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**Distributing Knowledge and Accountability in Medical Work.
An Ethnography of Multidisciplinary Interaction.**

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labour of division

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Preface

Most sociology of medical work focuses on doctor-patient or nurse-patient relations. With significant exceptions (Atkinson 1995; Latimer 2000a) very few studies take as their central concern how medical work and medical knowledge practices are distributed and accomplished by different practitioners.

The paper that follows offers preliminary analysis of an ethnography of multidisciplinary team-working in an elderly care directorate. The aim of the research was to provide a detailed picture over how practitioners of different disciplines work together over patient assessment and the organisation of care. The directorate included an acute medical unit, a rehabilitation unit, and a day hospital; the team included nurses, doctors, therapists, social workers, and managers. The interactions of these actors formed the focus of the study. The study exemplifies how multi-disciplinary working accomplishes:

- the definition of need
- the distribution of medical work
- a balance between the patients interest, the needs of the service and professional autonomy
- an ongoing form of audit and accountability

The study raises issues of power and control in multi-disciplinary interaction. While there were various forms of multi-disciplinary interaction, they were all medically-led and they were all hierarchical. Within this limited framework there were appreciable differences: some forms of working were much more open to a wider range of views and understandings than others. While this latter mode of organising had its problems it was preferred by most non-medical team members.

The extent to which different ways of working accomplished patients' interests would require further research. The study was presented to members at all levels of the Trust: almost all participants felt that it reflected their day to day experience of Trust life.

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Introduction

Hope Trust combines elements of hospital-based care for older people with a community health care unit. It is situated in the middle of England, and caters for a heterogeneous urban and rural population with one of the worst epidemiological profiles in Britain. The Trust's elderly care directorate included an acute unit based within the acute trust together with outlying rehabilitation and continuing care facilities.

The Trust were preparing to pilot 'collaborative care planning', a new document-based, problem-oriented 'social technology' developed in the US. The purpose of this technology was to enhance 'team working'. As Housley (2000) drawing on Øvreveit (1994) points out, the important features of team-work practice, include 'exchange of information, meaning and dialogue.' Collaborative care planning was seen by the Trust management as potentially enabling the enhancement of team working in line with Øvreveit. As such it can be seen as a part of a general trend within the Trust to democratise work practices and flatten hierarchies. While the stated objective was comprehensive patient assessment and continuity of care, a further stated objective was that enhanced team-working would be more efficient by reducing overlap, particularly in relation to patient information.

The project team, consisting of nurses, occupational therapists and physiotherapists, came to see me to seek my advice over how to proceed in terms of setting up the project within an evaluation framework. The on-going introduction of collaborative care planning was extensive and deeply problematic, the medical staff in particular were resistant to change. Indeed the drivers for change were the nursing and rehabilitation staff, and it seemed to me after many conversations with them that the impetus for change partly stemmed from a general feeling that paramedical staff were not valued as professionals by medical staff. The project team emphasised that the organisation logic as it currently stood derived from biomedical discursive practices and priorities to the exclusion of other views.

In talking with them and in examining the literature on collaborative care planning, I cautioned them over their expectations as to what this new management technology would help them accomplish: I suggested that my work to date on the nursing process seemed to me to imply that the technology cannot simply be introduced in order to do the work of change.

We discussed doing an action research project, introducing a 'strategic value', and 'participation', rather than a top down, change programme (Munro, 1991). In this way I felt that the methodology and the change programme would reflect each other as engaged in promoting a collaborative, bottom-up rather than top-down approach. In many ways this is the approach the steering group and project team took, but they rejected the proposal to do it as an action research project. I think, retrospectively, that they were worried that they would lose control of the project to an outsider.

After lengthy dialogue, and a number of proposals and presentations, the project team and steering group together commissioned the research, drawing on a regional health authority grant. The agreement was for research aimed at providing a detailed record of how members of different disciplines (the 'multi-disciplinary team') worked together over patient assessment and the organisation of care prior to introduction of collaborative care planning. The very way, then, that the research developed, reflected ambiguities over power and control central to multi-disciplinary working in medical contexts.

The following paper presents and discusses the research.

Research Approach

The underlying theoretical assumption for the study was that any organisation is the production of its' members (Bittner 1973) but that member's are not free to do what they will.

Practitioners in the current setting are members of different groups: they are members of organisations, (e.g. the NHS/Hope Trust), of professional groups (medicine, nursing, occupational therapy, physiotherapy etc.), and of society. Accessing the logic of practitioner's actions as members of multiple groups can throw light on the ways in which practitioners are working together over patient care. Therefore, the research approach taken was based on the notion that processes of assessment and organisation can be traced through:

- talking to the people involved
- watching them work together
- reading what they write about patients

The four sites under observation included:

The Day Hospital (Continuing Care and Rehabilitation, Outlying Hospital)

Ward 5 (Assessment and Rehabilitation, Outlying Hospital)

Ward 84 (Acute, General Hospital)

Ward 86 (Acute, General Hospital)

This means that the research was undertaken in two different hospitals, managed by the same medical director and senior nursing, therapy and operational managers.

During the preliminary period of the study the disciplines identified as directly involved in *most* patient assessment and care on a regular basis included: social work , medicine , nursing , occupational therapy , physiotherapy. How these disciplines worked together over patient care formed the focus of the study. However, from preliminary discussion, it appeared that charge nurses/ ward sisters (most of whom were called ward managers), consultant geriatricians, who doubled up as clinical directors, the therapy supervisors and the hospital managers themselves (also nurses) could also be understood to represent management. Accordingly both hospital managers as well as ward managers, clinical directors and therapy supervisors were interviewed to help further inform my understandings of the *organisational* context of multi-disciplinary practices.

Until the interviews were conducted, it did not come to light that the hospital managers were in fact only *directly* responsible for nursing staff. This makes an interesting issue in its own right: how managerial concerns can be seen to be distributed amongst the different disciplinary groups, none of whom have any *clinical* authority over the other. All the groups were of course answerable to the Trust Chief Executive in terms of efficiency criteria.

