actors in the production of grounded theory. Charmaz (2000: 510) argued that the original and subsequent formulations of grounded theory, by Glaser (1978, 1992) and by Strauss (1987) and Strauss & Corbin (1990) were based on an objectivist interpretive position which did not properly recognise the mutuality of knowledge and meaning construction. However, she acknowledged a shift in Strauss & Corbin's (1998) approach where they proposed:

*'giving voice to their respondents, representing them as accurately as possible, discovering and acknowledging how respondents views of reality conflict with their own, and recognising art as well as science in the analytic product and process'*

Glaser (2002: 1) rejected Charmaz's claims arguing that; *'constructivist data if it exists at all, is a very small part of the data that grounded theory uses'*. He argued that constructivist grounded theory was a misnomer, missing the point and purpose of grounded theory, where data are gathered by the researcher in the form of human contacts, documents, observations, interviews, and contextual or situational information. The purpose of this is conceptualisation, what he terms *'transcending abstraction'* as opposed to a *'worrisome concern with accurate description'*

(Glaser, 2002: 2). He further argued that focusing analysis of one form of data particularly that generated by lengthy in-depth qualitative interviewing, was not sufficient for the purposes of grounded theory which takes data to an abstract conceptual level and identifies latent patterns, or basic social processes.

No doubt Charmaz would interpret Glaser's (2002) arguments as reinforcing her analysis that his approach is objectivist and privileges the explanation of the researcher. However, Glaser (2002) and Strauss & Corbin (1998) recognised that the potential for researcher bias must be confronted in data analysis. These authors argue that objectivity is both possible and desirable in the context of grounded theory. I shared this view and regarded objectivity not as a negative concept based on denying the perspective of the social actor, but as a component part of the rigour required in qualitative research aimed at theory development. Glaser (2002: 6) firmly rejected the '*relativist ontology of multiple realities*' and declared that the conceptual reality identified in grounded theory is real, does exist and can be seen in everyday situations. This reflects a critical (rather than naïve) realist position, and argues that underlying mechanisms which connect phenomena can be identified. My own epistemological position is that it is possible to generate theory based on close engagement with participants in social settings. Generating theory in this way begins with thick description, which should as far as is possible accurately represent the perspectives and experiences of social actors. Drawing on the interactionist perspective I hold the view that developing understanding of how stroke unit work processes were experienced, understood and given meaning by social actors themselves will result in a rich, detailed and credible account of teamwork.

### Research methods

A grounded theory approach was adopted in the current study for two main reasons, firstly its capacity to develop theory from data, theory which had the capability to provide meaningful and relevant explanations of what was going on in the stroke units. The second reason was related to the methodological rigour of the approach. Researchers agree that rigour in the design, conduct

and analysis of qualitative research is of central importance if the interpretation developed is to be open to the scrutiny of others (Miles & Huberman, 1994; Coffey & Atkinson, 1996; Silverman, 2000). Grounded theory methods provided a clear structure for the design and conduct of my research, and were consistent with recording and justifying the decisions made in conducting the research. If research findings are to be regarded as credible and relevant by clinicians in this field, as well as by an academic audience, then it is important to be able to show how the findings were arrived at (Guba & Lincoln, 1989; Seale, 2004). This audit trail is an important means of demonstrating trustworthiness and rigour in qualitative research (Sandelowski, 1986).

Research methods must be used flexibly, but as a relatively inexperienced researcher I sought guidance on ways to generate, manage and analyse data which would result from fieldwork. I also looked for guidance on the field role of the researcher and in the development of theory grounded in data. This concern has been identified by many researchers who have used grounded theory methods (Stern, 1994; Dey, 1999; McCann & Clark, 2003; Heath & Cowley, 2004). Glaser's (1978, 1992) methods and those of Charmaz (1995) appeared overly complex, both from a theoretical, and practical perspective. In practical terms, Glaser's (1992) approach was inconsistent with undertaking a research degree. For example, he suggested researchers review the literature after fieldwork and data analysis, in order to prevent existing theoretical explanations constraining the researcher's thinking. Glaser (1992) also argued that rather than defining the research problem in advance of fieldwork, this would emerge once researchers entered the field and began analysing data. In contrast, Strauss & Corbin (1998) expressly acknowledged that the interplay between reviewing the technical and non technical literature and one's own personal and professional experience could provide the stimulus for a particular line of enquiry. Their approach to 'practical considerations' such as identifying a problem and stating the research question, maintaining a balance between objectivity and sensitivity and using the existing literature, provided the basis for developing the initial research question and design of my study. Critically examining methodology and methods was an important part of

preparing to conduct the research and was instrumental in decision making about the ways in which I planned to generate and analyse data from participant observation and interview.

### Participant observation

Benoliel (1996) argued that grounded theories cannot be developed on the basis of interviews alone. Reliance on interviews reduces the access that interviewers and interviewees have to each other and to their respective social worlds. Morse (2003: 155) also expressed concern that there had been an over reliance on interviewing in qualitative research almost to the exclusion of observational methods:

*'We are so entranced with the narratives of the self as truth that we forget that it is not the only truth; we are ignoring the uses, contribution and significance of observational methods'.*

Observations can complement interview data, individuals are not always aware of their behaviours and thus cannot be relied upon to report consistently upon them (Morse, 2003). The social relations of fieldwork are more complex than those of interviewing but provide opportunities to enter into and develop understanding of the daily lives of informants (Seale et al, (2004). My decision to undertake participant observation was based on the premise that the meanings that phenomena such as roles, hierarchy, actions and interactions hold for people cannot be separated from the settings in which the phenomena are encountered and experienced. Participant observation provided for recognition of those features of the everyday work of teams which might be perceived as ordinary. Interviews alone were unlikely to have identified these features, precisely because team members may have regarded them as unremarkable or may not have been consciously aware of some of their actions and interactions (Morse, 2003; Delamont, 2004).

Participant observations followed the work of two stroke unit teams; in this thesis the units are called Colebrook and Holton. Observations normally occurred over the equivalent of three consecutive half days at Colebrook followed the next week by the same at Holton. This was

partial rather than total immersion in the field. Observations occurred in the early morning (from 0645), and also late at night (up to 0100) but not overnight or at weekends. The research was concerned with the process of teamwork as a whole and whilst nurses provided twenty four hour care for patients, with the exception of SHOs on call at Colebrook, no other team members were present overnight and at weekends. Case notes and shared records held at the central workstations and separate disciplinary notes/records were reviewed. These documents helped contextualise the actions and perceptions of team members and contributed to understanding how information was communicated within the teams; these documents were not the subject of separate analysis of their content.

### Interviewing

Interviewing and qualitative research have become almost synonymous but the decision to use interviews should be rational and justified (Silverman, 2000; Rapley, 2004). Qualitative interviewing is consistent with the interpretivist ontological position which seeks to describe in detail, and develop understanding and explanations of the social worlds of research participants (Grbich, 1999; Rapley, 2004). Rubin & Rubin (1995: 5) identified a '*family of interview strategies*'. Qualitative interviews represent the open ended part of the interview spectrum and are concerned with giving interviewees maximum opportunity to voice opinions and make sense of their experiences. However, these interviews do not lack structure or focus, Bryman (1984: 102) described qualitative interviewing as '*conversations with a purpose*', whilst Rubin & Rubin (1995) noted that qualitative interviews are intentional, guided conversations.

Semi-structured interviews were used to gain understanding of experiences, interpretations and understanding of team working and its achievement. These provided a means to gain insight into the social reality of team members in so far as they were prepared to openly discuss their perceptions and the meanings that they derived from working in a stroke unit team. Their perspectives were important in their own right but these data were also compared and contrasted with those generated by participant observation thus adding to variation in data sources and

reducing the reliance on one form of data. Participant observations included informal interviewing in the sense that I asked questions and sought clarification from team members about particular aspects of their work. However, these discussions were spontaneous and narrowly focused on particular issues which arose in the context of participation in rehabilitation activities. In contrast, semi-structured interviews provided opportunities for in-depth and uninterrupted dialogue with team members. Interviews examined a series of common issues but also explored issues raised by participant observations and which emerged in comparative analysis of data (Strauss & Corbin, 1998; Dey, 1999). In this way interviews also provided opportunities to explore and check with participants my developing theoretical understanding of processes underpinning teamwork.

Detailing the research design and data generation methods underpinned submissions for ethical approval of the study and provided the basis for discussions with profession specific managers about my fieldwork role and proposed working relationship with participants. The discussion will now turn to the selection and characteristics of the study sites, gaining ethical approval and the conduct of the study.

#### Selecting research sites and initiating the research

Sampling decisions begin when researchers develop initial ideas about the research methods that will be adopted to answer the research questions posed (Blaikie, 2000; Silverman, 2000). Following approval of the research proposal within the University, it was necessary to determine where fieldwork would be undertaken, to seek ethical approval and to negotiate access to sites. Planning engagement with the sites and research participants and determining the timescale for the study were important considerations. A purposive approach was adopted in this first stage of sampling, this intentionally selects settings, groups and individuals where the processes it is intended to study are most likely to be occurring (Denzin & Lincoln, 1994; Silverman, 2000). Existing research has not comprehensively examined the process of stroke unit teamwork outside of MDT meetings; the current study was designed to address this



limitation. To develop understanding of the regularities and irregularities of work and teamwork I planned a sustained period of participant observation in two rehabilitation stroke units: a period of six months was decided upon initially. As part of these observations, review of selected documents used by health professionals would be undertaken. In-depth semi-structured interviews would be conducted during and following the period of participant observation (see Figure 1). The number of interviews was not decided upon in advance of the fieldwork, but determined as the study developed.

A key consideration was that sites selected should enable the research question to be addressed and could lead to a theoretical explanation of teamwork. An important issue related to the number of rehabilitation stroke unit teams which could be studied. A decision was made to focus on two units. Studying two settings provided a theoretically rich opportunity for exploring teamwork in depth and in detail, as opposed to a broader base of enquiry in more units which may have resulted in a superficial overview. Conducting the study in two units would enable within team and between team comparisons. This represented an opportunity to sample theoretically stimulating settings rather than representative sampling (Bechhofer & Patterson, 2000). I aimed to generate data which could be compared with findings from other studies of health professional teamwork such as those of McCallin (1999), Miller et al, (1999), Opie, (2000) and Borrill et al (2003). Each of these studies involved study of more than one team and identified shared and atypical features of teamwork; the findings of these studies were significant and generalisable.

Qualitative research has sometimes been criticised for focusing on single cases or case studies which may be unrepresentative of the overall phenomenon being investigated (Blaikie, 2000; Silverman, 2005). However, criticism of the lack of representativeness and generalisability of qualitative research is sometimes based on an inaccurate perception of the purpose and rationale for qualitative research (Sandelowski, 1986; Janesick, 1998). Representativeness of findings is a not a primary aim, but qualitative researchers should not be satisfied with '*producing*

*explanations which are idiosyncratic or particular to the limited empirical parameters of their study'* (Mason, 1996: 6). Strauss & Corbin (1998) argued that researchers must acknowledge their work will be evaluated for its scientific merit and application to the setting from which it was derived; they also argued, that as grounded theory is a theory building methodology, the question is not only one of generalisability, but of explanatory power. The explanatory power of substantive theory developed in one or two settings may be limited, but can provide insights which contribute to our understanding of similar situations. Bechhofer & Paterson (2000) suggested that where studies identify the workings of social processes, then we can have confidence that understanding of these processes can provide for some generalisation of the findings to social settings where similar instances of group activity occur. I considered the findings of the study could provide explanations of how these teams achieved and maintained teamwork, which would provide a basis for further study of teams in different stroke units or other rehabilitation settings.

The RCP's (2000) register of stroke units indicated 14 in the geographical area. Two units providing rehabilitation for stroke patients were identified; these were in two different cities approximately twenty miles apart. The consultant physicians for each unit were approached; following review of the research proposal they were prepared to support the study. As a result of this support no other units were approached. This was an important precursor to seeking Local Research Ethical Committee (LREC) approval, and managerial approval of the study within the organisations concerned.

The units were similar in terms of patient characteristics, number of beds and team composition. Colebrook was part of a large Teaching Hospitals NHS Trust comprising two major centres and smaller satellite hospitals. Holton was part of an NHS Trust comprising two district general hospitals and some satellite hospitals. At the time of the study both units had been established for approximately four years. The units normally received patients between five and ten days after their initial treatment in acute stroke units in another hospital. Both units had 21 beds for

male and female patients (normally) aged 65 and over, mainly in four bedded bays, or in single rooms. Team members worked in what they termed a 'multidisciplinary framework' providing inpatient care and liaising with community based providers for post discharge care. Working practices were broadly similar but skill mix and staff establishment differed slightly as can be seen in the following section.

### Characteristics of the participants

Staff at both units had worked there for between 1 and 4 years; the majority for more than three years. They expressed a preference for working in rehabilitation settings, citing reasons such as longer patient stays which provided opportunities to get to know patients as individuals and to develop effective working relationships with them and their families. Most team members were very experienced health professionals; only four (two social workers and a staff nurse at Holton, and a dietician at Colebrook) gained their professional registration less than two years prior to the study. Healthcare and therapy assistants had all been working in the stroke units for more than one year and, in most cases, in healthcare settings for more than five years. Staff retention was high in both units with little turnover of permanent staff in the four years the units had been open. In terms of gender, age and ethnicity, team members in both units were relatively homogenous. The majority of team members at both units were female and all except one were from a white British ethnic background. Consultant physicians, a senior house officer (SHO), two social workers and one enrolled nurse at Holton, and one healthcare assistant at Colebrook were male.

The majority of registered health professionals were over 30 years of age (range 26-58) and all but two (at Colebrook) of the unregistered staff were over 35 years of age (range 28-60). There are no national data on the social and occupational characteristics of professionals who work within elderly care services with which to compare the stroke units, although McCallin (1999) and Miller et al (1999) noted similar sample characteristics in rehabilitation teams they studied. Patients who participated in the study were aged from 54 to 88 years. Their ethnic background

was predominantly white British, but also included small numbers of individuals with African Caribbean, Indian and Pakistani backgrounds.

### *Colebrook*

The unit was located in a satellite hospital built in 1994 to provide inpatient and outpatient services including elderly care, neuro-rehabilitation, orthopaedics, gastrointestinal medicine and surgery. Originally an elderly care ward, it became a rehabilitation stroke unit following the appointment of a new Consultant in Stroke Medicine in 1998. A multidisciplinary group was established to set up the unit. Positions for nursing and allied health professions were internally advertised, applications came from existing and other staff. Those who applied were formally interviewed, not all were offered posts. Team members in post at the time of the study reported considerable movement of staff as the unit was established; not all staff wished to work with patients who are sometimes considered physically and emotionally demanding (Hoffman, 1974; Kumar, 2000). It was not possible to determine retrospectively the percentage of staff that was new or existing at the time the unit opened. The ward manager indicated that the majority of staff appointed to the unit were experienced and had worked in elderly care settings previously.

Multidisciplinary training led by physiotherapists and the consultant physician, focused on the pathophysiology of stroke and on moving and handling, this took place prior to the unit opening. Informal work-based training also occurred as patients were admitted to the unit and presented specific challenges to the team, for example in terms of safe positioning. The unit was part of a cross city directorate of elderly medicine and linked to an acute stroke unit at another hospital. Health services in this city are divided between east and west, so these units did not see all stroke patients admitted to hospital. Management of the unit on a day-to-day basis was the responsibility of a ward manager (a nurse) who worked closely with the consultant physician, senior physiotherapists (PTs) occupational therapists (OTs), speech and language therapists (SALTs) and dieticians; these in turn managed their own junior staff. Most team members were responsible to line managers from their own professions, some of whom were based at

Colebrook and some at the acute hospital. The ward manager was responsible for healthcare assistants (HCAs), clerical and housekeeping (domestic) staff based on the unit. The consultant was supported by a SHO; this unit had 24 hour medical cover. The SHO worked on the unit between 0830 and 1800 but shared an on call rotation with other SHOs in the hospital. The SHO was on the unit most of each weekday and some evenings, nights and weekends. Training for SHOs was held at the same time as the multidisciplinary team (MDT) meeting so they were rarely present at this meeting.

PTs, OTs and SALTs had offices on and worked almost exclusively on the unit; as did nurses, healthcare and therapy assistants and clerical staff. The consultant physician had responsibility for the linked acute stroke unit across the city and was present on the rehabilitation unit for only two half days per week. Dieticians had offices in another part of the hospital and divided their work between Colebrook and the acute hospital. A pharmacist visited the unit once per week to review prescriptions and liaise (mainly) with the physicians, but did not participate in the ward round or MDT meetings. Six community based intermediate care teams, were responsible for supporting patients discharged from hospital until they could be cared for by primary healthcare teams or live independently. Social workers were based in these teams and only made contact with Colebrook when patients were being prepared for discharge. They did not attend ward rounds or MDT meetings, but on occasion attended case conferences.

The unit took students in all disciplines on a regular basis. The MDT meeting was held once per week following the consultant's ward round, and had an average duration of two hours. Meetings were normally attended by representatives of all disciplines except dietetics and social work, SALTs attended infrequently. Colebrook had a PT gymnasium and rooms for OTs and SALTs to work with patients, but a significant proportion of rehabilitation took place in open ward areas. This meant that many activities took place where they could be observed by other team members and patients. Colebrook also had an 'apartment' which could be used to prepare patients and family members for discharge within a safe environment. Most team members used

a staff restroom on the unit, this facilitated development of relationships and enabled informal contacts to be used to talk about work issues. Some did not use the restroom, claiming workload pressures; these completed other work, for example writing up notes in their offices. The consultant physician and SHOs took breaks with team members before MDT meetings, but housekeepers did not. A central work-station located between the two main ward areas provided a space where team members frequently met whilst when writing up notes or making telephone calls. Frequency of contact between unit based team members was high.

### *Holton*

The unit was located in a hospital opened in 1965 to provide services including elderly care, dietetics, neurology, neurophysiology, wheelchair services, physiotherapy rehabilitation (stroke, cardiac and pulmonary) and speech and language services. A specialist day (rehabilitation) centre was added in the early 1980s; stroke patients used this facility mainly on an outpatient basis. Another NHS Trust provided services for people experiencing mental health problems and learning disabilities in part of this hospital. Originally an elderly complex care unit, the stroke unit was established in early 1998 following the appointment of a new Consultant in Elderly Medicine who had a special interest in stroke. This period coincided with a process designed to result in accredited Nursing Development Unit (NDU) status for the unit. This was led by a senior nurse manager and unit manager, both of whom left the unit approximately a year before the study commenced. The pursuit of NDU status was primarily a nursing concern, but some practice development activities were multidisciplinary; some staff in post at the time of the study suggested this helped generate initial enthusiasm for working in the new unit.

As at Colebrook, nurses and HCAs were invited to apply to work in the unit or to be allocated to other areas; considerable changes in personnel were reported to have occurred at this time. It does not appear that this process occurred for the allied health professionals. No formal interviews for posts took place; following an informal consultation process staff either moved to the unit or were relocated. In contrast to Colebrook, staff could not recall any multidisciplinary

training or unit planning prior to the opening of the unit. However, they did recall informal work-based training on the pathophysiology of stroke and on positioning, moving and handling in the early weeks after the unit opened. Team members were described by the consultant physician and former unit manager as being mainly experienced health professionals who had worked in elderly care for some time and who expressed a preference to work in stroke rehabilitation. Unlike at Colebrook, therapists did not have offices on the unit. PTs, OTs and rehabilitation assistants (RAs) shared offices with other therapists two floors below the unit. SALTs had offices in another area of the building and social workers were based in another building ten minutes walk from the stroke unit. Dieticians were located at another hospital across the city. Holton also had its own PT gymnasium and a room for OT work, but again a significant proportion of rehabilitation took place in open ward areas, including the dining and day room and in four bedded bays.

There were two consultant physicians supported by one SHO. Due to limitations on when I could access the unit, I observed only one consultant's ward round and team meetings. Team members worked with both consultants and permission was gained to observe patients of both. These consultants also had responsibility for acute elderly care services across the city, and spent only one half day per week at Holton. Medical cover was not 24 hours, SHOs worked a strict daytime rotation on weekdays (0800-1700); they were on the unit for a large part of each weekday but medical work required outside of these hours was undertaken by on call agency doctors or by transfer of patients across the city. A senior nurse (matron) provided clinical and managerial support for the unit and two other elderly medical wards within the hospital. This nurse, formerly the ward manager, was closely involved in the unit's initial development and retained a supportive interest in its work. However, she spent little time on the unit and had no involvement in patient care or team development during the study. The ward sister post remained vacant throughout the period of the study. Staff turnover was low and the majority had worked on the unit for more than four years. Two RAs supported both OT and PT. These roles were new to Holton and had been established just over two years. Social workers were allocated

to individual patients by the Social Work Team for the Elderly when a need was identified during the patient's stay. One member of this team always attended the MDT meetings and kept colleagues up to date with the progress of their patient. The social work team moved to a new base across the city towards the end of the study. Contact with community based Joint Care Management Teams was via social workers. Dietetics support was accessed on a referral basis. MDT meetings were held by each consultant once per week, the average duration was 90 minutes. The meetings were normally attended by all disciplines except SALT and dietetics. The unit took some nursing, PT and SALT students on a regular basis. At Holton there was no staff restroom; nurses, HCAs, and housekeepers, took breaks separately from therapists. However, as at Colebrook, therapists, social workers, SHOs and nurses frequently met and took informal breaks at the central work-station when writing up notes and organising resources or discharges. The consultant physician came to the unit once per week for the ward round and MDT meeting, and as a result had limited opportunity to engage in work related or social dialogue.

Table 1: Comparison of staff numbers and skill mix

<b>COLEBROOK</b> (full time positions unless indicated – includes night staff)	<b>HOLTON</b> (full time positions unless indicated- includes night staff)
Consultant Physician (1)- 2 sessions per week	Consultant Physician (2) -1 session each per week
SHO (1)	SHO (1)
Ward Manager (1) Nurse	Matron (1) Nurse
Ward Sister (1)	Ward Sister (post vacant)
Staff Nurse (9) –E and D grade – 4 part time	Staff Nurse (11) -E and D grade
	Enrolled Nurse (3)
Physiotherapist (2)- Senior I	Physiotherapist (1)- Senior I
Physiotherapist (1)- Senior II rotation for 6 months	Occasional sessional support from (1) Senior II Physiotherapist
Occupational Therapist (1) – Senior I (and managerial support from experienced Senior I OT)	Occupational Therapist (2) Senior I Part time job share
Occupational Therapist (1) –Senior II rotation for 6 months	Occupational Therapist (1) –Senior II rotation for 6 months
Speech and Language Therapists (2)- 4 sessions per week	Speech and Language Therapists (2)- 4 sessions per week (1 post vacant)



	Social Workers (6)
Dietician (1) (0.3 WTE) Senior I -1 session	
Dietician (1) (0.7WTE) Senior II -2 sessions	
Physiotherapy Assistant (1) – part time	Rehabilitation Assistants (2)
Occupational Therapy Assistant (1)- part time	
Healthcare assistants (6) -2 part time	Healthcare Assistants (12) 2 full time, 10 part time
Housekeepers (2)	Housekeepers (1)
Ward Clerks (2) – part time	Ward Clerk (1)

### *Comparison of working patterns*

At Colebrook nurses and HCAs worked shifts (0730- 1500 or 1300- 2100); the unit had permanent night staff although some registered nurses worked nights on a rotational basis to cover for permanent staff. Therapists normally worked between 0830 and 1700 on weekdays. Nurses and HCAs received a report from night staff, ward clerks and often the ward manager also listened and contributed. The report was conversational in style and lasted 20-30 minutes on average, focusing on priorities in physical care, planned therapy or investigations and discussed social issues including home circumstances or relatives' concerns. This process was repeated at 1300 for nurses working late shifts and at 2100 for night staff. Nurses and HCAs were allocated to two teams corresponding to the two sides of the unit. Care was organised around agreed MDT goals for each patient, taking account of planned therapy or investigations and prioritised according to an assessment of patients' need each day. This could include planned or unplanned work with therapists. A wall chart situated by the central work-station indicated planned therapy times and patient specific requirements, a similar chart indicated patients' moving and handling status.

Therapists normally came onto the unit at 0830 and spent 5-10 minutes informally reviewing their plan of work for the day as a group. They then met informally with other team members at the central work-station, where they either read the nursing and medical notes, or discussed plans for patients with nurses and with other therapists. These discussions could result in amendments to plans, particularly where the condition of a patient had altered overnight or over a weekend. No shared reporting took place other than for those team members who attended the

weekly MDT meeting. Although shared (MDT) notes were informally discussed, they were not developed during the study, and whilst each discipline had access to each others' notes they kept separate records of the care provided.

SALTs and dieticians did not work on the unit everyday and tended to review nursing and medical notes at the central work-station before seeking out the nurse caring for a patient and then seeing patients on their own or with another team member. SHOs were normally on the unit from 0830 and picked up work from a message board and supplemented this by informal discussions with team members at the central work-station throughout the day. Ward clerks were based at the central work-station for a part of each weekday and interacted with almost all team members. Although patient activities occurred in a wide variety of areas on the unit, these were accessible to all team members with the consequence that contact between team members was common and frequent.

Nurses and therapists shared responsibility for an informal evening information clinic (1900-2030) held after the MDT meeting. The Stroke Association also maintained an informal presence on the unit with information and contact numbers prominently displayed. Colebrook was identified as a specialist stroke unit by signs and informative poster displays at the entrance. Two further displays on the unit contained photographs of team members and identification of their roles, and identified that the philosophy of care in the unit was based on multidisciplinary team working with patients and families to provide rehabilitation and support.

#### *Working patterns- Holton*

The overall organisation of work in the unit was very similar to Colebrook but some differences were evident and are outlined here. The unit had permanent night staff but all registered nurses also worked nights on a rotational basis. Registered nurses mainly worked long shifts lasting 12.5 hours; this increased continuity of contact between team members but reduced the number of days these nurses worked. All but two HCAs worked a variety of part time hours. The ward

sister post, remained vacant throughout the study; two senior staff nurses acted into this position on a temporary basis (for six months each) but both declined to apply for the position citing family commitments. Therapists worked between 0830 and 1700 on weekdays. In contrast to Colebrook, whilst PTs and OTs spent the majority of their time on the unit, the PT also had responsibility for junior PTs working on two other elderly care wards. Because of their job share arrangement, the two senior OTs worked at opposite ends of the week and had limited contact with each other. A vacancy for one of the SALT positions increased the workload of the remaining SALT and reduced available contact time for the unit. These factors, together with the lack of 24 hour medical cover and the separate location of social workers reduced the frequency of contact between some team members.

Nurses and HCAs received a report from night staff at 0645, the report took the same format as Colebrook's and lasted 20-30 minutes on average. As no report was routinely provided for nurses and HCAs starting later in the day, a tape recorded summary report stored at the central work-station was often made available. A report was given to night staff at 2100. Nurses and HCAs worked in two teams based on the patients of the consultants. As at Colebrook, patient care was organised around agreed MDT goals, taking account of planned therapy or investigations and prioritised care according to an assessment of patients' needs each day. This could include planned or unplanned work with therapists, although planned joint working between nurses and therapists was less common here. Holton also used wall charts to indicate planned therapy time and patients' moving and handling status.

OTs, PTs and RAs met in their shared office at 0830 but used this time for writing up reports, coming on to the unit just before 0900. A short discussion to confirm or amend therapy plans took place at the central work-station, this sometimes but not routinely, included other team members. Joint working between OTs and PTs was common at Holton, RAs worked with PTs and OTs or independently with direction. Multidisciplinary records were used; there was less informal interaction between team members than at Colebrook at the beginning of the working

day, but this increased in frequency during the day as team members reviewed notes of other disciplines and completed multidisciplinary patient records. This informal review process could lead to amendments to MDT goals where a patient's condition warranted this. SALTs, social workers and dieticians spent less time on the unit but used shared MDT records and met with other team members informally at the central work-station. As with Colebrook, areas where patient activities occurred were accessible to all team members, this meant that contact between most team members was frequent. Holton also identified the specialist stroke rehabilitation service it provided with a large display on the nature and causation of stroke and the roles of team members. This was supported by a wide range of information on stroke and local health and social services. Large photographs of team members were displayed alongside the philosophy of care which focused on multidisciplinary team working to provide rehabilitation and support.

These were established rehabilitation stroke units with large multidisciplinary teams. The significance of the social and contextual features identified above is reported on in the discussion of the research findings. The discussion now turns to gaining ethical approval and identifies the overall research design.

### Ethical approval

As the hospitals were in separate health districts, two LREC submissions were prepared and submitted in September and October 2001 respectively. At Colebrook the research proposals were approved without amendment. At Holton the LREC suggested amendments to the inclusion criteria to broaden the potential sample. These suggestions were useful and as a result were included in a revised Colebrook application. LREC approval was gained by the end of January 2002 (Appendices 1&2). Although the research posed no direct risk of harm to any of the participants it was acknowledged that participant observation could be intrusive and that interviews with patients or team members may raise issues which could cause distress. The

LREC submissions addressed these issues in some depth outlining how informed consent would be sought and indicating support strategies which could be accessed if required.

### Sampling and informed consent

The staff sample potentially included all those who regularly worked on or with the stroke units, a total of 28 at Colebrook and 38 at Holton. All were regarded as having the potential to provide important contributions to the study. Prior to fieldwork commencing, team members were invited to short information sessions held on the units themselves; about half of the staff of each unit attended. These sessions proved important in understanding unit working patterns and gaining insight into the concerns of team members in terms of my fieldwork role. These discussions were instrumental in shaping my role as a participant observer. Written information including contact details and plans for gaining informed consent were left on the units for those who could not attend. When fieldwork commenced, team members were provided with copies of the staff information sheet and I repeated the explanation of the study and responded to questions on an individual basis (Appendix 5). Following consideration of the information sheet, team members were asked to provide written consent for their work to be observed. In addition, verbal permission to participate and observe was sought from team members and patients on every occasion. Where team members agreed to participate in interviews, written consent was checked and reconfirmed prior to commencement of the interview.

Whilst the study focused on the process of team working in stroke units as it was experienced by team members, the majority of teamwork was with, or on behalf of patients and thus their experiences and perspectives were also sought. All inpatients during the period of data generation who were able to provide informed consent were included in participant observations which focused on day-to-day interactions of team members and patients. A number of patients (n=15) were invited to participate in semi-structured interviews within three months of their discharge from the units. Patient interviews (n = 9) generated data about the experience and impact of stroke. However, after careful consideration it was clear that very little of these data

contributed to the explanation of the process of teamwork in the stroke units. The patient interview data are therefore not reported on in the thesis, but were the subject of separate analysis for discussion in other arenas.

Patients (and their relatives) were informed of the study at or soon after their admission. An outline information sheet was included in the Ward Information Packs of both units. This was followed up with a personal visit to each potential participant. An individual information leaflet (Appendix 3) was provided for each patient and their relatives, they were asked to consider the information over a minimum period of 24 hours before they were approached to consent to participate in the study. In addition to formal written consent to participate in the study, verbal consent to observe patients' interactions with team members on a sessional basis was always requested.

The majority of patients were able to give written informed consent for inclusion in the participant observation phase of the study; however, some were too unwell initially and were deemed not competent to provide written consent. Including some of these patients in the observations would provide information about how team members worked with this group of stroke patients. The inclusion of such patients in observations required provision of a separate carer information sheet (Appendix 4). Carers were approached to consent to the involvement of their relative in observations. Some of these patients recovered sufficiently over time to be deemed competent to consent to continue in the study, such patients were asked for written consent. Assessing competence was carried out in consultation with consultant physicians or SHOs and normally followed cognitive assessment by OTs. Where patients were unable to provide informed consent, or where this was considered inappropriate by family, carers or the stroke unit teams, they were not included in the participant observations.

### Confidentiality

It was important to ensure that participants understood how data would be used, analysed and stored. Informed consent can be difficult to achieve as it is hard for participants to know and understand in advance the sorts of issues which may arise whilst they are being observed or participating in an interview (Grbich, 1999; Knight, 2002). The right to withdraw from or terminate observations or interviews was regularly repeated. In the event no team member or patient exercised this right. The complexities of data analysis may be of little interest to participants but they have a right to know how data they have consented to being used in the study will be managed (Grbich, 1999). To address these concerns sensitively and to protect the rights of the participants I explained that I wished to record fieldnotes before, during or after observations and interviews. The purpose of fieldnotes was outlined and participants were invited to read these and ask questions about their content. In the event no patients asked to read fieldnotes but some team members did so. These commented on the relatively mundane nature of the information contained in the fieldnotes, however, their review did prompt questions about how such data were analysed and used to develop theory. This proved to be a useful process which helped those team members understand the research more fully and which in turn contributed to my understanding of my responsibilities as a participant observer. It helped me to reflect on how sharing fieldnotes in this way impacted positively on relationships with participants. It seemed that those who read and discussed the fieldnotes, regarded me as less of an outsider to the teams and were more prepared to actively engage with the research rather than passively provide information when requested to do so. Other researchers have also reported on the value of providing access to fieldnotes (Holliday, 2002; Delamont, 2004)

The first few minutes of interviews were spent seeking permission for audio-taping and explaining how transcripts would be made anonymous (contain only profession and unit identifiers). Fieldnotes and interview transcripts were entered into the qualitative data management software package NVivo 1:2. I personally transcribed the first fifteen interviews, and then an experienced transcriber who understood the requirements for confidentiality and

safe storage of audiotapes transcribed the remainder. Electronic versions of fieldnotes and transcripts were password protected and stored in NVivo 1.2 on my personal computer. Floppy disc file copies of transcripts were deleted after transfer into NVivo and no hard disc copies were retained by the transcriber. I retained the audiotapes of interviews as these were an important resource in data analysis; these were securely stored and were destroyed on completion of the study.

Hard copies of transcripts with initial coding were returned to each participant and they were advised of plans to continue to develop the analysis to provide an explanation of team working. An accompanying letter identified how data might be used in the thesis and in future publications and invited participants to contact me if they did not wish part or all of the data to be used in the ways described (Appendix 6). In the thesis only unit and profession identifiers are used. In this way confidentiality was maintained as far as was possible but anonymity could not be guaranteed, this was made clear to participants. As the units and the teams are relatively small it is not possible to prevent members identifying quotes that might be attributed to a particular member of the team, particularly when there is only one or two members of a specific discipline in a team. None of the participants requested that their comments not be used.

#### Study design and timetable of data generation activities

Grounded theory methodology calls for data collection and analysis to occur in a continuous and cyclical sequence. Analysis begins as fieldwork commences, this then influences the next set of observations and interviews, and constant comparative analysis drives subsequent data generation (Strauss & Corbin, 1998; Dey, 1999). The inter-relationship between the processes of data generation and data analysis is discussed in chapter 6.

Figure 1 (page 101) illustrates the four phases and overall progression of the research activity in this study. Tables 2 & 3 indicate the time spent on each of the principal data generation methods.



**Figure 1: Research timetable**

Ethical Approval	Access	Phase 1	Phase 2	Phase 3	Phase 4
Application for Ethical Approval : September 2001-end January 2002					
Gaining access to the selected stroke units August 2001- end February 2002					
	Pre data generation information sessions at the selected stroke units January-February 2002	March to August 2002 Participant observations. Cycle of 3 days per week at Colebrook followed by 3 days per week at Holton Interviews with a small number of team members at both sites.			
			November 2002 – June 2003 Further interviews with team members at both sites		
		October –November 2002 Seeking respondent validation Written report for team members on preliminary findings and further questions to be pursued.		July 2003-March 2004 Patient interviews	
					March and April 2005 Seeking respondent validation. Feedback and presentation of the research findings to the team members at both sites
<b>Data generation and analysis</b>					
<p>Recording notes on information sessions</p> <p>→ Recording and analysing field notes and memos-----open-axial and substantive coding</p> <p>→ Theoretical sampling – recording and analysing field notes and memos,</p> <p>→ open, axial and substantive coding</p> <p>→ Identification and development of core category and theory development</p>					

Table 2: Time spent in **participant observation** and identification of where observations were focused.

Site	Time spent overall	Time spent with PT	Time spent with OT	Time spent with Nurses	Time spent with SALT/Dietician Social Work	Time spent with SHO/Consultant Physicians	MDT Meetings (Normally preceded by 1-2 hour ward rounds)
<i>Colebrook</i>	95 hours	20 hours	12 hours	29 hours	5 hours SALT 5 hours dietician Social work 0	2 (+ ward rounds/MDT meetings)	22 hours
<i>Holton</i>	94 hours	20 hours	19 hours	35 hours	4 hours SALT Social work in MDT meetings and informally	2 (+ ward rounds/MDT meetings)	16 hours
Additional general observation time (approximately 15 hours at each unit) based at the central work-station							
Total time engaged in participant observation: 219 hours							

Table 3: Identifies the number of **interviews** (n=34) conducted and the participants.

<u>Healthcare Assistants</u> Colebrook x3 Holton x2	<u>Occupational Therapists</u> Colebrook x 1 Holton x 2	<u>Physiotherapists</u> Colebrook x 2 Holton x 1
<u>Senior House Officers</u> Colebrook x1 Holton x 1	<u>Registered Nurses</u> Colebrook x 3 Holton x 4	<u>Dieticians</u> Colebrook x 2 Holton x 0
<u>Consultant Physicians</u> Colebrook x1 Holton x 1	<u>Physiotherapy assistant</u> x 1 at Colebrook <u>Rehab assistant</u> x 1 at Holton	<u>Ward Clerk</u> Colebrook x 1
<u>Social Workers</u> x 4 at Holton	<u>Speech and Language Therapist</u> x 1 at Holton	<u>Ward Manager</u> Colebrook x 1 Holton x 1 (Matron)
<u>Patients (not reported on in the thesis)</u> Colebrook x 4 (3 males and 1 female) Holton x 5 (3 males, 2 females)		

### Summary

This chapter examined grounded theory approaches in the context of the qualitative interpretive research paradigm and established the reasons for selecting this methodology in the design and conduct of this study. This included the focus of grounded theory studies on identifying and generating explanations of social processes through direct involvement of researchers in social settings. This approach seeks to represent and include the perspectives of social actors in the development of theory which is grounded in data. The methods outlined by Strauss & Corbin

(1998) were adopted to facilitate the development of an explanation of the social processes at work in rehabilitation stroke unit teams. Participant observation and semi-structured interview are data generation methods closely associated with the development of grounded theory. These were considered necessary to generate an in-depth and detailed account of how teamwork was developed and maintained. The identification and selection of two sites for the study was discussed, these are established rehabilitation units where large number of staff from a wide range of disciplines come together to manage the complex care programmes required by stroke patients. It was anticipated that such groupings of different disciplines in stroke units would provide important opportunities to study the process of team working in contemporary NHS workplace settings. The general characteristics of the selected units, the participants, and their overall working practices were described. These exhibit a number of similarities and few differences but provide the basis for later comparison and discussion of the study findings as these apply to the two units. LREC approval of the study was discussed and the approach used to gain informed consent and manage data to preserve the confidentiality of participants was outlined. The phases of the research and time spent on data generation and analysis activities were summarised.

The next chapter will examine and reflect upon my research practice as I engaged directly with the methodological principles outlined in this chapter.

## Chapter 5:

### Reflection on fieldwork and research practice

## Introduction

Research practice requires more than application of a range of established methods, indeed most researchers face methodological and practical challenges in carrying out their research (Silverman, 2000). Seale et al (2004: 1) argue for pragmatic accounts of engagement with research principles in practice, pointing out that: *'learning to do good qualitative research occurs most felicitously by seeing what researchers do in projects'*. They do not underestimate the importance of research methods but link them to research practice seeking a dialogue between methods and researchers' actions. Seale et al (2004) encourage researchers to observe, question and write about their actions and decisions, a process commonly termed reflexivity (Finlay, 2002). In this process the researcher turns the analytical lens towards the self in interaction with participants and reports on that process. This is consistent with the position held by grounded theorists who argue that understanding of social processes can be achieved through observing and questioning the commonly taken for granted actions and interpretations of social actors and those of the researcher (Strauss, 1993; Dey, 2004). In this chapter I present a critical reflexive account of my fieldwork role spanning participant observation and semi-structured interviewing.

## Reflexivity

Examining the interplay between subjective and objective elements in fieldwork increases the integrity and trustworthiness of research by explicitly acknowledging how the researcher affects and is in turn affected by relationships and interactions in the field (Finlay, 2002). There are many definitions of reflexivity, not all of which confer clarity on the concept (Finlay, 2003; Allen, 2004). Finlay & Gough (2003: ix) define reflexivity as *'thoughtful, self aware analysis of the intersubjective dynamics between the researcher and the researched'*. I am using the term reflexivity to represent this critical self-awareness, my aim is to make transparent methodological and practical decisions and in so doing enhance the credibility of my research. I also examine the influence of my professional background, beliefs, and theoretical interests on my relationship with

social actors and how these may have affected data generation and analysis. Whilst I recognise reflexivity as a defining feature of qualitative research (Holloway, 2005; Finlay & Gough, 2003), I have tried to avoid indulgent introspection and excessive self analysis (May, 1997; Holliday, 2002).

### Negotiating access

My research aim was to understand and explain social processes occurring as health professionals engaged in the work of teamwork in rehabilitation stroke units. My experiences in negotiating access and gaining acceptance in the units are reviewed in the following section. Davis (1986) differentiated access and entrée; noting that whilst access is essential it confers no more than the right to move freely in an organisation, attention must be also paid to entrée. This relates to strategies and behaviours for establishing trust and gaining acceptance from the persons with whom the research will be conducted, until this is developed the researcher will be regarded as an 'outsider' and may be viewed with suspicion by participants (Hammersley & Atkinson, 1983; Davis, 1986). Gaining access to the stroke units took nearly four months. Profession specific managers were contacted by telephone and then sent the research proposal and confirmation of LREC approval. In practice this meant twelve managers were consulted before the stroke unit teams could be approached. Working through these 'layers' of managerial responsibility proved useful preparation for negotiating my fieldwork role with the teams. An early access conversation with the Physiotherapy manager at Colebrook identified the sorts of concerns and issues which I would need to address:

*'My physios are really busy as it is so I have two concerns; one that your observations will mean therapy may take a lot longer if they have to explain everything they are doing to you, and secondly that patients may not be happy with someone they don't know in the room when they are having therapy; you need to convince me that you won't be in the way'. (Research diary, February 2002)*

These were understandable concerns; I responded by outlining how I intended to agree observation times with PTs, and how I planned to gain informed consent. I realised I needed to be clearer about

the kind of observations I would be undertaking and what impact these might have on day-to-day work of the teams. At this stage I had not decided whether I would follow patients or individual team members. This manager suggested following patients through different therapy sessions and, given my focus on gaining support to conduct the study, I readily agreed. However, I only really understood the importance of the questions raised after the conversation ended. In writing about the theoretical basis for my 'observer as participant' role (Gold, 1958), I had not considered in sufficient detail how I would structure my observations, over what time period, whether patients or staff would be my primary focus, and the impact of my presence in the stroke units. Peberdy (1993) identified similar issues in her account of learning to use observation in an ethnographic study of beliefs about health and illness. She suggested that in research proposals, familiarity with the theoretical literature has primacy, but when accessing the field, practical details and straightforward explanations take precedence for gatekeepers and participants. The PT manager prompted me to focus on such practical details. I reasoned that following individual patients would generate data about their experiences with some but not all team members, whereas my research interest was broader. I therefore needed to maximise the opportunities to observe team members' interactions when they were with patients, in meetings, in one to one situations with others and in groups.

I was better prepared for concerns raised by managers of OTs and SALTs, about staff time and my potential impact on therapy and asked these managers how observations could be organised to bring about least disruption whilst generating useful data. This proved a productive strategy which helped position me as willing to work with managers and team members, to fit in with their regular work patterns. I tried to develop relationships of equality and partnership, rather than impose myself on the teams. Peberdy (1993) noted that it was only when she asked potential participants for their views and developed some insight into their concerns and perceptions of her fieldwork, that she was able to formulate a realistic plan for observations. These seem obvious requirements but reflect the

way in which access negotiations require researchers to make sense of day-to-day activities and take account of actors' perspectives in particular social settings (Peberdy, 1993; Finlay, 2002).

I used the perspectives of managers in planning fieldwork; they suggested observing timetabled joint working and case conferences or shadowing individual team members. However, when I began fieldwork it was soon apparent that observing interactions between team members as they commenced or before they ended their working day could also provide valuable information on informal and routine work practices. The practices which these managers and team members appeared to regard as everyday, ordinary and unremarkable, can contribute rich data related to underlying social processes (Blaikie, 2000; Delamont, 2004).

#### Discussing research methods with participants

It is common for participants to have a range of concerns arising from uncertainty about the nature and focus of qualitative research, or relating to establishing trust in the researcher's commitment to confidentiality and professionalism (Silverman, 2000). Recognising this, I arranged informal meetings at both units, to discuss the research and answer questions. Team members at both units expressed similar concerns to their managers, including what I would observe, what impact this would have on patients and staff, who would decide when it was appropriate for me to be present or not, what would be recorded and how data would be used. In contrast, the plan to interview team members caused little concern. This may be explained by the familiarity of interviews as a data collection method (Silverman, 2000; Rapley, 2004). At Colebrook, many team members had participated in interviews in other research projects. At Holton, two staff nurses had used interviews in small scale research projects, one said to colleagues:

*'there's no need to worry about interviews, you'll find you have lots to say and they are never as bad as you think they are going to be. I had trouble getting people to stop talking in my study, not the other way around!' [Group laughter] (SN: Holton, Fieldnotes, February, 2002)*



Interviews remained a potential source of anxiety for some team members, however, the staff nurse's comments legitimised and helped to normalise the use of interview methods in my research. I met team members at Holton over two lunchtimes; OTs took the lead in both sessions, with one asking '*what do you think you will learn about us by just sitting and watching?*' and another stating '*you will need to get into a uniform and do what we do if you really want to know how we work*' (Fieldnotes, Holton, February 2002). These statements suggested the OTs conceptualised 'observation' as a passive form of watching and indicated to me their preference for direct involvement in their practice. I confirmed that I shared their view and that in order to understand their work, I planned to participate in their practice.

Similar comments arose at Colebrook, with one PT saying '*you won't learn much if you just sit and watch; you won't do that will you?*' Nurses asked if I would work shifts as they did; with the ward manager saying '*there are no appointments for nursing you know, we provide rehabilitation 24 hours a day.... So are you going to do that too?*' (Fieldnotes, Colebrook, February 2002). My initial responses to these questions were somewhat defensive and more theoretical than practical. These were understandable questions but they pushed me to be precise about my intended actions before I really understood the working practices of the teams and the units. I talked about how observations could provide information to complement interview data. It quickly became apparent that team members, wanted specific answers. I had planned to work a range of shifts and felt confident to say that this was important in understanding their work. This raised the issue of skills required to participate safely. Despite my conviction that participant observations would provide rich and grounded data about team processes, I had some anxiety about my lack of clinical skills in this specialist setting and admitted this indicating I would need help and direction to be able to participate without disrupting work or compromising safety. With this, team members relaxed and described typical working patterns. A large part of day-to-day work involved providing direct physical care or working one-to-one with patients. A non participant role would have significantly

limited opportunities to observe team processes and engage with team members as they worked. These discussions were important in establishing working relationships with the teams. The sessions also identified my assumptions about the impact of study information sheets. These had seemed clear but the discussions indicated they were interpreted differently by team members and benefited greatly from being supplemented by face to face contact in advance of fieldwork.

Holliday (2002) suggested that early research encounters such as these are common, and reflect the fact that researchers essentially occupy different social worlds from those they wish to study. Social actors regard the researcher as a 'stranger' and are cautious about interaction even if the research is perceived as legitimate and relevant. Participants draw on their own prior experiences and cultural backgrounds in considering the intentions of the researcher and commonly seek to negotiate with the researcher so that they can control and manage access to their work and their practice. Holliday (2002: 148) conceptualised this process as a '*culture of dealing*'. In essence this represents a tentative dialogue where participants are prepared to give only limited information and access to their work until they have gathered information about the beliefs, motives and intentions of the researcher. This process is characterised by polite exchange of information, a tentative trading (*dealing*) which stays at a safe and superficial level until participants decide to share specific details and provide more unrestricted access to their lives and work

### Researcher biography

Hammersley & Atkinson (1983) suggested that participants are often more concerned with the 'kind' of person that the researcher is than the actual research itself. Team members asked direct questions about my professional background, research intentions, experience and plans for observations. I was open about my clinical experience and lack of knowledge and skills of stroke rehabilitation techniques. I had never worked in a stroke unit and last worked with stroke patients ten years prior to the study. Sharing this information helped team members get to know about me as a person and a

former clinician as opposed to seeing me only as a researcher. It also helped reduce my anxiety about what team members expected of me. I felt initially that openly identifying my anxieties might reduce my credibility and team members' confidence in me, but at the same time it was important that they understood my position as researcher as opposed to a substitute clinician. This dialogue reduced some of the uncertainty surrounding the research and addressed specific concerns about participant observations. Holloway (2002) and Savin-Baden (2004) noted that limited self disclosures such as these allow participants to recognise where their biographies and experiences may be similar to the researcher's, suggesting this can break down barriers and facilitate working together.

The challenge for me was to become less of a stranger in the eyes of the participants. I did this in part by emphasising what we had in common, my professional clinical background as a nurse, and to some extent, down playing my role as researcher, not a novice but not an expert either. This helped place my research in the context of studying for a research degree and provided another example of experiences I shared with these participants and in turn contributed to reducing our differences. I felt this enabled me to convey my intention to work with participants respecting their concerns and decisions as far as possible, I sought to equalise the potential imbalance in power between participants and myself through recognition of the expertise and knowledge of both parties (Hall & Callery, 2001).

Although I had anticipated that access would not be straight forward, my fieldnotes for this period record some concern at not being fully prepared for the amount of time this would take. More important was recognition of the necessity for this dialogue with team members who I wanted to observe and work with for a sustained period of time. In writing and defending the research proposal I had concentrated on observation as a research method and not as the interpersonal process impacting directly on participants and me (Savage, 2000; Finlay & Gough, 2003). I had

become so focused on gaining ethical approval for the study and negotiating access with managers that I initially underestimated the concerns and questions that those who I wanted to participate in the study were likely to have. However, these experiences sharply increased my sensitivity to my impact on the research setting and I understood that my engagement with the units would not be as a neutral and apart observer but required direct involvement in the work of the units and reflexive analysis of my fieldwork role.

### Data generation

Following the meetings, I negotiated specific times to observe team members and to continue observations at the central work-station at other times. The working practices of both units were very similar and were based around timetabling patients for therapy or investigations, so my booking observation times made sense to team members. Timetabling observation periods with nurses indicated my willingness to respect their workload and fit around their work despite their constant presence in the units. It was important to be willing to give and take at this stage, to be prepared to move at the pace of the participants and compromise on timescales or rigid plans so as to build trust and in time to be invited into the social world as actors saw and experienced it, as opposed to the sometimes sanitised version they may chose to present to strangers (Finlay, 2002; Holliday, 2002).

The methods I used to generate and analyse data were interrelated and overlapping rather than sequential (Coffey & Atkinson, 1996; Holloway, 2005). Whilst I recognise the importance of this integration, the discussion which follows will separate out the observational and interview methods in order to examine the experience and contribution of each in this study

Gold (1958) identified a continuum of observation from researcher as complete observer, through to observer as complete participant. Adler & Adler (1998) identified three roles: complete member

researcher, active member researcher and peripheral member researcher. In each of these formulations it is the degree of involvement of the researcher which is differentiated. Gold's (1958) first category implies no researcher participation in the setting, but it is not possible to be present and not participate in some way (Atkinson & Hammersley, 1998; Knight, 2002; Delamont, 2004). The very presence of the researcher changes the way in which social actors go about their activities, this was brought home forcefully to me in the access discussions. I believed that participation would reduce team members' perception of me as a stranger and help develop sufficient trust to share their experiences and perspectives; therefore the role I adopted was observer as participant (Gold, 1958). I tried to understand what the social and occupational world felt and looked like to those who worked as part of the stroke unit teams. Delamont (2004: 218) defined participant observation very broadly as '*a mixture of observation and [informal] interviewing*'. She said being a participant did not necessarily mean '*doing what those being observed do*', but did mean finding ways of '*interacting with them while they do it*'. This definition closely reflects the way I conceptualized and developed my observational role in the stroke units.

Gerrish (1997) identified the tensions she experienced in her dual role as nurse and researcher, wanting to appear credible as a nurse at the same time as engaging in participant observation for the first time. I recognised these tensions as being similar to my own on commencing fieldwork but in contrast to Gerrish's (1997) research with district nurses (her own profession) I participated with a wide range of professional groups and therefore was not initially concerned to be regarded as a credible practitioner by any group. I wore a plain polo shirt and dark trousers rather than a uniform associated with any particular professional group. My name badge indicated I was a Lecturer in a School of Healthcare; I did not hide my background as a nurse but did not identify it unless asked. Again, in contrast to Gerrish (1997) and later Savage (2000) I participated as a healthcare or rehabilitation assistant would, not as a registered nurse. This clarified my status for team members and reduced any expectations that team members might have had of my clinical role. However,

there were conflicts for me as a nurse; like Allen (1997) and also Gerrish (1997) I witnessed some practices which were not consistent with my own standards of care. I reasoned that provided patients' dignity and safety were not compromised I could confine my thoughts to writing analytical memos and did not need to intervene. These concerns also arose when participating with other professionals and reflect the ways in which we judge standards of care by reference to personal as well as professional expectations (Finlay, 2002).

#### Experiencing and managing fieldwork:

I was anxious to begin fieldwork, but the first few days of observation caused some anxiety and were more unnerving than I had anticipated. I began observations with three sessions lasting 5 hours each at Colebrook. In order to meet as many staff and patients as possible I arrived at 1000 on the first day to observe the ward round and the weekly MDT meeting. These represented routine but potentially significant activities for team members and patients. I felt like I was starting a new job and was left exhausted by the effort of trying to concentrate, observe, record and think about the interactions I observed. Fieldnotes for the first session took up seven sides of an A5 notebook and were filled with questions and issues to follow up. The notes were recorded in gaps occurring during the ward round and MDT meeting and in the car park before leaving the hospital. This pattern of making fieldnote entries during a break in or soon after an observation and in the car at the end of sessions became common and continued as interviews were completed. Selected extracts from the fieldnotes made on day one are included below to highlight some issues which were to influence later observations and interviews.