The subjects of the research were studied in a number of ways, these included interviews, focus groups (or group interviews), participant observation of the occasions in which practitioners meet to discuss patients, and examination of inpatient records. Some of the interviews, focus groups and case conferences were tape recorded. In addition, I met with many practitioners of each discipline on numerous visits to each site, talked with them and watched what they did. Unfortunately the limited budget and the concerns of the project group meant that patients were not directly included in the research. This was the choice of the project team and reflects how patients are not featured as participants in assessment and planning.

All interview and case conference material was transcribed. This material along with copies of inpatient documentation, and notes from episodes of participant observation have been analysed using a constant comparative method. With Silverman (1987, 1993.) Specific analytic methods used are drawn from conversation analysis (Schlegloff, 1991; Silverman 1987, 1993) and discourse analysis (Deetz, 1992; Silverman 1993).

Organisational context

The processes of organisation concerned with identification of patients' needs and planning care are discussed in this section in relation to some important features of the settings.

The settings

The pilot sites are located in two different hospitals which are both part of the elderly care directorate. However, the occupational therapy and physiotherapy departments serving these sites are managed through the primary care directorate, or the 'community', as some people refer to it. These departments have service level agreements with the elderly care directorate.

The four sites included three wards, two at the General Hospital, called 'the General', and one at Outlying Hospital, as well as the Day Hospital at Outlying Hospital.

These locations are all very different from each other and reflect the different place of each in relation to the overall services to the elderly. We move from the two wards at the General, and acute medical environments, where patients spend most of their day in or at the bedside, even though they may be dressed, through to the Day Hospital where there are no beds, only treatment and examination couches and patients are day visitors. At the General life revolves around patients' beds, whereas at the Outlying Hospital, there is a more 'naturalistic environment', with patients and nurses sitting, sometimes together, in verandas, sitting rooms, and around fire places and tables. Correspondingly there are more doctors available at the General than at the Outlying Hospital.

The wards at the General have a history which associates them with both acute medicine and rehabilitation. For some practitioners their identity as caring for people who are acutely ill is of great importance. For example, I was corrected on several occasions for referring to consultants as geriatricians: I was told that they were physicians, with an interest in geriatric medicine. Similarly nurses emphasised that patients could be elderly, with chronic multiple pathologies, but that they were acutely ill.

The association of the wards at the General with acute medicine, means that they are also exposed to pressure on beds and the perennial problem of increasing throughput rates to free up medical beds in the acute Trust. At the time of the research there was pressure to recognise this situation and take it more seriously. This pressure was extended through a length of stay audit and by identifying patients who could be moved to the Outlying Hospital or nursing homes for rehabilitation and multi-agency assessment early rather than late.

In contrast, Outlying Hospital is historically associated with slower stream rehabilitation, and in previous years, with continuing care. There is emerging pressure to increase throughput in this location as well so that there can be increased flow of patients within the elderly care directorate.

However, the research material suggests that practitioners across both hospital settings, are committed to ensuring that the older people in their care get access to the best medical treatment, and do not get categorised simply as 'geriatric' (see Latimer 2000b). This is a very important feature of the setting, but it does mean that a 'rehabilitation' as opposed to a biomedical ethos is not yet fully operational.

The global and the local: warring or complementary agendas?

There seemed to be an emerging pressure to change the functions of the different sites, to make the General more focused as an acute, fast track medical and rehabilitation unit, moving patients on to the Outlying Hospital for continuing and slower track rehabilitation.

For some practitioners, in each of the disciplines, the two hospital settings work as interrelated to each other: the ways in which these people spoke about and organised themselves made it clear that, while they consider the two hospitals as having different places in the service, there is an interface between them which can be managed productively.

Further, the ways in which this interface is to be managed, according to these participants, cannot be understood without reference to two other 'institutional' interfaces. These include the interface with the community on the one hand, the place where people come from and, hopefully, go to, and the acute Trust on the other. These participants see the two hospitals in this context, as offering different aspects of the same service, but also as no more than a *passage*, between these other contexts.

I will call this the *global* view of the service. In this view the aims of the service are not just about ensuring that each individual patient gets what they need, but that *populations* of patients are getting what they need. In this sense, then, this view is in line with a managerial concern for adequate patient turnover, to ensure that patients who need hospital care can get access to it. In terms of what practitioners said to me, while this view has begun to impact more directly only recently within The Outlying Hospital, most practitioners said that they are all well aware of the pressure to get patients through. As one participant put it 'it is all about turnover these days'.

However, it should be noted that while all practitioners are affected by this view of the service, it is, according to interviewees, only some disciplines whose performance is judged on them meeting certain targets. At present, rather than it being *overtly* in the interests of all the disciplines, it is only explicitly medical practitioners who have contracts which measure their performance in relation to numbers of patient episodes. But this is not to infer that doctors alone are accountable for accomplishing throughput: through practitioners' talk and the ways in which case conferences are conducted, it is clear that responsibility for different aspects of patient assessment and care, and particularly those practises which enhance the discharge process, is 'divided' up, or distributed, between the disciplines.

How the work, and at times it would seem the patient, is distributed forms the focus of multi-disciplinary team working. It should be emphasised, that these divisions are sometimes spoken about as if they are stable and easily identified, they are treated as self-evident, but in practice it is these divisions that practitioners are in many ways continuously accomplishing through their interactions.

The global view does not exclude, but does certainly contrast with what can be called a more *local* view of the service. This view is focused on patients as individuals, whose needs are very specific. From this view, it is the particular circumstances of patients which must be taken into consideration, even in the face of more global concerns. Arguments over the individual needs of patients can be mobilised very forcefully and persuasively. Tension between these two views, could arise for example, over transferring a patient from the General for continuing rehabilitation at The Outlying Hospital. Someone taking the global view might argue that the patient is no longer acutely ill, that their prospects for rehabilitation are slow, and that they must be moved to a slower track rehabilitation centre, e.g. The Outlying Hospital, to clear the bed. Whereas someone with the local view might argue that the patient needs to stay with the same team for their rehabilitation, that their progress will be badly affected by such disruption and change, that it is too far for their relatives to travel to visit, etc.

It is easy to dismiss the local view merely as arguments which help maintain the status quo, as a form of resistance to change. But in a well rounded service, these arguments may have their place, they are not just conservative but also *conservationist*. They help to conserve some of the principles which help inform a professional as opposed to a bald managerial organisational ethos. The tension between the global and the local is not necessarily negative: it can work both ways for quality of patient care where it provides a balance so that neither view is allowed to run away with the other. But this depends very much on the arguments used to legitimate each view and how much these are acceptable. Indeed, through making some practitioners, such as clinical directors and ward managers, have both managerial and clinical responsibility for patient care, there is an attempt to *embody* these two views.

The global and the local are two value systems about the purpose of the service. How practitioners enrol each other in each system is critical to understanding how practitioners interact and what they accomplish through their interactions. It should be stressed, that some participants quite clearly already have a view to balancing the local and the global in their ways of working, while for others the balance is accomplished precisely through working together with people who hold different views.

Patterns of organisation within each discipline

The ways in which the disciplines work internally is important to understanding why they might work with people outside their disciplines in particular ways. How each discipline organises itself and the ways in which each discipline views itself, is now discussed.

Social workers:

A social worker is allocated to each ward (a multitude of community social workers have responsibility for patients attending the day hospital, they were not included in the study). Some social workers are part-time, all social workers have to cover emergencies while other social workers are away or out of the office. Emergency calls from the community take priority over hospital in-patient work.

Social work is based at the Outlying Hospital, in the old Ward 12. The two social workers covering the wards at the General Hospital do not have offices there, but operate mainly from the Outlying Hospital. While they visit their wards a few times a week, the telephone emerges as a key means of communication for them. They do their telephoning work mainly from the Outlying Hospital, to relatives and agencies in the community, so they keep all their records at the Outlying Hospital.

Referral and assessment

Social workers 'pick-up' patients mainly through their attendance at ward rounds and case conferences. They said their involvement in patient care is usually over a patient's discharge, in terms of how a patient is going to be able to live at home, or if not at home, where they are going to be able to live. Increasingly they are involved in conducting multiple agency assessment (MAA). In general they said that they have little involvement in the on-going treatment and care of patients in hospital. This was borne out by observations where the social workers did not attend to what doctors were doing on ward rounds on those occasions where the patient had been identified as 'medical'. This indicates that some social workers rely to some extent on the other disciplines' assessment of a patient's psycho-social situation to indicate the need for their own involvement.

To do their assessments they speak with patients and their carers and relatives, as well as practitioners of other disciplinary groups, about a patient's living arrangements, and the resources and support he/she has or, in the case of carers, is able to give. For multi-agency assessment they also obtain written assessments from each of the other disciplines involved in the patient's care and do a financial assessment of the patient. Their aim is not just to ensure that the patient has the adequate resources to be supported at home, but to ensure that the patient is going to be discharged to the environment they want to be discharged to. They also follow-up patients who have had community care packages after they have been discharged.

The social workers I spoke with expressed very mixed views over how their work has changed since the introduction of multi-agency assessment and increasing amounts of report work. For some, their view was that in many ways their work was no longer 'social work', but it was about co-ordinating and arranging, and involved continuously filling-in forms to account for their practices. For some the lack of a therapeutic counselling dimension to their work was a

problem. Others expressed real enjoyment over the counselling aspects of their work, which, while not necessarily therapeutic, were focused on helping and supporting patients, carers and families over their decisions about their future lives and getting arrangements for this future right for them.

Who do they talk to/who listens?

The social workers interviewed said that they found that it was helpful and necessary for them to have an up to date view of the patient from a medical, nursing and therapy perspective, as they need to know a patient's limitations and what their future may hold in terms of recovery and function. They feel that they liaise most closely with patients and their carers over discharge arrangements, but when a patient is going home they also work with nurses and occupational therapists.

Social workers also talk and report to their managers about their cases, but in many ways they work as individual practitioners, but have to document every detail of their work. This situation is very different from the other disciplines, in that social workers do not have anyone under them to assist them, so they are not at the practitioner level at least, having to supervise, develop or manage practitioners.

In brief, social workers interface with many people, both inside and outside the hospital environment. One way of looking at this is that any patients' access to community care, other than nursing and medical care, is through the social worker. This means that the social worker liaises with the patient, their carer or family, and hospital staff on the one side, and with community services and residential/nursing home staff on the other.

The purpose of social work

Social workers can be seen as helping to accomplish the global objective of maintaining adequate throughput because they are mainly involved in discharge aspects of assessment and care. However, they also help balance the global view with the local view in that they emphasise how they feel that they act as the advocates of patients' and carers' perspectives, not over treatment and care within the hospital, but over discharge arrangements.

Social workers help provide the tension which holds the patient's long-term life arrangements in view, not just in terms of clearing a bed, but in terms of their future as persons, rather than just as people who are ill or who are recovering from illness. While they support one aspect of the global agenda - that the patient's hospital stay is always only temporary, that the hospital is merely a passage - their value system can be referred to as a 'community view'

stressing the patient's view in its social and psychological context. (Silverman 1987: 201)

Here the patient is considered not so much as ill, but as a person, with a future, to whom professionals are also accountable.

This value system occasionally leads to a social worker insisting on the postponement of a patient's discharge. Their argument here is that the patient and their families need time to come to terms with changing situations, and for the patient and carer or family to 'assess' what *they* want and need in the future. Some social workers expressed this as ensuring that patients had 'real choices' over their future living arrangements¹. Here the multiple, and potentially conflicting, temporalities (Adam, 1995) at stake in hospital work is evident: the 'social time' of patients and families seems to be in direct opposition to managerial times. The community view helps advocate the social time of patients and their families.

In terms of dividing up the work, the social workers help define a patient's past, present and future social situation, but they are trying to do this through working most closely with the

patient and their family or carer as persons, rather than just bodies.