*Extract 1 Colebrook March 2002:*

Figure 2:	Observations	Notes and analysis
	<p>Uncomfortable start to the day arrived just after 10 a.m. No one seems to know who I am and I don't recognise any of the staff from the access meetings. Felt very uncomfortable waiting at the central work-station for the ward round to begin. Declined the offer to wait in the day room, fearing that I might be overlooked but soon begin to regret this. The ward round doesn't start for another 20 minutes and I am in the way seated at the table where team members appear to check on and write up documentation. Feels like the first day on a new job, not knowing anyone and not knowing what is expected. The noise of conversation between staff is striking, there are so many staff congregated here and so many conversations going on at once that I cannot follow any of them</p> <p>Rescued by (name), who introduces me to the staff at the workstation and invites me to participate in the ward round</p>	<p>Why did I expect more people to know who I was? This will soon be resolved. I was not on familiar territory, and a stranger to the majority of team members and patients. Their work is uppermost in their minds not my research.</p> <p>I am used to being in control, knowing what to do. I worry that my sitting at the desk, getting in the way, will confirm negative perceptions about observation i.e. that all I will do is sit and watch. I need to be realistic about this. Is this just because of the round, how do they cope with this noise?</p> <p>Legitimises my presence</p>

Initial fieldnotes seemed like a jumble of text, focusing on my experiences and not on teamwork processes. However, even at this stage the discipline of entering fieldnotes into NVivo provided an important opportunity to re-examine, question and structure the record and analysis of the observations. The coding process in NVivo encourages reading and re-reading of text. Coding of certain words or passages automatically highlights the selected text in colour and I began labelling text with general codes such as '*communicating with other team members*' and '*team relationships*'. In turn, coding these sections of the fieldnotes prompted questions which were recorded in the databyte [memo] facility and provided some direction for future observations, for example:

*'Is this kind of gathering at the central work-station routine, if so what purpose does it serve? The discussions appeared to be informal and inclusive; healthcare assistants and ward clerks seem to have a lot to say. But these are just initial impressions, repeated observations at different times of the day and on days when the ward round is not occurring are going to be necessary'. (Memo 3: Fieldnotes, Colebrook, March 2002)*

Further extracts from that first day's observations again identify my experiences but also begin to identify interactional and working processes, which were initially coded under *communication with other team members* and *specialist knowledge of stroke*. I was struck by the technical language

used, and the apparent shared understanding of this between team members on the round and identified this as a feature of the interactions, to follow up.

*Extract 2 Fieldnotes, Colebrook, March 2002*

Figure 3	Observations	Notes and analysis
	<p>I'm included in the ward round discussions for each patient although I feel a little out of my depth and with little to contribute at this stage. There seems to be a clear structure to reviewing each patient. The SHO and ward sister provide diagnoses, current medication, results of diagnostic tests. Functional and cognitive ability are measured by scales such as the Barthel, reports from therapists, observations of nurses and reports of family members are provided. I'm struck by a number of things:</p> <ul style="list-style-type: none"> <li>-the range and complexity of the technical language, and how this is used by those present on the round (I begin writing lists of terms/test/scales I don't understand).</li> <li>-the discursive nature of the interaction, but with a sense of direction coming from the consultant physician if certain information is not forthcoming.</li> <li>-the physical contact made with each patient (a handshake, a hand on the shoulder or holding a patients hand), social contact is established before progress is discussed</li> </ul> <p>My inclusion in these discussions makes me feel more welcome but also points out my lack of understanding of the technical language shared by the team members.</p>	<p>1) The process seems routine but is thorough and appears to ensure that details are not missed- a comprehensive picture of the patient is developed.</p> <p>2) Team members seem to know what is expected of them and the process is quick, but thorough.</p> <p>3) Clear attempts are made to engage the patients (there is conversation rather than simply declaring what will happen or what has been decided.).</p> <p>The technical language is like a form of shorthand- how long does it takes to learn this and how important it is in feeling/being part of the team?</p> <p>Roles seem to be understood, and I am struck by the discursive nature of the interaction between the team members on the round. This may be for my benefit, but it appears natural and was sustained for nearly 2.5 hours, also similar in the later team meeting</p>

I regarded entering data into NVivo as a space and time for sense making, for thinking about data and my experiences, and for developing practical and theoretical questions. This was particularly useful after three days observations at one unit as the issues and questions identified, could be compared and followed up at the other unit over the next three days. The first three days observations at Colebrook sensitised me to some of their working practices and provided a baseline for comparison of interactions and processes observed at Holton.

My initial experiences at Holton were similar, but there were some differences. I was more relaxed as a result of completing three days observation, and after reflecting on and writing up initial



fieldnotes. Holton was less busy and the ward round and MDT meeting were two days away. I shadowed a staff nurse who introduced me to team members. Similarities with Colebrook included an appointment system for therapy, frequent gathering of team members at the central work-station and participation of healthcare (HCAs) and rehabilitation assistants (RAs) in discussions of patient's progress. Differences were apparent in terms of the higher number of HCAs at Holton and the presence of RAs. Therapists were not based on the unit and the ward sister's post was vacant. I used the opportunity of shadowing the staff nurse to gain background information on the organisation of work within the unit. This proved to be a two-way process as the staff nurse questioned me about similarities and differences in working practices between the units, she said:

*'The therapists are not based on the unit here, but they don't take the patients off the ward, like they do in some places I've worked, so we see a lot of them every day. The only problem is, they start a lot later than we do and sometimes that means we have to stop work to give them information so they can do their work....., because things can change overnight. What's it like at Colebrook, do they all start at the same time? Do they have a gym on their ward?' (Fieldnotes: Holton, March 2002)*

I could answer this kind of comparative question objectively, and made a note that her comments indicated some potential areas of tension (*we have to stop work to provide them with information so they can do their work*) as well as her perception that ward based therapy increased contact time between team members (*so we see a lot of them*). It also quickly became clear that some team members perceived that one of my research intentions was to determine which was the better team. Some voiced concern that I would be 'judging' the quality of their work. Team members at both units asked directly if I was there to see whether they were a good team and doing the job correctly, a response noted in other studies where observational methods have been employed (Miller et al, 1999; Holliday, 2002; Allen, 2004). A PT at Colebrook asked if my purpose in studying two teams was really to:

*'See which the best team was?' she continued, 'goodness I hope you won't show us up if they are much better than us'. (Fieldnotes. Colebrook, March, 2002)*

Naively, I thought participants would take my stated interest in how they worked in teams at face value. This clearly contrasted with the interests of participants who wanted to know why I had chosen their units and how I would view their practice. I had anticipated that they would be concerned about how the findings of the study might be used, but not that the primary concern would be with judgments about which was the better team. Questions like these were posed in a humorous manner but the concerns were genuine. I responded by explaining that understanding similarities and differences between the teams would help in establishing a credible account of the process of working in teams. I explained that it was not my intention to make evaluative judgements about which team was the better of the two, indicating that this would be a different piece of research requiring validated measurement tools. The PT at Colebrook appeared reassured by my explanations but it took many weeks of contact during fieldwork before she was able to take me to one side and say: *'you really are interested in what we do....., and not just whether we are any good as a team'* (Fieldnotes, Colebrook, May, 2002).

It is difficult to gauge how much my participation in the teams over a period of six months affected interactions and behaviours of team members, but some effect was inevitable (Atkinson & Hammersley, 1998; Delamont, 2004). In the early weeks of fieldwork I was conscious that team members in both units displayed some uncertainty in terms of whether to include me in their discussions, explain the nature and content of these discussions or just pretend I wasn't there. Early on there were a number of references to *'having to do things correctly'* because I was watching. My approach to dealing with this was to be open with team members about what I wanted to observe and participate in, and that I recognised the strangeness and unfamiliarity of working alongside a researcher. I asked team members, to assume I knew very little about stroke rehabilitation but was interested to learn why they worked as they did. I encouraged them to be clear about exactly when I could and could not observe and participate in their work, and as far as possible, not to make any adjustments to their working practices because of my presence.

Participating in the work of the stroke unit teams speeded up the process of acceptance of my presence and helped normalise the relationship between us. In time team members seemed to relax and include me in their work, explaining specific rehabilitation techniques and perceptions of patient progress when required rather than specifically for my benefit. Interactions with patients were facilitated by my regular presence on the units where most patients stayed for six to eight weeks, this meant I was a familiar face. I also discussed consent to observe and participate in care with each patient, and often their relatives, on an individual basis. I always began an episode of care by being introduced by a team member and seeking permission to participate. This served to legitimate my presence, but also conveyed the message to patients that I was engaged in a helping role with some understanding of their needs, as opposed to being a stranger with no direct involvement in their care. In terms of overall evaluation of my impact on the research settings, I noted that perhaps the main effect I had on team members was to cause them to reflect on and consciously consider their practice, usually during and after periods of observation or in individual interviews. As a counterbalance to my influence I became aware that both teams perceived my participation as useful to them when their workload was particularly heavy. I reasoned that in helping in the completion of some of their routine patient work I continued to observe team processes, in this way my participation was mutually beneficial.

The actual degree of participation with patients and staff varied based on the team member and the nature of their work. I participated in care giving with nurses, with PTs working to improve balance, posture and mobility, and with OTs in washing, dressing and kitchen practice. These activities required skills I had developed as a nurse and in each case I received clear and practical instruction from the team member responsible for the patient. Participating in this way helped develop informal working relationships with team members, which in turn encouraged them to talk about the team and their work. As team members got used to my involvement in their work they

would often spontaneously reflect on their work and my research. I had been observing at Colebrook for about 6-8 weeks when a staff nurse I was helping said:

*'I've been thinking about what you're doing and trying to... you know work out why we work well in this team and get on, all I can do really is compare it with my last ward, you know...there we never saw the therapists or if we did they just told us what we were doing wrong [laughs].....well here its been different from the start really'*

*INT: Different in what way?*

*'Well, we're all based here for one thing, but that's not it really...On here everybody wants to learn the best way to do things and nobody's bothered about asking if they don't know, even Linda (the senior OT) asked me the other day about how we were facilitating Toby with dressing and she's well you know the expert in that....that's the sort of thing I notice anyway'. (Fieldnotes, Colebrook, April 2002)*

This provided an important insight into this nurse's perspective on relationships and interaction with other disciplines and how a shared concern to *'learn the best ways to do things'* impacted on what she had experienced previously and described as strained and hierarchical relationships between nurses and therapists. Such conversations provided question areas for later interviews, for example suggesting comparison of this team with other teams would be one way to help team members talk about their teamwork in the stroke units. In participating with team members I was able to observe how they coped with practical problems such as staff sickness, difficult patients or changing their plans at short notice. Interacting with team members and patients in these situations meant I directly experienced some of these tensions and my observations encompassed much more than they could have with reliance on non participant observation.

Having a professional background in nursing was both an advantage and a disadvantage. As my basic competence in moving and handling, washing, dressing, and toileting became evident, team members increasingly involved me directly in providing therapy. They responded to my repeated questions about their practice as individuals and as a team in the same way they might induct a new member of staff or a student on placement. On one occasion the PT at Holton asked me to assess the

posture and sitting balance of a patient who had been admitted two days earlier. She physically positioned me to begin the assessment, stood over me and then positioned my hands on the patient's upper body, all the time talking to the patient. She asked me what I could feel, what I could see and what changed when I increased or reduced support. I found this experiential learning significant but also challenging for a number of reasons which for me capture some of the strengths and weaknesses of participant observations. Experiencing the physical sensations generated by undertaking the assessment task reminded me of how as a nurse I relied on physical contact in gathering data about patients, noting for example the warmth, moisture and texture of skin, the muscle tension evident or absent, the weight of a patient and the non verbal cues in patients' responses to questions. Delamont (2004) argued that it was important to participate in this way to be able to write feelingly and authentically about the nature of the work, its pains and pleasures, smells and sounds, physical and mental stresses. Similarly, Savage (2000) argued that participant observation was more than a method to be selected from those available and challenged researchers to be clear about how they understood data gathered through all of their senses. In this case I experienced the satisfaction of learning a new and specialist skill and the feeling of being trusted enough by the PT for her to share her specialist knowledge with me, a non PT. I also gained important insights into the reasons why this PT wanted everyone in the team to have these skills.

*INT: Why do you share these specialist skills and knowledge in this way?*

*'Well it's simple really, patients see me or the OT for only about forty minutes each day, if we are serious about rehab then everything that the staff do has to help patients progress and not stand still, .....so everyone has to know how to do that kind of assessment because patients change quickly and staff have to know these things before they can sit someone out of bed, at the table for dinner and that kind of thing, we need rehab all the time.. not just when I'm here'.*

*INT: And does everyone want to learn these skills?*

*'I think the nurses needed convincing that we weren't just adding to their work initially...well some did, but now we all have more of a 'rehab mentality' really.....it's not just about the therapists....and we all see the results.... And often I think people see that doing it like this, properly in neurophysiology terms if you like, well it just makes the work easier'. (Fieldnotes, Holton, May 2002).*

Again this spontaneous conversation provided data which could be compared with team members' reports on learning new skills in interviews or actively followed up, for example I was interested to discover if having a '*rehab mentality*' was a concept shared by the whole team at Holton or just the PTs and whether the same concept was identified by team members at Colebrook.

With SALTs, social workers and dieticians I did not have the skills to directly participate and so sat nearby when they worked with patients and families. This was also the case with cognitive assessments conducted by OTs, the medical ward round and the MDT meetings. In these situations I observed, asked questions and offered my perspective when requested to. This was sometimes challenging in that it was not uncommon for team members at both units to ask for my opinion about the degree of cognitive impairment of a patient or how well a patient had performed in therapy. I regarded this as a measure of my acceptance by team members who were acknowledging my clinical background and growth in understanding of the sequelae of stroke and principles of rehabilitation. Where I had participated with a particular patient and could comment objectively it felt right to do so. On other occasions I did not have the knowledge to comment or express a judgement and this was accepted by team members. I came to regard such participation as a reciprocal exchange for team members' time and effort in responding to my research questions. This helped to position me as an interested researcher with sufficient insider (clinical) knowledge to be useful to the teams from time to time. This often led to further informal questioning and reflection by different team members which contributed to my understanding of team processes and provided valuable data for comparative analysis. After a particularly busy morning at Colebrook the PT I had been working alongside invited me to join her at lunch, after some general exchanges she said:

*'How 's it going then...you know are you getting what you want?'*

*INT: Yes, I am... people have been pretty tolerant of my getting in their way but I still have plenty of questions about the way things have developed here....*

'Such as?'

*INT: Well, I was thinking just now that I don't see much tension or conflict here,.... like this morning for example when Maureen wasn't ready for therapy and her walking stick was not right, things weren't going to timetable at all, but you took that pretty well....*

*'Yes.... Well it wasn't always like that, at one time I might have flown off the handle [laughs] but there was a good reason behind why she wasn't ready. Nowadays I am more prepared to check things and talk through things because I know the nurses better and how they work, I don't always know what they are thinking but I understand 'how' they think a lot more- so this morning they were worried about Maureen's pulse being irregular, so the wrong stick and my therapy slot was not the most important issue, we trust each others' judgement more I suppose.....and that's maybe why we, or at least I... don't get so tense'. (Fieldnotes, Colebrook, June, 2002)*

Participating in this way led to many such conversations and provided me with detailed personal insights from team members. However, the disadvantage of this kind of participant observation lies in the fact that it is not always possible to record such conversations, perceptions and insights contemporaneously. It is also easy to become so invested in the activity being undertaken that observing as well as participating is temporarily forgotten. To overcome the problem of not always being able to write fieldnotes during and after every interaction I developed a system of writing key words and prompts, so for example immediately following the interaction with the PT above I wrote:

*Pt not ready, wrong type of stick-PT irritated expression —————→ talks with SN  
Conflict avoided- explained how, time, thinking, trust in judgement?*

Later, after the session, I sat in the car before leaving the hospital and wrote up the fieldnote, expanding on the key words, describing the situation more fully and making a record of the content of the conversation over lunch as closely as I was able. In this way I essentially 'replayed' and then reflected on interactions observed whilst participating in care. When the data was entered into NVivo it could be linked to similar comments expressed in interviews where team members talked about 'understanding each others' roles' and the relationship of the passage of time to current team practice. This facilitated comparing and asking questions of the data from a theoretical perspective.

Savage (2000) argued that participant observation cannot be separated from the theoretical or epistemological suppositions of the researcher; in this sense participant observation is theoretically informed by the orientation of the researcher towards an interest in developing understanding and explanation of the culture or social processes in particular settings. This is consistent with Delamont's (2004: 224) notion of foreshadowed problems, what she terms '*ideas that will guide the access negotiations, initial fieldwork and the early writing of the fieldwork diary*'. Whilst Delamont was writing about ethnography and Savage about participant observation generally, their concern with the theoretically informed nature of participant observation is consistent with the Glaser & Strauss's (1967) concern with 'theoretical sensitivity'. This does not mean that researchers are committed to one or more theoretical explanations, but rather that they do not operate in a theoretical vacuum and come to the generation and analysis of data with some prior knowledge the ways in which the data might be interpreted.

The theoretical orientation of the researcher is important in that this can be considered as one lens through which the researcher views the observations (Davis, 1986). I was cognisant of sociological concerns such as the influence of power, role and status, and organisation of work. I also considered observations in the context of social psychological perspectives concerned with interaction, expectations, perceptions and perspectives of team members. These sociological and social psychological elements were potentially interlinked, one impacting on the other. This theoretical focus did not preempt what or how behaviours or processes would be interpreted but rather guided or directed attention towards these areas, and I tried to remain open to other influences and explanations as they were suggested by the data. This was borne out by the actual fieldwork where the informal reflection and questioning of team members provided concrete examples of team processes, for example the PT's handling of potential conflict, which I was able to compare with established theoretical positions.



I was aware that my interpretation of what I was observing and hearing may be also influenced by my prior knowledge, understandings and identity as a nurse with experience of working in teams. We cannot extract ourselves completely from our personal and professional biographies and must recognise how particular ways of seeing and thinking can influence data generation and analysis (Hammersley & Atkinson, 1995; Savage, 2000; Finlay & Gough, 2003). I was helped in this by a number of things, firstly, at the time of the study I had not practiced regularly as a nurse for over ten years and secondly, I had no clinical or educational experience in rehabilitation settings. My work in higher education was with a range of health professions, and in the five years prior to the study I had encountered quite different ways of conceptualising professional practice. The working practices and team processes in the stroke units were quite literally unfamiliar and different to me. As a result, I feel I was less likely to make assumptions about the activities observed or to overlook features which a practicing nurse might have taken for granted (Hammersley & Atkinson, 1995; Gerrish, 1997). My prior clinical skills and interpersonal skills helped me participate competently and to become accepted by and involved in the stroke unit teams, but my involvement remained partial. Gerrish (1997) described her occupation of the dual role of nurse and researcher as being a '*marginal native*', having sometimes privileged access to participants and their perspectives, but at the same time conscious of the need to avoid over-rapport and with it a consequent lack of objectivity or ability to stand back from the emotional and intellectual involvement with participants. This concept of marginal native aptly describes the way my participant observation role developed in this study.

The preceding discussion has highlighted how participant observation led to direct and relatively close involvement with many team members; however it is important to acknowledge that my interaction with senior doctors, and social workers, SALTs and dieticians differed from that with nurses, PTs, OTs, HCAs and RAs. This was largely due to the less frequent presence of these team members at both units. My interaction with these team members relied more heavily on informal

interviewing at the central work-stations and observing their interactions with other team members and in MDT meetings. I made sure that these team members consented to my recording fieldnotes relating to these episodes. As opportunities for observations were more limited I tried to ensure that interviews were conducted with these individuals to develop understanding of their experiences of teamwork on the stroke units. Informal interviewing provided valuable data but this was extended and developed by the conduct of semi-structured interviews punctuated by periods of intensive data analysis.

#### Interviewing team members:

Rapley (2004: 19) was dismissive of developing core skills in interviewing but he conceded that there are '*multiple possible influences on the interaction and trajectory of the talk*'. He argued that interviewing need not '*involve extraordinary skills*' but was about finding ways to interact with the interviewee and trying to understand their experiences, opinions and ideas. I sought to develop a form of interviewing which Rapley (2004) termed engaged, active or collaborative; an approach based on a two way exchange as opposed to a question and answer session. This required strategies to move interviewees away from the relatively safe ground of recounting facts about teams, towards reflecting on their experiences of working in these teams, and being prepared to engage in discussion with me about their perceptions of how teamwork was developed and sustained, what made it work or not and how it could be explained.

Rapley (2004: 25) also identified what he termed '*the phenomenally mundane interactional methods cooperative interviewing involves*'. The use of the term mundane, struck me as unusual in this context as it implied that cooperative interviewing was dull as well as routine. Rapley (2004) rejected formulaic approaches and played down the special skills required for interviewing in favour of a more practical view of interviews as a distinct form of social interaction in which interviewer and interviewee collaborate to co-construct or reconstruct a version of a particular

social reality. In contrast, other authors argue that qualitative interviewing requires specific skills, careful organisation and planning and a willingness to learn from the experiences gained by conducting interviews (Spradley, 1979; Grbich, 1999; Silverman, 2000). I spent considerable time developing possible question topics, thinking through prompts and strategies to put the interviewee at ease, to gain their trust and confidence and to help them explore their, experiences, perceptions and interpretations. I also used skills of active listening, including paraphrasing, summarising, clarifying and reflecting back to elicit specific information or details of particular events, and to ensure that I understood the meaning of words, expressions or perceptions.

Although I had developed a series of question outlines (Appendix 8) using these as the basis for actual questions in the initial interviews felt quite artificial. In addition, feeling as though I ought to go through these in some sort of logical order meant part of me was not concentrating sufficiently on interviewee responses. An example of the need for revision of the interview questions illustrates the way in which the experience of conducting initial interviews alongside participant observation led to a better understanding of the context in which the team members worked and the way in which they described and understood their work. Initial interview questions included asking participants to define the type of team they were working in. This question was designed to compare participants views with published definitions of multidisciplinary, interdisciplinary and transdisciplinary teams (Garner & Orelove, 1994; Kumar, 2000) and to prompt discussion related to the degree of collaboration occurring in the teams. It quickly became apparent that these definitions had little meaning for most early interviewees, and as a result the question did not readily open up the line of discussion intended. For example in an interview with a social worker I asked:

*INT: I mean in your experience would you say there is any difference between the two.... would you define multidisciplinary and interdisciplinary differently?*

*SW: 'I don't know... I am not sure that I understand.'* (SW, Holton, Interview 1)

And in an interview with another social worker at Holton

*INT: I don't know whether you have come across it but some people say that there is quite a difference between a multidisciplinary team and interdisciplinary team, is that something that you've thought much about?*

*SW: 'What is an interdisciplinary team?' (SW, Holton, Interview 2)*

In my analysis of the transcript I noted:

*This is beginning to be a recurring issue [lack of familiarity with different definitions of teams]; It speaks to me of a difference between policy maker's rhetoric and the reality of work on the ground, or is it that it happens but people don't call it that? (Interview transcript 2, SW, Holton)*

Reflecting on the limited value of these questions and on early participant observations I realised that interview questions needed to focus more on the processes involved in teamwork in the stroke units concerned and less on the exploration of theoretically derived concepts. In subsequent interviews I used language which I felt had more meaning for participants, instead of talking about differences between multidisciplinary and interdisciplinary working I used the terms 'working together' or 'joint working' as these were commonly heard on the stroke units. The semi-structured approach to interviews was not abandoned because it helped provide a structure and sequence which I think helped the interviewees to regard the time spent on the interview as legitimate. Instead topics were used more flexibly depending on the issues raised by the interviewee and the overall progress of the interview. It was necessary to be able to think on my feet and adapt both the order and type of questions depending on the responses of the interviewees; my previous experience of conducting this type of interview in another study was instrumental in this process.

The relative power and status of interviewer and interviewee can affect the nature and progress of interviews (Rubin & Rubin, 1995; May, 1997). My status as a university lecturer and researcher had some impact on interactions with team members in interviews. This was evidenced in the more formal nature of the audio-taped interviews when compared to participant observations. In interviews, high status members including ward managers and consultant physicians were relatively

passive, ceding control and direction of the interview to me. Collins (1998) argues that both interviewer and interviewee come to the encounter with some knowledge of the rules for this kind of interaction, expecting the interviewer to take a lead and direct the focus. In contrast in participant observation situations, team members, by virtue of their specialist skills and knowledge took control and directed me. In an analytical memo written after conducting the first eight interviews, I noted that despite the time spent in participating in the work of the unit I was still a relative outsider to the teams, at best regarded as a regular and familiar 'visitor' to the units but still a '*marginal native*' (Gerrish, 1997). Whilst participant observation emphasised shared experience with participants, interviews essentially re-established some distance between us and more clearly defined my role as researcher.

However, where I had worked with an interviewee on a regular basis the relationships developed in participant observations did help reduce the formality of interviews. For other team members, interviews sometimes appeared to be a more daunting prospect, at least at the outset of the interview. I was usually able to recognise through a combination of non verbal and verbal elements of the interaction whether the interviewee was anxious or concerned about the process. I had some experience in conducting semi-structured interviews, but remained conscious of how difficult it can be to develop a degree of comfort and trust in this relatively short interactional encounter. I used a general opening question to try and put the interviewee at ease by discussing something concrete and none threatening (Rubin & Rubin, 1995). This was normally '*Can you tell me about how you came to be working on the stroke unit*'. Being sensitive to interviewees' responses provided cues and opportunities to ask more focused questions relating to how they perceived and experienced being part of the team. Rubin & Rubin (1995) discuss the balance that has to be struck between enabling the interviewee to tell his or her story and keeping the interview sufficiently focused so that what the interviewee talks about can enable the researcher to develop an understanding of the

context and meaning the interviewee attaches to events, situations or actions. I tried to do this without exerting tight control over what was discussed.

It is not possible to ensure that interviewees do not present a particular persona in interviews or to ensure that they do not present opinions and perspectives which they think the researcher will find acceptable, what Delamont (2004) terms 'impression management' and Collins (1998) the 'official account'. I endeavoured to overcome this by being open and honest about my interest in teamwork and my observations and the interpretations I placed on these. How far this encouraged open and honest presentation of interviewees' opinions and perspectives cannot really be known but the strategy did identify common ground and shared experiences between team members and myself, which normally facilitated further discussion and clarification. Later analysis of data suggested a high degree of congruence between perceptions expressed by team members in interviews and the data generated through participant observations.

Collins (1998) and Rapley (2004) point out that researchers cannot be neutral or dispassionately objective in interviews. At the very least interviewers bring with them a set of cultural values and beliefs, their ontological and epistemological positions; this may be in addition to professional experience in the area being researched. These may impact not only on what is heard in an interview, but can influence questions chosen and issues pursued. Importantly, beliefs, values and experiences will also potentially colour the ways in which researcher interpret and analyse the data generated. It is open to debate whether these cultural values and beliefs can be 'bracketed out', but I understood that it was essential to be consciously and reflexively aware of the ways in which these issues may impact on the way I 'saw and heard' the data. I utilised memos and fieldnotes to acknowledge and examine the influence of such factors on my interpretation and analysis of the data.

Two examples illustrate how my attitudes, values and beliefs influenced the conduct and content of early interviews with stroke unit team members. I am aware that in interactions with others I can give the impression of being confident and at ease in discussion. In my work as an educator, discussion and debate are frequent and I have developed a questioning and inquisitive style, I use this strategy when I know little about a topic as well as in situations where I am eager to debate issues in which I have an interest. Although I had a number of anxieties about participant observation and interviewing, I am aware that I kept these largely hidden from team members, choosing to explore them with my supervisors, and in reflections on fieldnotes. The effect of my confidence in interactions was brought home to me when I tried to work out why some team members at Colebrook seemed more reticent in individual discussion of their work and experiences than they did in my general conversation with patients and team members. I tentatively raised the issue with the ward manager in a conversation at the end of a shift:

*'I don't know about you but I think it's been a tough day today..... tough but typical though. Lisa and Ruth (HCA and PT assistant) were quite impressed with you helping to get Toby in that new chair so he could sit out for dinner'*

*INT: Yes, I'm really tired, but it's been an interesting day. I didn't think it would be possible to get him positioned in that chair.....*

*'You should put that your notebook, I mean how those two work together'*

*INT: I will, but I do find it hard to get them to talk about how much the PT's trust them with complex cases like Toby....*

*'I think that's because they're a bit intimidated by all your questions, you should relax a bit, talk to them about their holidays or their kids, let them see that you are not all about asking questions and writing in that notebook! (Fieldnotes, Colebrook, May 2002)*

This was important feedback on how some staff interpreted my questions aimed at discovering more about their work and their motivation. It reminded me that what I perceived as eagerness to learn and interest in working relationships could be regarded as intrusive and give the impression that team members' experiences and perceptions would only interest me, if they were out of the ordinary or unusual, whereas in fact I sought that which was routine, normal and ordinary. The

ward manager's informal but honest appraisal was uncomfortable, but I used it as a prompt to be more sociable and to think more about when and how to introduce questions in both observation and in interviews.

The second issue relates to recognition of how my previous experience of team working and exposure to theoretical perspectives derived from the literature were influencing some of my questioning and interpretation of answers in early interviews. I transcribed the first 15 interviews; this was a valuable exercise in engaging with and understanding the data. What I had not anticipated was how this process would highlight the unconscious, but recognisable assumptions implicit in some of my interview questions. When reviewing the first five or six transcripts I realised that in some interviews I seemed to be looking for examples of conflict and disharmony within the teams. So when interviewees focused on positive experiences of teamwork and highlighted few examples of conflict, I introduced these topics, sometimes citing the literature to support of my asking the question. Reviewing my approach, I reasoned that these were not inappropriate questions, but on reflection I was somewhat surprised at my apparent assumption that conflict may be inevitable, and that interviewees may not choose to recognise or discuss these aspects of team working unless prompted. The process of memo writing provided the opportunity to explore these influences on my thinking and questioning. I reasoned that I needed to be more balanced in my questioning, exploring team members' experiences in different settings and comparing these with the stroke unit teams. In subsequent interviews I focused not on searching for examples of conflict and disharmony but instead on how the teams had developed, how the working practices I was currently observing had evolved, and on the relationships between different professional groups over time. In this way, I felt I was more likely to elicit the views of team members, rather than have them respond to my implicit assumptions. Reviewing memos later as part of data analysis demonstrated that at both units observational data was consistent with interview data in that no real instances of conflict were noted. Reflecting on interviews did however



sensitise me to how instances of potential conflict were handled by team members such as the actions and explanation of the PT at Holton (page 122). This incident was matched by others at Colebrook where team members demonstrated considerable tolerance when for example; planned joint working sessions were cancelled or postponed. In these instances potential conflicts did not escalate, team members at both units claimed they could normally understand and judged there to be good reasons for disruptions; their willingness to give and take in this way was supported by their claims in interviews for the importance of established relationships with other team members and better understanding of their work. The key issue for me was understanding that data should have primacy and theoretical perspectives should be used in analysis as comparative data and not direct the generation of data.

#### Summary:

Reflexivity was an integral part of recording and analysing observational and interview data; I value the process of reflection and found that fieldwork experiences prompted almost continual monitoring of my thoughts and actions. More critical analysis occurred when working with fieldnotes and interview transcripts, but staying aware of everyday interactions also contributed much to my research practice in these settings. I do not think my background as a nurse restricted my ability to stand back conceptually from team processes in the stroke units. I was able to ask what was going on when team members spontaneously gathered with a patient, or why did things happen in certain ways. In contrast to Gerrish (1997) and Kennedy (1999) I had little professional experience of and no pre-existing explanations for these processes. Whilst my understanding of the team working and social science literature provided some anchors to explore the processes evident in the stroke units, this literature sometimes contrasted markedly and certainly did not fully account for what my data were showing. As a result, this prompted further focused observations and interview questions. Drawing on my observations and the perceptions and explanations of team members, I was able to ground my interpretations in the data, and conceptualise the achievement of

teamwork in a way which went beyond the individual and local interpretations of team members (Glaser, 1978; Strauss & Corbin, 1998).

Combining participant observation, interview and limited documentary analysis provided many opportunities to access the experiences, interpretations, actions and understanding of team members. During the first six months of the study, concepts or issues which arose in the interviews prompted observation of specific situations, actions or events and in turn, participant observations prompted questions to be explored in interviews. These different elements of data generation were part of a continuous circle with information flowing in both directions. In the latter part of the study after participant observation had ended, interviews provided the opportunity to clarify perspectives and check and revise developing explanations.

This chapter has explored my fieldwork experiences, in the following chapter the discussion will focus more specifically on my approach to analysing data using grounded theory methods.

## Chapter 6:

### Data analysis in practice

### Introduction

This chapter will focus on analysis of data generated through participant observation and semi-structured interviewing. The methods used will be considered in the context of Strauss & Corbin's (1998) grounded theory approach. The chapter will briefly outline the purpose of theory and explain how data generation and analysis interacted and led to the interpretive framework developed. Data extracts, memos and diagrams are used to explain how codes and categories were developed and revised through a process of constant comparison and the relationships between them explored and confirmed. The rigour of the analysis and the credibility of the interpretations are discussed.

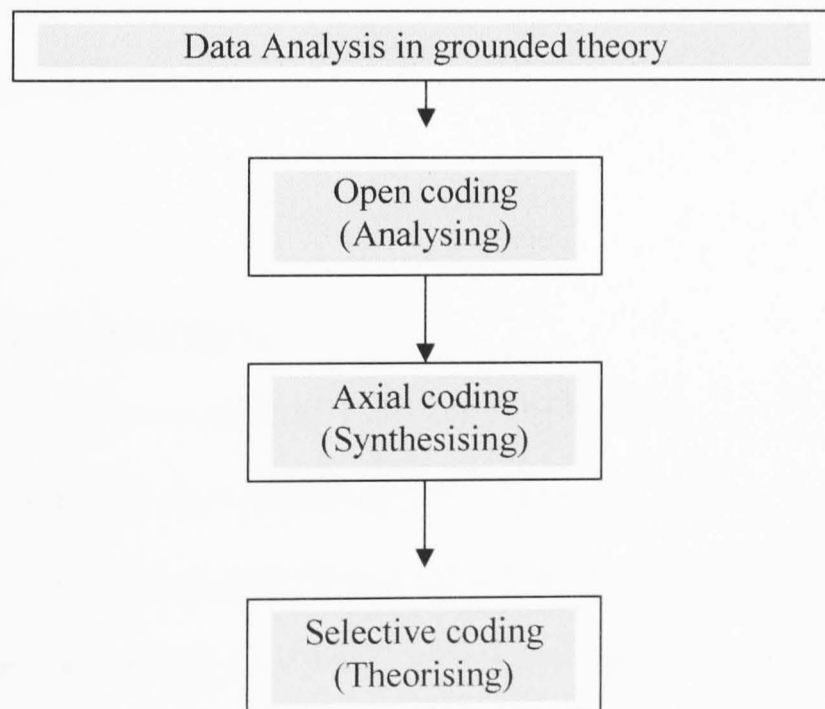
### The purpose of theory

Blaikie (2000: 143) argued that the purpose of theory was to provide '*explanations of some aspects of human experience that form non random patterns*', therefore social theories can be considered to be '*explanations of recurrent patterns or regularities in social life*'. Strauss & Corbin (1998) argue that the capacity to explain and predict is what differentiates theory from detailed description. Through systematic data analysis and development of clear statements of relationship between phenomena, grounded theories can contribute to knowledge and development of practice. The theory developed is usually termed substantive, that is, having specific and discernable relevance to the area from which data were generated. Developing credible grounded theory, which can be demonstrated to fit, work and have relevance to particular social phenomena, involves a series of interrelated processes including description, conceptual ordering and theorising (Strauss & Corbin, 1998). Grounded theorists draw on close engagement with social actors in particular social settings and develop relational statements to explain the phenomena under study.

### Data analysis-using a grounded theory approach

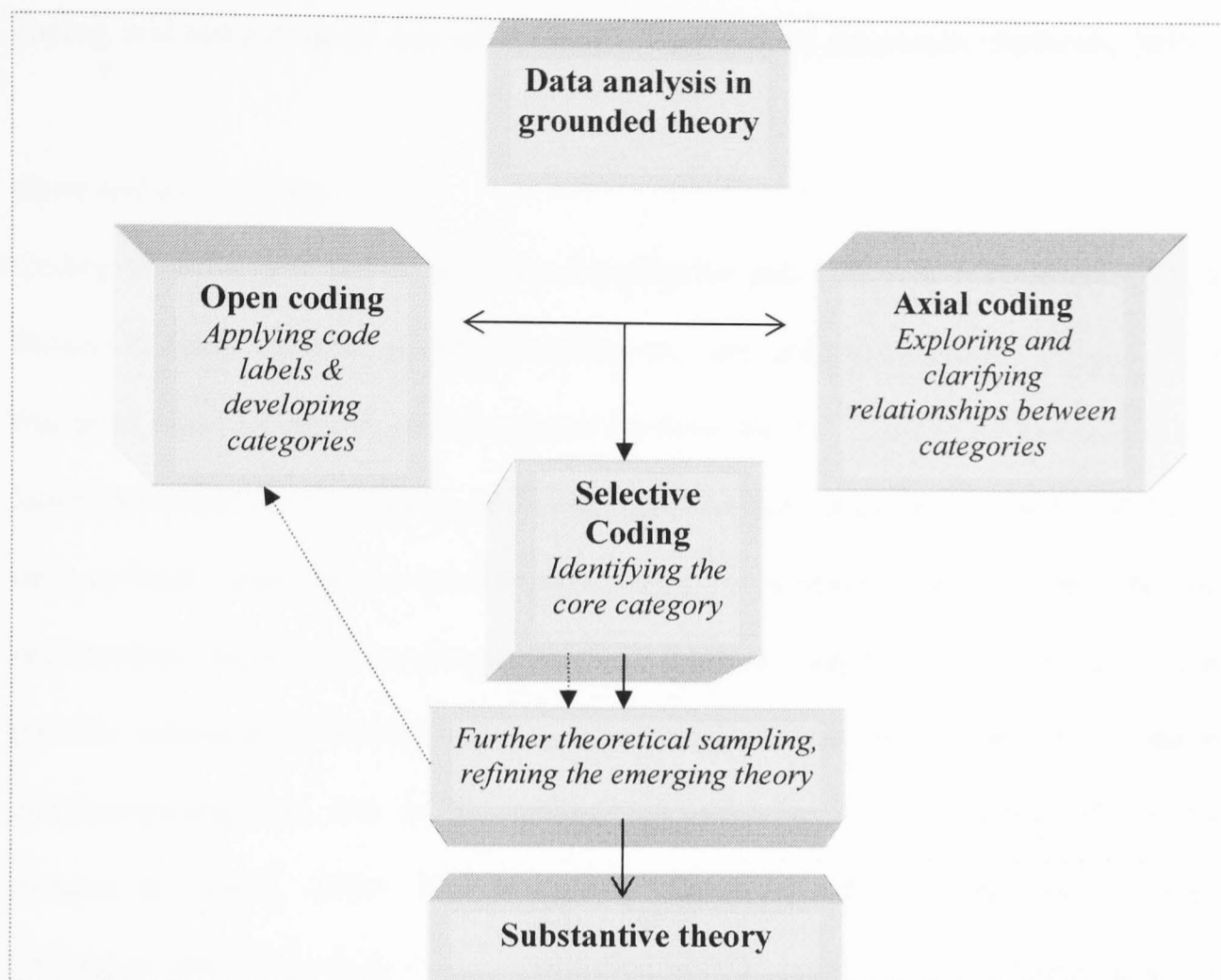
Grounded theory is commonly cited as an exemplar of an inductive research approach but in practice it involves a dialectical relationship between data generation, analysis and theory

development (Glaser, 1978, 1992; Mason, 2002). The methods outlined by Strauss & Corbin (1998) involve induction, deduction and abductive reasoning. The processes used to sort, organise and describe data, including coding and development of categories, are *inductive* strategies. Statements of the relationship between categories require *deductive* reasoning. These relational statements are verified through theoretical sampling and further analysis of existing data. The process of *abductive* reasoning accurately describes Glaser and Strauss's (1967) constant comparative method. In an abductive research strategy, data and theoretical ideas '*are played off against one another in a developmental and creative process*' (Blaikie, 2000: 181). Abductive reasoning is an iterative process, a frequent movement back and forth between data generation and analysis. The researcher becomes closely involved in a social setting for a time and then 'steps out' to reflect on and analyse the data before returning to the field to look for answers to theoretical questions posed in data analysis (Blaikie, 2000). This process may appear to be separate and sequential, moving from open (analysing) to axial (synthesising) coding and then finally selective (theoretical) coding. Figure 4: illustrates this:



However, a more accurate representation of the constant comparative method which illustrates the dialectical relationship between data generation, coding, analysis and theory development adopted

in my study is shown in Figure 5:



In the following discussion I show how coding and analysis proceeded concurrently, and how these interrelated stages encouraged progressive focusing and facilitated development of the substantive theory.

#### Coding and category development

Interview transcripts were transcribed verbatim and uploaded into NVivo. Fieldnotes were initially transcribed verbatim, but then annotated and linked to memos to ensure analytical insights were captured. These were entered into NVivo at the end of a period of observation, or at the end of three days of observations. In order to get a sense of the whole interview or observation period and ensure both content and context were recalled, fieldnotes and interview transcripts were carefully read and re-read prior to adding codes. The layout of project documents in NVivo (each line of text

is numbered and coding is separated from but clearly visible on the right of the text) facilitates coding, and comparison of data within and between project documents (Richards, 2005).

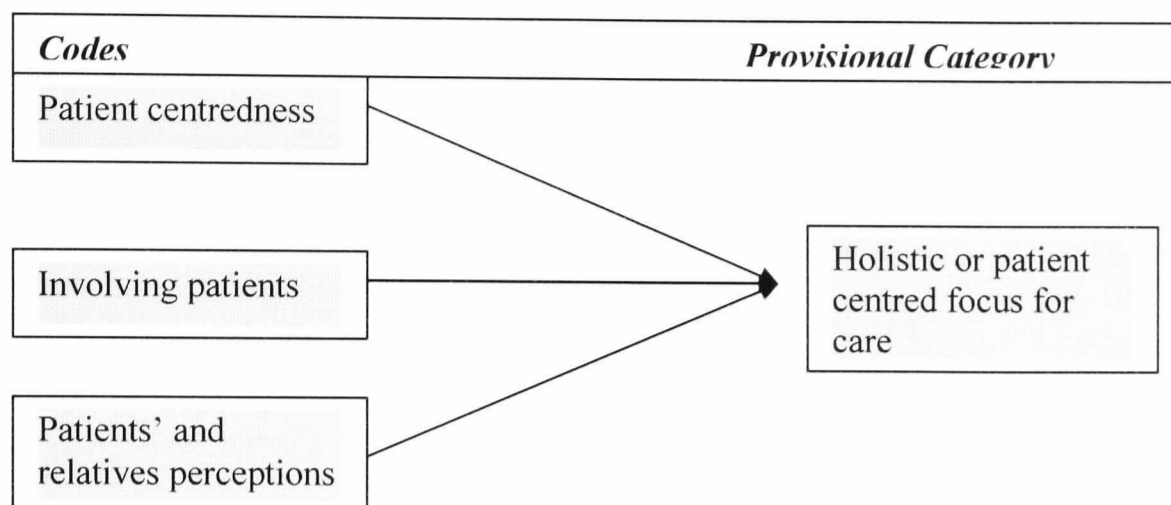
### *Open and axial coding*

Coding is an integral part of analysis of qualitative data (Miles & Huberman, 1994; Dey, 1999). Strauss & Corbin (1998: 3) defined coding as: '*the analytic processes through which data are fractured, conceptualised, and integrated to form theory*'. Codes are descriptive or conceptual labels developed from a reading of the data and represent phenomena. Open coding is the process used to break apart data to search for meaning, for significant concepts and also their possible relationships. Figure 5 demonstrates that axial coding begins as open coding is established and possible relationships between categories and subcategories are considered. To begin examining and interpreting data, line by line analysis of words, sentences or paragraphs is recommended (Strauss & Corbin, 1998). The interaction between coding and analysis is mediated by the researcher who brings both research and professional sensitivity to the interpretation of the data. This included my experiences as a nurse and educator, my understanding of professional and sociological literature and, as fieldwork progressed, my experiences of participation observation and interaction with social actors as they carried out their work and shared their interpretations. In the following section a number of data extracts together with my interpretation are used to illustrate development of initial codes and categories. The discussion then progresses to exploration of properties and dimensions of these codes and refinement of the categories. Strauss & Corbin (1998: 101) define categories as '*concepts which stand for phenomena*', and sub categories as '*concepts that pertain to a category, giving it further clarification and specification*'.

### *Examples of open coding and category development:*

What became the conceptual category of *concern for persons* in the substantive theory began with data being coded to the working codes: *patient centredness, involving patients, patient and*

*relatives' perceptions*. I considered these to be interrelated and initially located these in a provisional category labelled '*holistic or patient centred focus for care*'. Figure 6:



Codes and category were suggested by the data following review of fieldnotes and early interviews. The following example shows initial allocation of code labels. This is followed by discussion of analytic questions used. Subsequent examination of interview data for evidence of support and challenge to the interpretations is also considered. Table 4:

Fieldnote	Coding
NVivo revision 1.2.142 Licensee: David Clarke Project: Achieving teamwork3 User: Administrator Date: 18/03/2002 - 18:56:33  DOCUMENT TEXT REPORT Document: Fieldnotes18-03-02 and memo Colebrook Created: 18/03/2002 - 18:34:34 Modified: 18/03/2002 - 18:42:35 Description: (Fieldnotes: Colebrook-Ward Round 18.03.02) Document Text: 1: (Expanded Fieldnotes: Colebrook-Ward Round 18.03.02) 2: 3: Soon after the start of the round, reviewing male patient admitted 3 days previously from the acute unit, has marked right sided weakness, mild speech and swallowing impairment and pronounced visual impairment. The patient is sitting by his bed holding onto a newspaper. He is greeted by those on the round and after the SHO summarises his medical status, the staff nurse indicates his low Barthel score and then says: 4: 5: Staff nurse: Bob is frustrated at not being able to read....'Aren't you Bob?' [pause, then to consultant and SHO] his wife says reading is his big pleasure, she says he loves books about the navy.. ... 6:	Patients' and relatives perspectives Patient centredness



<p>7: Consultant physician [to the staff nurse and SHO]: Yes, I know he's got homonymous hemianopia,</p> <p>8:</p> <p>9: Approaches Bob indicating that he is Dr [name] and says, 'I gather you're a bit worried about your eyesight, tell me how you are,' kneeling at the side of the patient he puts his hand on the patient's shoulder and listens to Bob describe problems with walking and</p> <p>10:</p> <p>11: 'having such bad eyes' that he 'can't even read the paper', Bob asks 'can it [the stroke] affect my eyes as well then?.'</p> <p>12:</p> <p>13: Consultant: 'Yes this problem with your eyes is almost certainly down to the stroke, its as though only one side of each eye is working properly, so you only see half of what's going on around you [moves to the affected side] but we need to keep reminding you of things you don't see to keep you safe and involved in what is going on, so we'll encourage you to move and look this way, that's why your tray is here- does that make sense Bob? You'll have to be patient and work with us on this and we'll see what we can do about your reading.'</p> <p>15: <b>Linked Memo 12- 18.03.02 Colebrook (See Appendix 11)</b></p>	<p>Specialist knowledge of stroke</p> <p>Patient centredness</p> <p>Patients' and relatives perspectives</p> <p>Involving patients</p>
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Richards (2005) suggested no limits should be placed on coding at this stage, as familiarity with the data begins the process of comprehending meaning. If it seemed appropriate I attached more than one code to a section of text (see line 5 above). As a stimulus to line by line [open] coding I asked a series of simple questions including *what, when, where, why, with what consequences*, to focus on what these data might be indicating in terms of understanding stroke unit team working (Strauss, 1987; Strauss & Corbin, 1998).

Asking *what* is going on highlighted 'the round' as regular and routine activity, typically seeing 21 patients in two hours. Participating in these rounds, and observing interactions. prompted consideration of my previous experiences of doctor- patient interaction on rounds. These were often very formal with little contact or communication with patients, whose questions and concerns could go unanswered. In general, doctor-patient interactions are informed by patients' past experiences and expectations of this kind of interaction (Strong, 1979; Silverman, 1987). These may have been formal, one way interactions between the expert and the lay person. Because this and other interactions on the Colebrook round contrasted with others I had experienced, I considered it had

analytic relevance and made notes for later review. Drawing on my past experiences and the related literature informed my interpretation and represents an example of ‘theoretical sensitivity’ to possible meanings in the data (Strauss, 1987). An immediate confirmation of the difference between these and some other ward rounds came from informal discussion with a student who participated in the round:

*INT: Have you been on many rounds whilst you have been here?*

*Student Nurse: Oh yes, most weeks there has been enough staff to let me go for my side*

*INT: And is it useful, going on the round?*

*Student nurse: Well it was a bit scary to begin with really because they ask you questions.... you know about your patients, but I got over that and I do know about my patients so..... and I'm learning masses about stroke. On my last ward they didn't, I mean the senior staff that is [doctors and nurses] didn't seem to see patients as human beings, but they do here, they talk with them as people and about their worries not just tell what's wrong with them physically.... (Fieldnotes, Colebrook, March 2002)*

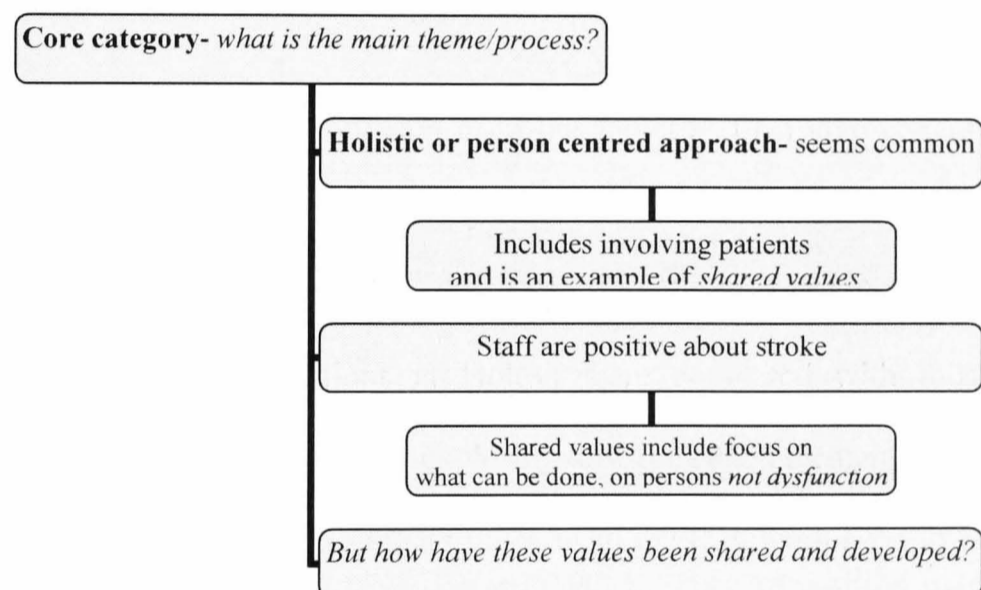
Treating patients as individuals is central to contemporary health policy (DoH, 1997; DoH 2002a; 2002b) and ideologically consistent with codes of health professional conduct. I was familiar with these policies and professional codes and identified that the label used to describe the initial category probably reflected my internalisation of this thinking and language. However, I was also aware that policy and professional expectations are not consistently met in healthcare practice (Commission for Health Improvement, 2004; Healthcare Commission, 2006). As data analysis progressed I used literature such as this to compare and review my data and explanations.

Returning to fieldnote analysis, asking *what was going on* in the interaction with Bob highlighted the nurse's comment on his frustration as significant. *Why* it was significant, was that it provided an example of the nurse's understanding of the patient's personal response to the visual impairment caused by his stroke. She emphasised this with her use of information provided by Bob's wife, on the meaning of this impairment for him. Bob himself then expressed his frustration, commenting that he '*can't even read the paper*'. He also indicated uncertainty about what was causing the visual

impairment. These elements made the personal consequences of Bob's visual impairment more immediate for team members on the round. I interpreted these interactions as suggesting a focus first on Bob as a person and then on stroke as a pathophysiological process. Also analytically relevant was *when* this was occurring, in this case early in Bob's experience of stroke illness; he was still trying to understand what had happened to him; team members appeared to grasp this, listening and responding to his specific concerns. *Where* the interaction occurs is significant in that the stroke unit was relatively new to Bob, he had come for 'rehabilitation' and his first encounter with the consultant provided some indication of what rehabilitation may mean for him. *How* the consultant responded to the nurse's information and the patient's comments, provided indicators for analysis of interactions between team members and with patients. The nurse's comment acted as a prompt, which was initially located within a medical explanation for the visual impairment, but was then explored in the context of the patient's own experience.

The interaction between consultant and patient opened with a specific question but was accompanied by verbal and non verbal attempts to put Bob at ease and communicate using language he understood. I considered this an instance of *patient centredness* because the consultant first listened to the patient's story, and then responded with simple explanations about the visual impairment. The immediate *consequences* of the interaction included recognition of the personal impact of visual impairment. The consultant indicated the purpose of some rehabilitation strategies (placing objects in the area of visual impairment) and made a clear request for Bob to '*work with the team*' in his rehabilitation. My interpretation of the interaction (and repeated exposure to others like it) was that it represented a deliberate attempt to limit formality, to focus on the patient by listening to and responding to his perspective, and to expressly indicate he was expected to become involved in his rehabilitation.