Nurses²

Nurses represent the largest group involved in patient care. Within nursing there was much diversity of understanding and views.

Systems for organising patient assessment and care

Nurses have been concerned to establish a 'team nursing' system of organisation in each of the wards in the study³. A patient is admitted under the care of a team. The team leader, or a named nurse within the team, is responsible for assessing the patient, liaison with other disciplines, assembling a care plan, and organising the delivery of care herself or by delegating to other practitioners in the team. The team leader also appraises team members and negotiates off-duty with the ward manager. Like collaborative care planning, team nursing appears to be part of the democratisation of medical work. Team nursing helps flatten (not completely) the nursing hierarchy at the operational level to refigure qualified nurses as individual practitioners, with accountability in their own right. Previously only the Ward Sister or Charge Nurse had this status. However alongside the devolution of work down the nursing hierarchy is the introduction of more and more standardisation over patient care: this means that at the same time as more junior nurses get more and more responsibility, their autonomy and discretion is increasingly regulated.

Nurses tell each other about patients at regular change of shift reports, usually the early morning change over is done at the bed side, from team nurse to team nurse, and is quite brief, while the midday change of shift report includes all the qualified nurses and takes place in the office or day room.

The labour within the nursing team is divided between what health care assistants can do and what qualified nurses can do. This varies across different locations and perhaps across different patients. For example, Sister in the Day Hospital was considering whether a health care assistant could be trained to take bloods, while at the General taking bloods is a qualified nurse's job. Roughly speaking, assessment, liaison, and planning are undertaken by the qualified nurses, but taking into account the views and observations of health care assistants. Qualified nurses also carry out investigations, do dressings, administer medications and arrange discharges etc. While the health care assistants do what is traditionally thought of as the hands on care, such as washing, helping people with dressing and eating, and mobilising.

Managing nursing

Ward sisters in some sites are now designated ward managers. The extent to which the ward managers feel that they are clinical practitioners as well as managers varied. Some felt that they should be more and more in the office than on the ward - what they termed 'in here' rather than 'out there'. Whereas others saw that the work going on 'in here' was merely a supplement to help facilitate the work that they do 'out there'.

There seems to be an emergent trend towards pushing more and more of what used to be thought of as managing work further and further down into the lower grades. The D and E grades are already responsible for managing the care of their patients, including liaison with other disciplines and services. But in some wards D grades are also increasingly becoming responsible for managing their staff. For example, some team leaders may be compiling staff rosters and appraising practitioners in their team. The rationale given here is connected to staff development and a flattening of hierarchy, but the consequences may be problematic in terms of relating to other disciplines. For example, an inexperienced staff nurse may end up on a ward round with a senior consultant, where there is such asymmetry in status having a meaningful dialogue can be difficult to accomplish unless it is initiated by the consultant.

Many nurses said they like the team nursing approach. Their reasons ranged from feeling that, theoretically at least, they have less patients and can therefore focus more on patients as individuals, and that care is more consistent, efficient and timely. However, some nurses also expressed the view that they are working in a skill mix situation which is inadequate to fully operate a team nursing approach. They are being given more and more responsibility while feeling that they also want to provide adequate bedside care. This appears to be adding to nurses' stress (and some nurses were quite clearly feeling very stressed). For example, in the acute wards at the General there can be shifts when one qualified nurse is on duty with health care assistants. Under these circumstances, the qualified nurse has to cover all the work of the other teams designated as the work of 'qualifieds'. This had led to times and incidents which the nurses felt were dangerous and unsatisfactory. In this respect there were differences between the two hospital sites which perhaps relate to the different types of service discussed in earlier.

Who do they talk to/who listens?

Patient assessment, according to the nurses, relies on talking with and observing the patient, talking with their family or carers, and talking to the other practitioners of their team. They also take into account doctors' views and the results of investigations, and through talking to the other disciplines involved in their care, once they have done their assessments.

From what the nurses said and from their documentation, they do not formally assess patients' functions, but rather see how they manage and wait for physiotherapists or occupational therapists to assess patients' functional aptitude and mobility. In this way some of the nursing is reactive rather than proactive. However, the nurses said that they would appreciate being given information about patients mobility early rather than late. This seems to relate directly to whether or not the physiotherapists and occupational therapists come to the wards and spend time there.

All the nurses in the study seemed to think it would help to have the other disciplines write on the nursing care plan or communication sheet. Some mobilised the idea of accountability to patients: they claimed that patients and their families themselves could then read about what therapy is being given and, importantly, *why* it is being done.

The purpose of nursing

There was a great deal of variety over what nurses felt nursing was for. For some of the nurses, their on-going assessment of patients is very much focused on how patients are coping, their recovery of function and at picking up what they can about their home situations and their chances of coping in that situation. Like the social workers, a few nurses are focused on how their care for patients in the present can help the patient accomplish the future they want. While other nurses are much more focused on patients as ill, as bodies, rather than as persons with futures, and as needing to be cared for.

Nurses define their work very much in terms of what they do for patients and how much they care about them. But what is interesting about the nurses' talk is that they all see themselves as wanting to help patients to get what practitioners of other disciplines have to offer patients. That is, they talk about themselves not just as caring for patients, but as ensuring that the care or the treatments that other people have to offer, get to them as well. So organising the workplace and the other practitioners within that workplace, is very much part of what nurses say they are there for. Some of them of course complain about this aspect of their work, while others simply emphasise its' importance.

Working with others

Some nurses seem to depend upon other people's assessments to plan their own care of patients. From what they say in interviews, and from observing them, making sense of what others' think about patients is all part of helping them know what patients need. But this has two aspects.

For some it is simply that they will include methods of care in their process of working with patients. For example, they will stand patients in a certain way if the physiotherapists tell them to. They almost take these as instructions, and appear to be willing to do so. Whereas other nurses say that while these 'instructions' are important, they also say that knowing what others think about patients actually changes how they see patients. This is not simply so that they unquestioningly agree with what the other person thinks should be done, but it gives them a chance to understand better where that other person 'is coming from'.