In this case the code labels adopted were not taken from the actual text (in vivo codes) but rather suggested by the interaction, and in time, confirmed by others similar to it. Constant comparison of data involved review of fieldnotes and interview transcripts for similar or different instances to these. In fieldwork and analysis, interactions at Holton were compared with those seen at Colebrook. This was important in recognising and exploring how the coded elements of interactions were related, firstly to each other and then to others inherent in the teamwork seen in one or both units; diagrams such as that below (Figure: 7) were used to examine links between codes and concepts.



Following analysis of interview data, *patient centredness* and *involving patients* were identified as examples of *shared values and goals* for team members in both units, which in turn, seemed to directly contribute to a *positive unit climate*. These were initially identified as subcategories of the category- *positive about stroke* and in turn were noted to impact on *patients' and relatives' perceptions*. These interrelationships are discussed in more detail in chapter 7, but even at an early stage in analysis, the challenge was to determine their significance.

*Comparing data generated by ward rounds and participant observation at Holton*

Observing ward rounds at Holton enabled direct comparison between the units. These demonstrated the same structure, timing and routine as at Colebrook and were attended by a staff nurse, SHO and consultant physician. The consultant was more formal in his communication style, referring to all patients by their surname and made little physical contact with them unless completing an examination. However, repeated observations suggested that he valued the person centred focus and attributed some of the improved outcomes for patients in the unit to the integrated and patient centred work of the team.

*INT: What's your view of the team contribution to improved outcome?*

*'Consultant: [...] That maybe there's something there about the actual experience of going to work in a unit like that... actually means people give more, they're more motivated. And maybe the fact that the patient experiences joined up care, there's integrity between what happens to them, whoever, whichever member of staff comes'.*

And later in the same response:

*'So I suppose I reflect on the positive influence on kind of mood and morale for the patients about having this unified, integrated approach from a kind of an end user point of view'.  
(Consultant physician, Holton, Interview 17)*

Additional data was consistent with the consultant's views and indicated why team members were motivated, gave more and integrated their approaches:

*INT: Tell me how you came to work on the unit*

*PT ' I think... stroke rehab I particularly enjoyed because of the variety and..... Very much hands on and very much you have to get to know and work with the whole patient, [...]...whereas a lot of other sort of specialisms in physio you...it's knees, backs, fractures that sort of thing, but you can't help but get involved with people with stroke so I think that's what I get most out of it really'. (PT, Holton, Interview 5)*

This focus on the person was also highlighted at Colebrook; a staff nurse on permanent night duty said:

*INT: You said it's hard work here but you wouldn't move, what did you mean?*

*SN: 'Well for one thing this unit cares for people not just 'strokes', we can really get to know them as people and you can't do rehab without that, without working with people.*

*even if they can't recover a lot in the end, knowing what matters to them is, well I think that's important'*

*INT: How do you know what matters to them?*

*SN: 'Well mostly it's because the pace is different to other wards, they are here for a long time normally so you really get to know them and what makes them tick, about their families and which granddaughter is which and all that.... even on nights we find out who these people are really and go from there'*

*INT: Go from there?*

*SN: 'I mean little things, ... like Emily is a very proud woman who wants to go back to her flat and cook her own meals and look after herself, but her daughters are afraid she will not be able to cope in the kitchen.... The day staff asked us to talk about an early home visit as a trial, you know to see what she needs to practice with the OTs, she talks to us a lot at night about what she wants to do'. (Fieldnotes: Colebrook June 2002)*

In a later interview an OT talked of the importance of seeing the patient as a person and the necessity of incorporating their perspectives ('*what they still want to achieve*') into rehabilitation plans:

*INT: Is it satisfying, as well as challenging?*

*OT: 'Oh definitely, yes... so.. a lot of them have had you know, they've had quite a substantial life .... So you do actually get to know the patients quite well within the rehab setting, you've got time to develop a relationship, a therapeutic relationship where you're meeting somebody and getting to know about their life really and what they've achieved and what they want still to achieve really (OT, Colebrook, Interview 8)*

At this stage in analysis, phrases such as '*with the whole patient*'; '*this unit cares for people not just strokes*'; '*we find out who these people are really*', were prominent and recurring in the data and were often related to instances of involving relatives. My interpretation was that these were instances of *patient centredness* and confirmed the appropriateness of coding and category labels.

At this stage, the working category of *holistic or patient centred focus for care* seemed an appropriate label under which to group related codes. Strauss & Corbin (1998) suggest that following initial category development, the analyst should explore its properties and dimensions. Properties are regarded as the specific characteristics of a category. for example a description of

what actions constitute *holistic or patient centred focus for care*. Dimensions further develop the category by identifying the ways in which general properties (e.g. *patient centredness*) may vary between individual team members or in different circumstances such as in decision making in MDT meetings or joint working with patients. Constant comparison was facilitated by using memos such as that at Appendix 11. I also developed and used diagrams (see Appendix 12) to move from code lists to test out code groupings, to identify gaps in the data and to consider further questions for follow up in subsequent observations and interviews. This first diagram was not meant to accurately summarise coding (as later diagrams did) but to make sense of the large amount of data, to display all of the recurring themes and explore where and how they might fit together or which elements could not be related or explained. This diagram contains many more of my thoughts than later diagrams (see Appendix 13 &14) which represent actual codes and evolving categories. Memos were prompted by fieldnotes and transcripts but also by developing diagrams. I used these as a means to think out loud, to capture thoughts and ideas but progressively I asked in memos, ‘what do these data mean’, what properties and dimensions are evident and do they explain the processes involved in teamwork, these questions were followed up through targeted fieldwork such as the following example.

#### *Exploring the subcategory- involving patients*

Fieldwork at Holton provided examples of *involving patients* as well as their relatives in rehabilitation. Table 5 below and linked memo (16) at Appendix 11 illustrate how inclusion and involvement of patients and their family members occurred even in complex cases where specialised techniques were necessary. In comparing these data with other observations and later interviews, it became clear that the category label *holistic or person centred focus for care* did not adequately capture the quality of interaction between team members. Examples began to emerge that *person centredness* was not only a value demonstrated in working with patients but one which team members felt was a necessary part of their relationships with each other and which contributed

to team working. Following this analytical work the category was renamed *concern for persons*; this category is discussed in detail in chapter 8. Table 5:

Fieldnote	Coding
<p>NVivo revision 1.2.142 Licensee: David Clarke  Project: Achieving teamwork User: Administrator Date:  02/04/2002 - 10:20:35 DOCUMENT TEXT REPORT  Document: Fieldnotes26-03-02  Created: 02/04/2002 - 10:19:46  Modified: 02/04/2002 - 10:19:48  Description:  Document Text:</p> <p>1: Participant observation with a staff nurse providing direct care (personal hygiene, dressing, positioning, and feeding) giving out medications and recording vital signs. Session included working jointly with a PT and RA assisting a 63 year old woman who had suffered a subarachnoid haemorrhage, to get used to sitting in an upright position again. A specialised tilting table had been arranged but was a new piece of equipment to most of the team. The patient's husband and daughter were visiting as the tilting table arrived. They immediately got up to leave whilst this activity was completed. The PT encouraged them to stay explaining that this would help them understand what rehabilitation was concentrating on for this lady, and the time it might take before she could sit out of bed unaided. The patient was asked for permission for me and two other nurses to observe and help the PT and RA working with the patient. The OT joined this small group for the last 15 minutes of the activity.</p> <p>2:  3: The interaction lasted approximately 40 minutes; the PT explained each stage from moving the patient onto the table to using the table to change her position. Explanation occurred on two levels, firstly control and maintenance of sitting balance and posture in lay terminology to the patient and relatives and secondly, using more detailed technical language, with nursing staff, RA and later OT.</p> <p>4:  5:  6:  7: During the interaction, the husband and daughter were encouraged to ask questions and directly involved in the activity, for example they were asked to position themselves so the patient could observe them as the angle of tilt was changed. They were encouraged to talk to the patient while she was held in the tilted position for 10-15 minutes, and lastly, they were involved in helping to physically reposition the patient once she had been transferred back to her bed. Here, the senior staff nurse and RA talked about the importance of positioning joints and limbs to prevent muscle contracture and pressure sore formation, understanding was checked through questioning and comfort with providing physical care checked throughout.</p> <p>8:  <b>9: Key additional features and questions</b>  10: – Drawing additional team members in spontaneously, OT also 'interested' so observed and questioned PT. Need to link to other instances- this 'stopping and watching' has been mentioned at</p>	<p>Joint working</p> <p>Involving patients and relatives</p> <p>Blurring role boundaries</p> <p>Understanding the roles and perspectives of other team members</p> <p>Involving patients and relatives</p> <p>Patient and relatives' perceptions</p> <p>Joint working</p> <p>Understanding the roles and perspectives of other team members</p>



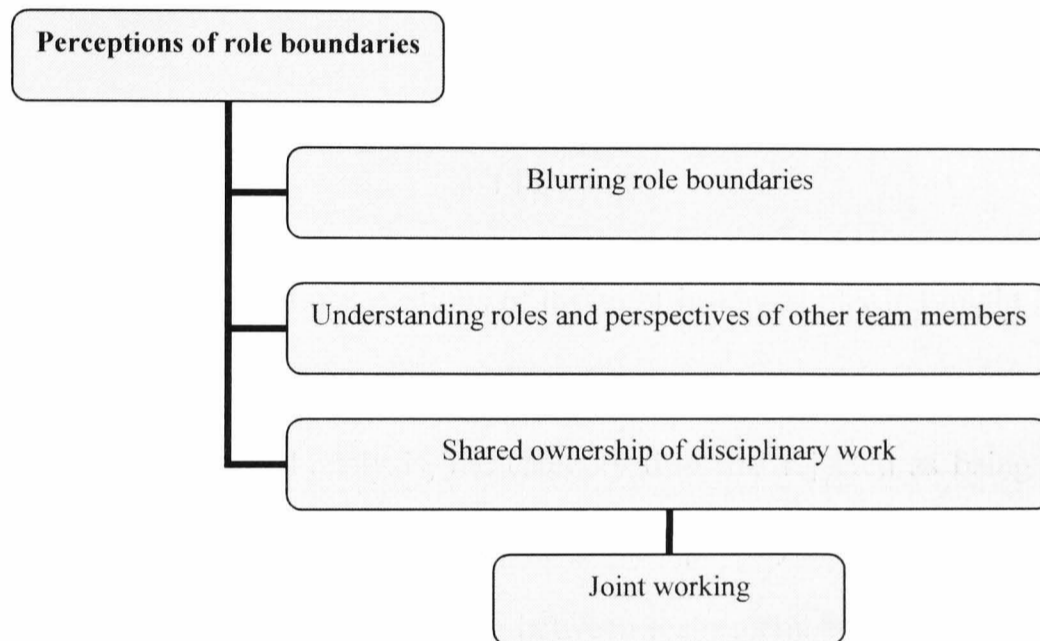
Colebrook too.	
11: –The PTs running commentary, telling, checking, requesting, thinking out loud, how does she explain this, what did the other team members get from this, how did the family feel?	
12: <b>Linked Memo 16 Fieldnotes: Holton 26-03.02 Appendix 11</b>	

Analysing cases where patients were involved in their rehabilitation by team members also pointed to the regularity with which *joint working* occurred and suggested this was closely related to developing *understanding of the roles and perspectives of other* team members. These data drew my attention to and led me to question the theoretical concept of boundary blurring in stroke unit teamwork.

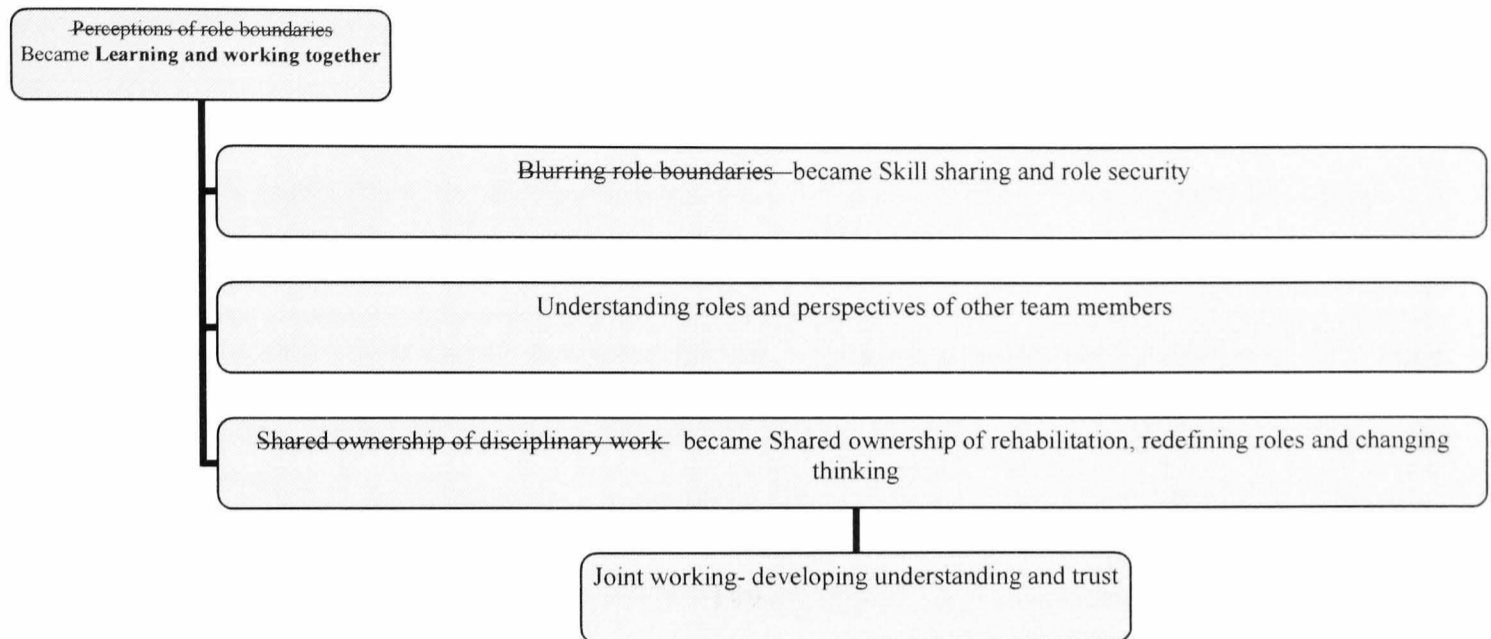
*Exploring properties and dimensions and revising category statements*

The data in Table 5 contributed directly to category development. Even at this early stage of participation observation I considered these interactions in *joint working* to be analytically significant because of their frequency and because they were specific examples of the ways in which team members carried out their work individually and collectively. In my initial analysis I used the term *blurring role boundaries* largely because the literature review identified this as important in movement from multidisciplinary to interdisciplinary teamwork (Garner & Orelove, 1994) but also because it represented instances where one professional (PT) was actively sharing skills with others and thus *blurring the boundary* between her role and that of nurses, the RA and OT. I included this code alongside those of *joint working*, *understanding the roles and perspectives of others* and *shared ownership of disciplinary work* under the category of *perceptions of role boundaries*. Appendix 12 illustrates an attempt to group codes and categories to get some sense of the data and emerging explanation. This kind of diagramming enabled exploration of the data by testing groupings and examining the fit of these grouping when compared with completed observations and interviews. This analysis suggested the need for theoretical sampling to generate more specific data in order to understand the properties and dimensions of the phenomenon *joint*

*working* at Holton. I used targeted observations of different instances of what might be considered *joint working* and developed interview questions focused on team members' perceptions of working together. Following more detailed analysis, the category title was rejected as being too narrowly focused on *perceptions of role boundaries* and lacking the capability to encompass the wider range of interactions than boundary blurring occurring between team members and the consequences of these interactions for teamwork. Figure 8:



This category was revised following further theoretical sampling and became: Figure 9:



To develop the interpretation of these data I pursued four main avenues of analysis. These were asking the Strauss & Corbin (1998) what, where, why, how and with what consequences questions; and asking in formal and informal interviews what significance did team members attach to this kind of (seemingly routine) interaction? I also compared my data with the literature reviewed, particularly in respect of temporal-spatial features impacting on stroke unit teamwork and the perceptions of professional boundaries, and also my own prior experiences in acute care settings.

Data analysis and reflection on participant observations suggested that *joint working* encompassed much more than boundary blurring and was an activity which could be traced back to the early stages of both teams' development. The rich and complex nature of the interactions observed were compared with interview comments such as

*PT: 'I'm wondering if you've actually seen much of this but we used to... I mean we still do it ... we used to say well she's transferring differently now and we'd gather all the nurses together that were on that day and show the nurses, well look we want you to change to this now, she's ready to do this'. (PT, Colebrook, Interview 4)*

An OT at Holton illustrated some of the consequences of joint working

*OT: 'We sometimes work with the nursing staff as well or with the auxiliaries, asking them to come in on sessions where we're doing feeding on a lunchtime trying to continue that, so that's sort of helped to sort of build up relationships within the team and for them to understand why we're doing things in a particular way'.*

She continues making reference to developing understanding of roles and breaking down barriers

*'I think sometimes we do get comments, I think it's half jokingly that we spend like an hour and half getting a patient ready [laughs] whereas they do it in ten minutes and what have we been doing all that time? But I think, sometimes, because they do come in and sometimes help us with moving and handling that they do get to see and understand why we do take that long and I think if they can understand that it helps them. [...] I think otherwise, they could feel that they're being left with a lot of the work and there could be some resentment, but I think because the team understands each other's roles that that helps to get rid of barriers'.* (OT, Holton, Interview 6)

*Joint working* of the kinds identified in Table 5 (page 146) and described above was observed occurring most days at both units, commonly in general ward areas but sometimes in the gym or dining room. Sometimes it was requested at MDT meetings and then timetabled for an agreed day. This was more common at Colebrook where the ward manager actively encouraged this approach and was supported by the senior PT and OT in regularly timetabling *joint working*. At Holton *joint working* was also frequent but occurred on a more informal basis. The PT and OTs frequently timetabled joint sessions and would then ask nurses to join them to discuss specific issues, point out new approaches or renegotiate patient goals. One interpretation of the interview extracts above could be that these are examples of therapists teaching or directing the work of nurses and maintaining the historical hierarchical division between these disciplines (Pietroni, 1994; Gibbon, 1999). I rejected this interpretation on the basis that my observations indicated that any team member could request joint working, and nurses in particular spoke about the way in which this had improved understanding of work roles and skills required. For example:

*Ward Sister: 'I think that one of the main things about team working is that we communicate with each other and we 'work with' each other not against each other so for example we do joint sessions with physio's ... so physio's can see problems that we as nurses might have'.*

She indicated a specific instance of *joint working*:

*'When they are asking us to get Joe up for nine o'clock...if we do a session with them at that time and they can understand you know that there's problems that we face at that time in a morning'.*

She also identified how *joint working* could help reduce potential conflict

*'I mean telling each other what problems we are having before they escalate and get where it becomes a bigger issue [.....] I think that's where we work quite well in that we do endeavour to do joint sessions, work with each other'.* (Ward sister, Interview 1, Colebrook)

Exploring these properties and dimensions of *joint working* helped to confirm its analytical importance. It was most often associated with patients with severe or complex disabilities and in these cases, occurred spontaneously as problems arose with rehabilitation. After reviewing fieldnotes it was clear that much of the data referred to *joint working*, in ward areas between PTs, OTs, RAs and nurses. SALTs and dieticians were involved but less frequently; also this kind of 'physical problem' orientated *joint working* did not often include social workers or physicians. As a result I examined whether this was about opportunity, exclusion, or different ways of working. In fact there were other examples of *joint working* which I did not initially pick up on as readily, this was mainly due to my approach to participant observation which normally involved working alongside specific members of staff. Theoretical sampling around the sub category of *joint working* meant observing and asking what was going on as other team members worked together. This identified and confirmed different instances which were termed *joint working*. As social workers, SALTs and physicians were on the unit less often, it was necessary to draw on observations at the central work-station and on interview data. I identified that central to the interactions when team members worked jointly was open, frank and patient focused discussion of clinical or social problems. Properties of this discussion in *joint working* included team members sharing information, questioning the reasoning for planned therapy, requesting or negotiating for help or advice from other team members or identifying a problem and seeking to negotiate for a change in planned rehabilitation.

Targeted observation and informal interviewing demonstrated that this kind of interaction was also occurring between physicians, OTs and social workers as discharge plans were finalised, and between SALTs, dieticians and nurses when swallowing deficits persisted, and patients and their families were being helped to understand and manage problems with eating and drinking. What differed was the frequency of occurrence and access to this, but no team member or group were excluded. Rather, because they spent less time on the unit and because their interaction with patients was more commonly on a one to one basis, some team members had to work harder to access *joint working*. I questioned why they *made the extra effort* to do so, and what the consequences were, this began to highlight why blurring professional boundaries and sharing skills did not seem to concern these stroke unit teams in the same ways as had been highlighted in the literature (Beattie, 1995; Adams; 1999, 2004; Timmons & Tanner, 2004).

#### Using the literature in analysis

Part of data analysis in grounded theory development involves comparing explanations suggested by the data with existing literature and theories. In my analysis I was increasingly struck by similarities, but more often by differences between team members' interactions in the stroke units and those described in other studies. For example, re-examining the studies of Mackay (1993), Walby & Greenwell et al (1994), and Allen (1997) focused attention on the significance of temporal-spatial issues in my study. My analysis centred on the extended time that patients spend in rehabilitation units, the stability of stroke unit team membership over time and the degree of regular and close contact between team members. These differences were partly able to account for the nature and content of the regular interaction and dialogue observed between team members in both units. In addition, and in contrast to the findings of some studies there was little separation between high status and low status team members in terms of deciding what work was needed and who would actually carry it out (Cott, 1997, 1998). I noted a high degree of professional and social proximity for all team members. However, like Cott (1998), I noted that this proximity contributed

to positive perceptions of team working and willingness to engage in *joint working*, a finding also noted in other studies (McCallin, 1999; Miller et al, 1999). Comparing Miller et al's (1999) and Pound & Ebrahim's (2000) findings with my data also confirmed the significance of *co-location* of team members in terms of realising integrated teamwork. These studies highlighted for me that the location for delivery of (physical) therapy in the stroke units was significant. This often occurred in open ward areas and commonly in view of other team members, as opposed to taking place out of sight, separately in a therapy department. Analysing this alongside other features of interaction between team members, I interpreted the location and process of therapy work as significant contributory factors in the explanation of why these teams were working in interdisciplinary and integrated ways. The existing literature was also used to explore team members' day-to-day interactions and their perceptions of professional boundaries and prompted comparison with literature focused on work at professional boundaries or on boundary disputes (Abbott, 1988; Adams, 1999; Timmons & Tanner, 2004). In these ways the literature was used as an analytical device in data analysis and prompted the regular questioning of how my data and findings were similar to or differed from other studies.

However, as more than blurring of boundaries was occurring and as both interviews and observations indicated that team members did not mention concerns with professional boundaries, a different and more accurate category label was needed. Analysing the cluster of interactions occurring as team members in both units worked with each other and with patients prompted examination of the processes underpinning this work, I focussed on what linked and drove the interactions in each unit. The analysis returned time and time again to two recurring phenomena:

*Working* directly with other team members (*together*) is frequent and not related to grade, there is mutual dependency in completing patient work

- Analytically it is linked to-



*Learning* about stroke and each others' ways of working. This partly explains the absence of boundary disputes- the work is overlapping but not contested

This kind of writing represents the beginnings of a storyline memo (Strauss & Corbin, 1998), an analytical device aimed at examining major categories and developing statements which illustrate how these are related; that is writing an account of what is going on in the social setting, determining what are the key features and explaining how are they connected. Using a storyline memo (Appendix 16) helped me develop relational statements and identify the gaps in my explanation. In turn the storyline memo was a precursor to developing more a formal theoretical explanation; examples of relational statements between the major categories and the core category of the substantive theory are provided in chapters 7 & 8. The following section outlines the way I developed the working explanation of the relationship between the major categories.

#### Developing the core category

The analytical strategies outlined above led to refinement of category labels and reduction in the number of categories. The latter stages of the data analysis involved selective coding; this is designed to identify the core category, which is the central and unifying theme of the research. Strauss & Corbin (1998: 146) argue that:

*'The core category has analytic power. What gives it analytic power is its ability to pull the other categories together to form an explanatory whole'.*

Deciding on the core category required progression from a collection of relevant and related major categories to a clear, accurate and plausible conceptual representation of the process through which stroke unit teamwork was achieved and maintained. This was arrived at through writing and re-writing relational statements such as those that follow.

Firstly, and in contrast to other stroke unit studies, *working* directly alongside or with team members from other professions was a regular feature of everyday work at Colebrook and Holton. Secondly, a direct consequence of the regularity of *working together* was team members' *learning*, which encompassed initial and ongoing development of specialist knowledge and skills related to



stroke; but also and significantly, development of *understanding about the roles and the perspectives of other* team members. Conceptually, and in practice, the phenomena of *learning and working together* are linked. These statements represented what was going on in the units; their accuracy was confirmed through examining how team members made sense of this kind of interaction. For example:

*INT: If you were to think about what's different ...what changed when you moved from being a general elderly ward to becoming a stroke unit?*

*SN: 'I think this is input from the physio's because you're working more... you're definitely working closer with the other disciplines'.*

*INT: What effect has that had?*

*SN: 'Well the moving and handling... I can to some extent ... prescribe a movement or, the ways they want to handle and move patients in the way that physios would, obviously not as detailed and in such great depth as she is, I feel in that way I have learnt some of their role or taken on their role, probably learnt rather than taken on should I say'. (SN, Holton, Interview 4)*

A PT also indicated how working in the stroke unit helped her to see things from other than a unidisciplinary perspective:

*PT: Compared to other places that I've worked, the more acute settings [...], I found that it worked very well as a team [...], I think partly because it's sub acute, so you don't have the same problems with patients suddenly becoming ill or going off when obviously your priorities have to change, but as well because there are quite a lot of experienced staff there...who kind of help the less experienced staff if you like, to see things from a multi-disciplinary view rather from purely their own professional point of view.( PT, Colebrook, Interview 9,)*

Having identified these data as significant, the analytical focus turned to the nature of these interactions, tracing how they had developed over time and asking how things such as changes in team membership affected teamwork. Developing the analysis by writing in this way helped to focus on *process*, on what it was that could account for the way in which these important elements, outlined as categories, interacted but also how this *process* operated in the context of the larger organisations (hospitals and health service) in which the stroke units were located. The core category should enable understanding of the interplay between actions and conditions contributing

to team and team member development. In turn this should explain the basic social processes which meant that the work of the teams and the social order in the stroke units could be maintained in the face of change in personnel and in the flow of work.

Stepping back from the detail of data analysis can be difficult, but is necessary to gain conceptual clarity about the explanatory process emerging from the data (Hammersley & Atkinson, 1983; Richards, 2005). Two things were useful for me, revisiting feedback from study participants and re-examining reflective summaries made after research conference presentations, for example:

**Study participants said:**

*Yes we recognise those things; they all contribute in some way. But we are not sure how they fit together.*

**I asked in analysis**

What is the basic social process which relates these categories?

**Conference audiences said:**

*Each category seems important but the key is what holds them together, how are they related?*

These were powerful reminders that an important piece was missing from my explanation; I shared this view but for some time could not decide whether *learning and working together* was the integrating process or whether the main process was based on the nature and content of the talk taking place in the interactions included in this category. An additional analytical strategy was to review and summarise the memos developed over the course of the study. This confirmed the central importance of the regular, but largely unplanned *dialogue*, which took place as team members in both units worked with patients and each other, formally and informally. The *dialogue* process identified in the data was both simple and complex. It was simple in that an everyday and commonplace interaction was defined as central, but conceptualising the nature and content of that interactive process illustrated the complex relationship between the antecedents, conditions, context and flow of work within the stroke units. Development of two process diagrams (Appendix 13 & 14) was instrumental in conceptualising and then writing statements which explained the relationship between the major categories. Returning to the literature also occurred at this stage of the analysis. This was necessary both in terms of examining the substantive theory against existing

explanations for achievement of teamwork but also in establishing the relationship of the substantive theory to existing social theories. It was at this stage that the theory of negotiated order (Strauss, 1978; Strauss et al 1985) and Strauss's (1993) theory of action were subject to more detailed review in terms of my own theoretical explanation of the social order evident in the stroke units. The substantive theory of *opportunistic dialogue* and the importance of *negotiations* as part of that dialogue are discussed in chapter 8. The utility of the negotiated order perspective is considered in detail in chapter 9.

### Quality and credibility in data analysis

In presenting my approach to data analysis I have attempted to show how data were interpreted and how I used grounded theory methods to develop and question my analysis. This is a response to Bryman and Burgess's (1994) suggestion that qualitative researchers are reluctant to explicitly state the procedures they use to analyse data and arrive at their findings. Seale et al (2004: 407) also noted that *'the quality and credibility of qualitative research has often been questioned'* pointing out that these and other terms were the subject of much debate in the social sciences. Debates about the language relating to quality and credibility are important, but largely secondary to finding ways to ensure that qualitative researchers address questions of honesty, accuracy and trustworthiness of their research practice. The issues addressed in this chapter report on my research practice and represent a decision trail which can be reviewed in terms of accuracy and trustworthiness.

Reliability and validity are concepts closely associated with demonstrating the credibility and trustworthiness of claims made in research. Long & Johnson (2000) noted that there are different definitions of reliability, but that in general the term has been used to refer to the consistency with which research instruments or data collection methods can be relied upon to produce the same results when used in similar circumstances. In social research the researcher is often the main data generation instrument and methods are not standardised but recognised as appropriate means of

generating data in the interpretive tradition (Whittemore et al. 2001). Qualitative researchers shift the focus of concern from stability and consistency of measurement tools to establishing the consistency of the researcher's engagement with the data generated. In the current study, this concerns how I developed and analysed fieldnotes and how observational and interview data were coded and categorised. Hammersley (1992: 67) redefined reliability in the context of ethnography stating that:

*Reliability refers to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions.*

In my study, coding, categorising and data analysis were undertaken independently and then discussed with research supervisors. In this chapter I have tried to make clear my decisions to amend, reject or add to codes and categories in order that the data analysis and my subsequent theoretical claims can be judged by others (Richards, 1999)

Researchers in any tradition must concern themselves with demonstrating that explanations, claims and conclusions are valid in relation to the phenomena which are the subject of the research. Hammersley (1992: 69) suggested:

*'an account is valid or true if it represents accurately those features of the phenomena that it is intended to describe, explain or theorise'.*

Seale et al (2004: 407) used the term quality to refer to the transparency of the whole research process and credibility to refer to the validation of findings and results. Claims for the credibility of an explanation cannot be considered absolute and irrefutable because the same phenomena can be subject to differing interpretations and competing explanations can be developed (Silverman, 2000: Whittemore, et al 2001). However, I have tried to provide a 'transparent' account and argue for the suitability of the research methods used and to provide sufficient evidence so that readers can decide whether the account of the findings which follows, convincingly and accurately represents the phenomena studied (Mason, 2002).

One strategy used to examine the accuracy of explanations is respondent validation or member checking (Lincoln & Guba, 1985). Hammersley & Atkinson (1995) warned against placing too much faith in the results of respondent validation, arguing that respondents' views on the accuracy of the findings presented to them by the researcher cannot be taken as directly validating or refuting the researcher's claims. They accept that the views of respondents might be interesting and challenging in terms of their reasons for acceptance or rejection of the findings but they question whether individual respondents can have true insight into the experiences of other participants. Bryman (2001) also pointed out that researchers write for other scholars and peers, and as a result the language of concepts and theory goes beyond the perspectives of respondents, this makes it problematic for respondents to check and validate researcher's findings.

I felt strongly that it was important to recognise the contribution of team members and patients and to provide them with an opportunity to comment on as well as receive my findings. Team members were provided with an interim written report on the findings of phase one (page 104) of the research and invited to a presentation of the findings in their own unit at the end of the study, their comments were actively sought. Involving team members in this way was based on Glaser & Strauss's (1967) belief that research participants should be able to recognise when an explanation of a social process, was close to, or a reasonable fit with their own perceptions of what is going on. I considered it important to ask the team members how far my developing and then final explanation of the processes involved in achievement of teamwork were an accurate representation of their work as stroke unit teams. In particular, I was interested in their views of the category descriptions, their relationships and the claims made for the core category.

It would not be uncommon for participants not to challenge researcher's findings. Sandelowski (1993) suggested that researchers aim to represent overall processes and phenomena whereas participants focus on their own experiences and how they represented these to the researcher.

However, she also acknowledged that prolonged engagement in settings can help build relationships where participants feel more able to challenge and criticise but there may still be reluctance to do so. I consider Sandelowski's (1993) and Bryman's (2001) criticisms to be valid in terms of asking participants to comment on written reports which can be so short as to provide little more than common sense accounts, or so detailed theoretically to be of no perceived relevance. However, in verbally presenting the findings to participants at an agreed time when they had no other demands on their time did allow for frank discussion at both units and for participants to seek clarification of concepts such as *opportunistic dialogue* or *negotiations*, and for them to comment on my representation of the team cultures as inclusive. It also highlighted further areas for consideration such as the role of dialogue processes in team development as opposed to responding to patient needs. I acknowledge that this process of respondent validation cannot be said to directly establish the truth and absolute accuracy claimed for the findings of my study but team members at both units confirmed the overall accuracy of the findings and the explanation of how they achieved and maintained teamwork.

### Summary

This chapter has presented and discussed my research practice in terms of my engagement with the data, and my use of grounded theory methods in data analysis and development of the substantive theory. In order to demonstrate the quality and credibility of the study findings, I have attempted to show how data were organised and interpreted and how codes and categories were revised as links between data were explored and further data generated for comparison and confirmation of categories. Data extracts from fieldnotes and interviews were presented with related analytical memos and diagrams in order to show how I thought about and worked with data and in turn developed an explanation of the achievement of teamwork. Grounded theory methods demand repeated and rigorous questioning and examination of the data. The use of memos and diagrams provided a means to move from detailed description of data to a conceptual understanding of the

meaning of the data. For me, these methods were instrumental in being able to stand back from the data and recognise the basic social process which I consider was central and which accurately represents the social order in the stroke units studied.

In the next two chapters I discuss the research findings in detail, exploring each major category in turn and then examine the relationship of the major categories to the core category.

## Chapter 7:

Research findings: *Positive about stroke; Learning and working together*



## Introduction

The previous chapter described the processes used to analyse the data generated in this study. The discussion addressed the development and refinement of categories which were indicated by the data. Examples of fieldnotes, direct quotations, memos and diagrams were presented in order to illustrate how data were reduced and key elements synthesised in order to construct an explanation of the achievement of teamwork in the stroke units studied. This chapter and the next will discuss the findings of the research. These are located in four major categories and a core category which are separated for the purpose of discussion; however in practice these were interrelated and interdependent. Following examination of data related to each category and its subcategories relational statements are presented. The core category is explored in chapter 8, this identifies a common basic social process through which the elements of each category interact. This represents the synthesis of the individual categories into an explanatory whole while the interaction of these elements explains the achievement of teamwork in the stroke units.

Data extracts and my interpretations of these will be used to illustrate the actions and interactions of stroke unit team members and to demonstrate the ways in which they made sense of these day-to-day interactions. The achievement of teamwork was dependent on and interrelated with a number of contextual properties which developed over time and which were most evident at the unit level. However, these properties were also influenced to some degree by broader structural conditions such as the system of professions and traditional organisation of work in the hospital, Trust and health service generally.

## Similarities and differences in findings between the stroke units

In chapter 4, it was noted although the stroke units opened at roughly the same time, they were geographically separate, and located in two different NHS Trusts. Moreover, team members had

had no contact with the other unit. Despite these physical indicators of separation and difference, data analysis consistently identified a large degree of similarity in the development, organisation, conduct and understanding of the day-to-day work in each unit. Differences between the units, where they were observed and articulated, were often subtle and commonly represented only slightly differing positions on the same continuum rather than contrary conditions, actions or interactions. For these reasons the discussion of findings explains processes which were found to be common to both units. Where significant variations between the units and their teamwork were evident these are explored in the discussion of the category and subcategories.

The discussion of the findings has been separated into two chapters. This is firstly to acknowledge the complexity and richness of the data generated, and secondly, to allow for comparison of the findings with existing literature where relevant. This comparison illustrates where and why these research findings are similar to or differ from other studies of healthcare teamwork in terms of the level of collaboration and the relative absence of interprofessional conflict observed. The stroke unit teams had to find ways to complete their individual and collective work. It will be argued that *dialogue* and *negotiation* were central to achieving teamwork; these were shaped by contextual factors and conditions over the course of the ongoing development of the stroke units. This chapter will focus on two categories (positive about stroke and learning and working together) which contributed directly to the way team members thought and acted in the units. These were conceptualised as important phenomena influencing the work and temporal order observed during the research. Data analysis identified the importance of tracing the influence and consequence of these phenomena over time in order to understand the team working in the stroke units. In the discussion which follows categories are underlined and *subcategories* indicated in italics. A category diagram precedes the discussion in each section. The arrows between the subcategories symbolise that these are interrelated. There was progression in these phenomena as they evolved

over time, however, this evolution was not strictly linear and there was continuing interaction between the subcategories as the teams continued to develop and change.

Category: Positive about stroke

Figure 10:

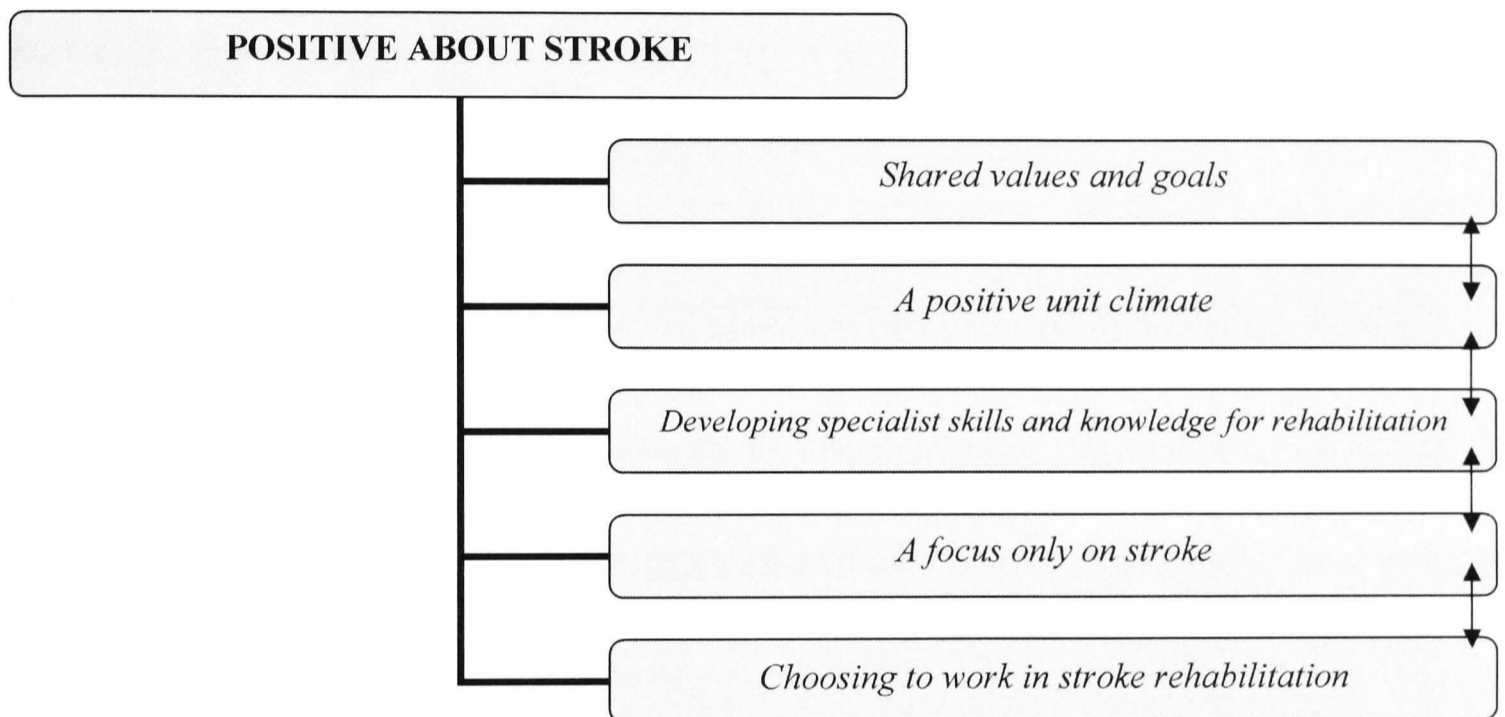


Figure 10 illustrates the subcategories indicated by the data; these clarify and explain the phenomena of being positive about stroke and the contribution this makes to achieving teamwork. Each subcategory will now be considered in turn.

#### *Choosing to work in stroke rehabilitation*

These stroke units were established in 1998 against a background of organisational change in both NHS Trusts, and health policy requirements to demonstrate that services were based on sound evidence of their effectiveness (DoH, 1996, 1997; Clinical Standards Advisory Group (CSAG), 1998). The units opened before the identification and later bi-annual monitoring of agreed national standards in stroke care contained in the National Clinical Guidelines for Stroke (RCP, 2000) but

were soon influenced by these, and more generally by the policy trend towards development of national service frameworks which gathered pace from 1999. The units were not reactive to national policy directives (for stroke) but were set up more than two years in advance of them. Senior professionals at both hospitals responded proactively to what they considered to be an opportunity to shape the structure and working practices of the units. Rather than waiting for Trust managers to dictate how the units would be organised and work, they drew on the recently published systematic review of the effectiveness of stroke units (SUTC, 1997) to make their case for change. The following quotes illustrate the beliefs and actions of these key professionals:

*'It seemed to be a good time to be doing that because the Stroke Unit Trialists' Collaboration had just published in '97 in the BMJ and it was a year later so, you know, it was clear to me that it would have to be done, there would be drivers for change that meant that you'd be knocking on open doors'. (Consultant Physician, Colebrook, Interview 12)*

The importance of individual professionals' attitudes to stroke influenced the selection of staff who would work in both units:

*I insisted on interviewing all the staff that wished to work there. So instead of just walking onto an elderly medical ward and changing its function, I was supported in actually interviewing everybody. So I made sure the staff actually wanted to be there. (Ward manager, Colebrook, Interview 10)*

This consultant physician also had clear views on the importance of recruiting staff committed to working with stroke patients:

*'I was very keen for instance that when the unit was set up the staff weren't simply staff who were already on a ward which sort of evolved into a stroke unit. Even people in that kind of ward had to apply for jobs. Now that might have been quite challenging to some people, but I thought it was essential because what we really wanted was people who wanted to do that sort of work. That was one of the key things that we did'. (Consultant Physician, Colebrook, Interview 12)*

Recruitment interviews did not take place at Holton but existing staff were asked to express a preference and considerable movement of staff was said to have occurred at this time:

*'We were meant to decide where our preferences of work were, whether it was acute, elderly general or whether it was the stroke unit'. (Matron-former ward manager, Holton, Interview 12)*

The ward manager at Colebrook indicated that only around 40% of the original staff remained on the unit after it opened. At Holton, although no records had been kept, the perception was that around half the original staff remained after the unit opened:

*'There was a lot of movement really at that time, I would say about, maybe just of half of the original group of nurses stayed here, but a lot didn't fancy working just with stroke'. (SN, Holton, Fieldnotes)*

It was clear that not all staff saw the concentration on stroke as an area in which they wished to work:

*'Some of the nursing staff that worked on here, didn't particularly want to specialise in stroke...[.....] they asked people whether they wanted to stay and work on here or not, and found them other posts, if not'. (SN, Holton, Interview 5).*

A colleague added:

*'We've staff that were originally here and wanted to stay and we've staff that wanted to come and work here, so we've got quite a committed team both with physio and OT. We've had people who've left, it just wasn't for them and people that would never come and work here in a million years'. (SN, Holton, Interview 4)*

Similar comments were made at Colebrook:

*'There's no point in coming to work on this kind of ward, if you are not going to be committed to stroke patients, because you know it's a difficult kind of nursing'. (HCA, Colebrook, Interview 4)*

These comments relate primarily to nursing staff, although there was evidence that therapists at Colebrook were interviewed for their posts, but not at Holton. However, the therapists indicated they had made an active choice to work on the units. A broader reorganisation of services was taking place in both units which facilitated the selection process and enabled staff that had no desire to work in the stroke units to request moves to other wards or departments. However, even nurses who chose to work on the units had initial uncertainties about the focus on stroke:

*'I think there was a lot of trepidation....and I certainly felt some myself, thinking 'oh am I going to get fed up only nursing one sort of patient all the time' but of course every patient is different and every stroke is different'. (SN, Holton, Interview 4)*

This extract hints at how experience over time altered her perception of stroke: working routinely with stroke patients was important in changing team members' perceptions. Both units recruited individuals who expressed similar reasons for choosing to work in stroke rehabilitation: this

commonly reflected a preference for working in rehabilitation and a perception that stroke was a specialist area where professional skills, whether in nursing, OT or PT could be used effectively:

*'I have always worked in elderly care and then the opportunity came along to work in stroke rehab, and it's something I found I quite enjoy doing stroke care, the rehab side of it which I found personally more rewarding than acute care'.* (Ward Sister, Colebrook, Interview 1)

*'I sort of began to choose it as a specialism about seven years ago'.* (PT, Holton, Interview 4)

*'One of the reasons I enjoy working on here is that it enables us to use a lot of our skills, I think it's brought in skills of mine from mental health because we're dealing with, because strokes affect peoples cognitive state and we're looking at mood'.* (OT, Holton, Interview 6)

*'I think all along I've been biased towards neuro [...] when I first qualified I didn't think I would actually want to work in the elderly environment in that situation [...] but I found that it was more of a challenge really working with people that are elderly because they have so many complex needs'.* (OT, Colebrook, Interview 8)

These comments highlight similarities in the personal and professional biographies of the majority of the permanent team members who made an active choice to work on the stroke units. Their biographies influenced their perceptions of stroke rehabilitation as an interesting and worthwhile area of work and had important consequences in terms of the achievement of teamwork. This coheres with the literature that one of the consistent features of effective teams is having a common purpose and a clear goal (Guzzo & Shea, 1992; Belbin, 2000; Mickan & Rodger, 2000; Borrill et al, 2003). Bringing together these like minded and mostly experienced professionals in the stroke units established the conditions for movement from a multidisciplinary approach to rehabilitation work towards an interdisciplinary approach characterised by sharing of knowledge and skills and sharing responsibility for integration of activities (Melvin, 1980; WHO, 1988; Long et al, 2003). Discussion later in this chapter will confirm this development in both units.

This initial concentration of staff committed to stroke could have quickly dissipated had acknowledged features of effective teamwork including effective communication, and sharing skills and responsibility for rehabilitation not developed (Miller et al, 2001; McCallin, 2004). A lack of

stability and large numbers of changes in team membership has been shown to threaten development of a common purpose and shared goals (Opie, 1997; Stark et al, 2000; Gibbon et al 2002). In the units studied, retention of core team members was high, with the majority having worked on the stroke units for more than four years when the research commenced. This stability and continued commitment to stroke rehabilitation, was commented on positively by temporary and peripheral team members, for example:

*'I think the way they involve themselves into rehab is what makes the difference. I've noticed that most of them are very, it's just they don't do it as a job kind of thing... they are just completely involved in it ... All the therapist they've been here for years and years and a lot of them I hope are very happy here; well must be because the turnover of staff is not very high'. (SHO, Holton, Interview 3)*

*'That's my perception, certainly senior staff, the staff nurses seem to be fairly or very static, and I have to say even nursing assistants seem to be. They don't seem to be terribly huge on turnover since I started up there'. (SALT, Holton, Interview 7)*

The positive view of stroke rehabilitation and perceived common purpose of stable team members directly influenced other team members who worked on the units as part of training rotations. Whilst often not having chosen to work in stroke rehabilitation, they talked about the positive climate on the stroke units and how this *'rubbed off'* on them. Senior professionals from physiotherapy, occupational therapy, medicine and nursing were commonly cited as being *'highly motivated'* or *'very committed'*. Newer or rotational staff suggested that these positive aspects of the climate of the units made it easier to fit in to and find their place in these established teams, and helped them see beyond the negative perceptions of stroke that might prevail in other settings. A PT working at Colebrook as part of a training rotation said:

*'I don't know, it's hard to say, because it is there when you turn up there, you're kind of taken into that environment, and you kind of take on that role, you know where you are working as part of a team and I think it would be hard for new people to come in and you know try to stand alone really, because everyone else works as a team, you almost get drawn in to it'. (PT, Colebrook, Interview 9)*

A similar comment was made by an OT at Holton:

*'It has always been one of the nice wards to work on, and because of that anyone who comes to work on here might not be so good at team working or whatever, but because they're following the lead of other people, they're sort of dragged into it as it were, well not dragged into it but guided that way and become a good part of the team'. (OT, Holton, Interview 16)*

These data were confirmed by the observational data. Over quite long periods of time the content of team members' dialogue indicated their positive perceptions about their choice of workplace and the satisfaction they derived from working within stroke rehabilitation. At different times during the study both units experienced staff shortages and had specialist posts that were not filled. They experienced high volumes of work with very dependent patients. Physical resources such as specialist hoists, beds and seating were sometimes inadequate and there was constant pressure to free up beds for new patients. However, the perception that stroke rehabilitation was a shared team responsibility contributed to their willingness to cope with the stressors described above. Negative comments about these issues were rarely heard. This was also reflected in the low levels of sickness and absence in both units. Although accurate sickness absence figures for the units were not available to me, the ward manager at Colebrook indicated that these were consistently below 5%; a similar perception was expressed by the senior therapists at Holton. The major UK study undertaken by Borrill et al (2003) highlighted the important positive relationship between satisfaction with teamwork, low absenteeism and increased team effectiveness.

#### *A focus only on stroke*

Another feature of these units which built on the active choice and commitment to stroke was the opportunity to work consistently with a diverse and complex, but also common clinical problem. The opportunity to *focus only on stroke* was perceived to have contributed directly to developing teamwork in these settings. As the units opened, team members in both units recognised that some of their (non stroke unit) colleagues had negative perceptions, for example comments about stroke patients being 'heavy', 'not interesting technically', 'too challenging', or needing too much 'basic care' were not uncommon. One staff nurse recalled her thoughts at that time:



*'I think everybody mentally conjures up a really dense left sided hemi', of somebody that can't move and you're pulling, well not pulling them, up and down the bed, that sounds awful but moving them in bed and really heavy work, and feeding people that can't...just real sort of drudgery, to be honest'. (SN, Holton, Interview 4)*

Similarly, a dietician at Colebrook noted that other dieticians could not grasp that stroke required specialist knowledge and skills in the same way that for example diabetic or intensive care patients would:

*'Nobody likes particularly elderly medicine, it's not seen as anything glamorous in dietetics..[.....] I don't think other dieticians in the profession really understand where the specialism is in stroke'.*

But she also noted changes in those attitudes driven by a shift in health policy:

*'I think since the National Service Framework came out there's been a much bigger drive in pushing people into those and having a specialist person at a senior level really...[....] ... it [stroke] is very technical or it can be you know'. (Dietician, Colebrook, Interview 7)*

The consultant physician at Colebrook expressed similar concerns about the perception of stroke amongst health professionals in general:

*'It still exists, I think that there's relatively few people who do find it a challenging and exciting area'. (Consultant physician, Colebrook, Interview 12)*

However, at the time of the study, team members rejected these negative perceptions of stroke and were able to point to positive and beneficial outcomes for most patients who experienced co-ordinated rehabilitation in the stroke units, for example:

*'I also think it's the wonder and the fascination of seeing patients that come across [to the unit] that can't even hold their head up, that can walk out. I've been a part of that; I mean it's an honour'. (Matron, Holton, Interview 12)*

Similarly a HCA at Colebrook said:

*'You know it's lovely to see people who could do nothing... eventually [able to do things]... even if it's only dressing their top half or doing very simple things for themselves starting off, it's nice to see that'. (HCA, Colebrook, Interview 3)*

Team members recognised the single disease focus of the units decreased fragmentation in their work and improved the consistency in their approaches to rehabilitation. Despite the complex and varied presentation of stroke, this focus facilitated the development of specialist knowledge and

skills. In both units team members expressed the view that they did not think it was possible to develop the same degree of specialist knowledge and skills in general medical or elderly care settings where presenting conditions were much more diverse:

*'You see how that patient is looked after when it isn't a specialist stroke unit and a specialist team and I think things like the swallowing might not have been assessed for days. Perhaps somebody's forgotten about it. I think that's probably one of the things that does happen when you're looking after one particular disease or condition. It does improve outcomes'. (Dietician, Colebrook, Interview 7)*

Her colleague commented that:

*'I think the reason they're better is because they're more focused. They're not as diversified in particular the nursing staff, if you've got loads of different kinds of patients, they are nursing a stroke patient, and they've got another rehab patient, they're diluting their experience all the time'. (Dietician, Colebrook, Interview 6)*

Similar views were expressed by the Consultant physician:

*'It's like anything in life, if you're doing something every day, you tend to be more confident and able at it and you make an effort to learn the things that are necessary to do your job. If you got 20 different conditions to look after it disperses your ability to develop yourself'. (Consultant physician, Colebrook, Interview 12)*

And by a social worker at Holton:

*'Because it's very focused on a particular illness on a particular form of rehabilitation, I mean, obviously everyone's different everyone's needs are individual, but I think because it's very focused on stroke rehabilitation that they may be do have to be more effective. There is a lot of specialist knowledge within that team, [......]They understand more about the condition and what causes it, about the treatment and the most effective ways to help rehabilitate someone'. (SW, Holton, Interview 10)*

The PT said:

*'I suppose that's where it's different from the acute wards where, in and out dozens of them sort of thing, people are here for a long time on the whole, you get to know them, you get to know their families, you get to see them move on and progress and that's probably why most people are sort of happy to come and work even though they feel worn down with it sometimes'. (PT, Holton, Interview 7).*

These comments are consistent with findings from Miller et al's (1999) study in medical units and Borrill et al's (2003) in both primary and secondary care, where the combination of diverse patient populations and involvement of more than two consultant physicians resulted in fragmented (team)

working. In contrast, McCallin (1999) and Miller et al (1999) demonstrated that stable teams working in focused areas such as neurological rehabilitation were successful in developing integrated team working and increasing satisfaction with teamwork. Focussing only on stroke also had consequences for the knowledge and skills required by team members. The establishment of these units required development of specialist knowledge and skills in all team members, rather than the more traditional reliance on sending patients to be treated by recognised experts in rehabilitation in separate departments. The way both stroke units responded to this requirement for specialist skills was significant in creating a *positive unit climate* and ways of working which contributed to the achievement of teamwork.

#### *Developing specialist skills and knowledge for rehabilitation*

When the stroke units were established, training equivalent to two days in each unit was set up to help to develop stroke specific skills and knowledge. The initial focus was on moving and handling but there did not seem to have been clear determination of the skills which should be shared and widely developed. This training may have had little impact, if not for the ongoing formal and informal opportunities to practice and further develop the skills observed in both units. Staff in both units indicated that following the training sessions spontaneous patient generated problem solving occurred; team members on duty would be called together to work through a problem or time was set aside to develop skills for specific problems:

*'I think it's probably because the team's developed.... I mean we still do it but its not done as much... we used to say well she's transferring differently now and we'd gather all the nurses together that were on that day and show the nurses, well look we want you to change to this now, she's ready to do this'. (PT, Colebrook, Interview 4)*

She recalls that this was not simply a one way process with PTs deciding and instructing other team members:

*'I mean we're not a stroppy physio team, [.....] we didn't rant and rave and say 'Oh this must be done, [.....] you know we've talked to everybody and come to an agreement and if they say well we can't do that because of, this and this, we say well we'll have to think*

*of another thing... I can remember instances where one lady in particular... one of the nurses worked out a fantastic way of transferring her and I only could step back and say well yes... I think we better do it that way'. (PT, Colebrook, Interview 4)*

I asked the PT and a senior staff nurse at Holton about this kind of informal approach to skills development:

*PT: 'We've always done them I suppose but they are a bit less common now because everybody is more skilled and can work things out more easily, few problems are new to us now'. (PT, Holton, Fieldnotes, May 2002).*

*SN: 'They still happen a lot but I think what is different now is that we can help work out what is going on, when we first opened we had to get Miriam in because we just didn't know what was causing the problem with balance or whatever, even the OTs didn't back then'. (SN, Holton, Fieldnotes, May 2002).*

These extracts indicate the importance of developing not just new skills but also underpinning knowledge related to when and how to employ the skills. The ward sister at Colebrook commented on how nurses developed and used some of the specialist skills:

*'We set aside time to work with the physios. But then we incorporate what we've been taught into our daily work, [.....] I think we've certainly got a better understanding of physio and are able to do physio or what we class as physio; we might not have been able to do that before'. (Ward Sister, Colebrook, Interview 1)*

Nurses and HCAs at both units stated they incorporated skills associated with PTs or OTs into their daily work, they were often careful to point out that they were not claiming to be able to replace the specialist work of those disciplines, but to make the point that rehabilitation was a shared enterprise.

The Matron at Holton said:

*'I mean there's no way we could do physiotherapy and occupational therapy, the very fine tuning that they do. But I think they've gained an awful lot of respect for us, as they see us moving and developing the way we move on with the patients and work better with the therapists, and there is a better coming together'. (Matron, Holton, Interview 12)*

In participant observations at both units I noted examples of specialist knowledge and its impact on patients:

*An example of the level of specialist knowledge which had developed in relation to stroke sequelae and the pathophysiology underlying these:- the staff nurse as part of an informal teaching session with a patient discussed with me and the new staff nurse: the origin of shoulder pain, the problem of subluxation, development and prevention of spasticity in the muscles and the return of sensation and movement in affected limbs. She confidently explained specialised technical language to us, and then discussed the possible use of a*

*new drug, Tizanidine, to treat increased muscle tone in this particular patient with the SHO. (Fieldnotes, Holton, June 2002)*

The longer-term patient benefit of developing such specialist knowledge and skills in all team members was identified by a consultant physician:

*'I wouldn't want someone to work on the unit until they've had the particular moving and handling in stroke work. A practical example that I can give you of that is that we now relatively rarely see shoulder pain, when previous research we'd done showed that it was sort of 60-70% of people who had it at one point after the stroke'. (Consultant physician, Colebrook, Interview 12)*

Another important factor in the willingness of core team members to develop specialist skills and knowledge was the way senior team members (in all disciplines) were directly involved in provision of specialist rehabilitation. This contrasted markedly with the experiences of many nurses and therapists at both units when working elsewhere and also with the literature in this area (Cott, 1997, 1998; Pryor, 2005). For example:

*'I think one of the reasons I enjoy working on here is that it enables us to use a lot of our skills, I think it's brought in skills of mine from mental health, because strokes affect people's cognitive state and we are looking at mood'. (OT, Holton, Interview 6)*

Much of the data generated to this point indicated that it was primarily nurses and health care/rehabilitation assistants who had to develop specialist knowledge and skills. However, further analysis revealed that comments from 'peripheral' and 'temporary' team members, including dieticians, SHOs, and social workers confirmed that nurses were not the only ones who found the rehabilitation practice in the stroke units initially alien and challenging and required specialist skills.

An OT on a six-month training rotation said:

*OT: 'It was a bit of a shock to begin with, working on here, because on my previous rotations in orthopaedics and then elderly care, we tended to be called in to advise the staff on the sort of therapy that patients needed. But because of a lack of time we often didn't actually provide the therapy, patients went to the main department, or the nurses tried to follow our instructions'.*

*INT: So how did you deal with that?*

*OT: 'To be honest, it's been a very steep learning curve, particularly learning how to use the cognitive tests, and some other specialist moving and handling skills'. (OT, Colebrook, Fieldnotes, May 2002)*

A social worker at Holton noted the importance of developing knowledge of stroke:

*'You become aware of what a complicated process that is [stroke] and you know, the kind of distortion could be in a number of processes really. I think with communicating with people that's ... Things like sitting on the right side of a person, you know if they're neglecting one side, you know I sometimes check which side would it be better for me to sit on to encourage them to be aware of, if their vision is affected you know is it better to sit on the other side to them'. (SW, Holton, Interview 13)*

Specialist knowledge was not only manifest in actions such as those described above but also in the use of technical language:

*'Yes [we've developed] a whole new language, we talk about 'central key points', that was the newly learned word a year or two ago, and that's quite comfortably bandied about now. It's something to do with being able to speak the same sort of language isn't it, being able to communicate in the same way'. (PT, Holton, Interview 5)*

*'I discussed Annie's shoulder earlier, Miriam thinks it's her increased tone... you find you suddenly think 'oh I'm talking about tone and proprioception and all this sort of business', whereas that's something we never really did discuss before, and if I probably discuss that with nurses next door they probably wouldn't have a clue what I was on about'. (SN, Holton, Interview 4)*

Such shared knowledge and understanding could impact on teamwork:

*'I think so because if you have the specialist knowledge of something I think you just work together as a team naturally [.....] if you've got all of that knowledge you're probably going to cover everything that needs covering really'. (Dietician, Colebrook, Interview 6)*

As team members understand the meaning of and then use shared technical language this can provide a shorthand form of communication, which is mutually understood without having to go into detailed explanations of particular terms, this is a good indicator of interdisciplinary team working (McCallin, 1999). However, experienced core team members could be intolerant of imprecision in the use of language for example:

*SN: 'He's got no motivation this chap; I think he is a bit lazy, he could try more'.*

*Consultant: 'No, no, look you need to be more careful in jumping to conclusions, don't you understand the effect that stroke can have on mood and volition, he has quite profound cognitive impairment, these things are much complex than you think' (Ward round, Holton, Consultant physician, Fieldnotes, May 2002)*

Here the physician had a very clear understanding of motivation as being related to volition; he was concerned that the staff nurse did not appreciate that cognitive impairment may mean that patients

may be unable to initiate actions. The staff nurse's observation that the patient was 'not trying' needed to be differentiated from functional and emotional difficulties related to the stroke. This is an example of how routine use of language may be problematic in a specialised context and, whilst core team members may confidently use technical language, new team members take time to learn and apply this.

#### *A positive unit climate*

Team members accepted that some patients would make considerable progress and others perhaps little. They were agreed that all improvements added something to the life of the individual and their family. The fact that something could be achieved for and with almost all patients reinforced the positive perceptions held by team members and directly influenced their perceptions of the value of working as a team:

*'I personally I think the rest of us, we do get a bit of a buzz out of it, there's nothing nicer than you know sending somebody home. Even if you know they're still quite disabled but have been set up with a package, they're going to cope. And yes, life is going to be a lot different for them, at least you got them back out there. You've got them back home'.*  
(SN, Holton, Interview 4)

These positive perceptions were a noticeable feature of the working climate in the stroke units. This was also noticed by patients who frequently commented on the difference in atmosphere between the stroke units and the wards in which they had been cared for acutely. A patient from Colebrook said:

*'There was an atmosphere of calm and peace in comparative terms, it was not the fault of the staff down at Ward J but people coming in shouting and it wasn't a pleasant spectacle in some ways'.*

When asked to clarify why the stroke unit was different he said:

*'Because the professional amongst them makes sure, they spend, they get to know them very well, they spend time and effort, they're sympathetic, they're helpful in many, many ways and the general atmosphere in the place is 'we're going to get you better whether you bloody well like it or not', which is fine by me of course and everybody else I guess. .*  
(Patient1, Colebrook, Fieldnotes, June 2002)

A carer at Holton commented:

*'No they're not, they're not the same [the wards] it's different, to me it's a different atmosphere between the 'General' and the stroke unit. Well you see, to put it in a nutshell, they seem to have more time at the stroke unit'. (Carer, Patient 4, Holton, Fieldnotes, July 2002)*

Peripheral team members who had regular contact with the units also noticed the positive approach and identified its impact on patients:

*'I do feel that they genuinely care for the clients upstairs [on the stroke unit] and put them at the forefront. I go up, sometimes and they are obviously short staffed. It must be a nightmare really but on the whole, they seem to be very.... I wouldn't say up beat but certainly positive in what they can do for the clients..... which is bound to rub off on clients..... I think if they are surrounded by staff who feel fairly... optimistic about things. Then they should feel that too'. (SALT, Holton, Interview 8).*

A HCA at Colebrook compared the positive climate in the stroke unit with her previous experience in another rehabilitation setting:

*HCA: 'I worked in the younger disabled unit for a long time but the outlook here is a lot different, despite the patients being much older'.*

*INT: Different in what way?*

*HCA: 'Well there it was as if nobody expected there to be much progress, and there wasn't, but here we always know and expect there will be some improvement, doesn't matter how small and that's important'. (HCA on night duty, Colebrook, Fieldnotes, June 2002)*

Part of the difference in atmosphere was this positive way in which the team members went about their work with each other and with patients; they displayed certainty that they had something to offer the patient in their recovery from stroke. This came from observing the outcomes of co-ordinated rehabilitation, and from the dialogue which occurred as part of learning and working together. Some team members traced the positive perception back to the establishment of the units and felt it had persisted:

*'It was still fresh in a way, the ideas were still being sort of bounced around regarding what was going to happen and how best to set up the unit, and we got fresh ideas from other units..[ .....] it's the newness of it, isn't it and that you want it to work'. (OT, Colebrook, Interview 8).*

And at Holton



*'As things develop because you are doing more and people were talking more, because of this excitement and because all this was going on, and there was much more people asking questions and on ward rounds, mini talks and mini teaching sessions'. (SN, Holton, Interview 14).*

*'I mean, you can have general rehab nursing obviously, but stroke is different. That is a speciality, and that is what we're interested in, and if that's the area you like working you'll be more positive'. (SN, Holton, Interview 11).*

Another important factor is the effect that working in the unit can have on perceptions of stroke, an OT commenting on the experience of temporary team members said:

*'It's a positive thing, if they if they go work somewhere else, they still think of stroke in a positive light rather than something more negative'. (OT, Holton, Interview 16)*

Despite the positive unit climate, a note of caution is important. The perceptions of patients and of team members did not always exactly match up in terms of the degree of improvement which could be expected or achieved. Often patients wanted far more in terms of being able to regain pre-stroke levels of independence. This difference in expectations has been noted in a number of studies of stroke patients (Hafsteindottir & Grypdonck, 1997; RCP, 1998; Wiles et al, 2002, 2004; Stein et al, 2003; Jones et al, 2004). In the units studied, team members developed a cautious but optimistic approach to deal with patients expectations. Observed discussions between patients, relatives and team members about recovery potential appeared honest and held to the view that predictions may have to be modified and achievement may be more or less than expected. This consistency in approach however could not completely remove the desire of patients to achieve pre-stroke levels of functional ability and remained a source of frustration for some patients in the study. The positive unit climate reflected the shared views held by team members in both units; these views were a function of personal and professional biographies and were reinforced by the experience of interdisciplinary team working.

### *Shared values and goals*

Much of health service work is concerned, at an ideological level, with making a difference in people's lives. Being positive about stroke care is an attitude and value in the first instance but it

prompts, directs and supports specific ways of working with other team members and with patients. It can be understood as a default position which asks ‘what does the patient want from their rehabilitation’, ‘what can we achieve with this patient’, and ‘how can we reconcile those two things and go about rehabilitation’? The majority of patients observed and interviewed were aware of and appreciated the positive perception which looked for and then emphasised what could be achieved rather than what could not. How *shared values and goals* were developed however, was more difficult to establish. The following comments give an indication of how team members understood this:

*‘I think it's working with like-minded people, because you are all working for the same means, and I feel really lucky to work on here’.* (SN, Holton, Interview 7).

*‘It doesn't happen on acute wards and there's still the same staff working there but because the team isn't together and it's not pushing for the same thing, they're not working towards the same goal. It just doesn't happen. And the patients just get left. They don't get the correct therapies. Which they do get here or on other stroke units because everyone is looking together at the same patients. Looking from a different perspectives but coming up with a plan of action which we all work towards’.* (SN, Holton, Interview 11)

*‘We have become more of a team since we became the stroke unit. I do feel it's very easy to work as a member of that team. You know we are all working to the same purpose as opposed to you know sort of clashing against each other, which I think can occur in other wards, unintentionally perhaps’.* (OT, Holton, Interview 16)

Similarly at Colebrook

*‘I think everybody in the team is important for that. From you know, the housekeepers to everybody sharing a philosophy about that and it's not something that was done consciously no, you don't write a mission statement saying you'll do this, or if you do, then that's not what would do it’.* (Consultant physician, Colebrook, Interview 12)

It is easier to see why those team members who routinely work on the units would be likely to develop and share these values, in that they frequently interacted with each other in the working day, could participate in rehabilitation and directly observe the outcomes. However, contact with more peripheral team members who were not unit based and who had additional patient responsibilities beyond the stroke units, confirmed that shared positive perceptions of stroke provided common ground on which to engage with core team members:

*'I think the fact that they, they are working towards the same goals and the same end in a way, aren't they, they understand what they are there for what the clients are there for'.* (SALT, Holton, Interview 8).

*'Well I think because we're all working towards the same goals with the patients, so we're all, we're all in the same theme with the patients and we're all doing the same thing with them'.* (Dietician, Colebrook, Interview 6)

The units sought involvement of the full range of specialist skills and services required to support stroke rehabilitation. At both units this meant negotiating for funding for specific posts or to be allocated sessions from particular therapists. The active recruitment of these specialists conveyed the message that their specialist skills were considered necessary if the unit was to work effectively. Dieticians at Colebrook recognised that they responded positively to the respect for their specialist knowledge and skills:

*'I suppose as a dietician you go onto those wards and because they're responding positively to you, you go more and you have a bias towards them, and whatever actions you ask them to carry out they do it and they... they use you more'.* (Dietician, Colebrook, Interview 7)

At Holton the SALT recognised and valued being part of a specialist group which she saw as a means to achieve some therapeutic interventions, such as initial swallowing assessments, that she could not achieve alone. Social workers at Holton also recognised the benefits of specialist rehabilitation. Regular contact with the stroke unit meant that most peripheral team members developed an interest in stroke and its impact on individuals and families. This included making efforts to understand and learn technical language related to assessment, diagnosis and management of stroke which in turn helped in understanding the disabilities and impairments experienced by patients. The development of shared understanding and shared language about stroke made dialogue and planning between peripheral and core team members easier. Comments from a social worker illustrate his perception of the value of this approach:

*'I think that's an area where as social workers we could improve on because you know unless you've had specialist knowledge in stroke we are just generic if you like in terms of the older people's wards, we're not, we don't have specialist knowledge in terms of one illness. So it's up to the individual to become familiar with the terms and you know some of the more specialised knowledge'.* (SW, Holton, Interview 13)

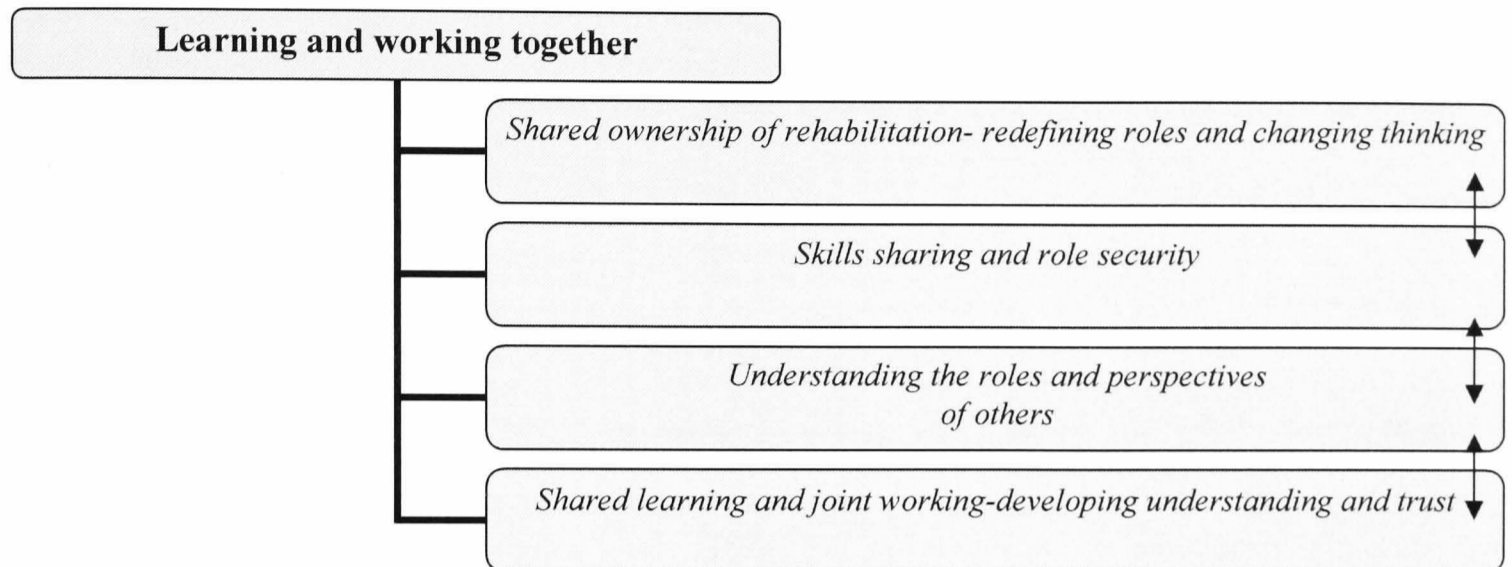
Social workers seemed clear that an effort to understand specific aspects of stroke illness would help them in their work with patients and also in their work as team members. Stroke unit team members shared a similar ideological position about rehabilitation in terms of the purpose and focus of their work and were not at odds with each other as professional groups in that they saw the professions involved as necessary and useful contributors rather than competitors. This appears to have underpinned their willingness to share knowledge and skills.

In summary, data analysis indicated the following relationships between the category positive about stroke and its subcategories.

- 1) Working in new stroke units which pre-empted national policy directives gave team members a sense of working at the leading edge and being innovators in providing specialist patient services.
- 2) *Choosing to work in stroke rehabilitation* is directly related to team members' professional/career and personal biographies and brought together individuals who shared positive perceptions of working with older adults and what rehabilitation could achieve for stroke patients.
- 3) *A focus only on stroke* removes much of the tension experienced by health professionals in general medical units where they are constantly faced with prioritising the most acutely ill patients and trying to respond to multiple and differing physician demands. Importantly, fragmentation of care planning and delivery (rehabilitation) is reduced when all team members can *focus only on stroke*.
- 4) *Developing specialist skills and knowledge for rehabilitation* can occur when all team members participate in formal and informal *shared learning* and routinely practice and develop the specialist skills learned.
- 5) The above features contribute directly to the identification and development of *shared values and goals* for stroke rehabilitation. *A positive unit climate* develops when permanent team members share the perception and demonstrate that 'something can be done' for all stroke patients, that is, they are positive about stroke.

Category: Learning and working together:

Figure 11:



Stark et al (2000) and Borrill et al (2003) noted that team working was often imposed by organisations without attention to team building. Gulliver et al (2002) and Hudson (2002) examined the problems caused by this approach in the primary care sector. They suggested that failure to address factors which can disrupt attempts to collaborate can mean that teamwork is merely a label, whereas in reality issues of power and control, traditional hierarchical structures and competing professional ideologies may remain. In the stroke units, team building in the formal sense was not organised but occurred informally and organically as part of the process of *learning and working together*. The context is important in that essentially self selecting team members took responsibility for the development of the teams within the new units. Concepts of power, hierarchy and competing ideology were not formally acknowledged by team members at either unit, but data analysis illustrated how these potential barriers to team working may have been overcome. Bringing together like minded professionals who were *positive about stroke* provided conditions conducive to *learning and working together*. Maines & Charlton (1985) and Bohm (1996) argued that when

individuals come together in work settings, they bring with them different opinions and assumptions from different professional cultures or subcultures. Despite shared interests, individual group members often have some tendency to defend their assumptions and opinions reactively (Farrell et al, 2001). However, these stroke unit teams developed ways of working which quickly moved from defending particular ideologies towards some common understanding and purpose; this began with shared learning and progressed to regular joint working.

*Shared learning and joint working- developing understanding and trust*

Education sessions were set up to provide specialist information and skill development opportunities, but these had a more important and enduring contribution to the achievement of teamwork. This was the establishment and endorsement of a system of *learning and working together* as a multiprofessional group which impacted on teamwork in both units in a number of ways. Bringing all the professional groups together to learn about stroke and its management conveyed an implicit but powerful message; this was essentially that team members could learn from each other, and needed to work together to address the complex needs of stroke patients. This process was inclusive, irrespective of grade of team member and became an accepted way to talk about and determine the order and pattern of rehabilitation team working. An OT and PT recalled the approach and contribution of the education sessions:

*'We did some joint training [... ..] probably about three years ago. It was initially based towards the nursing staff but I said that we should really include our assistant staff and anyone else who wanted to come really. So we were all working together with that and did a day looking at normal movement and the rehab that we're using and such like, [... ..] which I think helped us establish us working together as a team, obviously staff have changed since that time but I feel that sort of really helped to gel things'. (OT, Holton, Interview 16)*

*'We planned a day's training for every member of staff [... ..] and everybody from the ward clerk and the domestic through to senior staff nurses came on the same course and that was great. Partly, it did raise people's awareness. I mean the domestic a couple of days afterward she saw me doing something with somebody and she said, I understood that when you did it, I didn't know why you did that before'. (PT, Holton, Interview 5)*

At both units, the deliberate inclusion of all grades of staff in training and the commitment to *shared learning* was significant; this initial investment in specialist training and education was highly valued by team members. A frequent comment made was that 'everyone' was included:

*'I think what has been conscious is the sharing of information about how people need to be doing things, and like shared training, not making any distinction between even in the early days the training I did was qualified and non-qualified, the same things'.* (PT, Holton, Interview 5)

Team members at both units acknowledged how different this inclusion was when compared to their prior experiences of training:

*INT: Can you remember the initial training sessions you did?*

*HCA: 'Sure, it was all about stroke and moving and handling, fascinating to me because I'd never done that sort of thing before and never with all the others'.*

*INT: What do you mean all the others?*

*HCA: 'Well where I worked before the therapists didn't speak to us but here we were all learning about stroke together, I really liked it, I think It's good that you get other opinions as well' (HCA, Colebrook, Interview 14)*

Similarly at Holton:

*INT: I heard that you had some joint training when you first opened?*

*SN: 'Yes but I didn't know what to expect really, we weren't used to doing training with the therapists, it was bit daunting at first because you think... well they'll know so much more than us, but it wasn't like that really, we all just wanted to learn about stroke, we all needed to know more so it made sense to have everybody there. What I realised was that we couldn't do everything ourselves, you know the OTs need nurses to continue washing and dressing and we need the housekeepers to monitor how patients are eating, we all learned that I think'. (Holton, Fieldnotes, March 2002,)*

These sessions developed specialist knowledge, but perhaps more importantly identified the necessity for understanding the rehabilitation approaches being used on the units. Multiprofessional learning, is now a policy priority and supported by some research evidence (DoH, 2001b; NAO, 2001; Miller et al. 2001; Borrill et al, 2003) but is not widespread in the NHS. Investing in *shared learning* when the units opened impacted on the thinking of team members and provided the basis for later informal *joint working* where team members jointly discussed and worked on patient problems as they arose in daily practice. The importance of the culture of *learning and working*

*together* which evolved in both units is that it constituted a key contextual property required for achievement of teamwork; the consequences of this can be traced in current team practice. A staff nurse speaking about the differences between the stroke unit and acute units said:

*'I suppose the main difference is working with other people, other than the rest of the nursing team. On the acute side there's one physio who does all the elderly wards [.....], so you know she would come round about twice a week and you'd say oh well this patient is doing this, this patient is doing that, and occasionally she'd try and do something but a very, very different level to here whereas we do actually work very closely with the whole team. It is totally different, we do I'd say properly work as multi disciplinary team here and I've never worked anywhere like that before*

She acknowledged the importance of co-location in developing joint working:

*'I suppose it happens mainly because they're all here. So you know they are accessible so if you want to say something you just can find them and say something, whereas they're not someone that would turn up twice a week or so'. (SN, Holton, Interview 11)*

The ward sister at Colebrook also noted this difference and how regular access to other team members facilitated dialogue:

*'I mean, it's the opportunity to work closely together and talk to each other, to tell each other about what problems you might be facing. Just the other night I had problems with self-medication when it would just not work, it helps that everybody works closely together and we have the opportunity as a team to discuss and communicate well with each other'. (Ward Sister, Colebrook, Interview 1),*

Such regular interaction, together with discussion of patient problems and needs and how these might be managed provided opportunities to develop team members' understanding of rehabilitation approaches and built on their existing disciplinary knowledge. A PT at Colebrook recalled her initial concern at the ways the shared education days were run but also highlighted her surprise at how the information was received:

*'The courses were organised by therapists and Robert [consultant], in fact I think we were all therapists.... and I ... personally worried... and I thought you know they'll think oh it's these bossy therapists, who do they think they are telling us what to do, but they didn't and it was very, very much appreciated and everybody realised that they needed to know these things, you know if they were going to come and work on a stroke unit'. (PT, Colebrook, Interview 4)*



A staff nurse at Holton indicated that such approaches combined with the enthusiasm for the new units made later *joint working* easier:

*'As things develop because you are doing more and people were talking more, because of this excitement and because all this was going on, and there was much more people asking questions and sort of like on ward rounds and mini talks and mini teaching sessions. [...] Because you were in different meetings with people it wasn't as hard to say hello to a consultant or hello to the physio or go and ask an OT'. (SN, Holton, Interview 14)*

An OT also noticed the commitment to *joint working*

*'I think it's partly to do with the physio who is very good. Since I started on the ward, the team working aspect has been very much promoted to us. And she's been very open for me to go to her and say, do you want to do a joint session, and I was encouraged to do joint sessions with her initially'. (OT, Holton, Interview 6)*

A clear linkage can be seen between the early *shared learning* sessions and current team practice. *Shared learning* contributed to the development of a work climate where different team members were confident to come together to address novel or difficult situations. When team members were not clear on how to manage a particular problem related to achieving good positioning or safe handling then a mini conference would often be called wherever the patient was. These instances were commonly referred to as *joint working*. Data related to the subcategory of *joint working* were discussed in some detail in chapter 6 (pages 146-147) as an illustration of data analysis and refinement of categories, data presented there is not reviewed again here. Both core and peripheral members participated in *joint working*, but the ways they did so differed in large part based on the focus and conduct of their day to day work. In planned and unplanned *joint working* there was commonly negotiation and renegotiation of rehabilitation plans. One discipline was often acknowledged to have specialist technical skills in the identified problem area but dialogue frequently included a range of team members, who offered practical or professional opinions as to how problems might be resolved, and would argue their case in the negotiation of a solution. The extended fieldnote at Appendix 9 illustrates how in unplanned *joint working*, team members engaged in dialogue and renegotiated the rehabilitation plan for a patient whose level of disability made it difficult for him to sit safely in a chair for meals.

This example and that detailed in Table 5 (pages 146-147), were typical of the *joint working* observed. These identify how team members responded to problems in a current rehabilitation plan, and also their respect for physiotherapists' expertise in this area. There were attempts to include patients and relatives in discussion of rehabilitation plans, and the resulting plan was negotiated with team members who would be closely involved in its implementation. This included negotiating realistic review criteria and time limits with other team members. In the example related to safe seating, the views of the HCA were listened to carefully and her concerns about time and workload acknowledged and discussed with the senior nurse, OT, and PT until agreement was reached. This simple example differs significantly from those highlighted in the studies of Cott (1997; 1998) and Griffiths (1997) where senior team members decided a course of action and required others to carry out those instructions without the dialogue noted here. In those studies, satisfaction with team working was low which was not the situation seen in the stroke units studied. The process of dialogue in response to a change in rehabilitation plans did not always default to calling in senior therapists or nurses; one HCA recalled this situation:

*'One day one of the physio's Ellen, she 's not here all that long and she was talking to someone about, you know physio.... I was standing and she had asked me to help her with something ... [.....] and I said we're not, we moved on from that a bit, she'd forgotten, so she said ' You see, this ward never stops to amaze me, she said I've never worked with nurses like you', and I said what do you mean! And she said gosh you know so much... about physio and things and she said you're really rehab nurses you're not nurses'. (HCA, Colebrook, Interview 3)*

This further illustrates the culture and teamwork practice which had evolved, in that an experienced PT, but one relatively new to Colebrook was willing to trust in the knowledge held by the HCA and acknowledged her understanding of rehabilitation strategies. Almost identical examples were observed at Holton where, because of a job share arrangement, two experienced OTs did not work on the same days. I regularly observed their willingness to rely on rehabilitation assistants (RAs) to confirm progress made by a patient against rehabilitation plans:

*The OTs conduct their own assessments and record their judgment in shared notes on a daily basis but they trust the RAs to update them on what the current goals are and how patients are responding. Jose (RA) prompted the OT to change the washing and*

*... dressing practice planned for a patient to go back to working on establishing sitting balance to counter the patient's overuse of the unaffected limb. (Holton, Fieldnotes, May 2002)*

In these examples, trust in the information provided was related to recognition of the specialist knowledge and understanding held by the HCA and the RA but also to the experience of working in a team culture which role modelled inclusion of and confidence in the perspectives of different grades of staff. However, other data indicated that although understanding had developed and with it trust in the team members' judgement, the level of understanding was variable and some senior team members argued there was a need for more *joint working* if understanding was to continue to develop:

*I reflected on whether all disciplines understand rehab priorities in the same way that the specialist discipline might. I asked Miriam (PT) if the nurses and OTs understood the fundamental importance of trunk control. The answer essentially was no for the nurses, although they had improved their knowledge base enormously, and yes for OTs due to emphasis on this in their training. This led to discussion about moving from disciplinary thinking to team thinking and how that might be developed. Miriam commented on the value of joint sessions (with nurses and OTs) but how this was compromised by lack of time and availability of staff. (Holton, Fieldnotes June 2006).*

The impact of staff availability on *joint working* was also noted by an OT at Colebrook who wanted to see more formal *joint working*, suggesting this could improve teamwork and patient outcomes:

*'I think because of the shortage of staff, we tend to be a bit blinkered at the moment to what we have to do within a set time, and instead of maybe just slowing down a bit and communicating a bit more and saying well look, if we saw this patient together today, that might give us a better idea of what we're aiming for...[.....] and just see whether we could achieve more together than what we can individually'. (OT, Colebrook, Interview 8)*

There was also frustration particularly for therapists at Colebrook, that despite valuing *joint working* it did not always occur even when planned:

*A timetabled joint working session between a nurse and PT was cancelled at short notice because a nurse was off sick. This irritated the PT, because [she explained] she had altered her timetable to fit in with the Sister, and because of the importance which she placed on joint working. This resulted in some conflict between the PT and Sister, the PT did not let it drop, and within thirty minutes had found a nurse to do the joint session. The Sister agreed the session should go ahead. This partly defused the conflict and the joint working directly benefited the nurse who had help to complete washing and dressing with a very disabled patient (Colebrook, Fieldnotes, April 2002.)*

This example and the comments of the OT (above) represent instances where team members sometimes didn't take opportunities to work together because they were so concerned with getting through the patient work, they did not take the time to stop and think about how the work was done. Peripheral team members recognised the importance of *joint working*, but where their roles did not involve direct physical interventions, found it more difficult to participate in and for others to develop understanding of their roles and perspectives. A dietitian at Colebrook said:

*'I've got a particular nurse, who wants to shadow me and that's fine, but it's very difficult because it's not just shadowing. You have to be explaining exactly what you're doing, because if you don't. It's just like, 'oh well, they're just writing notes', because there is so much writing. But whilst you're writing there's a thought process, and there's a rationale for that patient going on in your head, but it doesn't appear because, [..... ] with Physios and OTs it's very visual'. (Dietician, Colebrook, Interview 6),*

A social worker at Holton had similar concerns but indicated that whilst individuals with complex disabilities were always jointly assessed with OTs and PTs as part of discharge planning, more straightforward cases were not, and he felt this was a missed opportunity for *joint working*.

*'I think it depends on how things sort of progress in general in the future, and I think there needs to be a lot more joint working between health and social services, and I sort of think the barriers need to be brought down in sort of attitude and the way people work together'. (SW, Holton, Interview 10)*

The need for senior team members to facilitate or direct *joint working* rather than wait for it to happen was acknowledged by the ward manager at Colebrook:

*Ward Manager: 'They are saying there is not enough to do at present, you know until the beds are all full but they should be using this time to work with each other. I need to ask Cath why they're not doing this when we agreed on regular half day joint working for everyone'.*

When the PT and ward manager met to discuss this she said:

*PT: 'I know we talked about that but to be honest after that first week no one asked me and I forgot about it really'.*

*Ward Manager: 'Well I think we have to timetable it, you know put it on the board and make it happen and get them talking to each other about what they are doing, you won't get this time again'. (Colebrook, Fieldnotes May 2002, on a newly opened stroke unit next to the established unit)*

The matron at Holton expressed a similar view about planned *joint working* as a way of developing new healthcare assistants:

*'Another thing that I really feel that we need to move on with is when the healthcare assistants start, instead of starting completely straight away on the ward, that they spend the first six weeks as they would do as a therapy assistant, so they get a better overview'.*  
(Matron, Holton, Interview 12)

Observation in both units indicated that planned *joint working* could improve skills, knowledge and understanding of new and experienced team members and in turn encouraged team members to undertake informal and unplanned *joint working* more frequently. However, it seemed necessary to remind the teams of the value of the approach. This is a function of team practice maintenance which is examined in chapter 9.

Existing teamwork literature suggested that introducing *shared learning* and *joint working* sessions could have resulted in interdisciplinary conflict with professional groups seeking to protect and reinforce their differences, or to dispute control and authority in respect of specific skills and knowledge (Farrell, et al 2001; Hudson, 2002). Senior PTs, OTs and SALTs at both units were prominent in sharing specialist knowledge and skills but did not perceive this as a threat to or an erosion of their professional autonomy, a problem noted by Long et al (2001) and Booth & Hewison (2002) in their studies of health professional relations in rehabilitation settings. A feature of work in the stroke units which contrasts with that seen in other studies was the direct, day-to-day involvement of senior team members in rehabilitation. A consequence of this in terms of teamwork was that team members were routinely exposed to different ways of conceptualising patient problems and thinking about rehabilitation interventions.

#### *Understanding the roles and perspectives of others*

Learning and working together contributed to team members' understanding of the diversity and complexity of stroke illness and the rationale for the specific rehabilitation required for each patient.

As a result of core team members being based on, or spending the majority of the working day on the stroke unit, regular and repeated role modelling occurred in 'public areas'. PTs, OTs, SALTs, nurses and dieticians in both units carried out many of their interventions where they could be directly observed by other team members. This had a number of consequences including that skilled and effective rehabilitation techniques were continually demonstrated by senior staff. This not only showed that 'specialist' techniques could be practised in busy and complex stroke unit environments but also challenged the view that senior team members providing advice and direction don't know what it is really like to manage patients (Cott, 1997; 1998). Working in this way on a daily basis made it easier to include inexperienced or new members of staff in informal *joint working* and teaching. Role modelling and direct engagement in rehabilitation was more powerful in bringing about behaviour change and compliance than classroom instruction or default to positions of authority, where telling others what to do has been shown to have limited success (Evers, 1982; Cott, 1997; 1998; Griffiths, 1997; Opie, 2000). A Colebrook PT commented on this:

*'I think because we all work on one ward and we're all primarily based on one ward that helps, because especially with new nursing staff or new physios as they get the opportunity day in and day out to see a bit of what you do and to see the work. It's not like you take your patients completely off the ward somewhere very different'. (PT, Colebrook, Interview 9)*

Role modelling good practice was not confined to therapists or nurses, a dietician at Colebrook noted the impact of the Consultant's concern with nutritional issues:

*'You don't come across very many consultants who on a ward round specifically make a point of [asking], what are they eating and drinking? What's their weight? I mean writing weights in the medical notes and noting these sorts of nutritional things [...] that really filtered through and the Sisters really started to put nutrition on their agenda, and it even filtered right down to the ward housekeepers and healthcare assistants. (Dietician, Colebrook, Interview 7)*

These activities were regarded as normal in the stroke units but yet stood out as different and as clear examples of interdisciplinary working. Co-location and frequent contact between team members meant that nurses, HCAs and RAs developed a better understanding of PT, OT, or SALT, and that therapists began to comprehend the ways in which nurses, HCAs and RAs think and reason

and to appreciate the pressures they face in day-to-day work with stroke patients. Ward managers at both units suggested that it had taken time but therapists were now likely to accept that if experienced nurses or HCAs said a certain activity was not feasible with a particular patient, then that view was respected and alternatives would usually be explored. This frequency of contact should build confidence and trust in the judgement of other team members, however, reduced or limited contact also makes it potentially more difficult for the role of peripheral team members to be understood and for their judgements to be valued and respected. At Holton an OT acknowledged that more effort could be made to understand the work and perspectives of social workers:

*'I imagine that they're having to form links with a lot more places than us [.....] So I mean, it's probably not possible for them to form a sort of close a relationship with the team, but I think it's something that could be improved but I don't know how. Maybe if some of us actually went and visited them and just saw what their role was how much they had to do, maybe we would respect more why it takes so long for things to happen sometimes'.*(OT, Holton, Interview 6)

A social worker held a similar view but again focused on the importance of understanding roles and perspectives for team working:

*'I might not have a full understanding of what the PT is doing with people or the OTs. I'm sure they don't always understand the work that we do with people once they leave the hospital, [.....] And sometimes there are problems to do with discharge that might not have been planned fully enough and I think if you just have an overall understanding of discharge processes, what's important, then you can work together'.*(SW, Holton, Interview 10)

Peripheral team members at Colebrook had similar experiences, the senior dietician pointed out the value of team understanding of her role:

*'Being part of the team is them knowing what you do, what they can expect from you, what they can't expect from you and what you expect from them in return really. I think that's probably the key thing in getting on'.*

But as a more peripheral team member she acknowledged this required continued effort:

*'Even now still building on that, sometimes there are nurses that you've been working in the team for quite some time. And they know what your role is and what you've come up to do but they still don't know how the logistics of some of those supplements or food or feeds actually get to the patients and that sometimes amazes me'.* (Dietician, Colebrook, Interview 7)

The lack of understanding of role was not confined to peripheral team members however. Core team members also identified that they had little understanding of the work undertaken by others before they worked on the stroke units:

*'Once a week you'd see the OT and occasionally they would make a cup of tea with somebody. That was my understanding of what the OT role was until I came here and I realised the depth of involvement they actually have'. (SN, Holton, Interview 11).*

*'I didn't know much about physiotherapy before to be honest, I just know their view of stroke patients, and about the way their assessment. It's very technical, when we listen to what they say in the meetings, and when they talk to us. We just say the patient isn't mobilising, but their role is very, their assessment is very meticulous'. (SHO, Holton, Interview 3)*

At Colebrook, the ward sister identified how they got past some of this lack of understanding:

*'There were a lot of problems to start with, physios couldn't understand that nurses can't just take an hour out and not answer buzzers or whatever. So a few teething problems to start with, I think one of the main things that made it work is perseverance with it because like anything you are liable to have teething problems to start with, and it would be easy to give up on group sessions but Lucy, she just kept plucking at it'. (Ward Sister, Colebrook, Interview 1)*

A willingness to try and develop understanding was commonly cited:

*'I think it is good to see things from another viewpoint. And when you work with someone they are obviously chipping in their, you know their perspective all the time, because you're bound to see things slightly from your own professional point of view, because that's where you used to working from. [... ..] from our point of view, you appreciate other people's problems a lot more, because it's very easy to think oh God they have let them lie like that all night. When in reality, it isn't like that at all' (PT, Colebrook, Interview 9)*

*'I think what you need to be able to do is to go to the nursing staff and say, I don't know about this.... but with time obviously you pick up bits of other peoples knowledge and you perhaps don't need to ask them all the time, or you've got a greater understanding of what they're talking about'. (OT, Holton, Interview 15)*

The development of *understanding the roles and perspectives of others* impacted directly on rehabilitation practice and team members' interactions. An important understanding in terms of teamwork was that because patients presented different problems and had a different recovery pattern, rehabilitation plans would have to be adapted or changed frequently. There was an appreciation that regular or sudden changes to moving and handling or dietary advice were not the vagaries of PTs or dieticians distant from the patient. Team members in both units were generally



willing to accept changed advice as they had developed both an understanding of the necessity for the advice and trust in judgement of team members. It was possible to observe the contribution of shared knowledge and understanding, for example focusing on ‘central key points’ and attention to maintaining the ‘midline’ (for posture and balance) was taught by PTs but was an integral part of the thinking and behaviour of OTs and nurses in preparing for and managing upper body washing and dressing activities. These principles were routinely communicated to RAs, HCAs or students. These are more than just carryover of skills and represented internalisation of the rationale and understanding of the specialist neuro-physiology approach required in stroke, as this quote indicates:

*‘In the beginning it was hard even to come to understand the physio's when they set down plans, I used to think oh God they keep us here for ages we could do this, you know we could have actually moved the patient much quicker and done things but we were kept at this slow pace and then gradually with stroke information, you know education programme and all that and understanding the reasoning all behind it, was all’. (HCA, Colebrook, Interview 3)*

Another important feature of effective teamwork is reciprocity and willingness to make allowances for each other (Sullivan, 1998; Mickan & Rodger, 2000, Long et al, 2003). In the stroke units when the flow of work was disrupted as a result of pressures such as staff shortages or competing organisational and unit demands, role understanding seemed to foster tolerance when requests from other team members were not met. For examples, a pattern of work had evolved in both units where therapists timetabled patients for specific activities; nurses agreed with this timetabling but sometimes were unable to prepare patients for activities at the time agreed. The response regularly observed was for therapists to check the reasons why the patients was not prepared and negotiate with nurses for an alternative strategy and time for that patient and to reorganise their schedule. Such reciprocity was more likely to be evident when the team members interpreted the reasons for the patient not being able to participate in a planned activity as legitimate. For example:

*‘The OT was going to a patient who became unwell and actually had a cardiac arrest, so I left the patient that I was tending to [.....] and obviously went to see the patient who was medically unwell. And when I came back the occupational therapist had washed and*

*dressed this gentleman[that the nurse had been with] that needed all care, but she said, well I could see you were busy, so you know its about helping each other out'. (Ward Manager, Colebrook, Interview 10)*

Stroke unit team members recognised developing such reciprocity took time, months and years in both units, but that it had developed as a result of regular *joint working* and seeking a rationale for and understanding rehabilitation plans. The PT at Holton indicated that team members there had grown more confident about working together, what had led to this, and how this growth in confidence meant that team members were sharing responsibilities for rehabilitation and not waiting for 'experts' to decide. This example also illustrates the trust that has developed amongst team members about their ability to carry out what was previously regarded as the PTs responsibility:

*'I think ... obviously one of the main things is people getting to know each other well enough so that they feel comfortable...to approach...both for questions and for sort of advice or sort of challenging opinions really about why something's being done or whatever... and I think we've got to that point now...It probably took....sort of....eighteen months, two years probably'.*

She explained that:

*'I think that [the education and training] definitely has helped because people understand what they are doing and why, rather than just being told. What's really one of the things that's really great for me and....reinforces the fact that people's knowledge base and handling skills has come on a lot is that.... for the first few years it was like Miriam has got to see this patient before we can handle them, [.....] and now quite often because I'm on my own here quite a lot... [...] new patients will come on to the ward and they'll transfer them with the ambulance staff and then they'll come to me and say we've done such and such a transfer and it seemed to work right and they were able to do this and they were able to do that, seemed alright to me.... See what you think... and that's great that they are doing that in the first place and quite often when I see them, they're right and they've got the confidence and the skills to be able to do that now'.(PT, Holton, Interview 5)*

The development of *understanding of the roles and perspectives of others* was important in moving towards an interdisciplinary team approach in the units. This development had taken a long time, had not been without misunderstandings and problems, and was not complete or all inclusive even four or five years after the units began working. McCallin (1999) argued that developing interdisciplinary team practice required a shift in thinking, away from single discipline perspectives based on treatment requirements, towards team thinking based on the needs of the patient. Opie (2000) also argued that developing team thinking is essential if teams are to be effective. In the

stroke units this shift in thinking was facilitated by the sort of dialogue between team members identified in Table 5 (page 146-147) and Appendix 9 & 10 whereby patients' needs and collaborative responses were explored and debated as an integral part of *joint working*. Wenger (1998) suggested that collaborative interdisciplinary teams can be regarded as learning communities, learning and working together in the stroke units helped team members *understand the roles and perspectives of others* and move towards team thinking rather than focussing only on disciplinary concerns. The subcategory of *skill sharing and role security* identifies how such skills, knowledge and understanding were shared and suggests reasons why *skills sharing* did not result in conflicts at the professional boundary.

#### *Skill sharing and role security*

A key feature of the interaction between team members in both units was a willingness to share skills and knowledge. This was an important finding given the extensive literature indicating tension and conflict between health professionals in some settings (Evers, 1982; Mackay, 1993; Beattie, 1995; Adams, 1999; Atwal, 2002). A number of reasons for this difference were identified; these include attitudinal factors related to the experience and professional maturity of team members, their perception of the significance of professional boundary blurring and their interpretation what was required to provide effective rehabilitation for stroke patients. In terms of perceptions of *skill sharing* the following comments were often made:

*'We're not precious about what's OTs role and what's physios role, it's partly something that I think that has come about with working in elderly care and rehabilitation. I think because you're working with the same patient for the same goal in the same place and there's only quite subtle differences between the sorts of things that you're going to be doing with people'. (PT, Holton, Interview 5)*

*'I think, because were all working towards the same goals with the patients, so we are all doing the same thing with them. Which you know rounds off to produce a good service to the patients, as opposed to us all doing our own little thing and mine might have conflicted with the physios who want to do things say in the normal way, and I might think I want to use a compensatory method, and the nursing staff might be wanting to use a caring role'. (OT, Holton, Interview 15)*

Similarly at Colebrook

*'Because if you're working in isolation and you don't want anyone to do any of your roles then that would mean that you had to be there 24 hours a day seeing all the patients on the ward if you were going to be effective and there is just no way you can do that. So the only ways that you're going to get your input on to that ward 24 hours a day is to share'. (PT, Colebrook, Interview 9)*

The impact of this on other team members' practice is evident in the following comment:

*'Sharing of information is the big, yes, that's the big thing, really, share your information. It helps, I mean there's no point in coming on and saying to someone [.....] You've not to move that person from that bed to there, you must use a hoist, and not explain to you why you're doing it [.....] when it's explained the reasoning behind things and you gradually learn and you know what all this is about' (Interview 3, HCA)*

Upskilling all team members was perceived as a means of improving the quality of rehabilitation for patients and staff were willing to participate in this process. The PT at Holton (above) identified that this was partly related to her prior professional biography and experiences in elderly care; in turn this influenced her interactions with other team members. Similar perceptions were expressed at both units:

*'I think sometimes we can be a bit too overprotective [of skills and knowledge], and I think the more you share, the more we give to the individual patient and to the team as a learning process'. (OT, Colebrook, Interview 8)*

A social worker at Holton expressed the same sentiment in response to questions about role overlap and boundary blurring:

*'It's not a worry that I have. Because I think ultimately you have to remember you're working together for a common aim to help a particular individual get back home or receive the care that is necessary for them, to help them meet their own goals and to support them in that and it's not just about you know, I am a social worker and this is my role and I don't want anyone else interfering in that'. (SW, Holton, Interview 10)*

These team members were well aware of broader professional debates about possible consequences of skill sharing but interpreted this in terms of their day-to-day work and the goal of rehabilitation.

At Colebrook the senior PT said:

*'I felt a little bit that it was my own profession, who were saying that we were so unimportant that we could be taken over by generic workers..... I just couldn't see what they were saying because to me the nursing and the care would be more therapeutic and therefore better so isn't that what we want? [.....] The handling is going to be better, and*

*the washing. And if they're working with OTs the washing and dressing is going to be better, everything should be more therapeutic'. (PT, Colebrook, Interview 4)*

*Shared learning and regular joint working* provided opportunities to equip team members with the knowledge and skills to work safely with stroke patients individually and collaboratively, towards the same goals using shared specialist skills. One reason why this was not seen as an erosion of professional boundaries and as a threat to professional identity is the professional maturity of many team members and the relative absence of any perceived jurisdictional competition (Abbott, 1988; Molyneux, 2001). These team members were secure in their role understanding and professional practice and defined sharing core skills as valuable for achieving continuous as opposed to episodic therapeutic intervention. At the same time, team members at both units were clear about what they considered appropriate boundaries between their roles and specialist skills they held that others did not, but they identified reasons why sharing was desirable or increasingly necessary in rehabilitation settings:

*'I mean, just because we wear a certain uniform doesn't mean you don't have knowledge of another field, I mean, you need your professional boundaries obviously in certain roles legally that we all do differently from each other so that still has to exist. We do physio as part of our role, you know, but OTs do washing and dressing which has always been perceived as a nursing role and physios get involved in little bits and pieces all the time'. (SN, Holton, Interview 11)*

*'I think there's enough of more specialist skills, not to feel threatened by passing on some of those assessment skills to the rest of the team. I don't think it can function properly without... if you do want to hold onto all the skills, because you won't get that same sort of sharing and understanding about why things happen unless people have got those skills'. (PT, Holton, Interview 5)*

*'I think it's about being sort of confident in your own (skills) as well. I think if somebody isn't sort of confident in knowing what their skills are and what they do, if other people do try to take aspects of it, they can become quite defensive'. (OT, Holton, Interview 6)*

A PT at Colebrook expressed the same sentiments:

*'I don't see that as an issue really. I think you know whatever everyone else in the unit is doing, you're still going to have your role, and it would just be a higher level probably... and there's always going to be that there, you know, you're never going to get someone taking over your whole role'.*

But she also identifies that the stroke unit is different in this respect to some other units:

*'It really does work very well on the stroke unit compared to other places that I have worked and I think it's because everyone is prepared to kind of share and be holistic. Because a lot of other units that I have worked on; experienced members of staff tend to be very much 'I've done this for years, don't tell me what to do', kind of attitude. That is honestly quite difficult and not very constructive '.* (PT, Colebrook, Interview 9)

The majority of team members in both units were secure in the knowledge that they had specialist skills and understanding which extended beyond those shared with others; they did not define role overlap as a barrier to team working. Laidler (1991) termed this kind of *role security* 'professional adulthood'; this concept is used to indicate that experienced professionals who are confident in their own work roles and identity, feel safe to share their skills and blur professional boundaries. McCallin (1999) and Molyneux (2001) argued that as team members begin to redefine their roles as being about meeting patient needs as opposed to discharging professionally driven responsibilities, then it is more likely that they will work collaboratively, sharing skills and knowledge. The quotations above identify this patient focus in the thinking of team members. Significantly, in the stroke units interaction with other team members was not about competition for control of resources, increased status, recognition or financial reward. Abbott (1988) and more recently Adams (1999, 2004) highlighted these factors as primary sources of interprofessional conflict. These issues are often part of wider professional struggles for occupational control played out at either a national level or a local level (Adams, 2004; Timmons & Tanner, 2004) but which had little direct relevance to day-to-day teamwork in the stroke units at this point in their development, where patient focused collaboration was the driver for *skill sharing*.