Because the named nurse or team leader is now responsible for liaison with other disciplines, she or he will attend the ward rounds or case conferences. This may mean that a junior nurse is in a position of conferring with senior practitioners from other disciplines. The rationale for this situation, according to some ward managers, is that they are developing their staff. Some ward managers keep a close eye on this situation and have methods for checking that their staff are able to cope, like attending the ward round themselves. While others express the idea that if Sister, the 'blue dress', is on the ward round the doctors will not talk to the team leaders.

Documentation

In two out of the three ward sites, the care plans were kept at the end of the patients beds. For all the wards the communication sheets are kept at the ends of the beds. These sheets cover anything that has been discussed or done. Some aspects of the care plans are standardised, while others are written especially for the individual patient. If kept at the end of the bed, patients and their families read these sheets.

Different nurses have different reasons for these arrangements. For example, one ward manager said 'knowledge is power': for her, openness and a lack of secrecy were paramount. She felt that patients and relatives should be able to 'see' what nurses are doing and why they are doing it, that they are participants in their own care programme. By making nursing visible, she said, nurses are being more accountable to patients as well as to each other and to managers. In contrast, other nurses are concerned with confidentiality and with patients finding things out about themselves before they or their relatives are adequately prepared. In this view, a nurse is their to protect a patient, and is able to decide what is in their best interest on their behalf.

Occupational Therapists

Occupational therapists work closely with each other and with their assistants. Like nurses they have regular meetings through the day in which they discuss patients and plan care.

Referral and patient assessment

Occupational therapists said that they basically operate a 'blanket' referral system: they assess all new admissions to the wards and to the day hospital (many day hospital patients obviously are already known to them as they come from the ward or post-discharge from the wards). They pick up patients by visiting the wards and seeing who is new. They then fill out a card and arrange for a time to do an initial assessment. This usually constitutes a dressing assessment. Here the aim is to see what the patient can and cannot do, talk to them and observe them, while they are trying to do something very ordinary and everyday, that is get

dressed. From this assessment they may take the patient to the occupational therapy department to do further assessments, like tea making etc.

Their focus is on how the patient can manage day to day activities, like getting in and out of bed, washing, getting dressed, eating and drinking, cooking, transferring, reading a book, turning on a light. In other words, all the day to day practical activities that are normally taken for granted. They then plan a course of therapy, exercises and practices, as well as the introduction of aids, such as eating implements, which are designed to enable the person to overcome the limitations of any disability, by helping them to adapt or by finding new ways of doing things, and through adapting and modifying their environment. Where they feel it is helpful, they will involve families and carers in the practice and treatment sessions, particularly over matters such as transfers, food preparation and eating.

Another key aspect of their work is where there is some question over a patient's ability to manage at home. In this situation they arrange and carry out a visit to the home. Here they assess how patients manage these day to day activities in their own environment, and what adaptations to the environment may be needed, such as raising the bed or fitting bath handles. A home assessment may be undertaken with community staff, such as home care organisers. The need for a home visit is not decided upon by the occupational therapist themselves, but is usually decided upon at case conferences/ward rounds.

Systems for organising care

The labour is divided in occupational therapy in ways similar to nursing: the qualified occupational therapists assess patients in hospital and at home, and plan treatments, while the assistants carry out many of the treatments and practice sessions. As in nursing, the assistants give feedback on their impressions of patients at the team meetings. These occur at the beginning of the morning and in the afternoon.

The purpose of occupational therapy

The occupational therapists, like the social workers, focus very much on what one of them described as where the patient is 'headed'. Rather than care for patients, they are focused on enabling and empowering patients.

Occupational therapists feel they must prioritise the home assessments and the treatment of in-patients who have a chance of returning home. In a sense they feel that they are not using many of their skills and fulfilling many of their ideals in that their assessments are basic, and do not involve the wider view of the patient and their lifestyle. While they maintain their concern over helping a patient to adjust and cope with disability, to live as full a life as possible, they feel that they are compelled to focus on more narrow concerns (function, safety and throughput), rather than take a wider view of identity in terms of meaningful lifestyles and quality of life. However, in relation to some day hospital patients, such as the Parkinson's Disease programme, there is a feeling that they are able to accomplish more over these aspects of patient care.

Like social workers, while their work is partly compelled by the organisational pressure for discharge, occupational therapists appear to try to balance the global view and the pressure for movement and throughput, with a focus on the patient as an individual, but not on them as just 'ill', but as a person with a future. They too then supply a particular community view of patients as an experiencing person with a future life beyond illness, or, at least, living with illness and disability. This may mean that, on occasions, like the social workers, they insist on a patient being given more time to adapt to their situation and make choices.

Working with others

To assess and plan care, the occupational therapists said that they need to have an up to

date understanding of the medical and nursing situation of the patient. They try to work closely with nurses and physiotherapists. They do this outside of the ward rounds and case conferences, through their visits to the wards, for dressing assessments and practice, and through their close proximity to physiotherapists in the day hospitals.

In the day hospital, occupational therapists, physiotherapists and nurses work very closely together, meeting several times a week to discuss different groups of patients. It is interesting that both the therapies allow assistants to represent their disciplines in some meetings over patient care. During the research period there had been some difficulty over physiotherapists being present at either case conferences or ward rounds at The Outlying Hospital, but the occupational therapists said that they often fed back to the physiotherapists after these events, and took these opportunities to catch up and compare notes on in-patients.

Who do they talk to/who listens?

Occupational therapists were sceptical about who apart from patients and carers, the nurses, and the physiotherapists listened to them over patient care. They expressed the view that what they did or had to say was not particularly valued by some of the medical staff, except over their input to accomplishing a discharge. They feel that practitioners of other disciplines do not really know what they do, nor do they understand the basis of their assessments and treatments.

They said that they talk mainly with patients and their relatives, and with nurses and physiotherapists, as well as each other, about patients.