Booth & Hewison (2002) examined role overlap between OTs and PTs during inpatient stroke rehabilitation and found a similar pragmatic view of skill sharing. However, in the current study, as in Booth & Hewison's, team members were quite clear that some boundaries should not be crossed. For example PTs said that nurses and OTs should not be independently engaging in primary neurological assessment and determining physical therapy interventions. In the same way dieticians

were clear that determining enteral feeding requirements would not normally be undertaken by PTs or SALTs. These were perceived as specialist skills, erosion of which was not negotiable because this would have a wider impact on the organisational and political perception of these professions. Team members recognised that significant shifts were occurring at a national level in professional roles, and were aware that these changes may call for re-examination of professional boundaries. Some of the *skill sharing* in the stroke units can be interpreted as pragmatic accommodation to both workload demands and the shortage of therapists. For example, teaching nurses, OTs and doctors a simple ‘sip test’ was defined by SALTs as being about ensuring early recognition and appropriate response to swallowing deficits following stroke and not as role erosion. At Holton the SALT said:

*‘I think it is inevitable because of the pressures to do so. I think there will be more sharing of skills and development, and as I mentioned particularly here, then I think the pressure area is in therapy, where there are very few speech and language therapists. We’ve already done work on dysphagia and nurses getting skills in the acute ward for that’.* (SALT, Holton, Interview 8)

The consultant physician at Colebrook acknowledged this policy imperative but was wary of forcing the process of *skill sharing* preferring a gradual transition:

*‘I’m certainly aware of the work in ‘Chesterton’ with the ‘changing workforce programme’, and trying to multi skill people [...] my view is that that will work better as an evolution rather than bang, let’s sort of change the way everyone works quickly. I think that if you’ve got a stroke unit, give it another five years and you’ll find people doing more generic skills, more sort of sharing of skills on an informal basis’.* (Consultant physician, Colebrook, Interview 11)

The stroke unit teams seemed to have adopted this evolutionary approach to *skill sharing* which was facilitated by early and continued commitment to *shared learning* and *joint working* and benefited from the professional experience and maturity of the majority of team members. There are other studies in rehabilitation settings which have similar identified positive and pragmatic attitudes towards boundary blurring and *skill sharing* (McCallin, 1999; Molyneux, 2001; Booth & Hewison, 2002). An important outcome of team practices discussed so far in this chapter is the shift in thinking which occurred for team members over time. A significant shift from thinking about

rehabilitation as being the responsibility of therapists and doctors to developing *shared ownership of rehabilitation* was evident in the data.

*Shared ownership of rehabilitation- redefining roles and changing thinking*

Inclusion of nurses, RAs, HCAs and housekeepers in *shared learning* suggested they had an active role to play in the teams and that stroke rehabilitation would not simply be the responsibility of experts working in therapy departments. This defined areas of skills and knowledge needed and in turn began to *redefine the roles and thinking* of team members. It contributed to a shift from membership of a single professional group to membership of stroke unit teams, teams with skills and knowledge in common and which saw a purpose in collaboration. Hudson (2002: 16) noted that '*socialisation to an immediate work group can override professional or hierarchical differences amongst staff*'. Farrell et al (2001) and also Gulliver et al (2002) found that as teams develop they can progress from investing energy in protecting differences and discover that they have common interests and good reasons to collaborate and resolve differences.

Teamwork in the stroke units was contrary to the ways in which most of the individual disciplines had learned and worked previously, which often was based on working independently of each other, coming together only to report on their individual actions, and where status and hierarchy influenced perceptions of the worth of different team members' contributions. A staff nurse at Holton commented:

*'You know', it does feel like a team and I feel that I could ask any of them anything or put my opinion on something and it would be listened to and taken at its own merit, whereas you never got that impression on the acute wards, it was like this delineation of there's nursing and there's therapists'.*

*INT: You don't perceive that here now?*

*'No, I could say anything to any of them you know even if it was something stupid they'd tell me and I wouldn't be offended by it, but at least they'd listen to It'. (SN, Holton, Interview, 11)*



This nurse clearly felt she could express her opinions within the team and that her colleagues would be willing to listen and respond to her views. A HCA at Colebrook noted that the unit was different to others she had worked in:

*'Oh completely because I've never worked with a physio really before, the physio always came in and do what they had to do and left you know, it's completely different on this ward'. (HCA, Colebrook, Interview 3)*

*Shared learning* was recalled as a prominent feature in cementing the team relationships and suggesting that stroke rehabilitation would be a joint enterprise and not just the preserve of experts directing the work of others. The HCA above expressed her view that:

*'That was the most difficult I found was anyway, after being used all the time to doing for people, was actually having to stand back, let's see first of all what people can do for themselves. We were actually learning what rehab was all about. I don't think of it being physio's work now at all I just think of it being part of the care on the ward you know, part of the care for the patient, I don't think anymore of them and us, I think of it as more of us, you know teamwork'. (HCA, Colebrook, Interview 3)*

At Holton a staff nurse expressed her thoughts on her rehabilitation role:

*'I think we all work together on that, [.....] because to me it could be something as simple as standing somebody up, to me that is rehab. It's movement and handling and it's activities of daily living, it could be at lunchtime in coaching somebody to feed themselves, to use a spoon correctly, [.....] So to me as a nurse our [rehab] role is ongoing 24 hours a day'. (SN, Holton, Interview 7)*

Although the role of medicine was more peripheral on the stroke units, one of the SHOs indicated the way in which her thinking changed as a result of exposure to the interdisciplinary activity occurring at Holton.

*'I realised how important that person's [OT] contribution was [....]I think it's a different speciality, with a medical problem the patients don't stay with us for more than a week or two, but here it's a matter of weeks and weeks. So whatever is happening is happening in front of us. Just, we tend to be more involved'. (SHO, Holton, Interview 3)*

A staff nurse highlighted a practical example of changes in thinking over time:

*'This is another example of how we have come further on, [.....] I came out on Friday [from the MDT meeting] and said, we don't want Charlie in a wheelchair anymore he is starting to get tight hamstrings, and achilles', Miriam wants him to lay on the bed for two hours in an afternoon just to try and relax him to get his tone down a bit. And nobody batted an eyelid, they all went 'oh right'.*

She continues

*I explained it, they understood it, it was carried out, not an issue, but go back to the earlier years it might have been 'why the bloody hell' you know what I mean, a bit more of that sort of attitude. [...] I mean, I think it's probably, it's fine getting to work the same but thinking the same way is another thing isn't it, there is a difference between thinking and doing and it's your thought processes as well isn't it, what we see as important'. (SN, Holton, Interview 4)*

These are indicators of changes in team members' thinking about and *ownership of rehabilitation* as an integral part of their nursing and medical work; the statements also position rehabilitation as shared work. Although there was clear evidence of *shared ownership of rehabilitation and changes in thinking*, some areas of patient care challenged team members at both units to examine their views about what was possible, practical and desirable and to consider how far each discipline had moved in terms of interdisciplinary working. At both units there was some reluctance to discuss areas where practice was not always shared. The following section highlights the different perceptions held at Holton and Colebrook about therapists' willingness to make changes to their traditional ways of working and involvement in wider aspects of patient care.

Some nurses at Holton identified issues which they felt had not been discussed openly, such as toileting being regarded as low status work which was seen only to belong to nursing. Some also felt that therapists not working shifts or at weekends meant that opportunities for the unit to develop further were being missed. This was highlighted in an informal comment made at the nurses' station at Holton:

*SN: 'Look at that board, times for everyone and everything, Charlie for washing and dressing practice at ten, Elsie to work on stroke stand at 1100, there are no appointments for nursing though are there'*

*INT: What do you mean?'*

*SN: 'Well we timetable everything except the bits no one wants to do, you know, who takes Charlie to the toilet and gets Elsie up for therapy?'. (Fieldnotes, Holton, May 2002)*

At Holton this issue of toileting and associated personal hygiene featured more regularly in informal discussions about how far therapists reciprocated nurses willingness to share ownership of 'rehabilitation'. There was however, some ambivalence about what this meant:

*'You're definitely working closer with the other disciplines and I think we would like to work closer still....and I don't think we've quite got there with that, I think we want them to we want them to work as we do and I don't mean we want them to work as nurses, we want them to work with us'*

What this nurse meant by not wanting therapists to 'work as nurses' was clarified when she added:

*'I definitely do see us as a team but there's still not that, it's still a bit our job their job, ....for example they'll still come and say 'oh so and so wants to go to the toilet' and you think well you can take them to the toilet as much as we can,.... I don't always think they do it consciously'. (SN, Holton, Interview 4)*

Her colleague was sure that therapists should be involved in these tasks:

*'Even something as simple as they could be in the middle of therapy with somebody and if they wanted to loo, they'd come and say to us... 'they want the toilet', you know, they wouldn't actually take them to the toilet'.*

*'Or we could be planning a discharge for a patient and the OT would maybe come up and say, 'how do they get up and off the toilet... all right? Do they need a toilet seat raiser to go home?' And I thought if they did take them to the toilet they'd know that, they wouldn't have to come and ask us'. (SN, Holton, Interview 7)*

When questioned about these issues, the PT said:

*'Oh yes, that's shifts [...]. if we had three times the staffing we could work shifts and weekends but that's the sort of thing that all you get's the chunter, you don't get the chance to actually have a proper discussion about sort of practically speaking why we physically can't work... work as they do'.(PT, Holton, Interview 5)*

Therapists at both units argued that any activity, including toileting, should be a legitimate part of their work if they were required during the course of timetabled therapy. But, that outside of this time, patients' needs might be more appropriately met by the nurse or HCA:

*'I'll quite happily clean somebody's bottom if they've been incontinent of faeces but I will also do hopefully a fairly skilled assessment of neurological deficits sort of thing and I feel quite strongly that therapists particularly need .to do that, to be part of that [toileting] I'm quite happy to do it if I'm with that person at the time or if I want to see that patient, then... then I'll do it but if I go round taking everybody to the toilet and helping them clean up then I never get to do my specialist bit'. (PT, Holton, Interview 5)*

Team members in both units, but particularly at Holton, had not discussed the meaning this aspect of work had for them and their ownership of rehabilitation. This concern with responsibility for helping patients with toileting may have less to do with teamwork than with the nature and status of the activity which can be conceptualised as low status or 'dirty work' which was defined by Hughes (1958: 121-22) as:

*'In professional as in other lines of work, there grows up both inside and outside some conception of what the essential work of the occupation is or should be. In any occupation people perform a variety of tasks, some of them approaching more closely the ideal or symbolic work of the professional than others. Some tasks are considered nuisances and impositions and even dirty work -physically, socially or morally beneath the dignity of the profession'.*

In terms of the developing career biographies of nurses who most commonly raised these issues within these units then it can be argued that as specialist knowledge and skills in stroke rehabilitation developed, some nurses were redefining their roles as being concerned with specialist interventions and may have resented the traditional association of nursing with intimate physical care. This can be viewed also in terms of the wider occupational biography of nursing where arguments about expanding roles have to address shifts in traditional perceptions of the proper content and focus of nursing work (Meerabeau, 2001). Some of this debate has been played out in the public as well as professional press in recent years with individual nurses and professional leaders debating the relationship of nursing with the provision of personal and intimate care (Meerabeau, 2004). This is an example of the intersection between broader occupational developments within a professional group and the local interpretation of professional roles. Within the context of the stroke unit teams there was a need for both intradisciplinary (nursing) and broader interdisciplinary dialogue about these aspects of team practice. This is an issue where interactions between team members may be negatively influenced by this unspoken but important difference in biographies and temporal images (Strauss et al, 1985). Reasons why the teams did not address these aspects of team practice are examined in chapter 9.

A similar lack of engagement of therapists with toileting was observed at Colebrook, but in contrast with Holton this was rarely raised as a concern by nurses. A possible explanation for this lies in the willingness of therapists to adapt their traditional working practice which influenced the perceptions of other team members about therapists' ownership of rehabilitation. At Colebrook, OTs were going into the unit an hour earlier than normal on certain days to work with nurses on getting patients out of bed, washed and dressed, to develop a common understanding of the therapeutic intentions underpinning activities such as facilitating upper limb movement in washing. An OT explained what she saw as the value of this approach:

*'We've just recently introduced where I'm coming in early to work with nurses with specific patients and that's certainly given the nurses quite a lot more insight into our role but I think on the whole people....no...I think other professions maybe don't tend to be as aware as they could be [about OT]. But I think we have to learn as much as them'. (OT, Colebrook, Interview 8)*

Working more flexibly in this way highlights the OTs understanding that direct involvement in *learning working and together* can make that learning more meaningful than giving written or verbal instructions alone. It also responds to nurses' concerns that rehabilitation is a 24 hour process and therapists also need to see patients outside of the timetabled (9-5) sessions.

Two other examples illustrate the ways this team was evolving the order and pattern of work and *sharing ownership of rehabilitation*. PTs had worked evening and night shifts in order to provide patient centred training for night staff. Nurses interpreted these activities as being evidence of a strong commitment to meeting the needs of the patients, and specifically mentioned the importance of the therapist working with night staff to see how patients differed at night and how approaches to moving and handling needed to be adapted. This in turn impacted on night staffs' understanding of the reasoning for therapy advice regarding positioning, movement and rest. One staff nurse said:

*'I was impressed by staff from days [therapy] coming onto nights to work with staff and demonstrate specific moving and handling or positioning techniques and passing on specialist knowledge'. (Colebrook, Fieldnotes, April 2002)*

The ward sister said of the senior PT:

*'She's changed her working time in that she's come in and done ....worked night shifts. now I have never worked anywhere where a physio has worked night shifts before... she's come in and done evening sessions so she's looked at problems encountered in putting patients to bed and how different they are when they are half asleep in the night [.....] So she's seen some of the problems that she doesn't quite see in the day'. (Ward Sister, Colebrook, Interview 1)*

This relatively simple change in working practice demonstrates a commitment to the patients but also to the team members who work at night and could easily be excluded from the work of the core team. Another example of more flexible working was therapists' involvement in regular evening information sessions (two evenings per week). These grew out of the recognition that patients and their families had information needs which were not being met by the normal contact in medical ward rounds, or at visiting times. One of the sessions occurred in the evening after the MDT meeting and provided information regarding progress and future goals. The fact that these sessions were jointly provided demonstrated that therapists were prepared to adapt their roles and working times to ensure that patient needs were met, by the team and not just by disciplines that normally worked beyond 1700 hours. Whilst one could suggest that these activities are patient focused, they contributed directly to the achievement of teamwork because they demonstrate ways in which team members were willing to adapt roles and share responsibilities. These examples of reciprocity contributed to the more positive perceptions of therapists' ownership of rehabilitation at Colebrook and may explain why helping patients with toileting did not acquire the significance it did for some nurses at Holton.

In summary, data analysis indicated the following relationships between the category learning and working together and its subcategories.

- 1) Deciding to include all team members in *shared learning* sessions ensured they had a common understanding of not only the pathophysiology of stroke but also the priorities, concerns and skills of different team members.

- 2) Participating in *shared learning* sessions and sharing the same work location directly contributed to the willingness of team members to engage in *joint working* with others on problem focused approaches to rehabilitation.
- 3) As a consequence of being *located* in the same work area and regularly participating in *joint working*, team members benefited from and participated in role modelling and public display of specialist skills in stroke rehabilitation. Over time, *joint working* contributed to team members developing a clear *understanding of the roles and perspectives* of other disciplines and *developing understanding and trust*.
- 4) Participation in *shared learning* and *joint working* in stroke rehabilitation encouraged team members to discuss the skills and knowledge required to provide effective rehabilitation. The willingness to *share skills* and knowledge with team members from other disciplines is a consequence of team members being confident and *secure* in their professional *roles*.
- 5) These features of learning and working together contributed directly to the perception that *ownership of stroke rehabilitation* was *shared* and not located solely with therapists. Over time this contributed to *redefining roles and changing thinking* about rehabilitation.

### Summary

These stroke unit teams held positive views about working collaboratively and described the benefits that this brought for patients and themselves. This contrasts with situations where some healthcare professionals give little conscious thought to the processes involved in teamwork, or describe situations where they found team working not to be practical, enjoyable or useful (Halstead, 1976; Griffiths, 1997; Borrill et al, 2003). Drawing on Strauss et al's (1985) concepts of temporal order and temporal matrix there are features of the stroke units which merit consideration in terms of the major categories outlined in this chapter. Strauss et al (1985: 280) conceptualised organisations as temporal matrices, that is social settings in which '*multiple lines of work, each of which has a biography*' intersect and comprise elements of the organisation which can suggest explanations of the way work in the organisation has developed over time. When opened, these units brought together specialist skills and knowledge which already existed in different work sites but which had not been utilised in a coordinated way for stroke rehabilitation. Team members indicated that prior to the units being established, the prevailing culture in the satellite hospitals was one where rehabilitation was implicitly valued, but not the primary focus of the of long stay elderly care units.

The biographies of the hospitals and the designated wards were disrupted at this time: however some continuity was evident in the continued focus on older adults (Wiener et al, 1997). The changes at this time were significant, driven in part by a need respond to external structural change in health policy but shaped also by local conditions, including staff seizing on the opportunity provided by service reorganisation and the perceptions of individual professionals committed to improving outcomes following stroke. In terms of the biography of the stroke units, they were at the beginning of their development, the order, pattern and pace of work within them was not defined other than by past linkages with elderly care or general neurological rehabilitation. Opportunities therefore existed to shape a new order and pace of work. Intersecting with this early developmental stage were a number of senior and experienced professionals whose personal and professional career biographies included positive experiences of rehabilitation work and who perceived stroke units as work sites where their specialist skills could be practised. The biographies of the occupational groups to which each of the professionals belonged also had a potential bearing on the division of labour, in that a medical model could have been adopted as this was familiar and could have provided the basis for determining the pattern and order of work in the units. It could have indicated a status derived hierarchy led by medicine and assisted by a number of subordinate groups each with their own hierarchy. These professional groups could have drawn on past experiences where for most; the order of work had been dictated by routine and organisational demands, and the pace of that work by the acuity of patients' illness. Working regularly and directly with other professions was not a common feature of the professional biographies of stroke unit staff initially. The biographies of stroke patients are important too and reflect not a slow, age related ill health trajectory but a sudden and acute episode which profoundly influenced their level of independence. their sense of self, and relationships with family.

Strauss et al (1985) argued that the intersections of these biographies can be regarded as conditions which give rise to interactions between social actors, the consequences of which can be discovered



or observed. The data demonstrated that key actors in this work setting came to the new stroke units with positive perceptions and temporal images of stroke and rehabilitation, they encountered others with similar images and these shared images influenced other professionals new to stroke rehabilitation. This intersection of hospital, unit and staff biographies was part of the temporal matrix in the early stages of the development of the stroke units and can be used to trace the consequences of the interactions at these intersections (Weiner et al, 1997; Strauss, 1993).

The relationship between major categories is not linear but reciprocal. This is illustrated in the relationship between being *positive about stroke* and the willingness of team members to share skills and knowledge and engage in *learning and working together*. Collaborative approaches to meeting patient needs were reported in the early stages of stroke unit team working and were clearly evident in data generated by the study. The fact that the team members were *positive about stroke* provided common ground between them, but working together and achieving teamwork required more than shared interests. It required team members to reconcile uniprofessional goals and aspirations which they learned and developed through single discipline socialisation, with those of other professionals who had different skills, goals and aspirations (Opie, 2000; Farrell et al, 2001; Hudson, 2002).

The two major categories outlined in this chapter identify key elements of the social and work context and some of the processes which directly impacted on the perceptions, interactions and thinking of team members. They identify that the division of labour is different to some traditional healthcare settings, being based on understanding, trust and respect for the skills and knowledge of other professionals as opposed to their status in a medically led hierarchy. Conceptualising the stroke units as temporal matrices locates the development of teamwork in these units over time and identifies how intersection of the components of the temporal matrix, including the career and professional biographies of the team members, the specific focus on stroke rehabilitation and the

needs of the patient group, influenced and were influenced by the ordering of work which has evolved. Interaction between team members has been frequent as a result of co-location of most team members, their positive images of stroke and rehabilitation contributed to a process of learning and working together which in turn required redefinition of perceptions of other team members and the way in which work should be ordered to meet the complex needs of stroke patients. These processes represent secondary professional socialisation to collaborative working as part of stroke unit teams.

The development of team working outlined in this chapter indicates that team members' thinking has been influenced by interactions and *shared learning* with other team members. Significant in this is the shift from defining work with stroke patients as being based on individual selection of the correct disciplinary therapeutic techniques, to collaborating with others, thus changing thinking from 'what do I need to do with the patient', to 'what are the needs of this patient and how can these be provided by the team'? Participating in these activities which constitute *learning and working together* is an important contributory factor in the development of the *inclusive team culture and concern for persons*. The findings in relation to these categories are explored in the next chapter.

## Chapter 8:

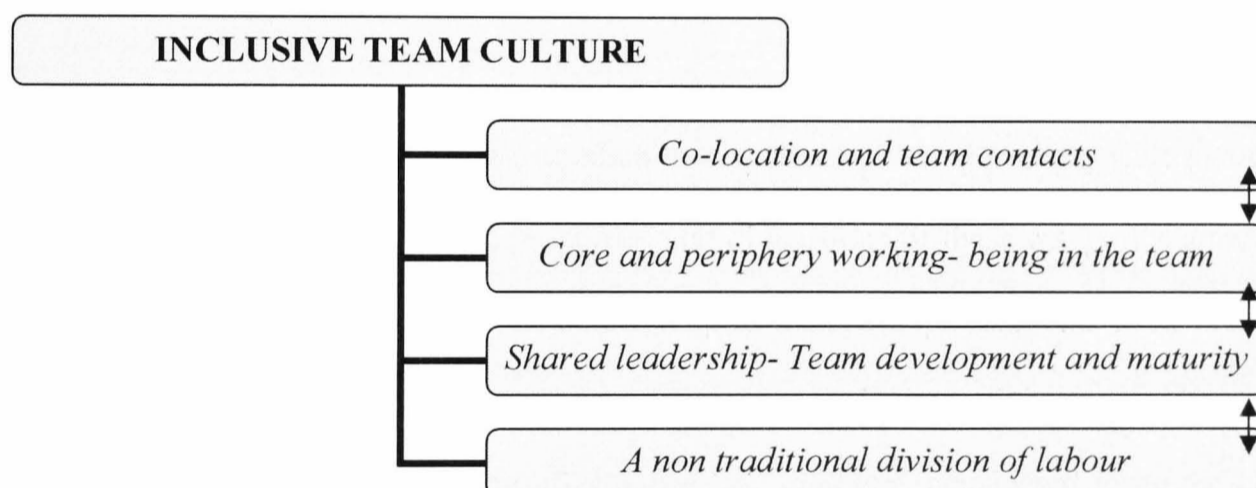
Research findings: *Concern for persons; Inclusive team culture and Opportunistic dialogue*

## Introduction

This chapter will present the findings of the research in respect of two major categories: *inclusive team culture* and *concern for persons*. The properties and dimensions of these categories and their relationships to the core category of *opportunistic dialogue* will be explored. This is in order to trace the temporal consequences of the interaction of these elements in determining the achievement of teamwork in the stroke units. Discussion of *opportunistic dialogue*, considered to be the basic social process which brings about the synthesis of these elements, will conclude the chapter.

## Category: Inclusive team culture

Figure 12:




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### *A non traditional division of labour*

Data analysis indicated that there was a relative absence of traditional workplace hierarchy and *a non traditional division of labour* in the stroke units. Power and authority are integral components of hierarchical position and status. Teams ordered hierarchically are unlikely to collaborate in their decision making and practice; instead they use status and power to control the allocation of work tasks for their advantage. In traditional healthcare settings it is generally accepted that medicine has positional power and exercises this through decisions regarding admission, treatment and discharge

of patients (Griffiths, 1997; Annandale, 1998; Opie, 2000). In a hierarchical structure, professions such as physiotherapy, occupational therapy, dietetics, speech and language therapy and social work are often considered to have higher status than nursing (Opie, 1997; Gibbon, 1999). In turn nursing occupies a higher position in the occupational hierarchy than healthcare and rehabilitation assistants. Thus professional status can dictate the division of labour and medicine may hold tight control of the power and authority to decide on and determine the allocation and use of resources (Freidson, 1994; Fournier, 2000). Exerting tight control over one's own work and that of others is contrary to the notion of interdisciplinary working and is frequently cited as a major barrier to effective teamwork (Beattie, 1995; Stark et al, 2000; Borrill et al, 2003).

The stroke unit teams did not exhibit a traditional medically dominated hierarchy. Team members identified a difference between the stroke units and other teams they came into contact with (see pages 185 & 199), indicating that stroke unit teams demonstrated a higher degree of collaboration, *shared leadership* and minimal recourse to exercise of power and authority. Interactions occurring as part of *learning and working together* demonstrated an intention to work towards inclusion and valuing of all team members, both by involvement in *shared learning* opportunities and in day-to-day working. The following discussion explores research findings which demonstrate an inclusive team culture in the stroke units, and identifies situations where more traditional patterns were evident.

The support of senior PTs, physicians, nurses, and OTs for *shared learning* and *joint working* provided significant practical examples of rejecting hierarchical structures and making inclusion a reality. Senior nurses at both units were noted for their enthusiasm for inclusion and demonstrated this by initiatives such as providing education for housekeepers. This included teaching about nutritional needs, the rationale for thickened fluids and use of food charts. At Holton, housekeepers were also included in *shared learning*. At both units housekeepers participated in providing

appropriate fluids or supplements and monitoring intake, and were involved by dieticians in discussions related to particular patients. Sharing responsibility with the housekeepers for these aspects of rehabilitation provided a powerful message that their contribution was important and valued. This view was endorsed by other team members:

*'I think everybody in the team is important for that. From you know the housekeepers to everybody sharing a philosophy about that'. (Consultant physician, Colebrook, Interview 12)*

Similarly at Holton:

*'We have gradually broken down the traditional ways of working, you know the hierarchy, and for example, dieticians in this unit will now accept referrals from any member of the team; that's in contrast to other areas where they will only accept referral from a doctor'. (SN, Holton, Fieldnotes, April 2002)*

The willingness to rethink the division of labour began as the units opened and understanding of work that could be shared developed. This occurred gradually as a result of team members routinely talking about and debating their practice and listening to the perspectives of others. For example, at both units in nursing handovers, information was directed at staff nurses who had responsibility for particular patients but HCAs and student nurses were actively involved and their views sought on patient progress. These views were listened to carefully and suggestions made were discussed in the same detail as those made by senior staff. All grades of staff at both units seemed used to contributing in this way and expected to do so. There was evidence that this was a deliberate strategy, a staff nurse at Holton, said:

*'I think it's working with like-minded people, because you are all working for the same reasons, and I feel really lucky to work on here [... ..] because, you feel as if your opinion is valued, and we try to do that with auxiliaries and students and make them feel they can speak up, and their opinion is valued, whereas in other areas that doesn't happen'. (SN, Holton, Interview 7)*

Another example of rejection of hierarchical ordering of work concerned therapy planning, at Colebrook where a PT assistant timetabled PTs work. This required negotiation with senior therapists and nurses to ensure that frequent changes in patients' rehabilitation were accommodated

and continuity maintained. OTs utilised this timetable to plan their work. An important element of this shift in the division of labour was the trust placed in this low status team member to plan the work of senior staff. This was not an isolated example; in the same unit ward clerks were encouraged and supported to take some budgetary responsibility in determining the need for and booking agency nursing staff. There were other examples of involvement of HCAs and housekeepers in direct patient care and a willingness to trust these team members, regardless of their role and status in the traditional health professional hierarchy, for example:

*'I don't have a problem relying on housekeepers if they are doing their job properly. I think they are valuable resource really that is often under recognised [.....] I do trust Jose quite a lot really because she knows how to do her job. Yes they do take a lot of responsibility, and really they could argue that their job is quite, has risk associated with it really, because if they're not informed properly their patients is on thickened fluids, they give them a normal diet and that patient can choke'.* (Dietician, Colebrook, Interview 6)

*'Lisa (HCA) came to me and said she wanted some green underpads. I had been told by the continence adviser, not to order them anymore, but Lisa gave her a rationale for that. And they ordered them, because you know at the end of the day she's the one looking after the patients, so by still listening to your staff, I suppose you keep them valued'.* (Ward Manager, Colebrook, Interview 10)

Similar comments were made at Holton:

*'It really makes me smile lately, a couple of days ago, Jane, the Matron said she was helping out on the ward when one of the healthcare assistants said to her ' Oh no you've got to stand her here because of such and such' and we just said isn't that great!'. (PT, Holton, Interview 5)*

This trust was founded on providing appropriate education to develop staff understanding. When team members could demonstrate their understanding in supporting rehabilitation, as in the examples above, then high status team members acted on their opinions and responded to information they provided. Involving all grades of staff in this way and rethinking the division of labour required in the stroke units contributed to building trust, commitment and team loyalty, and was important when the units were short staffed and under pressure. Team members who feel involved and respected are more likely to find ways to manage and cope with pressures and demands which may result in conflict and stress or absenteeism in other teams (Sullivan, 1998; Miller et al, 2001; Borrill et al. 2003).

At both units all team members were observed interacting with non unit based SALTs, dieticians and social workers. Inclusiveness was not something which featured only in relationships among unit based team members, but was also embraced by peripheral team members.

*'I would say the generally we do have quite a good working relationship and we sort of have quite a lot of trust and confidence in each other, which makes it enjoyable working in the unit'. (SW, Holton, Interview 13)*

Team members used to this non hierarchical approach, to some extent took it for granted. When questioned about this, some suggested that they could not see how it would work otherwise, making comments such as; *'well we're in it together aren't we?'* and *'unless everybody plays their part and is recognised for it, then we just would not function as a stroke unit'* (Ward Clerk and HCA, Colebrook, Fieldnotes, June 2002). An SHO at Holton indicated its impact on her perceptions and work:

*'Everybody knows it's a teamwork and if I don't know anything about this patient there is somebody else who knows more about the patient so it's, I should say I feel more at ease here because there is somebody else who can take more, equal responsibility unlike other places where everything is on you, on us to make decisions about..... And not many people really know about the patient'. (SHO, Holton, Interview 3)*

Here the SHO contrasts being part of the stroke unit team with the traditional expectation that she would take a lead role in patient decision making. The influence and support of the consultant physicians was also an important part of their involvement in both units. A traditional hierarchical approach would, at worst, have stifled the attempts to rethink the division of labour, or at best led to a situation where two cultures existed, one for working with the physicians and another for other team members. This sort of damaging division has been identified in health service settings where it was associated with maintenance of positional power and resulted in dissatisfaction and disharmony amongst non medical team members (Sands et al, 1990; Griffiths, 1997; Miller et al, 2001).

Much of the interprofessional conflict described in the literature occurs when two disciplines dispute jurisdiction and control in the same area of practice or where one profession seeks to free itself from control by medicine (Abbott, 1988; Opie, 1997; Adams, 2004). In contrast to some



healthcare settings, the stroke unit teams had considerable control and autonomy individually and collectively over their day-to-day work and were not reliant on medical staff to legitimise their work. Discussion in chapter 7 highlighted that the division of labour in the stroke units did not lead to disputes over professional territory, rather, the opposite occurred whereby team members were willing to blur work boundaries and share skills and knowledge with others. At the same time team members had autonomy in respect of their day-to-day practice; working jointly with other professionals using similar and complementary skills constituted only part of each working day. These findings indicated positive benefits of collaboration and are consistent with those reported by McCallin (1999), Molyneux (2001) and Booth and Hewison (2002) in similar rehabilitation settings.

Consultant physicians supported moves towards an inclusive and non hierarchical team culture; this was evident in their interactions with team members. But, ward rounds and MDT meetings were situations where more traditional approaches were sometimes evident in terms of the order, direction and control of these events. However, when team members compared these with experiences in other teams they suggested the physicians had become less hierarchical in their work. In interviews, physicians indicated they made deliberate efforts to reduce traditional medical dominance:

*'In terms of how roles have changed, in case conferences where the team as you know gets together and sort of develops the goal plan and reviews progress. I think it's interesting that I've taken much more of a back seat, it may not come across that way, you've been there, but that is true you know, and I think other people would recognise that'.*

He continues:

*'I am certainly not precious about maintaining some form of mystical hierarchy and I don't work like that. But to be fair I think most geriatricians are like that, I don't think it's, it's a speciality where people go in unless they're good in teams or reasonably good in teams'.*  
(Consultant physician, Colebrook, Interview 12.)

This consultant identifies the influence of his professional biography in relation to teamwork; prior experiences in elderly care work were also highlighted in chapter 7 as being influential for nurses

and therapists in both units. The consultant at Holton also indicated his perception of the team culture:

*'I suppose it's not leaderless because as you say I think there are a number of leaders and in a sense I think that would echo something I was alluding to before which is a desire to develop a very democratic culture'. (Consultant physician, Holton, Interview 17)*

An important factor in analysis of the team cultures related to consultants' interactions when they were on the units, both were very accessible, this led to team relationships where most team members felt able to state their opinions directly. This was contrasted by team members with experiences with physicians in other settings where they felt they would have been ignored by consultants. Fieldwork supported these claims as consultants were observed seeking the opinions of RAs or housekeepers, regarding improvement in swallowing, eating and drinking or overall mobility. In addition, social interaction was regularly observed between ward clerks, housekeepers and consultants. These individuals commented how they felt their 'banter' with consultants improved the working atmosphere of the units. A ward clerk commented:

*'I mean to put it bluntly everybody speaks to everybody else and I sense it's a happy cooperative environment'.*

Of her relationship with the Consultant physician she said:

*'Yes I feel more comfortable saying, like I did before Easter, him saying I'm having annual leave and I would say oh right fine. I actually said are you going away and yes they were going to Wales, and there was some dialogue there'. (Ward Clerk, Colebrook, Interview 16)*

However, some team members distinguished between this kind of interaction and their perception of physicians as team members participating in a *non traditional division of labour*. Whilst most team members felt the physicians had moved a very long way towards adopting a non hierarchical approach, some felt physicians found it difficult on occasion to devolve decision making or accept proposals for rehabilitation which did not match their own. This was most commonly evident in the MDT meetings. Where this issue was noted, team members tended to identify two ways of responding to this default to a more traditional medical role. The first was to challenge the position

in the MDT meeting; this was easier when the individual was experienced and when the challenge was openly supported by others. A social worker commented:

*'For example, one of the OTs, where we've actually joined forces in a ward meeting and said, wait a minute, you've set these goals for three weeks hence and you're saying now this person can't achieve this goal so there's no point continuing with it, and we've actually argued for more time, you know, well the time that had originally been agreed'. (SW, Holton, Interview 13)*

It was more difficult if team members were inexperienced and had less regular contact with the consultant. Here the professional status of the team member was less important than their experience, if support could not be guaranteed team members sometimes decided against challenge. Some team members took the decision not to challenge consultants because they did not feel it would be useful on a particular day, either because of the way the meeting had gone or because they themselves did not feel comfortable challenging the consultant. A social worker said:

*'I don't know, sometimes people tend to say what they perceive to be the right thing, and allow that other person to make the decision rather than feeling comfortable enough to challenge that'. (SW, Holton, Interview 14)*

Implicit in these comments is an acknowledgement of consultant physicians' power and authority, particularly in relation to decisions relating to discharge from the units. In these circumstances team members referred to opportunities outside team meeting to seek to challenge or change a decision. Data analysis indicated this did not mean that team members would ignore a decision made in the team meeting, or that team members would collude with each other to get things done their way. Normally team members indicated they felt that compromise was necessary and useful to maintain the collaboration and co-operation between team members. In this sense negotiation outside of the meeting was preferred to conflict and confrontation within it. Bohm (1996) and also Farrell et al (2001) argued that established groups preferred to find ways to minimise direct confrontation and sought instead discussion and negotiation. At Colebrook a PT said:

*'I feel the team is so precious really that we mustn't ...you know I mean I've worked in teams where people don't speak to each other you know, well heaven forbid, we don't want to risk that'*

Her approach to dealing with such situations was:

*'By generally by sitting down and having a talk or I go to their office... 'Shall we do this?', 'Do you think It's time we did this?' you know .... 'Wouldn't it be a good idea if we tried this?' You know and we come together '.* (PT, Colebrook, Interview 4)

An example of consultants' perceived power and how one team dealt with this relates to the conduct of the MDT meetings at Colebrook in the early months after the unit opened:

*'I think the case conference we did initially have problems with. I think people did feel quite intimidated, and I did speak to Robert about that and told him to back off. [...] I think some people found it very difficult to handle. So having a more structured format and me having a word and asking him to back off seemed to be the best way of dealing with that. And I think he was happy as long as somebody took charge and it was actually, there was some sort of flow'.* (Ward Manager, Colebrook, Interview 10)

Here the ward manager challenged the consultant's dominance in the meetings directly but also used the situation to negotiate an order for presentation of information in the meeting in an attempt to make the meetings effective ('*some sort of flow*') but also more inclusive. This form of ordering of information in meetings was also observed at Holton. The leadership of the Colebrook ward manager in addressing this issue on behalf of the team was important at that point in the team's development. Leadership is another factor commonly identified in studies of effective teamwork (Belbin, 1993; Mickan & Rodger, 2000; McCallin, 2003a). The kind of leadership seen in the stroke units was frequently cited as *shared leadership*.

#### *Shared Leadership and team maturity*

Wilson & Gleason (2001) argued that leadership and membership should be synonymous in a true interdisciplinary team. In this sense team members accept the responsibility for leadership, and collaborate in setting standards and leading the team. The consultant at Holton captured this effectively:

*'I mean the way I would see it and it's been in part opportunistic, in part deliberate, is to develop leadership as a competency, right throughout the unit and leadership as a responsibility and a desire, so that, in a sense you're not looking to other people to find solutions or to sort things out. That you know that you perceive it, that actually it's your responsibility and actually that you've got the power and ability to do it'.* (Consultant Physician Holton, Interview 17).

Neither consultant regarded themselves as the de facto team leader. Their influence in supporting staff to take responsibility and develop leadership competence and also in terms of championing stroke services within the wider organisation, were recognised. An example of such medical leadership, was the way in which the consultant at Colebrook, citing research evidence and RCP (2000) guidelines, argued for dieticians to work on the unit rather than reliance on referral and response from a generic team.

In interviews, team members generally concurred that there was *shared leadership* and with the consultants' perception that they supported shared leadership. This depended partly on the relationship of team members to the consultants. The less experienced the team member, the more likely they were to see the consultant physicians as in being in overall charge of the units by virtue of their power and authority. However, most team members differentiated being 'in charge' from leadership, noting the contribution of therapists and nurses in team leadership:

*'There's not any one specific leader, I think there is some strong leaders with heads of each discipline that work well together and communicate well with each other. It is certainly not led by medical staff; I don't really feel as if it's one particular discipline that takes the lead, I think it's more that we work well together'.* (Ward Sister, Colebrook, Interview 1)

The ward manager agreed identifying the different leadership roles adopted initially:

*'To be fair, it was shared. I think Robert [consultant] is a very strong character, and I think [when the unit opened] he was quite influential in prioritising what he felt the stroke unit needed from an evidence based perspective. I suppose I took the lead and was involved in a lot of the groups. The junior sister took a lead role in education, a senior physio took the lead and the OT took a lead in goal setting. So, we all sort of took on slightly different areas'.* (Ward Manager, Colebrook, Interview 10).

At Holton, the matron said: *'there is a nursing leader, a physio leader, and OT leader, that's how I feel it is basically run'.* (Matron, Holton, Interview 12). Interestingly, this statement makes no mention of medical leadership in the day-to-day running of the unit. One of the OTs at Holton commented:

*'Leadership, difficult actually, I don't know, there's leaders in different areas. [.....] I mean, when it comes down to medical aspects like incontinence and things like that, the doctors and the nurses or the nurse in charge of the team that day will tend to take a*

*lead, just depends where the main problem area for that particular patient is'. (OT, Holton, Interview 6)*

Observational data were consistent with the above comments; leadership was clearly evident from a range of disciplines in different clinical situations. In terms of the overall teams, both units had strong individuals in medicine; nursing, PT and OT, and all undertook broader leadership roles. However, the absence of a ward sister may have impacted on continuing team development at Holton. A staff nurse commented:

*'I think we suffered as well through a lack of a sister, however long it's been now, I think that's going to make a big jump forward again, I think we can do quite a lot, but we need that role'. (SN, Holton, Interview 11)*

This situation was affected in a limited way by the intermittent presence of the matron, who was a strong character. This nurse had been the ward sister previously, and tended to view teamwork occurring at Holton from an historical perspective, as she remembered it was, rather than the way, team members perceived it and acted during the study. Her contribution to the day-to-day work of the team was limited to managerial contacts and social support for nursing colleagues. Other team members acknowledged the absence of the ward sister at Holton but indicated that *shared leadership* and the experience of the senior nursing staff reduced the impact of the vacancy:

*OT: 'I think it must affect the nurses because there is no figurehead so to speak but I like to think we have come far enough as a team that they can rely on me and Miriam and the other therapists, you know we all have a say in the way things work now, because we are all here most days, it's our unit'.*

*SW: 'Well I hadn't picked up on that really, we just work with the staff nurses, you know, team leaders, and they are all very experienced and just get things done'. (Fieldnotes, Holton, May 2002)*

*'I don't think there needs to be anyone else to manage them, most of them are involved in what they're doing and they can manage without someone else looking to whether they are doing things right...[.....] and I don't think not having a ward sister or ward manager has made any difference'. (SHO, Holton, Interview 3)*

The main issue here is the difference between getting the day-to-day work done, which these comments show was not compromised by the vacant ward sister post, and the ongoing development

of nursing staff within the team. The preference of nurses at Holton for a recognised nursing leader within the team was evident in their comments.

Effective team interactions and the relative absence of conflict can be partly explained by the developmental stage and maturity of the teams. The stroke unit teams had been established for more than four years and had undergone considerable development. This was closely related to their observed willingness to *share leadership* with others in the team. Building on Tuckman & Jensen's (1977) work, Farrell et al (2001) analysed stages of team development in 111 interdisciplinary teams in geriatric healthcare in the US and used the concept of anomie to define the degree of collaborative interpersonal interaction as teams develop. They use the concept of anomie differently from Durkheim (1897) and Merton (1957). Farrell et al (2001) argued that in undeveloped and immature teams a state of high anomie exists. This referred to ambiguity about roles, uncertainty and confusion about the purpose of the team and alienation and separation from the team, as a result interaction is compromised. At the other end of this continuum Farrell et al (2001: 283) argued that:

*'a developed team is one in which members have achieved consensus about their mission, their division of labour and what they expect of one another with regards to cycles of work',*

This level of team functioning is at the advanced 'performing' stage. Farrell et al (2001) argued that there is little evidence of anomie where functioning teams have negotiated a team culture that the members internalise. Their explanation of stages in team development over time is consistent with the findings of the current study in that the *inclusive team culture* and *shared leadership* observed was a function of team and professional maturity. It is important however to focus more specifically on the kinds of interactions which occurred and which resulted in a state of low anomie in the stroke unit teams.

Effective teams develop through negotiation about ways of working together (Farrell et al, 2001; McCallin, 2004). *Shared learning* opportunities challenged temporal images held by stroke team members and began a shift in thinking towards a collaborative and patient focused team identity. This was further developed in terms of perceptions and actions of team members through the ongoing opportunity, to talk about the pattern and order of work and more specifically the sequencing of tasks within the units. Practical problems arising in day-to-day work led to spontaneous and *opportunistic dialogue* between team members. When a particular approach to rehabilitation was not achieving the desired outcome, this led to patient focused dialogue and negotiations focused on adapting or changing plans. These negotiations did not just involve senior team members as the example at Appendix 9 shows, and did not mean plans would always be changed. Explanation of the rationale for a specific prescription could mean those involved in direct care increased their understanding and enlisted more support and time to provide and manage complex actions, and were then willing to try again for a period of time before review. Team members at both units identified the contribution of experience and maturity in this process:

*'That's something about having a team that maybe developed together or planned, together, you know you have a joint role I think it's about your communication.[.....] I think again, if you've got a mature team, I don't mean that in mature years, and in a mature team, they have an understanding of the system, and there's no point spending hours weeping and wailing about a lack of resources, you just have to get on with it at the end of the day'.* (SALT, Holton, Interview 8)

At Colebrook:

*'One thing is we're very, I don't think I've said it in another context but we are a very mature team [.....] I feel that had a part to play, we were, we were all very experienced, weren't we that came'.* (PT, Colebrook, Interview 4)

*'I think certainly people are confident in their roles within the ward, and feel valued within the ward. So they feel able to say what they're thinking [...] and yes it is much better four or five-years on, as I suppose any working relationship is you know as you get more familiar with people. As you know them, I suppose inside and out, and you're more comfortable being yourself'.* (Ward Manager, Colebrook, Interview 10).

Negotiations about rehabilitation were informal, ongoing and subject to revision, but were common.

They were based on continuous or episodic dialogue between team members who were confident to



state their opinions about what was working, what might be improved and who were pragmatic in their assessment of resources required. Simple structural features of work organisation were developed, such as establishing and displaying a central record of moving and handling status, a timetable of patient activities and the discipline responsible in each unit. These elements, together with shared records of goals set, provided a basis for team dialogue and negotiations. At the time of the study, team members were operating as a coalition of colleagues, comfortable with challenge and operating in a situation of low anomie where team members were generally perceived as equal in participation and contribution and were respected for their specific skills and knowledge (Farrell et al, 2001). A major factor facilitating the development of the teams and their opportunities for regular dialogue was their degree of involvement in the teams and the regularity of contact between team members.

#### *Core and periphery team working- being in the team*

At both units there were essentially two types of team member. Those based on or who spent most of their working days on the units are referred to as *core* team members. Those who were not unit based but had regular contact either through patient referral or because some of their contracted hours were allocated to the units, are referred to as *peripheral* team members. These had other patient responsibilities over and above those to the stroke units. The use of the term *peripheral* does not question the contributions of these team members but signifies their reduced contact with the units and *core* team members. Students or registered professionals allocated to the units as part of their professional training were sometimes unit based and sometimes based with *peripheral* team members. These 'temporary' members' experiences were similar to those of *peripheral* team members and are therefore not considered separately.

With the exception of ward clerks and housekeepers, team members had a primary attachment to a professional group, for example nursing or OT. In multidisciplinary teams professional allegiance may be stronger than allegiance to the team (Strasser & Falconer, 1997; Miller et al, 2001).

However, in the current study, whilst professional allegiances remained a reference point for their practice for *core* team members in both units, they were more likely to define themselves as primarily members of the stroke unit team. Commenting on the need for a common identity as the teams were developing, the matron at Holton said:

*'We needed to have a rehab 'head on' rather than the, the therapists were the therapists and the nurses were the nurses, we needed to be a team'.* (Matron, Holton, Interview 12)

A senior PT at Colebrook discussed her gradual separation from the main therapy department:

*'Well we do have a base really in the department but we don't go, [...] you know I think our department is quite disappointed... so rather than go all the way down there where I hardly know anybody in my own physio department unfortunately, we stayed on the ward'.* (PT, Colebrook, Interview 4)

Gulliver et al (2002) and Hudson (2002) also noted the progression to a team identity in integrated primary care teams and how this impacted positively on team effectiveness. Miller et al (2001) reported similar findings in a neurological rehabilitation teams and McCallin (2004) in general rehabilitation teams.

For *peripheral* team members their primary professional focus impacted on their team membership. Their perception of themselves as stroke unit team members was dependent on the degree and frequency of contact they had with *core* team members. Where contact was relatively frequent, as with social work and SALT at Holton and dietetics at Colebrook, *peripheral* team members perceived themselves as being an integral part of the teams. However, their perceptions were also influenced by involvement in their primary professional group, as a social work team for the elderly at Holton, a Trust wide SALT team at Holton, or the Trust wide dietetics team at Colebrook. These primary professional groups were a reference point for *peripheral* team members and provided both support and challenge. Support came from regular contact, shared values and shared understanding of roles, responsibilities and workload. Challenges came from having to reconcile the different roles they played in different teams. *Peripheral* team members considered that being present on the stroke units and being acknowledged as part of the team was important for their contribution to be

seen as effective. A Social worker at Holton comments on how limited contact time affected his role:

*'I think just the accessibility, having more knowledge of what's going on. Individual needs of the patients, getting to know the patients personally, and that's something you're not able to do as someone who dips in and out'. (SW, Holton, Interview 10)*

The SALT also recognised the impact of reduced contact on team relationships but also how she was able to deal with this:

*'I have to say that the other professions do understand that there just aren't enough of us. And I know it must be very frustrating for them, but we never ever get grief from them [...]. The joint records, the care plan and things is a huge benefit to people like us that aren't there all the time, because we can just dip into the multidisciplinary notes and find out what's been happening with the family or the patient themselves'. (SALT, Holton, Interview 8)*

Dieticians at Colebrook felt that with some effort it was possible to develop working relationships:

*'Coming to the stroke unit, I did feel I had to sort of make my presence known, and even sometimes now I don't know if every single member of staff on this unit knows who I am. I certainly built up quite strong relationships with a lot of the primary nurses. I know them quite well, they're really good'. (Dietician, Colebrook, Interview 6)*

The consultants were also *peripheral* team members in terms of their main base and frequency of contact with the units. Both had responsibility for patients admitted to acute stroke units in other hospitals. They regarded themselves as being in the team but their limited time presence and the medical focus of their work meant they were less frequently involved in working with patients and other team members. This was noted by a PT at Colebrook:

*'You don't see the doctors very often on the ward unless there is particularly a problem. So I suppose in the medical point of view, that not alienates them, but almost makes it harder for them to a part of the team, just because they don't spend that much time on the ward and haven't got the opportunities to work with the rest of the staff'. (PT, Colebrook, Interview 9)*

The primary involvement of medicine within the stroke unit teams was through SHOs, who had to balance medical responsibilities for assessment, diagnosis and treatment, against working with other team members. SHOs mainly responded to medical problems as they arose, and carried out medical investigations agreed in MDT meetings. At Holton SHOs attended MDT meetings, reporting on

results of investigations or confirming medication changes, but had limited involvement in the meetings overall. At Colebrook SHOs attended training sessions when MDT meetings occurred and so did not normally attend. SHOs involvement in teamwork was most evident in the negotiations occurring as part of the frequent informal dialogue through which patient care was planned, evaluated or amended on an ongoing basis. This involvement was on an equal basis to other team members in terms of contributing specific knowledge, expertise or assessment of particular patient, rather than the more traditional role of directing the work of other professionals. Some team members felt there would be benefits from more SHO involvement:

*'It would be a good opportunity for the junior medical staff to kind of come in [to the gym] and get a good feel for what was going on. And what it was all about, really. So it's a shame that they can't be more of a team member, really, because I'm sure it would help them wherever they went as well, you know on other rotation not just there, just to give you a bit more insight'.* (PT, Colebrook, Interview 9).

The SHOs themselves whilst acknowledging in interviews that their rotation increased their awareness of stroke and team working showed no inclination to participate directly in *joint working*. Primary socialisation and role perception, as well as work experiences in acute medical settings probably account for this difference (MacKay, 1993; Walby & Greenwell, 1994).

Whilst the majority of *peripheral* team members described good working relationships with the Stroke units, some social work team members at Holton were more ambivalent about their involvement in the team. They perceived that whilst they made the effort to go to the unit and actively engage with other team members, that the same effort was not always made by unit based team members to negotiate with them about changing times and days for MDT meetings or revising discharge arrangements. Some social workers perceived they were denied the involvement and consultation they would expect if the team culture were inclusive of all its members. These gave the example of continued exercise of medical power as when the consultant physicians decided a patient should be discharged from the unit when social workers were not convinced that their social

needs were fully understood or would be met by the discharge plan. Social workers were able to challenge these decisions, however, they felt that the consultant could resort to positional power to close the discussion and insist on a particular course of action. This outcome was observed only once during the period of observation. It led to the social worker negotiating additional support with the OT outside of the meeting for greater consideration of the social needs of the patient. The decision on discharge was not changed but increased social support in the home was negotiated.

The two most experienced social workers at Holton suggested that the MDT meetings reflected a more traditional medically led and medically focused team culture. Other team members acknowledged that the consultant could hold strong views and on occasion would try to impose them. However, these team members argued that the consultant's views were often challenged and that others were not denied the opportunity to persuade the team that their opinion was preferable. The issue for the social workers extended beyond medical dominance of decision making to concerns that the majority of *core* team members implicitly shared a medical model perspective which could marginalise the social workers. There was some polarisation of views of with two experienced social workers highlighting concerns about the use of medical power and two more recently qualified social workers feeling that MDT meetings were more equitable and inclusive but not without some problems related to a medical model of thinking. One of the senior social workers said:

*'I think the people in the [stroke unit] multidisciplinary team actually feel more able to contribute than most other teams that I have met and I do think that's good. I think it's an interesting ward round in that everybody does contribute to it, what concerns me is that on many occasions I've seen that even though good information is being given by all the multidisciplinary team, for some reason outside the meeting the consultant will just decide to go against all that information'. (SW, Holton, Interview 1)*

This concern with decisions taken outside the team meeting was echoed by another less experienced social worker:

*'Whilst we can be part of the sort of evaluating how people are getting on, asking 'why' questions in the multidisciplinary meetings and feeling that we are quite involved in the decision making side of the process, sometimes we get presented with a sort of fait accompli, which hasn't come from the multidisciplinary meeting, because we've been at it, but at some stage somewhere a decision's been taken by a smaller group of people. 'oh this person's going home on so and so'. (SW, Holton, Interview 13).*

These team members had a more sophisticated theoretical understanding of power and control, and were more aware of subtle manifestations of these issues in meetings. They were less convinced that the conduct of MDT meetings was always non hierarchical and based on real equality. Interestingly there were no observed examples of the physician making such discharge decisions in isolation during the study. All of the social workers acknowledged the problems and consequences of limited contact time with unit based team members, which reduced their opportunities to influence decisions such as those identified above. If changes in the situation facing a patient occurred rapidly the allocated social worker was not always present to participate in changes to decisions made in MDT meetings. Social workers argued that their lack of opportunity for dialogue and consultation could be overcome by the use of the duty social worker system and by acknowledging their actions in making the extra effort to be seen as part of the team. The comments of this group highlighted two important factors which impacted on perceptions of inclusion in the stroke unit teams. Firstly, that *co-location* and presence on units meant consultation and inclusion in decision making outside of team meetings was more likely to occur, and secondly, that different ideologies of care and rehabilitation influenced the perceptions of professions regarding the needs of patients. The social workers acknowledged the strengths of teamwork in the stroke unit but felt they could be included more.

#### *Co-location and team contacts*

*Co-location* and regular contact provided key conditions for interdisciplinary teamwork to develop and flourish in the stroke units. For team members who shared the same working environment on a daily basis, work and social contact was frequent, but as was indicated in chapter 4 (pages 93-95) there were differences between the two units in terms of the physical location of staff and their

contact with each other. The ease and frequency of team member contacts was important, the fieldnote below reports on how *co-location* impacted on teamwork:

*Noted again how co-location and frequent contact at the nurses' station with other disciplines facilitates dialogue, discussion, problem-solving and treatment adjustments. Here the discussion began with a simple inquiry [student PT] about equipment location [walking frame], but quickly developed into a discussion regarding the frame's appropriateness for the specific patient and required the PT justify his mobility plan to a more experienced OT. The discussion involved shared understanding of technical issues in terms of determining postural improvement, but led to an agreement about the suitability of the use of the piece of equipment, which the OT agreed to work on and which she recorded in the shared notes for nurses to see. (Fieldnotes, Holton, April 2002).*

This was typical of the way informal and unplanned contact led to brief dialogue about a revised rehabilitation plan. The OT was present at the nurses' station when the enquiry was made and noted a change from that reported at the previous MDT meeting, she questioned the PTs approach until satisfied that it was appropriate, and then took responsibility for sharing the change with others.

Another OT at Holton expressed her views about *co-location* and teamwork:

*'I don't think the relationships would be as good between us and the nursing staff, if we had our therapy room downstairs. And if they weren't happy with us sitting at the station writing in the kardex's, if they wanted us to only sit in an office, [...], I think that would sort of spoil some of the closeness of the team; sometimes you might have gone behind there to write up somebody's notes but you'll overhear somebody else talking about another situation which you will know about'. (OT, Holton, Interview 6)*

The Colebrook ward manager noted improvements in teamwork when SALTs, previously difficult to access, were located on the unit:

*'The speech and language therapist as you know for the past four months now, we have a locum that's been based on here and covering Ward C, so that has been... we've seen a marked difference in that [......] I think because she has become more part of the ward. relationships with her are better, I mean. It's just more easy access; you know'. (Ward Manager, Colebrook, Interview 10)*

An OT identified the impact of changing work location within the unit

*'I just realised something else that we actually.... we were based on the ward [opposite a four bedded Bay] at that point, it's only recently we moved into an office [down the corridor], and I do think that maybe moving back to that situation where we actually were based on the ward would be better'. (OT, Colebrook, Interview 8).*

This OT was a *core* team member, and potentially had easy access to other team members but identified barriers to informal interaction resulting from moving to an office down the ward

corridor. At Holton, some team members felt the consultant did not appreciate the benefits of *co-location*:

*'I don't think he has a full perception of how we actually work day-to-day and how much closer, we have got, so they're not just stuck in their room [therapists] and never come out and we're not just at our station [...] we do come out and you know we flow between each other daily with problems and I will go into Miriam in the middle of her session I'll say, when you have finished, please come and see so and so because this has just happened'. (SN, Holton, Interview 4)*

The loss of this kind of access and contact was perceived to have negative effects on team relationships and patient care. At Holton the social work team were being moved to another hospital across the city, in response to a question about who was in the team a staff nurse said:

*'I would include social workers in that at the moment, but as you know it's all going to be changing unfortunately. Because we do tend to work with the same small team of four or five social workers, and, they all know us as we know them. There's that personal basis to a relationship, but unfortunately, that's all changing. Things will slip through the net yes, I mean they are going to have huge case loads and they feel the same way from talking to them. They feel they are going to lose a lot of the personal contact'. (SN, Holton, Interview 11).*

For non unit based team members extra effort had to be made if they were to participate directly in teamwork, this often involved making time to be present on the units over and above that required to work with specific patients. A telephone call could have addressed the issues but social workers and dieticians indicated it was worthwhile going to the units in order to have direct contact with core team members. Rehabilitation goals frequently addressed complex social or physical issues, making the extra effort to be present on the unit, contributed to team working and achievement of these goals. For social workers, given the concerns about exclusion from decision making outlined above, this effort was conscious and deliberate:

*'I do actually I try and make a point of if I've got time of you know making sure that I'm over there, just sort of bringing the records up to date or whatever, but you know deliberately spending just a bit of time hanging around a bit to see if there's anything that needs picking up or'*

*INT: Has that been worthwhile?*

*'Yes, I think so, yes, because I think that you know just the kind of chat is good at, sort of keeping the relationships going as well isn't it? The banter, spending a bit of time there'. (SW, Holton, Interview 14)*



*'It was actually in the meeting that we realised that we were of the same view. But of course we do, this is the advantage of being a hospital-based [social work] team, is that we do actually meet quite a lot the time, you're at the duty station, and we do. I go to discuss one person and end up discussing a couple more as well and getting a view on it'. (SW, Holton, Interview 13)*

A dietician talking about becoming a member of the stroke unit team at Colebrook also said:

*'I think it was coming to the ward, exposure with the nurses, again probably spent quite a lot of time sitting down and talking to individuals, nurses, [.....] I think they knew I had quite lot of experience and I think just asking questions when they had problems with patients, it transpired that I knew what to do in these situations so they used you more [....] it's probably been harder here because I've never gone to the case conference'. (Dietician, Colebrook, Interview 7)*

*Core* team members interpreted these efforts to be present on the unit despite other time and workload pressures, as evidence of commitment to patients and the team. This interpretation extended to defining these *peripheral* team members as 'being in the team' despite their reduced contact with the units. At Colebrook the consultant also made an extra effort, attending the unit for part of one morning per week in addition to the ward round and MDT meeting. He indicated that he did so partly to use the time to review patients with other team members but also just to be present and be available. This meant *peripheral* team members had regular interaction with *core* team members and could engage directly in informed dialogue about patients and could use this to realise their own contribution to rehabilitation.

A number of *peripheral* team members did not attend the MDT meetings but could still influence rehabilitation through presence and contact at other times. MDT meetings are an interesting phenomenon and have been a major area of focus in healthcare team research (Evers, 1982; Cott, 1997; Griffiths, 1997; Gibbon, 1999; Opie, 2000; Borrill et al, 2003). The meetings are interesting because they are the most obvious example of planned communication between most, but importantly, not all team members. In the stroke units dieticians, were never present, SALTs occasionally attended meetings at Colebrook, but never at Holton, and social workers were only present at Holton. Two other issues are of importance in terms of achieving teamwork in stroke

units; firstly, meetings lasted on average for 90 to 120 minutes. The work of the teams clearly took place largely outside of MDT meetings. Secondly, these meetings were the only situation where consultant physicians were routinely engaged in dialogue with a group of team members. These meetings and the conduct of the dialogue occurring within them are certainly important and interesting spaces for research, but as representations of teamwork they offer only a partial and incomplete picture; the interactions which occurred within meetings were an important but limited influence on the social order in these stroke units.

Observations indicated that MDT meetings constituted a small part of the work of the teams but that the decision making which occurred there was mainly arrived at through dialogue and some negotiation, although because this routinely followed an agreed order and structure, this differed from the much more frequent spontaneous and unplanned *opportunistic dialogue* episodes. Dialogue in MDT meetings normally involved making a case for a particular course of action, explaining that if questioned by the team, or being willing to renegotiate a course of action if alternative perspectives or contrary evidence were presented. The main difference in this process was the formality and structure of the MDT meetings and the limited number of disciplines normally present. Analytically, the absence of some team members from MDT meetings was significant and therefore required greater focus on interactions occurring as part of the daily work of team members. The value of the MDT meetings was mainly structural, they were a focal point, adding a check on and providing a basis for the much more frequent dialogue occurring outside the meetings. Also, MDT meetings were the only forum where team practice issues and decision making could take place with a representative group of team members. Discussions about shared goal setting and NSF standards (DoH, 2001a), were observed but discussion of team practice issues was infrequent at both units during the study.

The format of these MDT meetings was noted to be different to other multidisciplinary meetings team members had attended elsewhere. A PT compared the stroke unit MDT meeting to another rehabilitation team's meetings:

*'Its not set,[in the stroke unit] as to how long its going to take to discuss patients in the MDT, I know on the Ward down here, they work theirs differently and they have 10 minute slots for each patient. So the physio, the OT, the speech therapist who deals with that patient are all there for those 10 minutes and then they all disappear off and another lot come back'. (PT, Colebrook, Interview 9)*

It is difficult to envisage how a time limited slot can encourage collaborative decision making. Stroke unit team members felt their meetings had evolved from reporting information to a more inclusive and discursive enterprise. The meetings were seen as important and always ran whether or not consultants were present. In contrast to Cott's (1997) and also Gibbon's (1999) research, stroke unit team members did not perceive there to be an 'us and them' gap between those who attended MDT meetings and those who did not. Team meetings and ward rounds are part of the temporal matrix in each unit and as such they impact on the perceptions and actions of team members. The very limited time spent in these meetings and rounds by relatively few team members meant their impact on the pattern and order of teamwork in the units was limited. MDT meetings and ward rounds reflected and benefited from the more *inclusive team culture* rather than being the main instrument in shaping that culture.

In summary, data analysis indicated the following relationships between the category inclusive team culture and its subcategories

- 1) Decisions made when setting up the stroke units, including using *shared learning*, *joint working* and negotiating *co-location* for therapists contributed to the perception that all team members had a role in stroke rehabilitation. Involvement of team members in this way was instrumental in establishing a *non traditional division of labour* and demonstrated a commitment to an *inclusive team culture*.
- 2) As the stroke unit teams developed over time the *non traditional division of labour* encouraged the adoption a system of *shared leadership*. This is also a function of the *inclusive team culture* and of *team maturity*.
- 3) *Co-location* increases the frequency of *contact* and interaction between *core team* members and contributed to regular *learning and working together*.

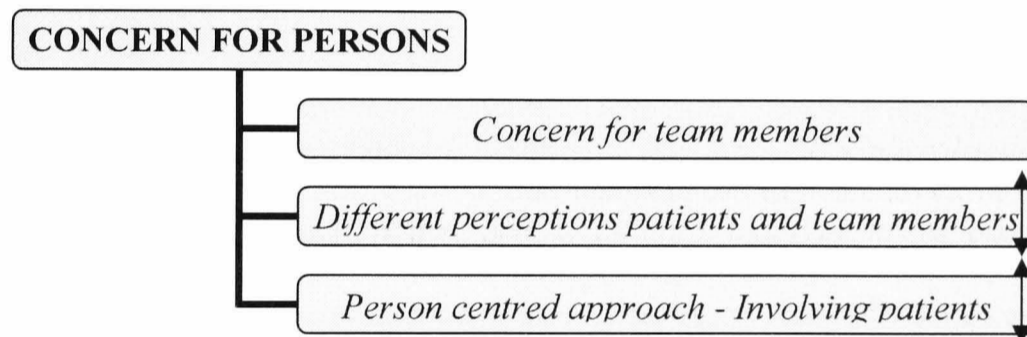
- 4) The stroke units had *core and peripheral team members*. *Peripheral team members* who perceived they were part of the stroke unit teams chose to make an extra effort in order to overcome reduced interaction and access to *core team members* caused by separate location.

The development of an *inclusive team culture* created important conditions for team members to work collaboratively but the focus of this work was with and for stroke patients and their relatives.

The final category, *concern for persons*, explains how *shared values and goals* were realised in the context of work with patients, relatives, and other team members.

#### Category Concern for persons

Figure 13:



This category explains how team members in both units worked towards and valued knowing the stroke patient as a person. This included concern with patients' past employment, their families, interests, goals and aspirations, and looked beyond disabilities and impairments caused by stroke. Concern for persons influenced determination of goals and actions aimed at their realisation; this encompassed a shift from a mechanistic focus on functional recovery to an appreciation that recovery included much more than returning limb function or adapting practical skills. Including and involving patients in their rehabilitation was a feature of concern for persons. This provided a basis for interacting with and involving relatives; including recruiting their support in ensuring safe mobility and promoting independence. The length of time that the majority of patients spent in the units meant that relationships based on regular and repeated social and physical care contacts were established:

*'Because the patients stay here for such a long time, you build up close relationships: you want to do your best for them'.* (SN, Holton, Interview 11)

*'A lot of them have had you know, quite a substantial life, so you do actually get to know the patients quite well as well within rehab settings; you've got time to develop a relationship, a therapeutic relationship, where you are meeting somebody and getting to know about their life really. And what they've achieved what they still want to achieve and going home, hopefully to be independent, if they can be'.* (OT, Colebrook, Interview 8)

Team members at both units argued that knowledge and understanding of patients as people helped increase patients' commitment to and understanding of the goals of rehabilitation, especially if goals could be targeted on patients' own priorities.

*'I think the stroke unit in general are very good at being sort of person focused if you like, and working towards an individual's needs and wishes'.* (SW, Holton Interview 10)

#### *Person centred approach- involving patients*

The NSF for Older People (DoH 2001a) called for *person-centred* care. Most team members interpreted this concept as understanding and responding to physical, social, psychological and spiritual needs of patients and claimed that providing such care was what made their work satisfying and rewarding. Concern for persons was not a token response to policy directives but was a *shared value* held by team members in both units. There was a perception that rehabilitation would not succeed if the patient was seen only as a 'stroke'. Examples of comments made illustrate this:

*'You're dealing with the whole person aren't you and their whole life is devastated so you can't just think of them as a weak arm and a weak leg, they're a person aren't they'.* (PT, Colebrook, Interview 4)

These comments succinctly express the views held by many team members. There was understanding of the profound impact that stroke could have on the lives of individuals and their families. There was a recognition that rehabilitation could not be concerned with physical recovery alone, it must be focused firstly on the person and who they are, only then could specific disabilities be addressed in the context of the future life of the individual and those supporting them. This PT continued:

*'This has affected their whole life and you've got to explain to them what the stroke has done, it's just such a mystery to them.... and why they can't transfer, why they can't go home... and you've got to explain all that to the family and so you're thinking of the whole person .. [...] Obviously we are aiming to get them home so therefore you've got to know about all that as well.... So that's, and their lifestyle you've got to try to help to them regain as much of their old life as they can'.*

In a similar comment a nurse at Colebrook expressed the ways she understood stroke unit work to be different to that in other areas:

*'I think you get a lot more closely involved with the relatives.... carers... I think we've got, we have to actively involve them more in the care which you don't seem to see so much on an acute ward, so you get to look more at the whole picture rather than just a little chunk of that patient you get to know them most of all ....and because, they are there longer, they are not just in and out in a couple of days which you often get in an acute ward'. (Ward Sister, Colebrook, Interview 1)*

*Person centred approaches* were more than policy rhetoric, team members referred to the satisfaction of working with patients and relatives to bring about situations where individuals could cope with their stroke and continue their lives. These comments contrast sharply with negative attitudes towards stroke patients identified in previous research (Hoffmann, 1974; Langhorne & Dennis; 1998) and which were identified by team members as still present in other settings. The concern to involve patients and their relatives was also evident at Holton:

*'Because it's rehab we've got more time with patients as well. So I think it's more holistic as well because we are working with the families a lot [.....]I think very strongly that the centre of the team is the patient and the family'. (OT, Holton, Interview 6)*

It could be argued that *person centredness* is simply part of the moral and professional obligation of each team member. Codes of conduct explicitly require health professionals to act in the best interests of patients. Stroke unit team members acknowledged this obligation but their actions suggested that they perceived *person centred approaches* as being more than a professional requirement. Rehabilitation is concerned with realising the potential of individuals (Hornby & Atkins, 2000); this required a commitment to knowing patients and developing a relationship where rehabilitation was seen as a shared enterprise. The intention at both units was to *involve patients* and their relatives in their therapy, to work with them and not simply on them. Team members who

were less experienced or new to the stroke units were quickly exposed to ways of thinking and acting which expressed *person centredness* in the dialogue between team members and through role modelling. These findings are consistent with those of McCallin (1999) who argued that effective interdisciplinary team working became possible when team members in her study in rehabilitation settings in New Zealand, shifted their thinking from disciplinary task based concerns to a patient centred focus.

Patients and relatives at Holton and Colebrook had involvement in their rehabilitation in that team members provided information prior to activities occurring, then during the activity patients' and or relatives' views were sought and discussion developed. This demonstrated concern to find solutions that would be relevant for the individual beyond the hospital setting, for example:

*'I think we tried to be more patient centred and more reality orientated, [...] I think as a team we've got a lot better at that generally'. (SN, Holton, Interview 4)*

In observations I noted:

*At both units, relatives were routinely invited to observe and participate in therapy sessions. One purpose of this was to develop knowledge and skills which would be necessary after discharge. Involving patients and relatives in this way tended to increase their commitment to rehabilitation. The other purpose, however, was to address the difficulty some family members have in understanding the complexity of stroke and its effect on their relative, teaching skills is not sufficient if they do not understand the nature of the disability and the purpose of the actions. This kind of involvement helps the patient and family members come to terms with the degree of recovery which is likely to be possible. (Fieldnotes, Holton, March 2002)*

A PT at Colebrook and staff nurse at Holton confirmed this interpretation:

*'We do encourage relatives to come into sessions, if they're visiting during the day, as long as that's okay with patient. It is good to involve them, because ultimately when this person goes home, they're going to rely on their relatives to help out'. (PT, Colebrook, Interview 9)*

*'There's nothing worse than discharging somebody when you know [...] the partner doesn't really understand that they're going home and no matter how many times you tell somebody, they think they're going to get up and walk out of here. You know that's not what's going to happen, but we try obviously, if you involve people in the process and they're actually actively involved in the rehab and obviously the more realistic [they are] about expectations'. (SN, Holton, Interview 11)*

More detailed examples of the way *person centredness* and *concern for persons* were displayed in team practice are provided in Table 4 (page 138-139); and also in Appendix 10 which outlines a case conference called at Holton to determine whether a severely cognitively impaired patient could be cared for at home rather than in long term care. This patient retained some awareness of his wife and family and could engage in non specific social conversation but was not orientated to time and place, did not recognise risks in his immediate environment and did not initiate or carry on activities despite prompts. The team view was that the patient was likely to prove too difficult for his wife to manage, but they accepted a home trial might prove otherwise. If the trial proved unsuccessful, the team argued it was a necessary stage in the family coming to terms with the patient's level of impairment.

The NSF for Older People (DoH, 2001a) called for joint goal setting with patients. It was apparent that whilst both units took this seriously, they were finding it difficult to make the transition from setting realistic professional goals to setting goals with patients. This can be related in part to the difficulty patients have in coming to terms with their stroke and the accompanying disability, whilst at the same time being asked to participate in planning their rehabilitation.

*'I think because we have quite a lot of patients with unrealistic goals when they first come here, I mean it's quite understandable after a stroke that they want to be back to how they were before. I think that's part of their education so that they're safe when they are doing things as well. Not thinking they can run when they can't'. (SHO, Colebrook, Interview 2)*

However, involvement is also about health professionals changing their thinking from that of experts deciding for patients, to developing partnership in goal setting and rehabilitation (Coulter, 2002; Jones et al, 2004). For some patients it was easier to acknowledge that they were being consulted but to let professionals to decide. For others, more direct involvement in negotiation of goals may have been beneficial (see below). Both units recognised this as a deficit in their current team practice and discussions about how this could be achieved were ongoing during the study. Despite the clear commitment to *person centred approaches* in the stroke units, discussion of



professional power and its influence on partnership with patients will be a necessary part of further development of these teams. This challenge has been recognised and investigated in the wider context of stroke services (Watkins, 2004; Watkins & Abbott, 2004).

*Different perceptions- patients and team members*

Commitment to *person centred approaches* did not always mean that all patients had outcomes they and team members were satisfied with. There were instances when severe cognitive impairments or severe physical disability meant that patients could not benefit from stroke unit rehabilitation. Withdrawal of active rehabilitation and planning to transfer patients to their own home with community or day care, or to long term care was interpreted by some patients as an indication that they would not recover further. However, those who could not benefit from specialist rehabilitation had to be managed and decisions about their care had to be explained and rationalised by team members:

*'When is the right time and when isn't it? Different environments help different people. And when they've been here for 3 months; do you feel that you're stuck, do you feel that you're not going to move on. We need to have somewhere else for people that need to perhaps move on and then carry on with their recovery'. (Matron, Holton, Interview 12)*

Patients and team members' perceptions of recovery and progress did not always match. Patients who were not in agreement with the rehabilitation goals developed by the teams or whose personal goals seemed unrealistic to team members were challenging. They were less likely to be satisfied with their level of recovery and were sometimes critical of the ways in which the team members worked with them. Two Colebrook patients felt that the team were not always able to adapt their approach or skills to their needs. These patients accepted that team members were concerned about them as people but felt that this was not enough if it did not translate into effective treatment for them as individuals. These patients questioned their rehabilitation and described situations where they perceived consultation to be tokenistic and felt they were not really listened to. One patient described how he resented 'being told' about adaptations which would have to be made to his toilet

and bathroom at home. Whilst he understood the concern for his safety, team members had not wanted to hear his objections about the inappropriateness of these changes which he considered would reduce his privacy and dignity. He refused the adaptations offered but felt this had not been well received by team members who accompanied him on a home visit. Another patient recalled his irritation when a PT acknowledged he needed specialist equipment to improve his mobility, but told him the necessary equipment was not available on the unit. He recognised the skill of the Colebrook team in managing the 'typical stroke patient' but did not feel his particular needs, which required a different approach, had been sufficiently considered. In this case, concern for him as a person had not extended to meeting what he regarded as his specific needs; instead he felt he had to fit in with what was available. If explanations had been offered he was not willing to accept the views expressed. Waters & Easton (1999) also reported that patients in their study had very limited opportunities to participate in their rehabilitation and were required to fit into the unit routine. In a wider review of qualitative research in stroke; Hafsteindottir & Grypdonck (1997) indicated that patients could accept that they may not regain pre-stroke functional abilities but were unwilling to accept professional assessments of overall recovery if these were lower than that expected by the patients.

The two patients described above were articulate and prepared to challenge any aspect of rehabilitation they did not feel was appropriate for them. Finding these patients more challenging to work with is not unique to stroke unit teams; there is considerable evidence that patients who are not compliant with professionals can be labelled unpopular (Stockwell, 1984; Johnson & Webb, 1994). The influence of liking cannot be ignored, and it works both ways. Interdisciplinary teamwork does not remove this but effective teamwork does act as a counter balance to labelling patients as 'difficult' or 'awkward'. At both units, team members were observed challenging perceptions which were not objective, and were not easily led by the opinions of other team members. In the stroke unit environments however, it could be difficult for patients to recruit allies

if they felt had a problem which the team were not addressing. Reconciling professional goals with patient goals involves compromise which may not satisfy either. Observations and interviews suggested that these occurrences were not common in the two units but serve as a reminder that the teams should not be complacent, patient involvement is not a one way process but requires opportunity for challenge, disagreement and negotiation.

#### *Different team member perceptions*

Whilst concern for persons was a basis for common understanding and interaction it had slightly different meanings for some team members. The most obvious example was in the way the term was defined by social workers at Holton. Concern for the 'whole' person was considered by social workers to be a more inclusive concept than that held by what they termed the 'health team'. By this they meant medicine and allied health professionals, disciplines they cited as being focused primarily on physical and functional concerns. This reflects the importance and influence of values developed as part of primary professional socialisation. This phenomenon was identified in Griffiths's (1997) study, where social workers, nurses and psychiatrists held different world views in relation to persons with mental health problems, and by Opie (2000) also in mental health settings. The comments made by three of the four social workers at Holton illustrate this different perception:

*'Well I think you've always got a different value base between social work and health in that inevitably you've got the medical model that's going on, on the ward'. (SW, Holton, Interview 1)*

*'I think certainly when you're ....staff are working with people's physical needs, you know there may be times when the social side is forgotten, not intentionally but because they're so focused on you know getting people's sort of physical functioning back'.(SW, Holton, Interview 10)*

*'So, does that mean we listen more to what people really, really want, I don't know, are we a bit more persuaded by the person rather than the 'er sort of medical knowledge I don't know'. (SW, Holton, Interview 13)*

Although hesitant, this social worker concluded that there were differences in focus and sometimes these differences meant that the prevailing view of the team had to be challenged in the interests of

the patient. These *different team member perceptions* at Holton meant staff were not always in agreement conceptually as to how far the needs of a patient would be met by rehabilitation plans after discharge from the stroke unit. This did not result in confrontation or conflict during the period of observation but it did surface in the interviews. A shared concern for persons provided the basis for dialogue and negotiation to explore and resolve differing perceptions. This dialogue was unlikely to occur in MDT meetings although it was often identified in that forum. Social workers were more likely to use informal dialogue particularly with nurses and OTs to clarify perceptions and options for post discharge care. This was facilitated by the requirement for these disciplines to collaborate to complete applications for care provision in the community setting. The applications could have been completed separately but dialogue frequently occurred prior to their completion.

#### *Concern for team members*

Concern for persons went beyond *person centredness*, extending to team members with whom regular interaction occurred. It was an important part of establishing and sustaining team relationships. This expression of interest and investment in knowing the person facilitated team membership for both core and peripheral team members. McCallin (1999) and also Mickan & Rodger (2000) argued that interdisciplinary teamwork, involves exchange, negotiation and compromise; an established relationship with other team members makes this easier but it requires some understanding of the needs and demands faced others. At Holton, for example:

*'Plus on a personal level, because you know we get on very well so you know, just in general chit-chat, how are you, what's going on in your life type of thing. You build up relationships in that way, so you feel more natural, at ease, if you want to talk about patients'. (SN, Holton, Interview 11)*

*'Chit-chat builds a team, useful chit-chat. Even non useful chit-chat does, because you're building relationships all the time, and the better your relationships to me the more you communicate'. (SN, Holton, Interview 4)*

These comments highlight how team relationships facilitated dialogue between team members.

*Concern for team members* also fostered tolerance:

*'I don't think it's just what you get from the patients, because it's a support you get from your colleagues within the team as well, [...]we've all got the demands of the structure and everything else, you know, the fact that we haven't got enough staff, sometimes people are off sick and things like that. We've all got those sorts of things to contend with, and yet we do come through it and I think it's only from the team support that we actually do come through that'.* (OT, Colebrook, Interview 8)

*'People are kind of stretched, but we still think on the whole this ward is quite good at teamwork and we would support each other. Anybody has difficulties we'd we.... wouldn't be the first like to point the finger at them. I think we would try to support them as much as we can'.* (HCA, Colebrook, Interview 3)

Peripheral team members at both units recognised how this contributed to their work with the teams:

*'It's the nature of any team I think you're in, you can't just be this sort of presence, it's a personal thing as well. And you need to know people on some sort of personal level, I think to be accepted. I mean, if you know a particular member of staff, and then you feel more able to make your opinion known, it's okay, if they disagree with that, you still feel confident enough to make that, whatever you feel known'.* (SW, Holton, Interview 10)

*'The nurses, you know, when I come on the ward, know who you are, speak to you, chat to you. They know what's happening socially with you as well as professionally, I think it's fairly obvious when you come on even if you don't go to the case conference; you're part of the team'.* (Dietician, Colebrook, Interview 7)

*Concern for team members* contributed to the relative absence of conflict in both units but there were instances when frustrations occurred and tensions arose between team members. Knowledge of team members' personal situation for example, they may have an ill relative, can mean tolerance will be shown. Team members at both units were prepared to give and take, to see work as a mutual concern requiring an understanding of the needs and contribution of other team members.

In summary, data analysis indicated the following relationships between the category concern for persons and its subcategories:

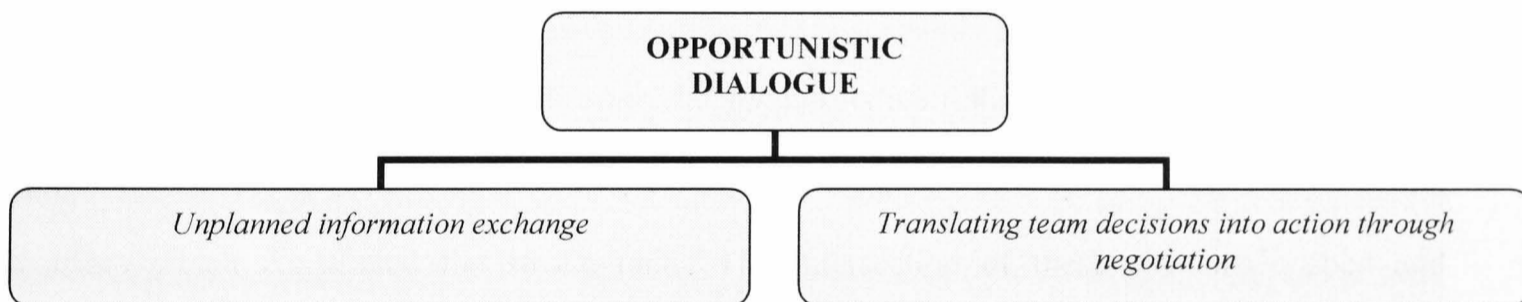
- 1) Stroke unit team members expressed a *person centred* philosophy and *approach* to their interaction with patients and other team members. They identified this as being related to their professional career biographies which in turn were related to their *choosing to work in stroke rehabilitation*.
- 2) This *person centred approach* was demonstrated in the way that individual rehabilitation strategies were developed and through regular attempts to directly *involve patients* and their relatives in order to personalise and maximise rehabilitation.
- 3) Although all team members expressed a *person centred* philosophy *different perceptions* of the meaning of the concept were evident, these are a consequence of different primary professional socialisation.

- 4) *Patients and team members* sometimes had *different perceptions* of rehabilitation and *person centred* approaches, these are related partly to patients developing a realistic understanding of the personal effects of stroke, but may also be related to professional paternalism.
- 5) *Concern for team members* was evident and was a consequence of *learning and working together* and also frequent contact and interaction between team members in an *inclusive team culture*.

Concern for persons was an important *shared value* but its realisation required action individually and collectively. The discussion of the major categories has identified key elements of the temporal matrices which constituted the stroke units. The intersection of these elements shaped and influenced each other to provide conditions conducive to the achievement of teamwork. So far, the process which has underpinned and brought together these elements of the temporal matrix has only been indirectly alluded to. The discussion will now focus on the process of *opportunistic dialogue*, which I argue was central to achieving and maintaining teamwork.

Core Category: Opportunistic dialogue

Figure 14:



*Unplanned information exchange*

Early in the fieldwork at both units, team members were observed using face to face contacts in a direct and structured way. These provided opportunity for information exchange, questioning, clarification, negotiations and decision making. The term *opportunistic* is used to denote that these contacts were essentially unplanned. Team members seized opportunities for dialogue as they occurred during the working day. Whilst this dialogue was essentially unplanned, the data showed that team members recognised its value and either actively sought it out, or made efforts to put

themselves in a position to take advantage of it. Dialogue was usually spontaneous and happened anywhere on the units where team members came together and discussed a patient. It was often opened by the comment: *'I've just been working with [name] and I wondered what you thought about'*. It was equally likely to occur at the central work-station, on the corridor, outside a patient's room, in the dining room, on the stairs, in the therapy rooms or in the kitchen; in short wherever team members came into contact.

*Opportunistic dialogue* was inclusive and did not differentiate between grades of team members. *Dialogue* content was patient focused and related to previously agreed goals or to the progress of rehabilitation. The term *dialogue* is used to refer to the conversational nature of the discussion which took place. It was characterised by exchange of perspectives, information and ideas but commonly progressed to include *negotiations* relating to planning rehabilitation, problem solving and decision making. In *opportunistic dialogue* team members expressed and checked opinions, debated the merits of different courses of action, argued for their particular contribution, and made compromises, bargains and trades (Appendix 9 provides a detailed account of one such exchange).

Bohm (1996) regarded *dialogue* as a process that went beyond common understanding of conversational interaction and which represented a means to engage in thinking at a collective level, that is, a conscious exploration of knowledge, values and experiences. This is not viewed as unproblematic as clearly people bring different knowledge, values and experiences to their *dialogue*, but for the stroke unit teams *opportunistic dialogue* provided the means to address professional perspectives and differences constructively and on a regular basis. Bohm (1996: 3) suggested that

*'If people are to co-operate (literally to 'work together') they have to be able to create something in common, something that takes shape in their mutual discussions and actions, rather than something that is conveyed from one person who acts as an authority to others, who act as passive instruments of this authority'*.

He acknowledged temporal features in development of *dialogue* of this kind, arguing that over time participants move beyond social niceties, acknowledging and working on differences and problems in understanding. The process of *opportunistic dialogue* was how team members in both units came to *understand the roles and perspectives of others*, where they heard others' views, revised their own and constructed a common view on appropriate courses of action as members of a team and not just as representatives of a particular discipline. *Core and peripheral* team members needed to think differently about their own work and that of others, this required reconsideration of responsibilities for rehabilitation and the realisation that knowledge and *skill sharing* could change the pattern and order of work in the units. As Bohm (1996) identified, this clearly differs from telling others what to do, *opportunistic dialogue* was not about those in authority instructing others. Instead it included talking about work, thinking out loud about the needs of patients and hearing the views of others who shared this work. Development of a *person centred approach* shifted the focus from professional and hierarchical ordering of work tasks to collaborative responses to patient problems and goals. Data analysis highlighted the development and consequences of team members 'talking about' their work during the initial organisation of teamwork and through *learning and working together*. Their *dialogue* progressed from tentative exploration of patient needs and professional responses, through growth in knowledge and understanding of other team members roles, to a process through which teamwork was achieved.

Achievement of teamwork in the stroke units did not occur serendipitously but was dependent and consequent on access to *opportunistic dialogue*, through which plans made in MDT meetings were realised. *Opportunistic dialogue* influenced the observed and expressed cohesiveness of the teams and was the principal means by which they responded to change and development within and external to the team. This basic social process and the interaction of elements identified as major categories directly influenced team members' perceptions and actions.



The data demonstrated that to access *opportunistic dialogue* peripheral team members were required to make an effort to be present on the units, for example writing up notes at the central work-station. Being present facilitated *unplanned information exchange*, for example overhearing that the PT and the OT were working with a patient in the gym and deciding to go to the gym and talk about a patient whilst the PT, OT and patient were together. When it occurred during therapy sessions *opportunistic dialogue* also normally involved the patient and their relatives. Through *opportunistic dialogue* team members clarified roles, responsibilities and boundaries, recognised jurisdiction and defined collaboration and teamwork as beneficial and not as competition. Data analysis indicated that *role security* enabled definition of collaboration as a rational response to the problems presented by the complex needs of stroke patients, needs which could not be met by one discipline alone.

The relationship of *opportunistic dialogue* to communication in MDT meetings is important. The two are inextricably linked in terms of their influence on one another, but they are quite different in terms of their frequency and main functions. *Opportunistic dialogue* was not a fixed entity but occurred regularly across each working day and throughout the week between MDT meetings. More team members had access to this form of interaction than the MDT meeting; *opportunistic dialogue* was more informal; access to this did not depend on status and so was more inclusive. MDT meetings occurred weekly, but with fewer team members present, in these meetings communication was more structured and focused on agreeing patient goals and assessing progress. The relationship between MDT meetings and *opportunistic dialogue* was a reciprocal one; decisions made in meetings generated plans which were addressed through *opportunistic dialogue*. In turn issues raised by working with patients were identified in *opportunistic dialogue* which informed decisions made in subsequent MDT meetings. These forms of communication were interdependent and enabled the rehabilitation work of the teams to be achieved, not just in the sense of the physical activities of rehabilitation but in the co-ordinated and collaborative approach developed by team

members and experienced by patients in the stroke units. Sullivan (1998: 12) suggested collaboration required:

*'Being open to negotiating differences of opinion, to putting aside their own agendas and status concerns and making decisions in the best interests of the patient, organisation or student depending on the given situation'.*

The data showed that through engagement in *opportunistic dialogue* team members learned to set aside prior assumptions and explore different possibilities. Sometimes this required redefinition of situations and changes in thinking following *dialogue* with other team members who often displayed quite different world views. A *person centred approach* and the *focus on stroke* provided 'common ground' for examining different views of rehabilitation. The *opportunistic dialogue* which took place as part of *learning and working together* was where many of the potential barriers to achieving teamwork were worked out. The processes of team learning and development of team thinking were slow and not without difficulties and disagreements. In these, as in any other work setting, team members had to make decisions and carry them out; the difference in the stroke unit teams was that decision making was a collaborative process and not a default to physician or other authority directing the work of subordinates. The decisions made by the teams were commonly arrived at through a process of *negotiation* through which team members arrived at agreements for ways of working with patients and with each other.

#### *Translating team decisions into action through negotiation*

An important component of *opportunistic dialogue* involved engaging in *negotiations* between team members. Strauss (1978) suggested the outcomes of *negotiations* were more likely to be perceived as positive and useful when positions on getting the job done were broadly similar. When this is not the case people can become frustrated, and may decide to leave the team. The data indicated some evidence of this in the early development of the stroke units. However, whilst there had been staff changes, turnover remained low and the majority of team members had been working in the units since they opened.

*Negotiations* occurred in relation to two main areas; firstly, the ways that team members would carry out their work with each other, with patients or individually. This was their work on collaboration and team practice. Secondly, *negotiations* occurred in respect of designing and carrying out specific aspects of rehabilitation, this was their patient focused work. Examples of *negotiations* related to collaborative work include the initial skills training and practice related to specialist positioning, moving and handling of stroke patients. Incorporating these skills in the practice of nurses, HCAs and some OTs initially added to the workload of these disciplines. It also required some of them to define rehabilitation as a core part of their role and not simply the province of specialists like PTs. Both bargaining and exchange occurred here, for example, PTs shared specialist knowledge and skills with other disciplines in exchange for something. In agreeing to develop and use specialist skills other disciplines contributed directly to PTs realising their professional goals of increasing the frequency of provision of specialist rehabilitation, of 'therapeutic intervention 24 hours a day'. Data analysis suggested that the other disciplines were willing to engage in this exchange, despite an increase in workload, because in return they developed new skills and knowledge and enhanced their perceived status as contributing team members.

Patient focused *negotiations* were often serial in that they occurred throughout patients' stay in the units. The individual consequences of stroke varied considerably so rehabilitation approaches required continuous adaptation. *Negotiations* rarely involved all team members but occurred between those who had responsibility for specific areas of care. For example a social worker, OT, PT and nurse would negotiate about the support required for a patient to be discharged to his own home. Here other forms of *negotiations* including compromise and wheeling and dealing were more prominent. For example, some patients were not quite safe to walk unaided but did not always require a wheelchair. Decisions regarding equipment provision, adaptations to the home and timing of discharge were complex, involving many team members as well as patients and relatives.

*Negotiations* involved PTs and nurses compromising their position regarding the desire to work with patients for longer to reduce reliance on wheelchair use, which they believed would be in the patient's best interest. This was set against the more pragmatic view of the OT and social worker following home visits and discussion with patients about their personal aspirations. This view argued for early discharge and recognition of the patient's preference for wheelchair use if it meant earlier discharge. Wheeling and dealing also involved social workers and OTs using their networks within social services and with appliance suppliers to strengthen their *negotiation* position, arguing that equipment could be in place and adaptations made to support an earlier discharge date. The success of these *negotiation* strategies increased the likelihood of coming to agreement within the team about early discharge.

*Negotiations* addressed concrete practical problems in many instances which often required immediate solutions. Being prepared to present a case for a particular course of action, and being willing to debate the ways in which goals might be reached was a key element of the achievement of teamwork. *Negotiations* were facilitated by *co-location* of team members. Interacting in this way was initially novel for many team members but *opportunistic dialogue* provided the space to work out what needed to be done and how. At the time of the study team members came to *opportunistic dialogue* not with entrenched positions about rehabilitation but ready to enter into discussion about treatments, tasks, goals, problems and needs, and how these might be met or resolved.

The outcomes of *negotiations* were defined positively in terms of patient benefit, role enhancement for nurses and HCAs and workload sharing for PTs, OTs, social workers and SALTs, as a result they contributed to making work and teamwork satisfying and rewarding. As team members relinquished some control over traditional areas of work as a form of exchange, this provided evidence of commitment to the work of the team but also legitimated requests for the greater involvement of other team members. For example, SALTs taught other disciplines sip testing and

swallowing assessments and PTs shared basic physical and neurological assessment skills. In both examples team members came to see these skills as core to rehabilitation practice and necessary for effective patient care. In so doing they shifted their thinking and practice away from the compartmentalised and separate specialist approach which defines tasks as being associated with particular roles, to meeting patient needs collaboratively. This is consistent with Abbott's (1988) concept of assimilation, a strategy he argued professions often adopt in day-to-day practice. In this they acknowledge that concern with and preservation of rigid professional boundaries sometimes has little practical value in situations which require divisions of labour which can get the required work done. Working in this way also meant that team members could evaluate, praise or challenge each others' work or *negotiate* for its change. Team members could not simply issue directives on the basis of authority or position but were expected to provide a rationale, and they learned to expect that their rationale may be questioned. Whilst *negotiations* were important in achieving teamwork, not every situation was resolved by *negotiation*, direct requests were also made or instructions given, these were usually derived from the agreed rehabilitation plan. Senior team members were respected for their experience and knowledge; so some instructions were accepted without question or *negotiation*.

The stroke unit teams sought to act in patients' best interests, but patients were not always involved in *opportunistic dialogue*, and were never present in MDT meetings, so their ability to actively present their perspectives was limited. The difference in power held by patients and health professionals makes it difficult for patients to assert their views when these differ from or challenge those of health professionals. Few situations where patients felt this way were observed but the stroke unit teams could not assume because they treated each other equally and with respect that they also and automatically achieved this with patients. Discussing the interface between nurses, patients and their families in medical wards, Allen (2002) noted that lay people and health professionals come from two essentially different worlds and whereas healthcare workers seek to

control the conditions of their work, patients and families seek to control the illness experience. *Negotiation* in the stroke unit context took place in a situation of unequal power in that team members whilst seeking to engage patients and enable them to participate in their rehabilitation may have done so only in so far as patients complied with the advice given by health professionals. There were examples of direct patient involvement in decision making in the stroke units but it cannot be said that patients were full partners in all decisions made.

*Opportunistic dialogue* was not a one off or time limited process and most team members took part in *information exchange* and *negotiations*. At the time of the study team members were primarily negotiating about day-to-day rehabilitation work on the basis of patient responses and agreements reached in MDT meetings. However, some structural factors affecting team practice in the stroke units were largely non-negotiable, for example the continuing demand for admission to the stroke units, the requirements to meet the standards set as part of the NSF for Older People (DoH, 2001a) and in particular, the separate organisational management of professional groups. Team practice issues relating to working times and working patterns of therapists, medical staff and nurses could have been reviewed and alternative patterns of working debated and *negotiated*. However, team members suggested that separate management structures and historical professional traditions (for example weekday only working for therapists) within the NHS Trusts were responsible for existing differences in working times and patterns. At the time of the study team members at both units were not prepared to enter into *negotiations* to change these patterns individually or collectively.

The data demonstrated that the achievement of teamwork was consequent on the interaction of the four major categories which constituted the basis for collaborative work in these stroke units. The core category of *opportunistic dialogue* explains how these potentially separate elements of stroke unit work are brought together by a basic social process which is central to realising the collaborative action defined as teamwork.

In summary, data analysis demonstrated the following relationships between opportunistic dialogue and the major categories:

- 1) The term *opportunistic* denotes that contacts and information exchange were essentially unplanned; team members seized opportunities for *dialogue* as they occurred as part of their work on any given day. This was facilitated by *co-location of team members*, and their commitment to and experience of *learning and working together*.
- 2) Although *opportunistic dialogue* was essentially unplanned, team members recognised the value of this kind of contact and either actively sought it out, or *made an extra effort* to put themselves in a position to take advantage of it. Access to and participation in this *dialogue* was important in team members' perceptions of being in the team.
- 3) *Opportunistic dialogue* was facilitated by the *inclusive team culture* which did not differentiate between grades or seniority of team members.
- 4) The *shared values* of being *positive about stroke* and having *concern for persons* gave meaning to patient focused contacts and provided a common basis for *dialogue* between team members.
- 5) The term *dialogue* refers to the conversational nature of the interaction and exchanges which took place. *Dialogue* included exchange of perspectives, information and ideas which contributed over time to *redefining roles and changing thinking about rehabilitation*.
- 6) In *opportunistic dialogue* team members expressed and checked opinions, debated the merits of different courses of action, argued for their particular contribution. *Opportunistic dialogue* normally involved making compromises, bargains and trades, in short it involved *negotiations*. Through *dialogue* these *negotiations* contributed directly to planning rehabilitation activities, problem solving, decision making and team practice that is, the work of *achieving teamwork* in the stroke units.

### Summary

*Opportunistic dialogue* was an active and creative process which provided a mechanism for exploring and negotiating shared meaning in stroke rehabilitation; it was a process through which team members could learn about, and bring about, teamwork. Table 6: summarises the internal and external factors which influenced the achievement of teamwork in these stroke units.

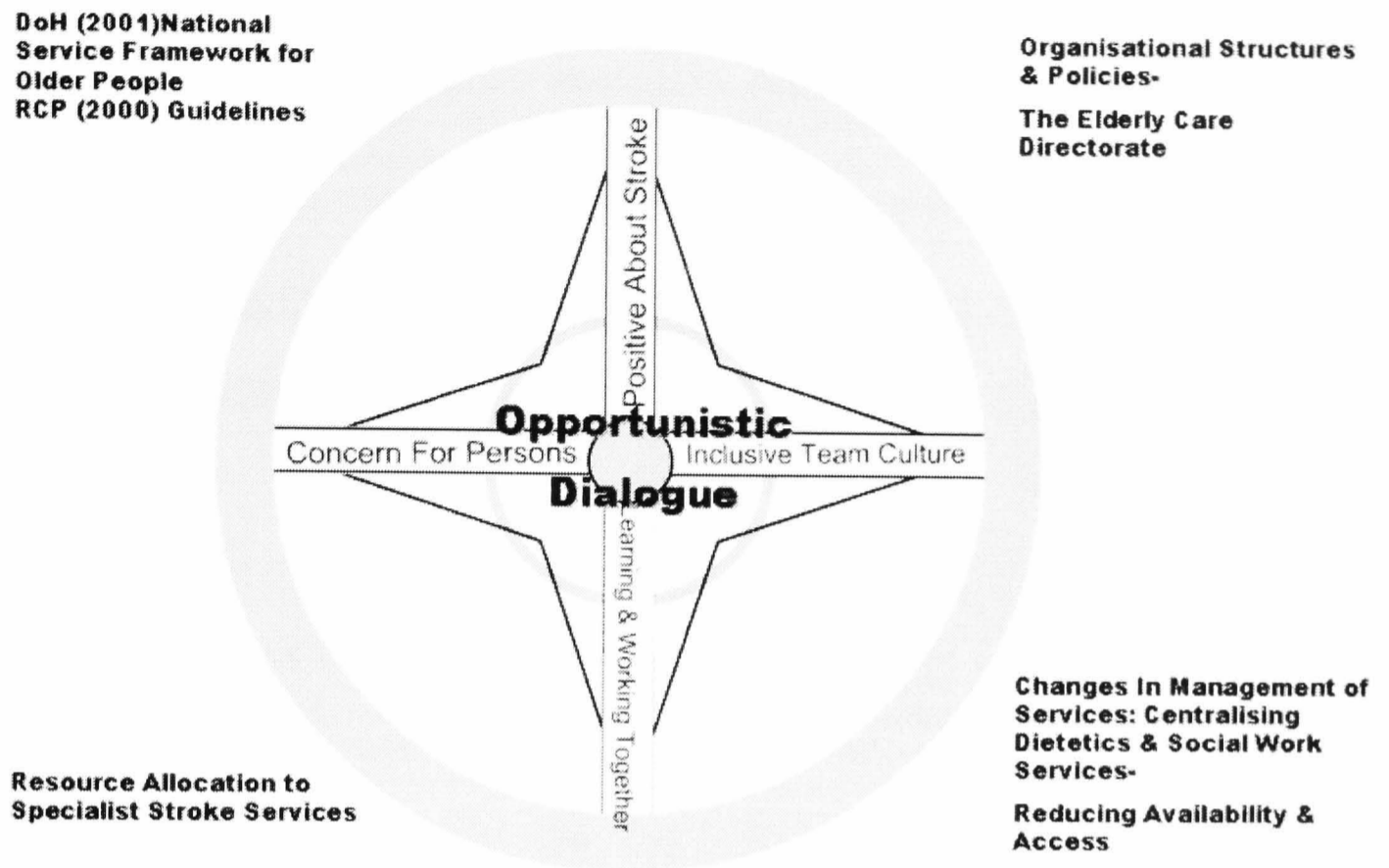
Table 6: Factors influencing the achievement of teamwork in the stroke units

<u>Structural context: Influencing factors at a national level</u>			
Professions and power, NHS structure and organisation, National Service Framework for Older People (DoH, 2001a)			
	<i>Negotiations</i>	<i>Negotiations</i>	
	<b>Opportunistic dialogue</b> <i>Translating team decisions into action through negotiation</i>  <i>Unplanned information exchange</i>		
Negotiation context-	<u>Concern for persons</u>	<u>Inclusive team culture</u>	Negotiation context-
	<i>Concern for team members</i>	<i>Co-location and team contacts</i>	
	<i>Different perceptions-patients and team members</i>	<i>Core and periphery team working-being in the team</i>	
	<i>Person centred approach- Involving patients</i>	<i>Shared leadership- Team development and maturity</i>	
		<i>A non traditional division of labour</i>	
Stroke units	<u>Positive about stroke</u>	<u>Learning and working together</u>	Stroke units
	<i>Shared values and goals</i>	<i>Shared ownership of rehabilitation- redefining roles and changing thinking</i>	
Hospital /Directorate	<i>A positive unit climate</i>		Hospital /Directorate
	<i>Developing specialist skills and knowledge for rehabilitation</i>	<i>Skill sharing and role security</i>	
Professional management structures and working practices	<i>A focus on only stroke</i>	<i>Understanding the role and perspective of others</i>	Professional management structures and working practices
	<i>Choosing to work in stroke rehab</i>	<i>Shared learning and joint working- developing understanding and trust</i>	
<u>Structural context:</u> Research and evidence based practice, RCP (2000) Clinical Guidelines for Stroke			

This table highlights the influences on teamwork; however, it does not adequately represent the social processes involved; the dynamic nature of achieving teamwork is conceptually represented in the model below:



Figure 15: Achieving teamwork in selected stroke units in the North of England -a hub and spoke model



In this model *opportunistic dialogue* is represented by the wheel's hub to which four spokes are connected, these are the *major categories* and they in turn are connected to the wheel rim. These elements collectively provide the conditions and structure for teamwork and are necessary for its effective function. The wheel rim represents the interaction of stroke unit teams with the local and wider contexts including elderly care directorates, the respective hospital organisations, NHS policy and standards and with broader professional relations within society. The achievement of teamwork is influenced by these wider social structures at both an individual professional level and at the collective team level. The impact of these external influences was mediated by the inclusive culture and professional maturity of the teams. The teams were not isolated from external influences but had considerable autonomy in the negotiation and organisation of their work. In this model the wheel's hub is central to its continued and effective structure and function, in the stroke units,

*opportunistic dialogue* represents this hub. It was the central and basic interaction process which synthesised the interconnected elements of team interactions and was the principal means by which teamwork was achieved and maintained. This process provided the means to harness the positive dispositions to working collaboratively evident in the categories outlined and at the same time work with and through common barriers to interdisciplinary working.

In next chapter, the study findings will be examined in the context of the literature relating to negotiated social orders and also that examining achievement of interdisciplinary teamwork in healthcare.

## Chapter 9:

### Research findings: Discussion and conclusions

## Introduction

This chapter will discuss and define in more detail the concepts of opportunistic dialogue and negotiation. These are central to the explanation of the achievement of teamwork developed from data generated in this study. These concepts will be critically examined in the context of literature examining the importance of dialogue processes in developing collaboration and joint action. The role of negotiations within opportunistic dialogue will be reviewed in terms of the wider theoretical context of the negotiated order perspective developed by Strauss (1978, 1993). The strengths and limitations of this perspective for explaining team working processes in the stroke units will be discussed. The research findings will also be considered in the context of Abbott's (1988) explanation of how professionals manage the day-to-day interactions and division of labour in the workplace. The chapter concludes with an examination of the contribution of this study to knowledge, and to understanding how co-ordinated interdisciplinary teamwork was achieved in the stroke units. Ways in which the research findings could be used in healthcare education and practice are also suggested.

## What is (opportunistic) dialogue?

Dialogue serves a range of general social functions including greetings and information exchange, such as:

SN: *'Hi Lisa, did you speak to Toby's sister today?'*

OT: *'Hello Judith, Yes, she will be meeting the social worker on Wednesday on the ward.'*

(Fieldnotes, Holton, April 2002)

At their most basic, dialogue episodes involve conversational exchanges; these are represented as simple turn taking in speech in order to progress interactions such as that identified above. Dialogue is also used to achieve specific goals such as requesting resources, or in problem solving interactions, for example:

SHO: *Wendy, I cannot find the CT scan report in the notes, do you have any ideas where it might be?*

Ward Clerk: *Well, have you checked it has been sent from radiology?* (Fieldnotes, Colebrook, April, 2002)

Most social dialogue episodes are short, single interactions and, provided that original goals are achieved, are not repeated or only repeated infrequently. In such episodes, social actors' development of knowledge and understanding of each others roles and perspectives is limited and may have little influence on future interactions. However, when dialogue is frequent, repeated and regularly involves the same actors in the same setting, the potential for developing shared understanding is markedly increased (Bohm, 1996). This can be instrumental in reaching agreements on what can or needs to be done in certain situations and in realising joint action (Grosz & Kraus, 1996). In this study, fieldwork and data analysis confirmed that frequently observed episodes of informal but structured talk-in-interaction between team members were much more than social conversational encounters. The concept of *dialogue* represents problem or task oriented talk-in-interaction between team members. The data showed that these episodes occurred opportunistically, were unplanned and were not constrained by location, time or team member status. Their occurrence in each working day was closely linked to team members' perception that the circumstances were appropriate to seize the moment to enter into dialogue about issues in patient rehabilitation. The term *opportunistic* most closely defines the stimulus and basis for this interactional process.