Physiotherapists

At the time of the research there were tensions within physiotherapy. These tensions were explained as due in part to a shortage of physiotherapy staff and in part to a clash between physiotherapy and some medical practitioners. This clash derived from some doctors' lack of regard for physiotherapists professional autonomy and discretion. One senior physiotherapist wept in her interview with me - she expressed a great deal of bitterness and frustration. These tensions made it difficult to 'see' physiotherapy organisation and practise.

Referral and systems of organising

Physiotherapists are ward allocated. Like occupational therapists, physiotherapists operate a blanket referral system and assess all patients admitted to the wards and the day hospital.

Physiotherapists assess patients according to their diagnosis, their history and a physical and psycho-social examination. Treatments are planned to be carried out on the ward or in the department in the day hospitals, depending on the type of work. Frequently it is the assistants who carry out the treatments, while the qualified staff supervise and evaluate progress as well as assess.

Patient assessment

The foci of physiotherapy are chests, and the mobility of patients. Physiotherapy focuses on function but in a different way from nursing and occupational therapy. Physiotherapists feel it is very important that nurses and OT's communicate with them over how they are helping patients because they can, unwittingly, work against what they are trying to achieve.

Their assessment is focused on how a patient is able to move their body in relation to how a normal body moves, and their treatments are directed at helping the body to return to normal function. In this sense rather than being only remedial (and there are some situations where remedial or adaptation work is all the physiotherapist may be able to accomplish), treatment is directed at practices which will accomplish a 'cure'.

The purpose of physiotherapy

Physiotherapists are concerned with helping the patient to live a normal, or near normal life, through helping patients to regain normal function of the body. As one physiotherapist put it:

I can give him [a patient] back the building blocks of movement that will allow him to walk up and down the stairs safely.

Another physiotherapist made a different distinction, and said that: 'we divide the body up between us: OT's take the upper limbs, while physiotherapists take the lower limbs'. As physiotherapist put it:

At the end of the day the people who are expected to get the patient on their feet and walking are the physios. So I suppose a lot of time and energy is spent on finding the most effective ways of doing that where somebody will actually stay on their feet and walking.

Like occupational therapists, some physiotherapists feel that their work is compelled to a narrow focus by the organisational pressure for throughput. As one respondent put it to me:

The priority is in-patients first. We need to keep the turnover on the beds going, we need to put the input there so we have to put all efforts into those

Working with others

All the physiotherapists said that they talk with nurses and occupational therapists, but the reasons differed. Some said it is because they are aiming not simply to help the patient adapt and find ways to function, within the limits of disability, but actually wherever possible, to re-educate the body and they need to communicate with these practitioners to ensure that they know what the physiotherapist is doing.

However, some physiotherapists have a slightly different view, which works more closely within the conditions of possibility, as they pick these up from other practitioners of the disciplinary team: they realise that it is important for them to know the full medical, occupational therapy and nursing view of the patient, so that they can adapt their methods to suit the individual situation. They recognise that it is the very issue of *possibility* which is frequently ambiguous and arbitrary in the care of ill and disabled older people.

Who do physiotherapists talk to/who listens?

Some physiotherapists said that they talked to the nurses and the occupational therapists, and that nurses and occupational therapists listened. Some felt that not all doctors listen and that at present they could not speak to them anyway on ward round or at case conferences due to time constraints, but sent notes to ward rounds updating on treatment and assessment issues.

Doctors

There is variety in the ways in which medicine is conducted in the directorate.

Assessment and the organisation of care

On analysis of interview material it emerges that the two main systems for organising the medical assessment and treatment of patients are very visible and open to view: that is the ward rounds and the medical notes.

Patients admitted to the wards are examined and a history taken by the doctor covering the ward (either a staff grade doctor, registrar or house officer). At the General the doctors do not just cover the elderly care unit, but also have two and half medical wards to cover. They are therefore responsible for taking younger acute medical patients as well as older patients. Where possible they move older acutely ill patients to the elderly care unit, to help free up the

acute medical beds in the medical directorate, and to ensure that the older people have the rehabilitation services available to them. This is partly done on the principle that these patients may take longer to rehabilitate than younger acutely ill patients.

Patients at the General are mainly admitted from the medical admissions unit, from medical wards, and from the community (either the patients home, or from a nursing/residential) or sometimes a continuing care unit. Some of these patients are what are called 'domiciliaries', that is they have been assessed by a consultant at home and admitted by them. Patients are admitted to the ward at The Outlying Hospital from the General arm of the elderly care unit or from the other locations mentioned above.

The general day to day treatment and investigating of patients is done by junior doctors. However, their work is more or less directed by the consultants and it has to be said by the nursing staff in their absence.

The ward round is the location when the consultant assesses, decides the treatment of patients and evaluates progress. Like the nurses' handovers and the occupational therapists team meetings, these occasions are important to the functioning and regulation of standards: they enable evaluation and reassessment of patient care, reporting and supervision work, as well as education and staff development. The medical notes are used very much as a record of these rounds and for communicating instructions over investigations, treatment and care. In a sense the ward rounds serve as the arena through which the consultant themselves directs the treatment and investigation of each patient but are also a critical part of junior doctors training. Usually nurses also attend medical ward rounds.

Consultant ward rounds at the General occur twice a week, while at The Outlying Hospital the consultant goes around once a week, and the staff grade doctors goes around on one other occasion each week. However, the junior doctors it must be emphasised are in daily contact with the wards, visiting them several times a day. Several of the consultants also said that they check for and visit new admissions as soon as possible outside the usual ward round times, or might just visit the ward to catch up on something, or because they have been asked by the nurses or doctors to do so. This they said could happen once a week.

The consultants direct the investigation and medical treatment of each patient. Either the junior medical staff go around with the consultant, and/or the consultants write in the notes their opinions and instructions. Some consultant were sceptical about how much junior doctors always followed through their instructions, and they had cross-checks on this. For example, they did their own discharge summaries. One of them described this work as a form of medical audit, which, although time consuming, meant that they could pick up on things which were missed or simply done wrongly, to help them to identify processes which needed adjustment, and to put systems into place to make sure things did not get missed in the future. As far as I could ascertain no patients are discharged by junior medical staff without the permission of the consultant.

The nurses also seem to help keep close tabs on what the junior doctors are doing. On the whole the impression was that the nurses, who also accompany the doctors ward rounds, help, in the consultants absence, ensure that patients get the investigations and treatments requested by the consultants. For example, at the nurses change of shift reports there are concerns with checking that investigations have been booked and/or carried out and with whether other matters have been attended to by the junior doctors. Added to this the nurses post requests and reminders on the doctors memo boards for their attention.

Who do they talk to/Who listens?

Consultants mainly talk to patients, relatives, other doctors, secretaries, and nurses about treatment and care. Outside of the multi-disciplinary occasions they said they do not talk much to practitioners of other disciplines. One of them said that sometimes they are not sure

who listens, while others said that they think that nurses and patients listen. Some of the doctors said they see their talk in terms of overseeing and training their junior colleagues, and the giving of instructions. One doctor said that they felt that they never stopped talking with people.

The purpose of medicine

For some of the doctors the primary importance and focus is to try to ensure that patients have their medical problems thoroughly investigated and treated. Their own reluctance to allow more junior staff to decide over the matter of discharge can be seen in this light: as an aspect of their conscientiousness, as well as their insistence on holding on to the power.

There are very different views within the medical staff over what constitutes the remit of 'medicine'. These differences could be divided into the purists and the all-rounders, while some vacillate between the two.

All the doctors have a view that patient medical needs can be assessed and decisions over their medical treatment taken in the absence of understandings provided by the other disciplines. Diagnosing and patient treatment are based upon rational and objective clinical evidence. But some doctors are more purist than others.

The purists seem to have a view that there can be a separation between medicine and rehabilitation. In this way some patients are described as 'medical'. For these doctors, the details of rehabilitation are their concern, but their focus is on the outcomes of rehabilitation and social assessment, because it is these outcomes which enable a patient's discharge and enable the place of discharge to be decided. Views from other disciplines do not affect their medical assessment, but have to be fitted into such categories as a patient's mobilisation, function, mental/emotional state, resources and future care. Other doctors, the all-rounders, allow that there are grey areas of diagnosis and treatment which are influenced by the non-medical aspects of patients, for example pain control.

All the medical practitioners insist on the importance of ensuring that older people receive equitable access to medical care. This value system can be seen as a device through which to reproduce medical eminence. But it can also be seen as of great importance in a health service under strain with an increasingly explicit rationing of resources: this value system can help protect older people's access to specialist medical diagnosis as an important life chance (see also Latimer 2000b). So that on occasion, a doctor's insistence on the primacy of the clinical view is not to the exclusion of other views, but is their way of protecting a patients' interests.

Working with others

All of the doctors emphasised the importance of multi-disciplinary working. However, they saw this as mainly occurring within the ward round or case conference structure. With one exception, they did not really see themselves as working closely with other practitioners of other disciplines, although some of the doctors said that they believed that they were accessible to the nurses.

Summary

The ways in which the different practitioners organise themselves and the purpose of their work has been presented. Themes have emerged to do with how responsibility for different aspects of a patient's needs and care are divided between the disciplines. What is important to emphasise is that each discipline in its methods of organising, whether these be a team model or a delegation model, imposes its own demands on practice: for each there must be methods and occasions through which to evaluate and reassess patients and care/treatment, to allow reporting and supervision work, as well as education and staff development. Coupled with this the different value systems, summarised as the global, the local and the community view,

provide grounds for very different forms of accountability. The disciplinary boundaries which seem to be resolved are those between physiotherapy and occupational therapy, and to some extent between nursing and medicine. Whereas those between medicine, management and a community view, expressed by the social workers and the occupational therapists, seem to be more complicated and unresolved. Here a tension emerges between the need for throughput, for adequate rehabilitation and the need to appreciate that the patient is being discharged, to live as a person with a future.

In the following section the ways in which the different practitioners work together is presented and discussed.

Multi-disciplinary interaction

The ways in which practitioners of each discipline organise and view themselves has been discussed. This section focuses on those occasions in which practitioners interact over the assessment of patients and the organisation of care.

The occasions when people meet to talk about patients include the following:

- Day to day, ad hoc encounters
- Multi-disciplinary consultant ward rounds
- Multi-disciplinary case conferences
- Medical ward rounds
- Multi-disciplinary case conferences - at which no medical staff were present⁴.

These occasions are configured in different ways for the four different sites. For example, one consultant does a case conference followed by a medical ward round at the General, but holds a multi-disciplinary ward round with no case conference at The Outlying Hospital. From interviews with the consultants, the ways in which these matters are organised has been evolved by them, sometimes in response to discussions with other practitioners. One senior doctor's comments imply that the process is not discussed or regularly reviewed with all practitioners concerned.

The following analysis draws on interviews, participant observation of ward rounds and case conferences, and the transcriptions of tape recordings of case conferences. It must be emphasised that the analysis here is based on practitioners' accounts and on those events in which multi-disciplinary working was observable at the time of the study.

Ad hoc encounters

Day to day encounters include chance encounters and ad hoc meetings. Although the research included minimal participant observation of these occasions, many practitioners mentioned them in their interviews. The extent to which practitioners feel that they work in ways that make them accessible, and bring about occasions through which to allow others access to them, came up as a subject of importance. Many practitioners consider these day to day encounters as much more than chance meetings: some are arranged by practitioners as part of their day to day work.

For example, some therapists are aware that their visits around patients act as important opportunities to talk to ward staff. They make a point of using these ward visits to catch up on the medical and nursing views of patients, on new admissions, on patient's progress and on any changes, as well as communicate what they themselves are up to. For example, one physiotherapist said that, while she did not officially attend medical ward rounds, she tried to make sure that she was available on the ward at the time of medical ward rounds, 'in case they wanted to ask her anything'.