Researchers from many disciplines including, linguistics, computer sciences, psychology and sociology have focused on the structure, content, verbal and non verbal features of dialogue (Strong, 1979; Mann, 1988; Silverman, 1997; 2004; Hulstijn, 2000a). Interpretation and analysis has focused on these features of talk-in-interaction in a variety of social encounters and settings and contributed to understanding the meaning and processes at work in talk between social actors (Renkema, 2004). Analysis of *opportunistic dialogue* processes was informed by reference to some of the above research. Some features of talk-in-interaction described in the literature were consistent

with dialogue episodes in the stroke units. Hulstijn (2000b) outlined three phases in task directed dialogues; these were inquiry, negotiation and confirmation: *opportunistic dialogue* episodes often followed this pattern. The *inquiry* phase was equivalent to common dialogue opening strategies where one team member asked for another's perspective on a patient's progress. In the *negotiation* phase, actions or interventions to meet agreed goals were proposed and debated by team members involved in that dialogue episode. Hulstijn's (2000b) *confirmation* phase was equivalent to reaching agreement on revised goals, and actions individual team members would take to achieve these. In the stroke units, *opportunistic dialogue* rarely followed a simple linear pattern and often revisited inquiry and negotiation phases before confirmation was reached. These were normally short and rapidly conducted dialogues, but proposals could be challenged and had to be defended or amended in different situations. These dialogue episodes were instrumental in realising teamwork, conceptualised here as complex group (joint) action. In theorising the characteristics of joint action, Grosz & Kraus (1996) argued that pre-existing 'recipes' or patterns of interaction were required if different agents were to effectively coordinate their actions. *Opportunistic dialogue* contained many of the features identified by Grosz & Kraus (1996); including debate between actors about what would be required to achieve agreed patient goals and a familiar, patterned or loosely phased communication process through which decisions could be made and agreement reached.

However, in contrast to some of the above research, analysis of dialogue episodes in stroke units has not focussed specifically on semantic and linguistic structures evident in these episodes. Rather, it was concerned with the processes occurring in *opportunistic dialogue*, the context and conditions through which this arose and the consequences of dialogue for team working. Close examination of dialogue episodes was instrumental in locating and defining the different kinds of interactions which occurred, including *negotiations* between team members. Fine (1984:241) in his review of negotiated orders and organisational culture argued that '*negotiations follow lines of communication, i.e. they are patterned not random*'; this patterning of negotiations was evident in

stroke unit dialogue episodes. *Opportunistic dialogue* had a social function, but it was primarily an instrumental and task oriented process incorporating 'means-ends reasoning' which resulted in agreements on the day-to-day division of labour (Grosz & Kraus, 1996). The data indicated this process was not static and that there were constant and changing features over time.

Initially *opportunistic dialogue* episodes represented an information exchange forum, which included discussion and debate, and where team members, unfamiliar with each other and with each other's work, proffered their views on interventions which could resolve novel and complex patient problems. Regan (1984) argued that regular dialogue was instrumental in building co-operative structures needed for the joint action required of different health professional groups. Engel (1997) identified that innovation could result from interactions within and between groups who are mutually interdependent in their work, and are willing to pool their intellectual and physical resources to bring about desired change. Repeated engagement in sharing and validating patient information and in exploring different perspectives within dialogue episodes contributed to mutual learning in the stroke unit teams. Over time this led to development of shared understanding of patient problems and of the need for joint action to resolve these problems. The consequences of this were development of familiar patterned interactions which underpinned dialogue between team members. These ensured that dialogue and joint actions developed the structure and organisation required to sustain innovation and change in these units (Engel, 1997). The data indicated that at the time of the study, team members in both units had accepted and internalised the necessity for joint action. Thus, *opportunistic dialogue* had developed to the stage where it was the preferred process for problem solving and responding to changes in patients' needs, and also for increasing team members' knowledge and understanding.

*Opportunistic dialogue* provided an interaction process (the hub) where the division of labour in respect of specific rehabilitation activities was worked out and agreed. The example below

illustrates the interaction pattern evident in many of these episodes, which commonly opened with identification of changes in patients' condition:

OT: *Tom's still neglecting his left side and he's not co-operating with us in washing practice.*

Questioning and seeking clarification often followed this kind of opening, knowledge was shared and understanding could be increased:

SN: *I don't understand the neglect, what causes that, why does he turn his head away like that?*

Brief discussion aimed at developing understanding and suggestions or proposals would be made by dialogue participants. In turn, developing understanding increased commitment of team members to the strategies agreed for future action:

PT: *I think he would do better if his wife were present, he responds well to her prompting.*

SN: *We should ask her to come in early on Friday then, yes that's a good idea.*

OT: *Sally, you know her better than Miriam and I, if we set up the joint session and prepare Tom, will you ring and tell his wife why we think this is important?* (Fieldnotes, Central work-station, Holton, June 2002)

The last sentence in this exchange is indicative of opening the kind of *negotiation* which occurred within *opportunistic dialogue* episodes. This represents an example of a simple 'exchange', within dialogue, the OT offers to organise the patient and the joint working time in 'exchange' for the staff nurse encouraging Tom's wife to attend. The PT is not silent in this dialogue and in effect sets up the exchange by suggesting a rationale for inclusion of Tom's wife in the joint session. The division of labour in this instance is justified by the OTs claims regarding the staff nurse's relationship with Tom's wife. Hulstijn (2000a:145) identified this kind of proposal as a '*directive dialogue act*', one used in negotiations intended to get others to do certain things. The offer of an exchange increases the likelihood of agreement as both parties take actions related to achieving a mutual goal. This is quite different from those in authority directing the work of subordinates (Bohm, 1996). This distinction is important in that *opportunistic dialogue* was not a passive conversational process but frequently an active debating space for exchanging views and perspectives. Proposals were regularly challenged or rejected and alternative courses of action proposed as team members



*negotiated* for specific courses of action and to get others to share in or take on the work that needed to be done.

### Opportunistic dialogue and MDT meetings and ward rounds

Dialogue and negotiation also occurred in MDT meetings and ward rounds but the origins, context and often content was different to that seen in opportunistic dialogue episodes. In MDT meetings and ward rounds dialogue was framed by prior expectations of the purpose and structure of these events. In both units, ward rounds normally only involved a nurse, an SHO and the consultant physician. They followed a routine and agreed structure which was focused on and ordered by patients' medical conditions. For example, checking neurological status, blood pressure, medications, continence, weight, and dietary intake, before progressing to assessment of independence using agreed quantitative measurement scales such as the Barthel Index. These episodes were characterised by presentation of objective and factual information. Progress and problems in rehabilitation were identified, but discussion and debate on these was normally deferred until the MDT meetings which followed the rounds. By definition, these were not *opportunistic dialogue* episodes; however, *negotiations* were sometimes evident, with for example, nurses arguing for changes in medications:

SHO: *He seems to be more mobile and steadier on his feet now*

SN: *No, I disagree; I don't think you've seen him since he went on Tizanidine*

Consultant: *How long has he been on it?*

SHO: *Five days now*

Consultant: *So we could wait a while, you know how things can settle down with this drug Jenny*

SN: *No, no, the side effects he's having are like we saw with Mr Roberts; he is much drowsier than before and although his tone has gone down he is actually less able to stand and transfer than he was. I talked to Miriam [PT] too and she thinks we should consider stopping the Tizanidine.*

Consultant: *Ok, well it does sound like a classic Tizanidine response, [to SHO] it is a good drug Alison but it doesn't sound as though things will improve, we'll stop it now. (Fieldnotes, Holton, June 2002).*

In this interaction the experienced staff nurse persists with her request despite the SHO's different perspective and the consultant's initial challenge, she uses objective and factual information to

negotiate for the change. She also supports her position by indicating that the PT shares her opinion on the effect of the drug. The staff nurses' knowledge and experience together with her established working relationship with the consultant appeared to influence his willingness to accept the argument for stopping the drug.

In both units, dialogue in MDT meetings frequently followed a similar pattern. Meetings had two primary functions, updating the teams on patients' progress in rehabilitation and planning for discharge. The meetings included larger numbers of team members and information presented and discussed was more wide ranging. Both teams had evolved a routine for the order and content of presentation of information, but where complex problems were occurring or where differences of opinion on progress or discharge arose then *negotiations* such as those described above were common. These were again framed by the prior expectations and experiences of team members in terms of the meetings. These were more formal events, team members prepared notes in advance, and they expected to have to explain their rationale for a proposed course of action. The consultant physicians normally chaired and directed the flow of the meetings, in their absence the ward manager at Colebrook and the senior PT at Holton took on this role. As a result, dialogue normally followed a routine pattern of information exchange which ended in a summary statement or propositions from the team members chairing the meeting.

The main differences seen with *opportunistic dialogue* episodes were the situations which prompted the dialogue, the number and range of team members present, and the frequent focus of the dialogue and *negotiations* on early or immediate resolution of specific and often unanticipated problems. These were normally short, focused episodes relating to one patient (instead of many) where team member responsibilities overlapped and where dialogue to coordinate joint action was necessary. Despite these differences it is important to reiterate the argument developed in chapter 8 that

*opportunistic dialogue* informed and was in turn influenced by dialogue and negotiations occurring in MDT meetings and to a lesser extent on ward rounds.

### Managing differences of opinion in dialogue

Disagreements in observed dialogue episodes rarely resulted in an impasse or conflict, instead, proposals were normally reworked and restated and *negotiations* continued until agreement was reached. However, the data showed that rejections of proposals were often indirect, for example in the dialogue episode described on page 263, after arriving at what appeared to be an agreement on a joint session the PT said:

PT: *'Wait on; I'm going to find it difficult to do a joint session anytime Friday morning'*.

Here the proposal is not flatly rejected and a way is left open for its revision and further negotiation without personal challenge:

OT: *(sounds irritated) But you know I am not in Friday afternoons, Anne [other OT] doesn't really know Tom, I don't want to leave this for her. Why can't you move things around this once?*

PT: *I know but there are no RAs in on Friday and I am really pushed that day.*

OT: *So what if we left it till late morning, say 1130? Is there any reason his wife can't come then instead?*

PT: *It will still make my life more difficult, but I guess I can fit it in then, but you owe me one remember.* (Fieldnotes, Central work-station, Holton, June 2002)

This interaction demonstrates the willingness of an established work group to seek accommodation rather than reject the OTs proposals (Bohm, 1996; Farrell et al, 2001). Reaching agreements often involved compromise for one or more team members, what Strauss (1978) termed 'give and take' or 'bargaining'. Judgements of the significance of the compromise, required consideration of the benefit of the proposed action to the patient and the work involved to bring about the action. *Opportunistic dialogue* did not always result in complete agreement, the important issue in the interactions of these teams is that dialogue episodes encouraged differences to be aired and worked through on a regular basis. Differences in perspective were a normal part of professional responses to complex patient problems. The above example and that in Appendix 9, illustrate the kind of

*negotiations* regularly observed in the stroke units and how these impacted on the day-to-day division labour. Similar kinds of interactions were also noted in the teamwork research of McCallin (1999) and in Hulstijn's (2000a) study of dialogue models for transactions.

#### The interrelatedness of dialogue and negotiation in the stroke units

So far, the discussion has concentrated on *opportunistic dialogue* as a process which informed or provided the basis for decision making regarding patient goals, and facilitated joint action. In this study *opportunistic dialogue* and *negotiations* were interrelated and complementary. The difference between these concepts can be addressed at two levels. Firstly, *opportunistic dialogue* represented unplanned but structured conversational episodes. *Negotiations* did not have to be part of this process for it to be an effective means of coming to agreement on the division of labour. Agreements were also arrived at following information exchange, brief education, or simple requests for help or direct action. However, at another level, *opportunistic dialogue* was the main process used by team members to debate, explore, clarify, *negotiate* and manage their overlapping division of labour. Therefore, it is important to emphasise the major role played by *negotiations* in coming to agreement on the teams' rehabilitation work. Whilst a distinction can be drawn between these concepts, the study findings emphasise their interrelatedness and interdependence as core interactional processes contributing to the achievement of teamwork.

The negotiated order perspective and the concept of processual ordering provide an important theoretical lens through which to view the study findings (Strauss, 1993). The following discussion explores the extent to which these perspectives were useful in explaining the basic social process evident in the data.

### Strengths and limitations of the negotiated order perspective

The negotiated order perspective has influenced a wide range of studies analysing intra and interorganisational development, interactions and working practices, particularly in the public sector (Martin, 1975; Maurin, 1980; Hall & Spencer-Hall, 1982; Mesler, 1989, 1995; Nathan & Mitroff, 1991; Svensson, 1996; Parhankangas et al, 2005). In particular, the perspective has been identified as providing a theoretical basis for explaining how order is maintained in the face of change in organisations (Maines & Charlton, 1985; Allen, 1997). A major strength of the negotiated order perspective is its focus on how work is defined and managed by actors in the context of external and internal organisational rules and constraints. An important consideration is the positioning and purpose of negotiations themselves. Negotiated agreements occur at different levels, for example between individuals, between groups and between organisations or nation states (Rahaman & Lawrence, 2001). Implicit in much organisational level research on negotiated orders is a focus on the negotiated management of conflicting interests. These are commonly associated with the intention of actors or groups to resist change or to get their preferred course action agreed, often at the expense of another group; sometimes seeking a win-lose outcome as opposed to agreements which benefit both parties (Regan, 1984; Beaulieu & Pasquero, 2002; Degeling & Maxwell, 2004). Regan (1984) in his discussion of integration of psychiatric services into three general hospitals in Canada drew attention to these elements and showed how negotiations in one hospital were disrupted and blocked by groups of actors who held very different perspectives on medical and non medical management of psychiatric illness. This is one of a number of studies which demonstrate that whilst negotiations have been shown to be an embedded feature of healthcare organisations, structural constraints such as resource allocation models, the system and power of professions and medical dominance can block negotiation, and compromise or undo agreements reached (Mesler, 1989, 1995; Griffiths, 1997; Snelgrove & Hughes, 2002).

Three criticisms of the negotiated order perspective are important in terms of the findings of this study. These include, firstly the perspective's failure to acknowledge the influence of structural constraints on negotiations in the workplace (Fine, 1984; Farberman & Perinbanayagam, 1985). In healthcare practice this relates to the influence of professional power on what can be negotiated and by whom (Regan, 1984; Griffiths, 1997). Secondly, the claim that all social orders are essentially negotiated orders (Strauss, 1978) has been shown to be problematic in that social orders develop and change in the absence of formal and informal negotiations (Goldie, 1977; Hall & Spencer-Hall, 1982; Allen, 1997). Lastly, and closely related to this, is the concern that what counts as negotiations has not always been defined by researchers in the interactionist tradition. These criticisms led to calls for location of workplace interactions and negotiations within a broader theory of action as an important but not defining feature in understanding the interrelationship between negotiations and social actors and their interprofessional relations within public sector organisations (Fine, 1984; Denzin, 1994; Allen et al, 2004). In order to locate the contribution of the current study to knowledge, the research findings will be discussed in the context of each of these criticisms.

### Constraints on negotiations

Strauss et al (1985) outlined a framework for the analysis of factors impacting on negotiations in their discussion of the influence of the structural and negotiation context on social actors' workplace negotiations. In essence, this framework directs researchers to consider how macro conditions (social structure) interact with and are connected to micro conditions (social actions) (Giddens, 1993). In his theory of action, Strauss (1993) proposed the conditional matrix as an analytic device for tracing the existence and influence of these factors which he argued could highlight and explain the complexity of what may appear to be routinised local actions. Hall & McGinty (1997) described the conditional matrix as a device to understand the web of interrelated conditions and consequences in social orders. In the current study, these conceptual frameworks

directed attention to two important elements of the structural context; the influence of external rules in the form of national clinical guidelines for stroke (RCP, 2000) and stroke related NSF standards (DoH, 2001a); and the relationship of consultant physicians to the teams.

Early interactionist research in hospitals (Strauss et al, 1963; Stelling & Bucher, 1972) suggested external and organisational rules were either not known or largely ignored by hospital workers responsible for getting patient work done, and so work was negotiated without reference to the rules. In contrast, tracing the influence of external rules on the study settings demonstrated that the stroke unit teams had a good knowledge of national clinical guidelines and relevant NSF standards. They regarded these as relevant and useful, and normally incorporated them in their daily work. The incorporation of these guidelines is subject to external professional audit on a biannual basis (RCP, 2004). However, whilst there was no inclination or indeed opportunity to negotiate *about* these guidelines, the Holton and Colebrook teams often negotiated *around* them or their interpretation, a situation similar to that reported by Maurin (1980) in her study of nurse-midwives in the US. The stroke unit teams used these external rules to define the scope of their work and also to underpin their assertion that their rehabilitation practice was specialist and required all team members to develop particular skills. On the other hand, these teams also negotiated their team practice *around* some of the guidelines such as that indicating that goal setting should involve patients and carers (RCP, 2000). Both teams maintained that patients and carers were largely unable to identify appropriate goals, and argued that consultation with them on professionally determined goals was more useful. A similarly pragmatic approach was evident in terms of guidelines requiring multidisciplinary assessment using a single assessment process (RCP, 2000). Both teams argued that it was impossible to get relevant team members to carry out joint assessment (though this is not what the guideline specifically required) and that a single assessment document was impractical. At Holton, the team maintained separate systems of record keeping alongside a shared team record. At Colebrook the team had no shared record but provided access to each other's notes. These external

'guidelines' were understood, but both teams negotiated a form of practice that they believed fitted the local circumstances. The conditional matrix is an analytical device which can be used to trace how these structural conditions (national guidelines) influenced team practice and made visible how teams interpreted and partially embraced such external rules. For example, at Colebrook, the consultant and ward manager justified their actions by arguing that there was no research evidence supporting single assessment or multidisciplinary records. The actions taken to get the required work done show that external guidance did not directly constrain the locally determined day-to-day work of the teams, even though the degree of unit compliance with the guidelines was externally audited. This confirms the relevance of Strauss's (1993) position that analysis of the ordering of work should examine how actors define and respond to external and internal rules.

#### Medical dominance as a structural and negotiation constraint

Whilst the relationship between politicians, professions, and health service managers is changing, few commentators doubt that medical dominance remains a major organisational feature of healthcare systems (Friedson, 1994; Fournier, 2000; Annandale et al, 2004). However, healthcare research examining interprofessional relations suggests a much more varied practice reality than might be supposed from that outlined in the literature (Mesler, 1989; Walby & Greenwell et al. 1994; Svensson, 1996; Allen, 1997; Griffiths, 1997; Miller et al, 1999). The negotiated order perspective acknowledges the political and institutional power of organised medicine but resists the argument that medical dominance is inevitable, arguing instead that particular local conditions and contexts may result in a more fluid social order.

The relationship of the consultant physicians to the stroke unit teams did not reflect traditional hierarchical medical dominance; instead the findings demonstrated a number of similarities with interprofessional relations identified in other studies (Mesler, 1989; Walby & Greenwell et al. 1994; Allen, 1997; Gair & Hartery, 2001). Firstly, in terms of the temporal-spatial ordering of work in the



stroke units, it was clear that consultant physicians were only present for very limited time periods, interacting with team members mainly in the ward round and MDT meetings for one half day per week. Secondly, the focus of medical work was related to, but largely different from, the rehabilitation work of other team members. The degree of interdependence between doctors and other team members was more limited. Doctors' influence on *negotiations* therefore was restricted to particular aspects of decision making, namely that in relation to admission and discharge of patients and medical, mainly pharmacological, management of the consequences of stroke. Physicians' involvement in the teams' rehabilitation practice was largely limited to supporting or challenging the interventions planned.

The data showed that the physicians believed that doctors working in elderly care were more team orientated, and did not use hierarchical or positional power to direct the work of others. Fieldwork demonstrated that rather than blocking or rejecting proposals and *negotiations* in MDT meetings, physicians mostly collaborated with other team members, for example, in challenging decisions made by Joint Care Management Committees allocating long term care, and in interpreting certain RCP (2000) guidelines. Physicians also encouraged team members to take more active leadership and decision making roles. These findings are consistent with those of Walby & Greenwell et al (1994). In their study, although points of conflict clearly existed between doctors and nurses, the authors also found that physicians supported expansion in nursing roles and collaborated with nurses in resisting other consultants' or senior nurses' intrusion in to their work and also some directives from general managers. In the stroke units this kind of support related to the teams as a whole, rather than single disciplines. Gair & Hartery's (2001) study also demonstrated that contrary to expectation, discussion and decision making in MDT meetings in elderly care settings was not dominated by physicians. They showed decision making to be most often the outcome of dialogue between team members, with no single profession dictating the final decision. These studies did not focus on *negotiations* per se but they identified aspects of interprofessional relations and

interactions which contributed to social orders where *negotiation* and collaboration in decision making were influential in determining the division of labour in complex care settings, similar to the stroke units.

Mesler's (1989) study of pharmacists' actions to develop their clinical role in two North American hospitals highlighted the influence of structural conditions including the power of medicine on the local negotiation context. He showed how this constrained the possibilities for negotiations, by slowing, but not halting changes in the social order. A key factor highlighted by Mesler (1989) was the perception of senior physicians that they could no longer control and safely manage complex drug therapies without the specialist knowledge of pharmacists. In the current study the consultants and SHOs also recognised their dependence on the specialist knowledge and skills of the stroke unit teams for achieving the improved patient outcomes associated with stroke units (SUTC, 1997) and for which they argued they had ultimate responsibility. The physicians' willingness to participate in a division of labour which eschewed traditional hierarchical structures, shared aspects of decision making and developed a shared leadership model is a consequence of this mutual interdependence, but also of their perception that stroke rehabilitation required a non traditional division of labour. In common with the current study, the studies identified above reinforce the position that focusing on the actual accomplishment of work itself provides clearer insights into the influence of structural conditions on complex but often taken for granted social orders existing in specific settings.

#### Non negotiated orders, proximity and temporal-spatial ordering in stroke unit teamwork

Goldie (1977) and Hall & Spencer-Hall (1982) addressed the negotiated order perspective in their studies and showed that professional work in organisations develops and changes in response to evolving structural conditions, but that negotiation does not necessarily represent the primary process through which change in the division of labour and in interprofessional relations is accomplished. In particular, Hall & Spencer-Hall (1982) in their study of two School districts,

demonstrated that the location of decision making about change and development could be completely separate from the day-to-day work of those most affected by decisions, and so their ability to influence or participate in negotiation about change was either limited or absent. However, whilst these studies are important in identifying that negotiation may be limited or have no role in determining some social orders, the stroke units studied represented quite different settings where access to and involvement in *negotiations* was possible and common. In terms of the current study, the research conducted by Allen (1997) and also Cott (1997, 1998) is more relevant for examining reasons why *negotiations* in relation to boundaries and interdisciplinary working between professional groups may be present, limited or absent in healthcare settings. As part of Allen's (1997) study of nurses' accomplishment of occupational jurisdiction, she examined the boundary between nursing and medicine and identified a number of important features influencing this occupational boundary. These features are discussed below in explaining the positioning of *negotiations* in ordering the day-to-day work in stroke units.

Whilst the stroke units were busy and demanding work environments they were less 'turbulent' than some hospital settings. Patient stays were longer and the flow of work was normally more stable with fewer discontinuities and disruptions than occur in acute stroke units or medical and surgical wards (Allen, 1997). However, the '*transience and permanence*' of staff (Allen, 1997: 508) was an important factor in access to *negotiations* and development of teamwork in the stroke units. Core team members and the majority of peripheral team members were permanent employees and most had worked in the same unit for approaching four years. This provided a high degree of continuity and contributed to development of professional relationships where team members' regular contact and joint working practices resulted in a high level of shared understanding of each others' work and the needs of patients. No single discipline exerted more influence than another and the co-location of the majority of permanent team members in both units emphasised their mutual interdependence. Staff on training rotations e.g. junior OTs, PTs, SALTs and SHOs and also

students, were transient members of the teams. However, only SHOs remained somewhat outside of day-to-day working practices and therefore negotiation of work activity in the stroke units for any length of time. This is largely explained by the different focus of medical and routine rehabilitation work which limited doctors' work with other team members.

The data demonstrated how influential the interdisciplinary team ethos was in both units, with transient team members describing how they were rapidly drawn into collaborative interdisciplinary working. Thus, the effect of different professional cultures and ideologies which could have led to tension and conflict between team members was minimised by regular engagement of permanent and transient team members in overlapping and interdependent work practices. Doctors (SHOs) were not excluded from this work and their continued daily presence on the units ensured that they developed a good understanding of where their medical work contributed to stroke patients' rehabilitation. The temporal-spatial problems identified by Walby & Greenwell et al (1994) and also Allen (1997) in terms of access to junior doctors and different ordering of nursing and medical work were not evident in the stroke units. Here, the diagnostic role of medicine was less prominent in determining what work was required. There was more focus on responding to patients' physical and intellectual impairments following stroke, impairments which were mainly managed by non medical team members. These factors are one reason why both permanent and transient team members accessed and regularly participated in *opportunistic dialogue* and *negotiations*, but they also point to and explain where boundary-blurring mainly occurred. Whilst there was some boundary-blurring in respect of nursing and medical functions, a much larger degree of boundary-blurring occurred between non medical team members, where mutual interdependence and the integrated nature of rehabilitation practice led to pragmatic accommodation and assimilation rather than jurisdictional and boundary conflict (Abbott, 1988).

In her study, Allen (1997) defined two forms of boundary-blurring, *de facto* and *purposive* and clearly showed how these strategies, through which nurses constructed their occupational boundary with medicine, were non-negotiated. Stroke rehabilitation work required different disciplines to work with and manage patients' experiences of the same clinical problems, including impairments relating to control of balance, posture and movement, co-ordination of chewing and swallowing and cognitive impairments affecting perception and communication. In essence *de facto* boundary blurring was evident in the stroke units in that a division of labour based on maintaining separate disciplinary responsibilities for these elements of rehabilitation would have been inappropriate and almost impossible. The concept of *purposive* boundary-blurring was also relevant to examination of the stroke unit teams' perceptions of occupational boundaries and achievement of teamwork. However, only one of the five types of *purposive* boundary-blurring identified, that of *continuity-oriented* boundary-blurring (Allen, 1997: 511) was evident in the stroke units. Whilst stroke unit team members desired the same outcome as nurses in Allen's (1997) study, that is to ensure patient care was not adversely affected by the division of labour, the reason continuity-oriented boundary-blurring developed in stroke units was different. In Allen's (1997) study, the nurses' actions in deciding to do some work normally carried out by doctors were pragmatic responses to difficulties they experienced in contacting doctors and the intermittent presence of doctors on the wards.

In the stroke units the primary driver for continuity-oriented boundary-blurring was team members' recognition that achieving continuous as opposed to episodic therapeutic activities for patients required that every team member develop knowledge and a common set of specialist skills. These skills are traditionally defined as belonging to PTs, OTs and SALTs with some limited overlap with nursing and dietetics. Sharing knowledge and skills was a deliberate and pragmatic response, initially by senior members of each profession, over time this became a routinised element of introducing permanent and transient staff to the teams. *Opportunistic dialogue* provided a talk space to engage in *negotiations* which were an important feature of continuity boundary-blurring and

which shaped the division of labour. The data showed that team members, particularly nurses, HCAs and RAs and OTs agreed to develop new skills and to take on additional work for example in conducting initial moving and handling and swallowing assessments. *Negotiations* were evident in these agreements in the form of bargaining, with for example, nurses at both units agreeing to increase the time spent with patients to follow very specific moving and handling plans, provided that PTs worked outside their normal office hours in order to see the problems nurses faced incorporating such plans into patient care at night and in the early morning.

Nurses' concern with ensuring continuity in complex rehabilitation cases was also demonstrated by O'Connor (1997) in the context of nursing roles in stroke units, and by Pryor (2005) in the context of rehabilitation nursing practice in Australia. In the stroke units, dialogue and *negotiations* aimed at ensuring continuity boundary-blurring involved core team members from all grades and all disciplines. In the main this process was reciprocal with all groups developing knowledge and skills which supported their mutual teamwork. However, some nurses at Holton desired greater therapist involvement in what they regarded as core aspects of rehabilitation care. This issue will resurface in the discussion of negotiations about team practice issues as opposed to patient focused negotiations. For peripheral team members this process had more limited impact, largely because the focus on their work did not require joint working around physical issues. However, continuity boundary-blurring is evident in the data and occurred for example, between nurses, OTs and social workers in relation to the management of case conferences, in their work with families to facilitate discharge and in accessing resources to support patients in their own homes. These processes contributed to the continuing accomplishment of overlapping occupational boundaries for both core and peripheral team members and were instrumental in establishing and maintaining the interdisciplinary division of labour seen in both units.

The teams were not insulated from and did experience problems caused by the wider temporal-spatial ordering of work within the hospitals and NHS trusts. For example, as satellite hospitals they were required to send patients across the city for certain investigations or treatments. The teams had no control over these events and their patient work was significantly disrupted by this requirement. The teams also experienced problems in co-ordinating home visits and community care assessments with external intermediate care teams or social care agencies. These could occupy one or two team members for up to a full day and their absence from the units directly impacted on the flow of work. Within the units however, the physical, organisational and professional proximity of team members (Cott, 1998) and the negotiated ordering of much of their day-to-day patient work meant that coordination between and with other team members was not disrupted by the temporal-spatial features noted in other studies. Cott's (1997, 1998) research with five multidisciplinary, older adult care teams in Canada highlighted the important role played by organisational, professional, and physical '*proximity*'. The findings of the current study confirm those of Cott (1998) that increased proximity contributes to positive perceptions of, and satisfaction with, interdisciplinary teamwork. However in the current study, proximity is positioned as a contributory factor to the regularity of *opportunistic dialogue*, and within that of *negotiations*, rather than a defining feature of satisfaction with teamwork.

#### What counts as negotiations?

The character of 'negotiations' has been the source of continuing debate (Day & Day, 1977; Farberman, & Perinbanayagam, 1985; Allen, 1997; Degeling & Maxwell, 2004). The definition of negotiation is important both in terms of Strauss's (1978, 1993) perspective on social orders and also in terms of what has been counted as negotiation in achieving teamwork in the stroke units. Simply defined, to negotiate involves '*conferring with others in order to reach a compromise or agreement*' (Concise Oxford Dictionary, 1990). Within the negotiated order perspective, types of negotiation include: bargaining, making trades or deals, wheeling and dealing, colluding, brokering

or making agreements and also compromises (Maines, 1977; Strauss, 1978, 1993). Fine (1984) argued that despite a concern with understanding how order is constructed and maintained through negotiations between individuals, relatively few studies have explicitly defined the actual types of negotiations taking place. This criticism can be applied to some studies conducted in healthcare settings which are located within the negotiated order perspective, including Mesler's (1995) study of the way hospice practitioners defined and accomplished their work. He defined negotiations as '*daily working interactions of practitioners*' (Mesler, 1995: 251) and suggested that a strategy of education, or what he termed 'tactical socialisation', was used by hospice practitioners in their interactions with new and temporary employees, their management, and with funding agencies. The study provided a valuable insight into the impact of growth and change in a small organisation, and the ways hospice practitioners worked to promote an ethos of care and support rather than medical intervention for patients. However, despite the frequent mention of negotiations between groups, no specific strategies are identified and his discussion of daily interaction does not easily accord with Strauss's (1978, 1993) definition of negotiations.

Similarly, Svensson's (1996) study was important in understanding how structural changes such as increased healthcare demand, together with new ways of managing nursing work, may have impacted on doctor-nurse relationships in Sweden. Svensson (1996) focused on these changing aspects of the negotiation context and detailed the ways nurses perceived they were able to negotiate for changes in medical practice where it was perceived as detrimental to patient care, and to participate in decision making related to discharge planning. He also argued nurses perceived some aspects of the division of labour to be non-negotiable or likely to result in conflict which could impact on patient care. In these circumstances nurses chose not seek changes, reasoning that continued good relationships with medicine were more important and could be used to support negotiations in other areas such as ward rounds. In terms of defining the types of negotiations occurring between nurses and doctors, only achieving 'compromise' in discharge discussions with



doctors is identified by Svensson (1996). In common with Mesler (1995) he appears to regard improvements in nurses' day-to-day working interactions with doctors as an example of negotiations. These studies demonstrate the utility of the negotiated order perspective in understanding healthcare organisation but provide little clarity about whether negotiations of the kind outlined by Maines (1977) and Strauss (1978) contributed to shaping the social order in the study settings.

### Stroke unit negotiations

Negotiations commonly arise when there is uncertainty, ambiguity and disagreement but they also occur at times of change (Strauss, 1978; Maines & Charlton, 1985). In the stroke units change and uncertainty were certainly drivers for *negotiations* as the units opened, but at the time of the study these were not in evidence in terms of the day-to-day organisation of the units. However, the need for *negotiations* in stable work environments such as the stroke units is explained by the complexity of their patient work which was subject to flux and change. The day-to-day division of labour was subject to some negotiation within regular *opportunistic dialogue* episodes. These were horizontal *negotiations* between colleagues rather than vertical negotiations between team members and managers (Fine, 1984). They formed part of a patterned dialogue process which was positively influenced by team members' perceptions of stroke rehabilitation and commitment to collaborative working. In the stroke units, team members had or made the opportunity to 'confer with each other' face-to-face in order to reach agreements principally in relation to determining what patient work needed to be done, how that work could best be achieved and who would be responsible for some or all of the overlapping areas of this work. The forms of negotiation identified by Maines (1977) and Strauss (1978, 1993) including bargaining, making trades or deals, wheeling and dealing, brokering or making agreements, give and take and compromise, were all observed or reported on at some time, although colluding was not evident in either unit.

Bargaining about timing, content and responsibility for specific areas of patient work was the most common form of negotiation seen in the stroke units. For example, in setting up joint washing and dressing practice OTs had to negotiate with nurses, PTs and usually family members about timing, what would be focused on and who would lead the activity. Typically, team members sought support for, or involvement in, related activities in return, thus bargaining about use of time and skills. At Holton this involved RAs who brokered these agreements on behalf of part time OTs. Making trades was also seen: for example, PTs at Colebrook were observed trading therapy appointment times with OTs to ensure that they could work with patients for longer periods of time in the pre-discharge apartment with nurses and relatives on bed to chair and wheelchair to toilet transfers. In return OTs sought PT or nursing cover for therapy slots they would miss when managing a half day home visit.

In common with other studies, the data showed stroke unit *negotiations* and agreements were rarely fixed and unchanging as the dynamic nature of rehabilitation necessitated re-negotiation and revision, sometimes in the same day, and often in the time between MDT meetings (Martin, 1975; Regan, 1984, Strauss et al, 1985). The data also demonstrated that whilst *negotiations* were a key element of *opportunistic dialogue* and important in shaping the day-to-day ordering of the division of labour in these teams, they constituted only part of the range of interactions evident in these teams.

#### Negotiation as part of wider team interactions and processes

The negotiated order perspective has made an important contribution to understanding how work is structured and maintained in many organisations but clearly negotiations do not constitute all forms of work and social interaction (Denzin, 1994; Allen, 1997). Strauss (1993: 254) acknowledged this criticism and sought to locate negotiation within a broader framework of processual ordering, arguing that the original formulations (Strauss, 1978; Strauss et al, 1985) '*did not preclude the role*

*of other processes*'. Processual ordering incorporated these other social processes which included key concepts such as biography, trajectory, social worlds and arenas. Strauss (1993:255) argued that together these processes constituted a theory of action which recognised:

*'The lack of fixity of social order, its temporal, mobile and unstable character, and the flexibility of interactants faced with the need to act through interactional processes'*

Strauss (1993) argued that the theory of action provided a framework for detailed analysis and understanding of social orders. Importantly in this work he acknowledged that alternatives to negotiations, including education, persuasion and manipulation, also contributed to establishing and maintaining social order in different settings and at different times.

The current study has identified the important role of *negotiations* in achieving teamwork but also highlighted the major contribution of regular *opportunistic dialogue* processes in the ordering of work which was perceived to improve patient outcomes, was satisfying for team members and increased their commitment to collaboration. Through their interactions in *opportunistic dialogue*, team members came to appreciate that collective and alternative perspectives could take them beyond their own sometimes narrow vision of what was possible. Dialogue contained more than *negotiations* and provided a seemingly regular means for coming to agreement on the content and division of labour. The study findings confirm the importance of co-location and proximity in facilitating interprofessional interaction but also identify that it was through the dialogue process that these supportive conditions influencing the negotiation context contributed to achieving teamwork.

*Opportunistic dialogue* between stroke team members was focused on patients that many of them worked with jointly. This marks out a key difference in multidisciplinary and interdisciplinary team working and directly contrasts with the situations described in Griffiths (1997) and Miller et al's (1999) fragmented teams where team members worked separately with 'their' patient and did not

often have to engage with other team members to agree or reach goals. Stroke unit team members engaged in day-to-day work did not always recognise and sometimes took for granted the important role that *opportunistic dialogue* and repeated *negotiations* played in the achievement and maintenance of teamwork. However, the findings also highlight an issue reported by McCallin (1999) and Opie (2000) which is that whilst teams may regularly consider, debate and negotiate their work with patients, they do not seem to recognise that the same processes can or should be used to examine their overall team practice. Therapist involvement in toileting, working times of therapists at Holton and the involvement of SHOs in rehabilitation work at both units are all examples of broader team practice issues which continued to surface in interviews with team members but which they had not addressed openly in either unit. The data suggested some support for Bohm's (1996) and Farrell et al's (2001) claims that established workgroups prefer accommodation and consensus to conflict and challenge. Despite the development of effective dialogue processes, team members at both units displayed some reticence in introducing the above issues into day-to-day discussion about team practice, the reasons for this merit further investigation.

The findings of the current study largely support existing claims about the significance of routine patterns and phases in dialogue episodes (Bohm, 1996; Grosz & Kraus, 1996; Hulstijn, 2000b). However, currently only McCallin's (1999) account of pluralistic dialoguing in rehabilitation units in New Zealand identifies the potential contribution of repeated dialogue episodes in facilitating interdisciplinary teamwork in healthcare. The findings of the current study support but also extend McCallin's (1999) claims by drawing attention to other important functions of *opportunistic dialogue* and to the kinds of *negotiations* within dialogue episodes. Highlighting the role of dialogue processes in providing structures for exploring differing professional ideologies and perspectives on problems and needs is particularly significant for policy makers and practitioners seeking to develop interdisciplinary team approaches within stroke rehabilitation settings and beyond. Focussing on real time but structured dialogue where professionals are encouraged to talk

and think out loud about their reasoning and preferences for particular courses of action provides a means for developing, exploring and understanding alternative perspectives. Complex and chronic illness episodes require co-ordination of interventions from a wide range of health professionals. It is likely, if not inevitable, that these professionals and the patients they work with will hold differing views of the most desirable or effective course of action. Areas of agreement and disagreement will emerge when care is discussed. Provision of time and space to explore and work through care options is an essential precursor to collaborative joint actions which take proper account of the needs and preferences of patients and carers (Borrill et al, 2003; Allen et al, 2004). Inherent in dialogue episodes is the potential for gaining knowledge and increasing understanding, for example, of the perspectives, needs and wants of other actors as well as increasing ones own understanding of situations, actions or facts. The current study has identified the potential of structured dialogue in joint working as a process for learning, change, and team development; at present this is not recognised in the context of developing interdisciplinary teamwork and patient centred packages of care.

#### Acknowledging barriers to interdisciplinary team working

There is a substantial literature in health and social sciences documenting barriers to team working in practice. The most commonly cited include disputes about professional boundaries and jurisdiction, role conflict and uncertainty, and traditional hierarchical structures (Abbott, 1988; Cott, 1997; Griffiths, 1997; Long et al, 2001, 2003; Miller et al; 2001). Separate professional education and socialisation, socio-political and organisational factors can also impact negatively on team working (Payne, 2000; Cooper et al, 2001; Leathard, 2003). However, the findings of the current study demonstrate that these need not be sources of disharmony or conflict.

Abbott (1988) identified competition between professions for an exclusive scope of practice as central to understanding relations between professions and between professions and the state. This

work has influenced a number of interactionist studies examining interprofessional relations; however it is Abbott's (1988) concept of workplace assimilation which had most resonance for the findings of this study. Abbott (1988) and also Freidson (1994) argued that close examination of division of labour as it is played out everyday in healthcare settings was essential in understanding professional relations. Analysis of stroke unit team members' interactions at work provided support for Abbott's (1988) claim that interprofessional relations in the workplace often do not reflect the clear cut, objective, legal and social definitions of jurisdiction and occupational boundaries. Assimilation, in the sense of including all grades of worker in the larger group constituting stroke unit teams, and accommodation in terms of adjusting traditional working practices were clearly evident in both stroke units.

The current study findings are consistent with other recent studies of health professional relations which also demonstrate that competition at jurisdictional boundaries is not inevitable. These suggest that interactions between collectives, whose work involves dependence on others, can differ markedly from interactions between two professions where some or all the work can be completed by either (McCallin, 1999; Molyneux, 2001; Borrill et al, 2003). Contested jurisdictional claims take centre stage when the power, status and financial reward of one profession are threatened by the advancement of another (Abbott, 1988; Adams, 2004). In the stroke units, team relations and working practices did not begin or develop as a 'labour of division' (Fournier, 2000); moreover, team members did not seek to establish or maintain exclusive jurisdictions. Day-to-day work requirements with stroke patients dictated working practices rather than roles and positions in traditional hierarchical professional groups. Boundary blurring was not defined as competition but as a means to incorporate rehabilitation in every patient contact. Redefining skill sharing, as being for patients, largely removed the threat of competition for jurisdiction between team members, particularly as they identified benefits and rewards including workload sharing and patient improvement as a result of blurring boundaries. The division of labour was not perceived as a

threat to occupational identities, but instead interpreted as being consistent with the claims of each professional group to contribute specialist knowledge and skills to stroke rehabilitation. Team members understood the importance of maintaining a public image of clear and separate jurisdiction between disciplines to continue and enhance their status, recognition and rewards. However, these stroke unit teams showed how the complex reality of professional life was worked out in practice in response to the work they each participated in, and also as the units and the demands on the teams changed when required provide specialist services for stroke patients. The study findings reinforce Abbott's (1988) and Strauss's (1993) emphasis on understanding the intricate web of day-to-day interactions between professions in the workplace. However, I argue that more specific examination of *dialogue* and *negotiations* in the context of working with patients and responding to policy directives is necessary to understand how assimilation and accommodation arise and are managed in healthcare teams.

More detailed study of dialogue patterns within interdisciplinary team interactions would add to our understanding of how health professionals structure and manage their thinking and dialogue when working out co-ordinated joint action. Examining the differences in dialogue and interaction patterns in newly formed and established health professional teams would make an important contribution to developing practical strategies for helping such teams move from recognition of the characteristics of effective teams, to building these characteristics into training and practice in specific settings such as stroke units. In the context of analysis of dialogue and interaction patterns Hulstijn (2000) suggested that the metaphor of dialogue games could be used in tracing the way actors responded to each other in tasks requiring joint action. Conceptualising dialogue between actors as 'moves' influenced by internal and external rules some of which are shared and understood, some of which may be novel and not previously encountered, may provide a framework

for analysis of talk-in interaction which would illuminate how agreements and disagreements between healthcare professionals are understood and managed.

Conversation analysis has been used extensively to analyse a wide range of healthcare interactions including medical consultations, discussions around diagnosis and giving professional advice (Strong, 1979; Peräkylä, 2004; Silverman, 1997, 2004). These methods offer an approach to focussing on and understanding the relationship of regular and patterned conversations between participants in *opportunistic dialogue* episodes such as those identified in the stroke units. However, focussing on the content and structure of dialogue alone would be of limited value. Understanding the relationship between the decisions and actions agreed as part of *opportunistic dialogue* and *negotiations*, the consequences for patients, and the continuing development and interactions of healthcare professionals would have more relevance for health services managers and practitioners. The care trajectory game (CTG) framework outlined by Allen et al (2004) was used successfully to combine analysis of interactions between health and social care professionals and patients and carers in complex care situations, with tracing the local interpretation, implementation and consequences of policy pressure to increase collaborative interdisciplinary working in the NHS. This framework could prove valuable in examining the contribution of structured approaches to dialogue as a means to ensure the perspectives of those who are directly affected by complex illness and those who are charged with providing interdisciplinary team care are heard and explored.

#### Reflection on study design and methods

Earlier research called for sustained engagement with stroke unit teams and for direct observation of their work (SUTC, 1997; Gibbon, 1999; Pound & Ebrahim, 2000). The current study appears to be the first qualitative investigation focussing specifically on the process of achievement of teamwork



in stroke units in the UK. Some of the limitations identified in previous research have been addressed by examining team working in more than one setting and by analysing team interactions outside of MDT meetings. The use of Strauss & Corbin's (1998) grounded theory approach enabled development of a detailed explanation of the social processes contributing to achievement and maintenance of teamwork in the selected stroke units. In common with other researchers, I found grounded theory methodology provided a systematic and rigorous approach to qualitative researching. Grounded theorists aim to produce substantive theories which are '*more orientated to the pressing practicalities of the here and now*' (Dey, 2004: 83). The findings of this study focussed on those practicalities and are expressed in the grounded theory of *opportunistic dialogue*. Grounded theory methods require researchers to think theoretically, that is to analyse and conceptualise and not simply label data (Silverman, 2000; Dey, 2004). The research methods utilised required confirmation of properties and dimensions of categories in data, and ensured developing explanations integrated the perspectives of social actors, and existing theory without privileging any one of these perspectives. It was possible using these methods to stand back from the detail of data, to identify and conceptualise the basic social process connecting phenomena in the setting and develop a substantive theory which accurately represents the social reality of achieving teamwork in these stroke units.

Grounded theory studies have been criticised for reliance on interview data alone (Benoliel, 1996; Glaser, 2002). This study combined data generated in interviews with that from direct participation in the social worlds of two stroke unit teams, and was conducted over a period of time sufficient to develop understanding of the ways in which the teams interacted and went about their daily work. Participant observation provided opportunities to experience the day-to-day reality of teamwork and to develop an appreciation of the complexity and range of factors impacting on this work.

Interviews facilitated exploration of team members' perspectives and my developing theoretical explanations of this work. Fieldwork is not unproblematic and my presence in the stroke units inevitably impacted on the teams. However, participation in their work provided invaluable access and insight into their thoughts and perceptions, interactions, experiences and their frustrations and rewards. This degree of access to the social worlds of stroke unit team members increases the credibility of the study findings.

I found grounded theory methods stimulated rather than stifled creative thinking and therefore reject Glaser's (2002) claim that Strauss & Corbin's (1998) methods force theories on data. The substantive theory emerged from analysis of study data, but also from examining conceptual frameworks including Bohm's (1996) work on dialogue and Strauss et al's (1985) negotiated order perspective. These perspectives could not fully account for the basic social process identified in the stroke units but they highlighted the importance of analysing interaction and dialogue between team members and the relationship between their interactions within particular negotiation and structural contexts. The concepts of temporal order and temporal matrix contributed to locating and explaining the development of team members and teamwork over time.

The study generated data from interaction with two geographically separate stroke units which proved to be remarkably similar in their teamwork practice. These are distinct social settings and therefore the claims this study can make about the achievement of teamwork have limited transferability. However, the substantive theory developed contributes to knowledge in the field by establishing the importance of the concepts of dialogue and negotiation and exploring their relevance in a stroke rehabilitation context. These have value for analysis of teamwork in these and other settings and contribute to the literature examining the utility of the negotiated order

perspective. The findings also provide further concepts for analysis of substantive theory developed in similar settings, for example supporting and extending McCallin's (1999) grounded theory of pluralistic dialoguing. The study findings also indirectly verify Opie's (2000) model for developing effective teamwork in which she argued dialogue and negotiation were of central importance in enabling team members to move beyond narrow disciplinary perspectives towards knowledge based teamwork focused on the needs of patients.

The study was undertaken by a single researcher on a part time basis. As a result there were limitations on the time available for data generation. A longer period of time would have enabled further theoretical sampling, which could have increased variation in data relating to different influences on these teams. Incomplete or unsuccessful negotiations occurring in *opportunistic dialogue* could have been more comprehensively explored and the consequences of disagreement followed for longer periods of time. Situations where actions of team members were not the result of dialogue and negotiation could also have been more fully explored. The variation in interpretation of the decision making process in MDT meetings, specifically in respect of social worker perspectives at Holton, could have been further examined through recording and analysis of dialogue in these meetings. These issues were actively explored in interviews but more direct focus on the content of dialogue in these meetings may have added to category development and further refined the core category. When the decision was made to cease data generation, I considered theoretical saturation had been achieved, that is, category development had reached a point where no new properties or dimensions were evident. However, I recognise that there is always the potential that exposure to additional and different elements of teamwork in these settings could have meant that new properties would emerge.

Data and their meaning were presented to and discussed with research participants and at conferences. These discussions helped clarify analytic interpretations; questions and comments

particularly after conference presentations, prompted further analysis of data and greater concentration on establishing the relationships between major categories and the core category. In larger scale projects, data analysis can benefit from comparison of individual and collective interpretations by a project team. In such teams, alternative interpretations of data will be presented and explored before theoretical explanations are agreed (Richards, 1999). I acknowledge that my theoretical explanation is open to debate and challenge. However, the approaches outlined above ensured that these interpretations and analysis were subject to debate and scrutiny. The substantive theory will benefit from further development through exploration of its applicability in similar settings, such as stroke teams which are not unit or hospital based and in other rehabilitation settings.

#### Directions for future research

In 2001 only 26% of UK hospitals had designated stroke units, the most recent National Sentinel Audit results (RCP, 2007) will show that by 2006 the number of hospitals with stroke units had increased to 91%. This dramatic increase in the number of units means many more stroke patients should experience specialist co-ordinated multidisciplinary care. However, the increase also means that large numbers of newly formed stroke unit teams will be engaged in trying to develop collaborative ways of working so that improved patient outcomes associated with stroke units are replicated across the UK. The National Sentinel Audit results (RCP, 2007) confirm that almost 100% of stroke units now have weekly multidisciplinary team meetings but also recognise the central importance of co-ordination of the work of these disciplines. The findings of the current study are significant and provide clear evidence of how stroke unit teams can achieve and maintain effective teamwork. These findings could contribute directly to developing newly established stroke unit teams by focusing attention on co-location of team members and introducing and researching the effectiveness of promoting team processes including joint working and structured dialogue

opportunities. The discussion on pages 286-287 identified methods which this research could utilise and develop.

The findings may also have more general relevance to understanding and developing health professional team working in the NHS. Increasing attention is being given to the kind of healthcare workforce required to meet the needs of patients, families and communities in the future. (DoH, 2000b, 2001b; BMA, 2002; Kendall & Lissauer, 2003). There is growing consensus that working practices will need to change if the objective of developing patient centred health services based on consultation, information and partnership is to become a reality (Coulter, 2002). The changes proposed are wide ranging and require reconsideration of the differences between meeting the needs of patients, and operation of services which may perpetuate the interests, power and control of professionals. This demands commitment to acknowledging and tackling professional and organisational barriers to change. Research on interprofessional education identifies that this is a necessary part of changing professional cultures and encouraging collaborative working, but suggests the ways in which a commitment to collaboration and team working can be realised are not clearly understood (Barr, 2001;2003; Cooper et al, 2001; Miller et al, 2001; Zwarenstein et al, 2002; Carlisle et al 2004)

Patient focused and problem oriented shared learning in undergraduate and post graduate education programmes represent an important way of preparing health professionals for situations where collaboration and teamwork are required in practice. However, there is currently little evidence that these approaches explicitly engage students and experienced health professionals in presenting and debating their individual or collective rationale for their proposals or that the approaches take sufficient account of patients' perspectives. There is also little evidence that analysis of the dialogue which develops in these interactions is explicitly used to examine how decisions were arrived at or examines what can be learned from single or repeated episodes of joint or separate working. The

findings of the current study suggest that facilitated interdisciplinary joint working can provide opportunities for health professionals to engage in structured dialogue about preferred ways of treating patients. These could provide significant learning and development opportunities in terms of commitment to collaboration and development of knowledge and skills for team working. These opportunities should be exploited.

It is acknowledged that team solutions are not always required; treatment on an outpatient and day case basis has increased significantly and more patients are using extended primary care facilities and walk in centres for investigation and treatment (DoH, 2006). Hospital stays are shorter with only the very ill and disabled remaining in hospital for periods of time exceeding one or two weeks. However the burden of chronic disease and the increasingly complex needs of an ageing population (DoH, 2005) mean collaboration and teamwork will increase rather than decrease in importance as healthcare and the working practices of health professionals change in response to new and different challenges. Although many healthcare organisations support the concept of team working, the reality is that few have invested in developing a culture where interdisciplinary teamwork is identified as likely to improve patient outcomes, is specifically planned for and actively supported (Stark et al, 2000; Wilson, 2000; Borrill et al, 2003). The findings of the current study emphasised the importance of co-location, frequency of contact and regular opportunity for interdisciplinary dialogue and joint working in the stroke units. Health professionals demonstrate a remarkable capacity to find ways of overcoming or compensating for barriers to team working but NHS organisations could do more to aid them in this work. Introducing planned and timetabled joint working and problem oriented dialogue opportunities in some areas of rehabilitation, elderly care, child health and mental health settings, where patient groups are more stable, and there is opportunity get to know and work with patients and families, represents one way to increase health professional understanding of each others' thinking and working practices. In turn this could clarify

roles, reduce uncertainty about shared and individual responsibility and lead to improved and effective collaboration in healthcare practice.

### Conclusions

Teams and team working have been a focus of interest for social scientists and health professionals for approaching fifty years. Health service providers in the UK are slowly acknowledging that the increasing complexity of health and illness demands more effective and flexible responses based on the identified needs of patients as opposed to reliance on existing but often fragmented services. Working to provide services based on patients needs requires health professionals who know not only why they should collaborate and work in teams, but more importantly who know how they can work together to achieve collaborative interdisciplinary practice. The findings of this study add to and extend the argument that our efforts as researchers and practitioners should focus on exploring ways that professionals work well as teams and finding ways that teams can directly involve patients as partners in determining their needs. This requires that we acknowledge the existing evidence of possible barriers to teamwork and inclusion of patients, but turn our attention to actively examining the ways that these barriers are understood and overcome. This study of stroke unit teams has provided important evidence relating to the social processes which contributed to the development and maintenance of interdisciplinary teamwork. These processes need not be unique to stroke units; specific features of these processes are transferable to other settings and could contribute to achieving and maintaining collaborative interdisciplinary working. In turn these processes can contribute to developing patient focused services that must be central to our health service.

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## Appendices

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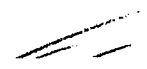
Date: 30<sup>th</sup> January 2002

Dear Mr Clarke

**Re: CA01/126 Achieving “teamwork”: a grounded theory investigation in selected stroke units in the north of England**

Thank you for your letter of the 21<sup>st</sup> January 2002 explaining your request for an amendment to the above research study protocol to include patients who are unable to give consent.

I can confirm that this is acceptable and I am able to give full approval by chairman's action for you to proceed.

Yours sincerely , 



24th January 2002

Mr David J Clarke  
Lecturer in Nursing  
Baines Wing  
University of Leeds  
PO Box 214  
LEEDS  
LS2 9UT

Dear Mr Clarke

**56/2001 Achieving “teamwork”: a grounded theory investigation in selected stroke units in the North of England**

The above was discussed and Chairman's Action ratified at the Committee meeting held on the 14th of January 2002.

No deviations from, or changes of, the protocol should be initiated without prior written LREC approval/favourable opinion of an appropriate amendment, except when necessary to eliminate immediate hazards to the subjects or when the change(s) involves only logistical or administrative aspects of the trial (e.g. change of monitor(s), telephone number(s)).

The investigator should promptly report to the LREC:

- (a) deviations from, or changes of, the protocol to eliminate immediate hazards to the trial subjects.
- (b) changes increasing the risk to subjects and/or protocol affecting significantly the conduct of the trial
- (c) all adverse drug reactions (ADRs) that are both serious and unexpected.
- (d) new information that may affect adversely the safety of the subjects or the conduct of the trial.

You must now register your Study with the R&D Department to gain Trust approval before you can start this Study. The Committee will be interested to be kept informed of your progress and look forward to receiving your annual report.

Yours sincerely

Project title: Teamwork: a study to investigate how health professionals understand and carry out their work in selected stroke units in the north of England.

You are being invited to take part in a research study. Before you decide whether to participate in the research you will want to understand why the research is being carried out and what it would involve if you were to take part. Please take the time to read the following information and to discuss it with other people if you wish. Please contact the researcher directly if anything is not clear or if you have questions and need further information. Take your time in deciding whether you wish to take part.

Background to the study:

We know that stroke is a leading cause of ill health in England and has a major impact on people's lives. Many stroke patients are now being cared for in specialised stroke units like this one on Ward . There is now good evidence that if people who have had a stroke receive prompt admission, treatment and care provided by a specialist stroke team in a hospital based stroke unit, they are more likely to have a better recovery. We think that the benefits associated with stroke units are not just due to the physical treatments provided in them, but are also related to the way in which health professionals work together in teams. However at present, the ways in which health professionals work to achieve teamwork is not very well understood. The members of the stroke team in this study include the doctors, nurses, physiotherapists, speech therapists, occupational therapists, social workers, care assistants and therapy assistants. The study is being conducted as part of a research degree (PhD) at the University of Leeds.

The study aims:

This study will look at how the staff of the stroke units work as a team. The study will involve one researcher observing or watching the work of members of the stroke unit team for three days each week over a period of four to six months. The research will also involve interviews with the team members and a selection of patients who have had a stroke but have been discharged from the ward. The patient interviews will occur after the patients have been discharged from the ward.

What would participation in the study involve for me?

Firstly it is important to say that participation in the study is entirely voluntary. There are two ways in which you might be asked to take part in the study:

1) As part of the observational study:

The researcher will be watching the way in which the stroke unit team members work with each other and with patients. Your participation would involve giving permission to the researcher to watch the team members providing you with treatment such as physiotherapy, speech therapy or nursing. The researcher would also request permission to listen and watch team members talking to you and your family about your treatment, your care and your progress.

2) Taking part in an interview about being cared for by the stroke unit team:

The main purpose of working as a team in the stroke unit is to improve the care that is offered to patients. One way to find out how patients feel about the way they were cared for by the team is to interview the patient. A small number of patients who are well enough to take part in an interview will be approached approximately six weeks after they have gone home from the ward and asked if they would like to be interviewed.

Do I have to be involved in both parts of the study?

It is up to you whether or not to take part. If you do decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form. If you decide to take part you are still free to withdraw from the study at any time without giving a reason. A decision not to take part, or to withdraw from the study at any time, will not affect the standard of care you receive.

Confidentiality of information:

The information collected during the research (both observational and interview) will be kept strictly confidential. Information provided by you will be made anonymous by the use of letter and number codes to ensure that you cannot be recognised from your comments.

The study findings:

The study should help us have a better understanding of how the teams work in the selected stroke units. We hope what we learn from the study will help the stroke team on Ward \*, and staff who are setting up new stroke units and teams in other parts of England. A better understanding of teamworking should contribute to improved services to other stroke patients.

It is planned to present the results of the study in summer 2004 as part of the requirements of a research degree at the University of Leeds. It is also planned to publish some of the findings of the study in academic and professional journals. In any publication the approach to confidentiality and anonymity described above, will be adopted to ensure that individuals are not able to be identified in the publication. Copies of publications which arise from the study can be made available to you if you wish to see them.

If you would like further information regarding the study please contact:

Mr David Clarke, Lecturer in Nursing at the University of Leeds. Telephone: 0113 3431298 or email [d.j.clarke@leeds.ac.uk](mailto:d.j.clarke@leeds.ac.uk).

### Carer Information Sheet

Project Title: Team Work: A study to investigate how health professionals understand and carry out their work in selected stroke units in the north of England.

This study is being carried out on Ward \* at present. It is possible that your relative who has suffered a stroke may be able to be included in part of the study. This information sheet is to help you understand what the study is about and to understand why the researcher may ask permission to include your relative in part of the study. Before you discuss the study with the researcher you will want to understand why the research is being carried out and what it would involve if your relative were to be included in the study. Please take the time to read the following information and to discuss it with other people if you wish. Please contact the researcher directly if anything is not clear or if you have questions and need further information. Take your time in deciding whether you consider it appropriate for your relative to be included in the study.

#### Background to the study:

We know that stroke is a leading cause of ill health in England and has a major impact on peoples' lives. Many stroke patients are now being cared for in specialised stroke units like this one on Ward \*. There is now good evidence that if people who have had a stroke receive prompt admission, treatment and care provided by a specialist stroke team in a hospital based stroke unit, they are more likely to have a better recovery. We think that the benefits associated with stroke units are not just due to the physical treatments provided in them, but are also related to the way in which health professionals work together in teams. However at present, the ways in which health professionals work to achieve team work is not very well understood. The members of the stroke team in this study include the doctors, nurses, physiotherapists, speech therapists, occupational therapists, social workers, care assistants and therapy assistants. The study is being conducted as part of a research degree (PhD) at the University of Leeds

#### The study aims:

This study will look at how the staff of the stroke unit works as a team. The study will involve one researcher observing or watching the work of members of the stroke unit team for three days each week over a period of four to six months. The research will also involve interviews with the team members and a selection of patients who have had a stroke but have been discharged from the ward.

#### What would participation in the study involve for my relative?

Firstly it is important to say that participation in the study is entirely voluntary. Many patients will be able to give written consent to participate in the study; however some patients may be too unwell to give this permission initially. Including some of these patients in the observational part of the study could provide valuable information about how team members work with this specific group of stroke patients. The way in which your relative would be included in the study is as follows:

#### As part of the observational study:

The researcher will be watching the way in which team members work with each other and with patients. Your relative's participation would involve giving permission to the researcher to watch the team members providing your relative with treatment such as physiotherapy, speech therapy or nursing. The researcher would also request permission to listen and watch team members talking to

your relative and perhaps you and your family about your relative's treatment, care and progress. When your relative's condition improves and they become able to give their consent to participation in the study, their written consent will be sought by the researcher. If you agree that your relative can be included in the study, you are still free to ask for them to be withdrawn from the study at any time without giving a reason. The researcher will also withdraw your relative from the study if at anytime he or she appears unhappy or uncomfortable being observed with team members. A decision not to take part, or to withdraw from the study at any time, will not affect the standard of care your relative receives.

Confidentiality of information:

The information collected during the research will be kept strictly confidential. Information in your relative's case notes and information provided by you or them will be treated in the strictest confidence, and will be made anonymous by the use of letter and number codes to ensure that they cannot be recognised from observational records or comments.

The study findings:

The study should help us have a better understanding of how teams work in the selected stroke units. We hope what we learn from the study will help the stroke team on Ward \*, and also staff who are setting up new stroke units and teams in other parts of England. A better understanding of team working should contribute to improved services for other stroke patients.

It is planned to present the results of the study in summer 2004 as part of the requirements of a research degree at the University of Leeds. It is also planned to publish some of the findings of the study in academic and professional journals. In any publication the approach to confidentiality and anonymity described above will be adopted to ensure that individuals are not able to be identified in the publication. Copies of publications which arise from the study can be made available to you if you wish to see them.

If you would like further information regarding the study please contact:  
Mr David Clarke, Lecturer in Nursing at the University of Leeds.  
Telephone: 0113 3431298 or email [d.j.clarke@leeds.ac.uk](mailto:d.j.clarke@leeds.ac.uk)

**Project title: Achieving 'teamwork': a grounded theory investigation in selected stroke units in the north of England.**

Staff Information Sheet

You are being invited to take part in a research study. Before you decide whether to participate in the research you will want to understand why and how the research is being carried out. Please take the time to read the following information and to discuss it with your colleagues. Please contact the researcher directly if you have questions or need further information.

Background to the study:

Stroke is a leading cause of disability in England and has a major impact on people's lives. Many stroke patients are now being cared for in specialised stroke units and the recently published National Service Framework for Older People requires all hospitals to develop specialised stroke services by April 2004. There is now clear evidence that if people who have had a stroke receive prompt admission, treatment and care provided by a specialist co-ordinated stroke team they are more likely to both survive and to recover more function. These important benefits are thought to be due in part to the way in which care is co-ordinated and delivered by the members of the stroke team. There is a widely held view that the outcome of stroke rehabilitation will be directly influenced not only by specific clinical interventions, but also by health professionals working together in teams. However at present, the ways in which health professionals work in teams is less well understood. There is very limited research evidence on how health professionals 'achieve teamwork' and how the team members think that team working contributes to the positive outcomes associated with stroke units. This study is being conducted as part of a research degree (PhD) at the University of Leeds.

The study aims:

This study is designed to examine and develop understanding of the process of achieving teamwork in two stroke units. The study will involve one researcher in (participant) observation of the work of members of the stroke units' teams on three days per week, over a period of four to six months. Semi-structured interviews will also be conducted with the team members and a selection of stroke patients.

What would participation in the study involve?

Participation in the study is entirely voluntary. In addition to formal consent to participate in the study, specific verbal permission will be sought to observe staff working with patients or each other as situations arise. Staff can decide not to take part or to withdraw from the study at any time. Observations will focus on the day to day work and interaction of the team members, for example informal and formal interaction with each other, with patients and relatives and in formal settings such as team meetings, ward rounds or case conferences. In practice this will mean the researcher will be present on the unit three days a week at various times during the course of the day and night.

Interviews with staff will be arranged at times convenient to team members, and (with permission) will be audio taped. The interviews will focus on individual team member's experiences of, and perceptions of the nature and process of teamworking in stroke units. Interviews will be conducted with all team members on at least one occasion. In accordance with the method adopted for data generation (grounded theory), team members may be

approached to participate in a further interviews as issues arise which seem important to understanding the process of teamworking as it appears to the team members.

Confidentiality of information:

The information collected during the research (both observational and interview) will be kept strictly confidential. Information provided by specific individuals will be made anonymous by the use of alpha-numeric codes to ensure that staff cannot be recognised from their comments.

The study findings:

The study findings should provide a detailed insight into teamworking in the selected stroke units. It is envisaged that the findings will be of direct value to the stroke teams studied, and also to staff who are setting up new stroke units. A better understanding of teamworking should contribute to improved services to stroke patients. It is planned to present the results of the study in summer 2004 as part of the requirements of a research degree at the University of Leeds. It is my intention to discuss the results of the study with staff on the stroke unit. It is also planned to publish some of the findings of the study in academic and professional journals. In any publication the same approach to confidentiality and anonymity will be adopted in order that individuals or their workplace are not able to be identified in the publication.

If you would like further information regarding the study please contact:  
Mr David Clarke, Lecturer in Nursing at the University of Leeds. Telephone: 0113 3431298  
or email [d.j.clarke@leeds.ac.uk](mailto:d.j.clarke@leeds.ac.uk).

Tel 0113 3431298  
Email: [d.j.clarke@leeds.ac.uk](mailto:d.j.clarke@leeds.ac.uk)

Dear

Re: Transcript of your interview on

I am sending you a copy of the full transcript of your interview which was conducted on . As you requested I have also enclosed a copy of the transcript with preliminary codes attached. The coding at this stage of the research is quite generalised and represents broad conceptual areas which act as anchor points for the issues arising in the data. As the work develops the initial codes will be revised and concepts explicitly linked in order to develop a theoretical explanation of team working within the selected stroke units. At the end of the study it is my intention to seek to publish a report for the units concerned, and also a summary of the findings in professional journals. I will not make any reference to individuals in any such publication but may wish to use selected extracts from transcripts to illustrate a point or support claims or comments made. It would be helpful if you would contact me directly if there is any part of your transcript that you would not wish me to make reference to in a report or publication.

I would like to thank you again for giving up your time and for participating in the research in this way. Please do not hesitate to contact me if you wish to discuss any aspect of the transcript, its coding or its future use.

Yours sincerely

David J Clarke  
Lecturer in Nursing and PhD student, Department of Sociology and Social Policy.



## Appendix: 7 Research question and secondary research questions

The primary research question was:

What is the nature and process of health professional team working in selected stroke units?

This question prompted a number of secondary research questions which were identified prior to fieldwork as possible areas for exploration with the stroke unit teams. These included:

- What do the concepts of team, and team working, mean to the different health professionals working in stroke units?
- How do health professionals conceptualise their role in the team and the roles of other health professionals working in stroke units?
- In what ways do health professionals conceptualisations of team working in stroke units, affect their actions on the stroke unit?
- What do the health professionals working in stroke units believe effective team working to be?
- How do team members communicate with each other in stroke units?
- In what ways do the health professionals working in stroke units believe that stroke unit care contributes to improved patient outcomes?
- How are the perspectives of the patient and family members taken into account by team members in the stroke unit?
- How do team members make decisions in stroke units?

## Appendix: 8 Interview structure and topic guide:

### **1) *Introductory overview and explanation of the nature of the interview:***

Covering issues such as: Format, timing, confidentiality of the data, consent to audio taping, opportunity to review the transcript and analysis, possible need to interview again later in the study.

### **2) *Warming up/relaxing strategies:***

Covering issues such as: Would you tell me a little about yourself, a brief professional history and how you came to working in the area of stroke care/medicine?

Followed by (if it does not emerge) 'Please can you tell me about your role on the stroke unit'?

### **3) *Research focused questions:***

Possible questions are listed under topic areas (these are avenues which are likely to be useful and could provide a basic structure for the interview particularly where the interviewee needs more prompting). For other interviewees these question areas may act as reminders for the researcher to consider as the interview progresses. It is NOT intended to ask all of these questions of all interviewees.

#### ***The nature of 'team'***

- Can you tell me what you think about when you think about the word 'team'?
- How does your definition of the word team match up to your experience of the team on this unit?
- Who would you say was 'in the team' on this unit? (Sub question here should focus on the role of the patient and carer).
- Can you compare for me the team on this unit with other teams you have worked in previously in other settings?
- Is it important to be a team member?

#### ***The nature of 'team working'***

- The words team work and team working are frequently used, what do those words mean to you?
- Do you think health professionals need training to work in teams?
- Does team working contribute to patient outcomes on this unit and if so, in what ways does it do this?
- Can you tell me about the things that make it enjoyable for you to work in a team and what things cause problems for you as a team member?
- Team working sometimes requires health professionals to be flexible about their roles and their skills, what do you feel about this?
- If you think about the difference between the ideal and the real in team working, what would you say about team working in this unit?

#### ***Team process***

- What do you think is required to achieve teamwork, to make it happen here on this unit?
- Is there a team leader on this unit?
- Tell me about the ways in which the team meetings/patient care conferences/team rounds/consultation contribute to team working.
- How much do you know about the roles/work/functions of other team members?
- Tell me about the ways in which team members communicate with each other.
- How are decisions made in and by the team?
- Is it important to know about the roles/work/functions of other team members?
- What do you think effective team working is and what makes team working effective on this unit?

Appendix: 8 Interview structure and topic guide:

- How much do external factors affect team working in this unit?

**4) *Accounting for contextual factors:***

See contact sheet for record of any factors which relate to the conduct of the interview: e.g. when the interview was carried out, non verbal responses, distractions, interruptions, any issues during the interview, then (researcher) immediate reflection on the interview.

**5) *Closing the interview:***

Covering issues such as: Thanks for time and sharing views and understanding, repeating information re confidentiality of the data, storage of audio tapes, opportunity to review the transcript and analysis, possible need to interview again later in the study.

## Appendix 9: Fieldnotes- Negotiations- Patient safety in chair

*The activity was focused on getting a patient in a better sitting position in a new and different chair (many had been tried). The physiotherapist responded to comments from nurses and other physiotherapists that the current chair was not helping this patient achieve an adequate sitting position so that he could be assisted to eat or read when he wished to. The patient expressed his desire to try another chair because he wanted to be able to spend time out of his bed, indicating that he saw sitting out of bed as part of progressing his recovery. The current rehabilitation plan was not meeting this patient's needs. The physio and patient relationship was well established due to the length of time the patient had been in the unit (approximately 8 weeks) this was important for some of the discussion and negotiation which took place.*

**The negotiation context.** This draws on regular but unplanned patient focused dialogue between registered nurses, healthcare assistants (HCAs) and physios.

*Positioning the patient in the new chair required use of specialist supports attached to the chair and required the patient to work with the physiotherapists to continue to improve his upper body strength and posture. He was clearly very tired by the effort required to achieve a satisfactory position in the chair but worked at this with two physiotherapists and myself. Recognising his fatigue the physio discussed with the patient his right to refuse physio on days when he felt very tired or if he did not agree with the hard work the physio's were requiring him to do. The patient expressed some surprise that he could have a say in whether to 'do physio' or not. After some thought he said that he felt he must do what the physio's had asked if he was to get better.*

This patient was actively **included in** the dialogue. He had considerable residual disability. The shared value of being **positive about stroke** contributed to a shared belief that this extra effort was worth it. 'something could be done' if the patient wanted it. **Concern for persons** was evidenced through involvement but also the sensitivity to his beliefs about his future progress and rehabilitation

*The physio later explained (to me) that in part she was preparing the ground for being able to tell this patient that his rehab would probably be maintenance activities rather than further improvement. The physio had some personal and professional conflict over asking the patient to work very hard at regaining some degree of postural control, for what he might perceive as minimum benefit. She was able to rationalise this professionally and practically in terms of the adverse consequences of not maintaining the work. These concerns were discussed with another physiotherapist and other team members later in the morning.*

*The time spent on getting the patient positioned in the chair was considerable (25 minutes) but again was an example of the thoroughness noted previously. It also reflected careful objective assessment of the patient's expressed concerns about his comfort e.g. pain in his arm was responded to and resolved by changing the positioning of the chair arms. This occurred as part of a continuous dialogue, a sort of 'thinking out loud' with the other physiotherapist and the patient about how he felt, how he looked and whether the position would enable him to be assisted to eat and drink in the chair and what the consequences of this position would be for his ongoing rehabilitation.*

**Concern for persons**

Also an instance of exploring the rationale for professional actions, thinking aloud, sharing knowledge and perspectives.

*This was followed by the physio going to find the healthcare assistant (HCA) who was caring for the patient that shift and the next few shifts and negotiating a rehabilitation plan (30 minutes twice a day as a minimum in the chair to facilitate sitting upright for lunch/evening meals) in*

## Appendix 9: Fieldnotes- Negotiations- Patient safety in chair

considerable detail with this HCA. This included explaining the chair, its purpose, benefits, and problems, lack of safety over time, the patient's physical and postural characteristics which reduced his safety and how to respond if this happened. Key safety concerns were repeated and appropriate actions forcibly stated. The HCA was part of this discussion and was encouraged to use her judgement about managing this patient. She asked questions to clarify how she could recognise the problems which would mean the patient was unsafe and asked for a further demonstration of how she should respond. This coincided with the arrival of the lunchtime meal so the physiotherapist then sat with the HCA whilst she helped the patient eat and both the HCA and the physiotherapist noted the patient's loss of initial posture and jointly took action to help him regain this until he had completed his meal.

**An inclusive team culture** and team working practice. This kind of action was *common*: the division of labour was not traditional and demonstrated trust for other team members. **Learning and working together**, directly on patient problems as they arose directly contributed to changing the thinking of team members and helped them to understanding the role and perspective of others.

During the meal the senior nurse on duty and one of the occupational therapists visited another patient in the same four bedded bay and noted the new chair in which this patient was sat. A further discussion of the rationale for changing to this chair occurred and both the nurse and the OT asked for guidance on supporting this patient in the new chair. The dialogue here was inclusive and involved seeking clarification, checking out understanding, asking for explanations of why safety would be compromised and how to prevent that. The HCA and the physio responded to these questions and the HCA agreed that she felt able to pass on this information to the late shift staff and the night staff. The HCA and senior nurse were keen to establish the time period and criteria for review of this change in planned care and persisted in this line of questioning which included debate about the criteria for review including how the patient felt but also whether the position remained safe, and the time it would take for team members to get the patient in and out of the chair set against the perceived benefit of the change.

The dialogue here was a typically 'frank exchange'. The physio had to **negotiate** with the HCA and senior nurse. The goal of the intervention was clear but achieving it with this very disabled patient would be time consuming and hard physical work. The physio was challenged to explain her rationale and the nurses engaged in **bargaining** – they were prepared to work at the agreed goal but wanted a clear timetable for review.

The physio recognised the amount of time and effort that would be required to carry out this rehabilitation plan and enlisted the patient's support in confirming that he was willing to try using this and repeated her explanation of the therapeutic (balance and posture) benefits of the trial. Following more dialogue the physio agreed to run over the positioning issues again before she left for the day and the small group agreed to review the situation with the patient after lunch the next day.

The physio also enlisted the patient's support in her *negotiation* with the nurses. Here there was some **bargaining**- We'll work with the plan if you agree to the review timescale and demonstrate the positioning required again later that day.

This is an example of the kind of **opportunistic dialogue** commonly seen, the process which underpinned the negotiation of the social order and resulted in achievement of teamwork in these stroke units.

## Appendix 10: Case conference- Patient safety at home

Extract from fieldnotes Case Conference, Holton, May 2002

In the team meeting it had been agreed that the patient's level of cognitive impairment meant he would be at risk and would be a major challenge for his family. There seemed to be a team understanding that the patient was at risk and that 24 hour care was probably the best solution, but his wife needed to try at home before she would be ready to accept 24 hour care. This seemed to reflect a good understanding of the possible guilt or distress which the patient's wife may experience at 'putting him in a home'. The team held the view that the patient's wife and niece did not fully appreciate the level of impairment, but they understood their desire to have the patient at home and were willing to work with them to see whether their wish for the patient to be at home was realistic and could be supported safely. The patient's wife and niece were invited to join the occupational therapist in a session with the patient where he would be asked to undertake some simple tasks. This was a difficult session for the family as the level of cognitive impairment became clear quite quickly when the patient was encouraged to undertake simple personal hygiene tasks and tasks aimed at recognising and using household objects. The patient became frustrated and angry in the session, gesturing to his family but unable to articulate his wishes. The occupational therapist skilfully defused the anger and frustration by removing the requests to engage in the tasks and shifting the session to simple conversation in which the patient was included. Once the patient was calm and had returned to his bed the family visit continued as if normal and only after the family had 'left the ward' did they meet with the social worker, nurse and occupational therapist.

A very brief report on the previous session was provided by the occupational therapist to the nurse and social worker in advance of the meeting but the team members acknowledged the strength of feeling of the family and resolved to see what they had to say in the meeting, no decision or course of action was agreed in advance of meeting with the family.

The meeting was led by the OT but each team member had input and responded to the family's questions as appropriate. I was impressed by the shared concern for the patient's wife and niece, there was honesty about the risks but also a tacit understanding that the patient's wife needed to be given a choice and supported in that choice. There was no indication in this conference of the team imposing its views. It seems that the comfort at managing this situation comes from regularly working together and a shared understanding of what might be possible for this patient. The team members' non verbal communication in the meeting gave the impression that they could 'read' each other, that they knew what to expect of each other without rehearsing the team position.

The patient's wife and his niece were listened to, the language used was mostly toned down for the lay person but not in a patronising way, sometimes technical terms were used but they were usually explained. The family were encouraged but not pressured to make a decision. The same sort of checking out and listening to different perspectives which I see in other situations, at the nurses' station or the MDT meeting was evident but this time with the patient's family. A consensus was reached on a trial home visit at a time agreed. It was agreed to meet again following the trial prior to making a recommendation to the team meeting.

## Fieldnote- Linked memo 12: 18.03.02

This is the third round I've observed and while they are 'routine' in some ways they are not like medical & surgical rounds I was used to and have seen recently in surgical wards. Thinking about what the main differences were, these relate to team talk in interaction (*little hierarchy but some turn taking based on seniority, and also apparently on knowledge of 'what comes next'*), the structure of the review of each patient (*covered technical medical but also strong functional, social and emotional focus-this was really comprehensive*) and the efforts made to involve the patients themselves in reviewing their progress (*some were more able than others to do this, some were deferential in their response to the consultant but most were not*) team members already knew, or listened to what was important to particular patients (*See notes re Bob and reading, Miriam and living alone*). This could be an observer effect but if so the round would take longer than normal (and staff report rounds of 2 hours duration as 'normal'), nor will it be sustained over time. It was similar at Holton but only one round seen there to date. Comparison of acute care and rehab settings should be fruitful to question the differences- Also look again at Strauss & Corbin (1998) on contextual factors and their impact on social actors and interactions. How much of this is shared? Is it evident on other interactions? How do team members explain and understand this?

## Fieldnote- Linked memo 16: 25.03.02

This episode is a good example of what the teams (at both Holton and Colebrook) define as joint working. Three issues to explore are:

- 1) that therapists and nurses appear comfortable working in the presence of family member and other relatives, it is happening on a regular basis, both planned (please can you attend to help with dressing practice with your husband at 1000 tomorrow) and unplanned in the case of the tilt table. The 'comfort' was reflected for me in the pacing of the work, the use of both social and technical conversation and the use of the ward area rather than removing the patient to the 'gym'.
- 2) The nature of the joint working, the PT led because of specialist knowledge of the tilt table but the session was inclusive of the RA, nurses and later OT. There was direction (from the PT) to observe, participate, check out rationale for actions, this was aimed at relatives too but was much more 'two way' and discursive with team members- this is an example of working in public and working on problems or changes as and when they arise.
- 3) Lastly but importantly, I have coded this as *boundary blurring and understanding the roles and perceptions of other team members*, because I observed the PT sharing specialist knowledge and skills, she also requested specialist wound dressing and healing information related to a sore at the back of the patient's head from the nurses – *The question is that boundary blurring is a convenient theoretical concept, but how do the team members explain and make sense of what they do in joint working, do they perceive there to be professional boundaries to be blurred?*

Appendix 12: Working diagram 1- October 2002 Reviewing developing codes and categories

**KNOWING THE WHOLE PATIENT**

- Holistic/patient centred concern (shared and valued)
- Active recruitment and involvement of relatives
- Rehab requires knowing patients as people
- Involving, giving choices, educating for rehab
- Carrying this across
  - to MDT meetings
  - to planning care/therapy
  - to ward round
  - to working with others
  - to working with (not on) the patient and family.
- Cross disciplinary sharing of this value/belief

**MEETING FORMALLY AS A TEAM**

- To review, make decisions and move forward.
  - We do this elsewhere too.
  - Its not just a talking shop
  - Collaboration, challenge, clarification, communication.
  - Decisions based on evidence, inclusion of views of all disciplines prompted by medicine.
  - High profile for PT's in some circumstances
  - Members prepare for this meeting.
  - Opinions are heard and valued (if they are credible) (see across).
  - Some members are not present but opinions are heard and valued
- Decisions are recorded and communicated and explained to others.

**RESPECTING AND VALUING TEAM MEMBERS**

- Grade and seniority does not seem to be the key contribution and commitment might be
- Credibility in role is important = knowledge, skills, commitment and experience
- Night staff, housekeepers, ward clerks, as well as consultants and senior therapists/nurses
- Opinions sought, voices heard
- Included in processes/ care/rehab
- Seen as in the team
- Education for all grades.
- They enjoy being in the unit and doing this work – made to feel part of the team and respond to this.

**MANAGING CONFLICT OR DIFFERENCE**

- Tolerance and respect
- Judging when to intervene or make a point
- Conflict avoidance or professional adulthood
- Team identity provides security
- Using the disciplinary team for letting of steam and checking the way ahead
- Established relationships allow challenge and criticism to be defined/seen as professional concern

**Diagram 1 ACHIEVING TEAMWORK**  
Issues emerging from the data

**COMMUNICATION STRATEGIES**

- Frequency of contact and access
- Opportunistic dialogue/problem solving/decision making.
- Negotiation around achieving a goal or prioritising.
- Address it when it happens.
- Openness to alternatives.
- Use the expertise available.
- Make sure key people are informed
- Shared info sheet.
- Ward diaries.
- Be at the 'station'.
- Check the nursing notes.
- Have breaks as a team.
- Be based largely on the unit or visit regularly.

- Seeking to understand the demands placed on others – but communicating need.
- Care team unity helps cope with staffing and resource uncertainties.
- Team challenging system rigidity.
- NSF acknowledged and utilised where understood to be benefiting patients.
- The team against the system.
- Working the system for the patient
- Working for patients and with families.

**DEALING WITH EXTERNAL AGENCIES PRESSURES AND**

- Specialist knowledge/skills shared.
- Its ok to interrupt, to observe and to ask why or how.
- Approachability of senior staff encourages questions.
- Seeking out the member of the team most likely to know or get things done.
- All team members are valued regardless of grade.

**NON HIERARCHICAL RELATIONSHIPS**

**PROVIDING CARE AND REHAB**

- Commitment to stroke care and rehab
  - Shared values
    - stroke matters
    - patient centredness
    - rehab makes a difference
    - change and development are possible.
  - Its a collective effort
    - if we do not work towards and on the same goals we are not effective.
  - Role sharing/skill and knowledge sharing are valued when they improve patient care/outcome
- Adaptability and flexibility in attitude and approach – moved on from a narrow disciplinary focus – the stroke patient versus aphasia, dysphagia and calorie deficits



<b>Diagram 2 Early (2003) example of diagram to support analysis of coding and categorising</b>			
<b>Achieving team work in selected stroke units: key categories</b>			
			<b>Structures and processes</b>
<b>Category</b>	<b>Working together for patients</b>		
<i>Subcategories</i>	<i>Team thinking versus disciplinary thinking</i>		
	<i>Thoroughness</i>		
	<i>Interdisciplinary Team working</i>		
<b>Relationships between team members</b>	<b>Communication between team members</b>	<b>Perceptions of role boundaries</b>	<b>Responding to the challenges to stroke unit team working</b>
<i>Non hierarchical relationships</i>	<i>Decision making</i>	<i>Shared ownership of disciplinary work</i>	
<i>Supporting team members</i>	<i>Specialist knowledge of stroke</i>	<i>Blurring role boundaries</i>	
<i>Team relationships</i>	<i>The multidisciplinary team meeting</i>	<i>Understanding the roles and perspectives of other team members</i>	
<i>Importance of relationships</i>	<i>Shared records</i>	<i>Interdisciplinary or transdisciplinary</i>	
<i>Negotiating changes in team working</i>	<i>Ward round behaviours</i>	<i>Joint working</i>	
<b>Being in the team</b>	<b>Influences on team working</b>	<b>Barriers to team working</b>	<b>Challenges to stroke unit team working</b>
<i>Core and peripheral team members</i>	<i>Prior team working</i>	<i>Barriers to team working</i>	
<i>Being a new team member</i>	<i>Political compromises</i>	<i>Conflicting values</i>	
<i>Owning team members</i>	<i>Policy imperatives</i>	<i>Power and control in the team</i>	
<i>The disciplinary team and the multidisciplinary (SU) team</i>	<i>Contextual factors</i>	<i>Organisation demands that challenge the team</i>	
<i>Different roles in different teams</i>			
<b>Making team work happen</b>	<b>Positive about stroke care</b>	<b>Holistic or person centred focus for care</b>	<b>Foundations for stroke unit team working</b>
<i>Team maturity</i>	<i>Nature of stroke unit working</i>	<i>Patient centredness</i>	
<i>Team leadership</i>	<i>Defining rehabilitation</i>	<i>Involving patients</i>	
<i>Education for team work</i>	<i>Negative perceptions of stroke</i>	<i>Patient's and relative's perceptions</i>	
	<i>Commitment to stroke speciality (Choosing stroke as a place to work)</i>		

Appendix 14: Working diagram 3- Refining categories and identifying the core category

<b>Diagram 3 February 2004: Achieving team work in selected stroke units: key categories</b>			
<b>Category</b>	<b>Core category: Opportunistic dialogue</b>		<b>Structures and processes</b>
	<i>Team thinking versus disciplinary thinking</i>		<i>Think about helping and</i>
	<i>Thoroughness</i>		<i>Hindering or mediating forces</i>
	<b>HAVING THE ACCESS TO THIS AND BEING ABLE TO USE IT</b>		
	<i>Interdisciplinary Team working-Working together for patients</i>		Problems for peripherals but not insurmountable-
<b>Subcategories</b>			requires hard work creativity and compromise?
<b>Inclusive team culture</b>	<b>Communication between team members</b>	<b>Learning and working together</b>	<b>Responding to the challenges to stroke unit team working</b>
<i>Non hierarchical relationships</i>	<i>Decision making</i>	<i>Shared ownership of disciplinary work</i>	Structural
<i>Supporting team members</i>	<i>Specialist knowledge of stroke</i>	<i>Blurring role boundaries</i>	Contextual
<i>Team relationships- team maturity</i>	<i>The multidisciplinary team meeting</i>	<i>Understanding the roles and perspectives of other team members</i>	Interpersonal and Intrapersonal
<i>Importance of relationships</i>	<i>Shared records</i>	<i>Interdisciplinary and transdisciplinary</i>	
<i>Negotiating changes in team working</i>	<i>Ward round behaviours</i>		
<b>Being in the team</b>			
<b>Being in the team</b>	<b>Influences on team working</b>	<b>Barriers to team working</b>	<b>Challenges to stroke unit team working</b>
<i>Core and peripheral team members</i>	<i>Prior team working</i>	<i>Barriers to team working</i>	Structural
<i>Being a new team member</i>	<i>Political compromises</i>	<i>Conflicting values</i>	Contextual
<i>Owning team members</i>	<i>Policy imperatives</i>	<i>Power and control in the team</i>	Interpersonal and Intrapersonal
<i>The disciplinary team and the multidisciplinary (SU) team</i>	<i>Contextual factors</i>	<i>Organisational demands that challenge the team</i>	
<i>Different roles in different teams</i>			
<b>Making team work happen</b>			
<b>Making team work happen</b>	<b>Positive about stroke care</b>	<b>Holistic or person centred focus for care</b>	<b>Foundations for stroke unit team working</b>
<i>Team member maturity</i>	<i>Nature of stroke unit working</i>	<i>Patient centredness</i>	Structural
<i>Team leadership</i>	<i>Defining rehabilitation</i>	<i>Involving patients</i>	Contextual
<i>Education for team work</i>	<i>Negative perceptions of stroke</i>	<i>Patient's and relative's perceptions</i>	Interpersonal and Intrapersonal
	<i>Commitment to stroke speciality (Choosing stroke as a place to work)</i>		

## Appendix 15: Theoretical/analytical memos

Theoretical Memo 10.02.2004

In a nutshell the shift in the importance attached to elements of the model has been prompted by a number of things which include:

- Time to think about the meaning of the data and explore/conceptualise its meaning, what is behind it and how does it work (freeing up)?
- Presenting at conferences and being asked to summarise the core of what was going on, or questions about why it worked so well, was it too good to be true? What was the role of medicine; did it only work because senior medical staff were not often present and SHO's were regarded as temporary and instrumental team members and this altered the problems of power, influence and traditional medical dominance?
- Recognising I had not really progressed beyond coding and thematic analysis as a result of being stuck in the data or too close to the data (reading and re reading it as opposed to thinking about what it meant and how it could be understood)
- Systematically working on identifying and developing the categories and beginning to examine the relationships between them, looking at applicability and (fit, work and relevance)
- Going back over the observational data and recognising its significance, power and importance, using this to re-examine the interview data
- Engaging in conceptual work as opposed to only coding and memo work, from asking questions to thinking about some answers but again asking about the degree of fit, work and relevance of the core category and the sub categories (e.g. the attempts to model the achievement of teamwork in other than a simple liner or hierarchical diagram and thinking of analogies or far out comparisons, flip flop technique (see p 94-95 Strauss & Corbin, 1998)

Review note:

This has been a significant couple of days in terms of thinking about the ways in which the data, ideas, concepts and achievement of teamwork might be conceptualised. Until now I have been/was bogged down in lists and codes and accuracy of coding/interpretation (not that this is not important) so much so that I could not lift my head and say 'but simply, what is going on', what is really core to the achievement of teamwork in the selected units.

So what happened? Re reading and thinking about the observations was important and salutary (beneficial) partly because it was challenging to see if I had done what I said I would but also to look again at how I had seen things. Reading a piece by Christina Hughes (cited in Bryman and Burgess, 1994) also struck a chord in relation to how she made sense of her observations and began to develop her thinking. It was a short piece but somehow struck home when she was discussing the challenge to reconsider her data in terms of 'myth' and the literature surrounding this. I know this does not apply to my own data but her comments just struck a chord and prompted me to write differently (about categories) yesterday which has resulted in the need to get this 'changed thinking down on paper. This is also about doing this work part time and moving from structuring and ordering the data (simply getting it into NVivo and coded) and then having the time and understanding to 'play with it' to ask questions of it and of myself (and not simply berate myself for not understanding). It is also about moving from reading and re reading to actually doing. I don't think this is just about deadlines becoming more pressing, but about readiness.

## Appendix 15: Theoretical/analytical memos

Theoretical memo 23.02.2004

It has also been about trying to understand and get to grips with my concern at the conference presentations and the oft asked question, so what are your findings? Whilst I have had a list of themes which were clearly linked and suggested a core process, I was not satisfied with the explanation as it did not really synthesise the elements but tended to identify them and their importance but did not explain how they fitted together, or did not fit together. Two things helped here, firstly some re reading of the observational notes and being struck by the importance attached to the unplanned exchange of information and the frequency of reference to its occurrence in the data. Secondly was the discipline of trying to write descriptive and then storyline memos (Strauss & Corbin, 1998). These memos require a real sharpening of focus and a concise explanation of what is going on and how it comes about. Writing in this way shifted from the focus on individual elements as categories to a focus on the process by which the elements were related to suggest a core process for the achievement of teamwork. The challenge to think again about the things which made teamwork difficult or suggested that some team members felt they were not or said they were not involved in team decisions prompted me to ask how they were included and excluded and what they did and thought about that, how they explained their thoughts and behaviours and their perceptions of the behaviours of the other team members. Looking at the negative experiences and how these were addressed was illuminating because it further suggested the importance of the informal processes to both core unit based team members and more peripheral non unit based team members. It suggested the readiness to 'work' at being involved and being heard and made me ask again why they would make the effort and not take the traditional tack of retreating behind disciplinary boundaries. Some of this is about foundations being built and the teams maturing as a unit. This in turn has brought stability and continuity which is helpful in creating a climate for collaboration. Looking at the literature surrounding health professional team working now becomes a more useful comparative exercise. This does not mean that the core category outlined answers every challenge posed by the literature but it does suggest some of the reasons why the traditional problems encountered by some health care teams have been largely but not completely overcome or can be compensated for. There is still the problem with categories as concepts as opposed to labels or headings. The process of reviewing each of the categories is proving valuable on focusing on conceptual as opposed to thematic identification.

Storyline memo: February 22<sup>nd</sup> 2004

Most healthcare professionals work with and collaborate with other professionals as part of their daily roles. For some this involves working in teams or as part of a team, the function of which is to provide care and treatment for individual patients who often have complex needs. Many healthcare professionals give little conscious thought to the processes involved in **achieving teamwork**. The stroke unit teams generally held very positive views about working as a team and were aware of the potential benefits that their collaboration could bring for patients and for themselves as professionals. The team members recognised the weaknesses as well as the strengths of their teams, but both teams had developed ways of working which largely overcame the commonly encountered barriers and problems associated with health professional team working. The same core process results in the achievement of teamwork in these two units even though the units face some different practical and organisational constraints in their day to day work.

The team members who came together to establish the stroke units were mostly (but not all) mature and experienced professionals in the sense that they had worked in a number of clinical settings and roles prior to joining the stroke units. The stroke unit team members recognised that their initial team structure and development conferred some potential advantages which they were able to exploit and build upon to create some of the **foundations** for their current effective team working practice. These advantages included the fact that most of the team members actively chose the stroke units as a place to work. This essentially self selection by team members reflects their shared interest in this area of neurological rehabilitation and indicates that they were and are **positive about stroke** care. The team members contrasted this with the negative perceptions of other health professionals they had worked with, who not infrequently regarded stroke patients as having little hope, and stroke care and rehabilitation as non technical and not challenging. The stroke unit team members reject these negative perceptions and pointed to the positive and beneficial outcomes for most patients who experienced co-ordinated rehabilitation. Many of the original stroke unit team members were still in post over four years after the units had been established. This suggests commitment to the speciality of stroke rehabilitation and satisfaction with the way in which the stroke units were now working. The team members also recognised the single disease focus and how, despite the complex and varied presentation of stroke, this facilitated the development of specialist knowledge and skills in stroke unit team members. The team members in both settings expressed the view that they did not think it was possible to develop the same degree of specialist knowledge and skills in a general medical, or elderly care setting where the types of presenting conditions were much more diverse.

There were two types of stroke unit team member. Those team members who were physically based on or spent the majority of their working day on the stroke units, are referred to as the **core team members**. Secondly those team members who were not based on the stroke units but who had regular contact (sometimes daily, sometimes a number of times each week) with the stroke units either through specific and regular patient referral to their service or because part of their contracted hours of service were allocated to the stroke units. These individuals normally had a range of other patient responsibilities over and above those required by the stroke unit. These team members are referred to as **peripheral team members**, the term is used to identify the lesser contact with the stroke unit and the core team members. Other factors which were an important part of the **foundations** for the current team working and which appeared to underpin the ways in which the team members (core and peripheral) thought about and engaged in their work with each other and with patients was their **concern for persons**. This was expressed for patients, their relatives and for other team members. It was a personal belief and value and often cited as a shared professional value. Its expression differed in part as a result of profession specific socialisation. The different expression of this belief and value appeared to be the source

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of some tension between team members on occasion but paradoxically it also provided the basis or the common ground for the resolution of that tension.

Setting up the units led to some formal shared education sessions which in addition to providing specialist information and skill development opportunities, had a more important and enduring contribution to the achievement of teamwork in the two stroke units. This contribution was the establishment and endorsement of a system of **learning and working together** which impacted on the achievement of teamwork in a number of ways. The formal coming together of the different professional groups and different grades within those professions in the same room to learn about stroke and its management conveyed a powerful but not directly stated message that 'team members can learn something from each other, and all the team members need to be able to work together to address the complex needs of stroke patients'. However, the more informal commitment to learning and working together now seems embedded in the teamwork practice of the stroke unit team members and seems to be a significant factor in the **inclusive team culture**.

The story so far might suggest a relatively unproblematic progression to effective teamwork and a smooth daily operation where team members collaborate without difficulty. This was not how team members saw their development or their daily work, however whilst they recognised and had to address the **challenges to team working** which follow, they had found ways to overcome or at the very least cope with **barriers to team working**. Some of these challenges and barriers are practical, organisational problems which, for some team members, make contact with and access to the stroke unit teams very difficult. Examples which affected both core and peripheral team members include service reorganisations resulting in social workers and dieticians being based at another hospital across the city (Holton), or taking social workers out of the stroke unit and hospital setting altogether (Colebrook). Other examples include the problems of filling vacant posts or trying to achieve the most effective balance of service provision with limited resources. Sometimes departmental policy decisions directly impacted on the way in which peripheral team members carried out their work. At Colebrook for example dieticians were advised by their line managers that they should not attend multidisciplinary team meetings as the time spent in the meetings (often up to two hours) could be more effectively utilised in providing more direct patient contacts.

Other barriers originated in or were related to professional socialisation and traditional role expectations. Here the concerns about role boundary expansion or erosion and exercise of power, control and medical dominance in the team context were issues which arose from time to time. The concept of being in the team helps explain the ways in which both core and peripheral team members perceived and understood their role as a team member and also points to how they worked with the barriers to team working. All the team members with perhaps the exception of the ward clerks and housekeepers could point to a primary attachment to a distinct professional group, for example nursing, occupational therapy, medicine or social work. For **core team members** in both units this primary attachment remained a key reference point for the basis of their professional practice but these team members saw and defined themselves as part of the stroke unit team.

For more **peripheral team members** their primary professional focus tended to define their team membership and their perception of themselves as stroke unit team members was largely dependent on the degree and frequency of contact they had with the core unit team members. Where the degree and frequency of contact was relatively high as with social work and speech and language at Holton and dietetics at Colebrook, these more peripheral team members were more likely to perceive themselves as involved members of the stroke unit teams. The ways in which the peripheral team members responded to potential and actual barriers to team working

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was dependent on a number of factors. These included the degree to which they were able to regard themselves as part of the stroke unit team, the opportunities they had or made to engage in **learning and working together** with other team members and the way they were able to access and make use of the core process of **opportunistic dialogue** with other stroke unit team members.

The **inclusive team culture** reflected the kind of team relationships which had developed over time. These relationships were mature in the sense that challenge and criticism could be sustained as part of the relationship and not be perceived as a personal attack. Team members, core and peripheral, highlighted the importance of their relationships with each other and the team as a whole as one of the reasons that they were able to collaborate and work together effectively. Team members described the importance of making time to get to know other team members, to develop social as well as professional relationships. This investment in developing relationships provided the foundation for effective and mature dialogue with other team members. Thus it was easier to seek information, to ask for clarification and to challenge particular perspectives when team members had formed a working relationship. This was closely linked to the relative absence of traditional hierarchical relationships between the professions and the different grades of staff who worked as part of the stroke unit teams. The non hierarchical relationships provided the conditions for different team members to seek information from other team members, to ask for explanations or advice on aspects of stroke care and rehabilitation and to express opinions.

The culture of **learning and working together** which had its origins in the formal shared education sessions also provided and supported the conditions for developing working relationships with other team members and highlighted the non hierarchical team practice on the stroke units. One of the main outcomes of these relationships was the opportunity for different professional groups in the teams to develop understanding of not only the specific actions and roles of other professionals but also the underpinning rationale of these professionals, that is, the reasons for their prescriptions. This is different from one professional giving instructions to subordinates. In some settings the professional who gives directions may not then participate directly in the subsequent day to day care of that patient with those team members. In this situation understanding of rationales for specialist advice does not develop. In the absence of understanding the rationale for the prescriptions of the physiotherapist for example, team members were able to cite situations where the prescription which may have been more time consuming or different to previous practice, was more likely to be abandoned than continued.

The **inclusive team culture** extended to all core team members and included healthcare assistants, housekeepers and ward clerks, groups of staff who have not traditionally been given responsibility for aspects of the support, direct care or observation of stroke patients. This was the case in both the stroke units in the study. Peripheral team members were not excluded from this **inclusive team culture** but they did have more difficulty in taking advantage of the opportunities for learning and working together and were not always convinced that all relationships were **non hierarchical**. These comments can be further developed in relation to the nature of the work done by the more peripheral team members. For example, where the work of the more peripheral team member involved direct care, often physical care interventions, then this work was visible to other team members and often impacted directly on their own work patterns. This was the case for dieticians where they were involved in working with team members to ensure improved dietary intake. In this case the dieticians observed and interviewed felt included as part of the stroke unit team and tended to view team relationships as non hierarchical. This contrasts with the work of the social workers at Holton whose work was not related to direct care and was less visible to other team members. This made it more difficult for the roles, skills and underpinning rationales of social workers to be understood by other team members. In this case traditional role

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stereotypes were expressed by some core team members on occasion though most team members had a broader and more realistic understanding of social work. In some cases social workers worked closely with team members such as occupational therapists on pre discharge assessment and planning and here there appeared to be good working relationships and understanding of the work, and the constraints on that work, of the other.

Senior house officers were also **peripheral team members** in that although they were based on the stroke units for the majority of their working day they rarely worked collaboratively with other team members. Their work was characterised by responding to requests from team members. This could include requests for investigations or drug prescription from the consultant physicians, or for examination and diagnosis of patients who were considered to be medically 'unwell'. The short duration of their team membership was also a factor for the senior house officers in that this made it difficult for them to participate in the opportunities for **learning and working together**. This did not mean that the senior house officers did not benefit from the **inclusive team culture** and the **non hierarchical relationships**. Some clearly found the shared responsibility for patient outcomes removed some of their usual burden, and the shared decision making broadened their perspective on the complex needs of stroke patients.

In respect of the **non hierarchical relationships** both core and peripheral team members recognised that this was a relative concept in that there were situations and instances where more hierarchical relationships reflected the power and authority associated with traditional professional roles. Examples included the lead taken by consultant physicians and sometimes physiotherapists in the multidisciplinary team meetings and the response of these team members to a direct challenge or difference of opinion about goals or plans for care. These challenges were sometimes met with responses which appeared to reflect a default to positions of power and authority to make the final decision even when other team members were not convinced of the wisdom of the decision. These situations were rarely observed in the two units but in interviews a number of team members made reference to more regular occurrence in the earlier developmental stages of the teams and the occasional occurrence during the period of study.

Team members communicated in a number of different ways but these can be divided into formal and informal communication situations. In the formal sense there were two main situations, the **medical ward round and the multidisciplinary team meeting**. In respect of the ward round this occurred on one occasion per week for each consultant physician and was normally only attended by the consultant physician, senior house officers and nurses. The rounds varied to some degree but were essentially structured and formal medical reviews of patients at the bedside with some involvement of the patients themselves. The ward rounds were the clearest example of a more traditional hierarchical approach to team practice. However, in both units established relationships between the consultant physicians and the nursing staff meant that the rounds observed were mainly collaborative in nature and whilst they were clearly led by the consultant physicians, the rounds were characterised by information sharing, consultation and participation in decision making. The only occasions when this was less evident was when either the nurse or the senior house officer was new or relatively inexperienced. In these circumstances the absence of a developed professional relationship, the relative inexperience and lack of stroke specific knowledge and understanding impaired the ability of the new team member to participate in the ward round decision making.

The ward round was perceived by the remaining team members (core and peripheral) as a 'medical review' and as a result they did not feel excluded from this communication opportunity. **The multidisciplinary meetings** followed a similar pattern at both units in that there was a clear structure to the meeting with each team member presenting information about a particular patient



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in essentially the same order. Specialist knowledge of stroke facilitated communication in the meeting in that a shared technical language allowed the majority of the team members to converse quickly and with apparent understanding. Team members felt that the meeting provided an opportunity to share information and to formalise the decision making process. There was a shared view that the meeting was an active and collaborative process in which team members could influence the decisions made. Not all team members were able to attend the meeting but one other key difference between these stroke unit team meetings and those reported in some other studies was that the team members who could not attend the meeting did not perceive that they were excluded from the decisions which were being made. It was also evident that those who made the decisions in the meeting were an integral part of ensuring that the decisions were translated into action. This occurred both through ensuring plans and goals were shared with other team members but more importantly through active participation in delivery of care or rehabilitation.

Team members recognised however that these formal communication situations were a small and time limited part of their team working practice. For the majority of each working week the team members did not meet and talk in these formal settings but engaged in informal **opportunistic dialogue** with each other in the course of working towards agreed goals and translating team decisions into action. This opportunistic dialogue is regarded as the core process which synthesises the elements or factors which represent the foundations for teamwork, the barriers that teams must respond to and overcome and provides a mechanism by which team members can collaborate. It is in this **opportunistic dialogue**, this essentially unplanned exchange of information and ideas that teamwork is achieved and maintained in the two stroke units.

What was striking early on when engaging in the observations, and then grew in importance as it featured indirectly in many interviews, was the ways in which the team members would use their unplanned face to face contacts with other team members in a direct and structured way. This was an opportunity for information exchange, questioning, clarification and decision making. These contacts were usually spontaneous in origin, and could happen anywhere on the unit where two or more team members came together and discussed a patient. The contacts and the associated dialogue which developed frequently occurred at the central work-station and normally involved more than two team members. The dialogue was inclusive and did not exclude or differentiate between grades or seniority of team members. The content was usually patient focused and related to previously agreed goals or issues related to the progress of rehabilitation or discharge planning. It resulted in sharing of perspectives, knowledge, skills, and in **negotiation** about actions or treatment options and the allocation or acceptance of responsibility for those treatments or actions. This dialogue and negotiation was usually the means by which agreements or plans made in the formal weekly MDT meeting were realised sometimes through necessary modification or renegotiation. The dialogue took place in a context which was built on or dependent on a number of important conditions which increased its likelihood of its regular use and its perceived value for team members. These conditions included the inclusive team culture which generally valued the skills, knowledge and contributions of all its members. It was also related to the established pattern of team members learning and working together, and it was underpinned by the shared value of concern for persons evident in the language and practice of the team members. The extent to which team members could access and participate in this **opportunistic dialogue** was related to the degree of satisfaction that they expressed about their involvement in the team and its work. Team members who were more peripheral to the units, i.e. not based on the units or who had responsibilities to other teams and in other parts of the hospital often spoke of and were observed using this process to ensure their perspective was heard and their contribution to the patients rehabilitation was realised.