Nurses very much appreciate this accessibility because through it they also find out what treatment and care other practitioners are giving patients. One practitioner described this as

'keeping in touch'. However, the willingness or interest expressed by practitioners in interviews in managing work time to allow for such meetings with other practitioners emerges as widely varied. There are a number of constraints (these are discussed in the next section).

Presence it must be emphasised does not equate with accessibility: accessibility is a matter of conduct. As one practitioner put it, people can act to let other people in, or to keep them out. For example, several practitioners expressed the view that they deliberately make themselves approachable, and that they make themselves and their understandings *accessible*. In interviews with other practitioners it emerged that some people for them were approachable, and accessible, while others definitely were not.

Members then make it quite clear that while we typically think of these occasions as informal, they are in many ways *brought about* by practitioners through the very ways in which they organise and conduct themselves.

From what practitioners said accessibility is variable and is dependent on how they see what other people have to say as part of their work or as getting in the way of their work. This in itself may vary from day to day and with the pressures of work. For example, for some practitioners ad hoc encounters are what they avoid when they are under pressure, while for others it is the report work that has to go, in order to maintain access and contact. While for other practitioners again it is through this work that they attempt to get to know and understand things about patients, which they then absorb into their own view of the patients and the ways in which they care for them. For others again it is through these occasions that there may be an opportunity to check up on things, pick up on potential trouble or get other practitioners to change their point of view, to see things differently.

In brief, there is great variation in how accessible practitioners feel other practitioners are and over what matters. A critical point was made by some practitioners over the ways in which some people make, or do not make, their work accessible, through their written statements about patients: while some practitioners write for others to read, some participants make their understandings and view inaccessible, because they are written in disciplinary code or jargon. In this way making understandings accessible, is also connected to making practices accountable to others: inaccessibility is seen as a way of concealing and hiding, as a method of avoiding the scrutiny of others, of remaining invisible.

Informal inter-disciplinary occasions help practitioners accomplish multi-disciplinary patient assessment and care. However, like the ward rounds themselves, the ways in which practitioners conduct such occasions varies enormously to reflect complex matters of ethos and discipline.

Structural constraints on interaction

Structural constraints on ways in which different groups of practitioners interact include:

- Methods of patient allocation - practitioners can find themselves working with different sets of practitioners over different groups of patients.
- Part-time working, and inflexibility over hours as well as shortages of staff (particularly in physiotherapy and in medicine at The Outlying Hospital) - leads to additional constraints over cross-disciplinary communication.
- Limited access to assessment and care plans of other disciplines
- Where there is access, the use of disciplinary jargon can limit understanding
- Demands of within discipline organisation (e.g. team-working and delegation)

The conduct of multi-disciplinary ward rounds and case conferences

Some ward rounds are multi-disciplinary, that is each discipline is represented on the ward round. In this method of organisation the group of people concerned travel from patient to patient, with the notes trolley. There is sometimes also a 'mini case conference', either at the

beginning of the round or at the end, which takes place in the doctor's room or day room.

The round is composed of doctors, nurses, occupational therapists, social workers and, at the General, the physiotherapists. It should also be noted that a practitioner of the community nurse liaison group and the respite care Sister regularly attend case conferences/ward rounds. Physiotherapists do not attend the ward rounds at The Outlying Hospital, but send a written statement concerning their assessment and treatment of each patient. Nurses have a ward round book which they write in, and use to pass information on to other nurses.

The multi-disciplinary case conferences occur before or after a consultant's *medical* ward round. Physiotherapists do not attend the case conferences at The Outlying Hospital, but send a written statement about each patient.

Case conferences and ward rounds are usually organised around the nursing teams, so that the team nurse for each team can participate in the relevant part of the round for their patients. Sometimes tea or coffee is served at the case conference, making it a slightly more social occasion.

These groups do not only work together, they come together in different configurations. That is, all the participants concerned are practitioners of different multi-disciplinary groups. Some practitioners are allocated by ward, such as Social Workers, and will work with different ward based teams, while some practitioners are allocated by consultant. So that nurses move in and out of different teams depending on the consultant's whose patients are in their team; while doctors themselves work with different groups, at the General and at The Outlying Hospital.

Ward rounds and case conferences can be understood in relation to what they help accomplish in a functional sense: as the locations through which there is a massing of evidence, an assessment and review of the patient's progress, treatment and care, and to some extent an audit on investigations, treatment and rehabilitation.

But they can be understood as doing other work as well. On the one hand they help accomplish the *division* of work, responsibility, and accountability, and on the other hand they help to generate an *ethos*. These occasions, by balancing (or not) the different value systems over the purpose and meaning of work and organisation - such as the local, the global and the community view - help to generate and regenerate organisational ethos.

The conduct of ward rounds and case conferences is a subject of controversy amongst the disciplines. There is enormous variation in the conduct of ward rounds and case conferences, and equal diversity over practitioners' views on their function and appropriateness.

In the following sections the conduct of these multi-disciplinary occasions is discussed in detail. What marks all types is that, on multi-disciplinary occasions the hierarchy of expertise goes unchallenged, with the doctor at the top.

Who leads?

All the multi-disciplinary occasions are referred to by the name of the consultant and they are usually led by medical staff. On one occasion, a mini case conference, which took place after the ward round, the social worker 'led' it by raising each patient's name, but in a sense all the major decisions had already been made on the ward round, and the case conference appeared to be perfunctory apart from recapitulating decisions already taken.

Where there is a senior doctor present, she/he controls who speaks, and when. There is very little *spontaneous* talk coming from other practitioners, except in response to the doctor's queries or on the occasions where only more junior doctors are present together with more senior non-medical staff. However, the *ways* in which the doctor brings in other practitioners, and the *extent* to which the doctor brings in other practitioners, and over what issues, varies enormously. The main features of these modes of conduct are now discussed.

The medical process of diagnosis and care

Whether the occasion is constituted as a ward round or a case conference, the initial phase of the discussion over each patient starts with a review of the patient's medical condition. Many of the occasions observed also involved some medical assessment or diagnostic features.

On multi-disciplinary rounds, the medical processes frequently revolve around the notes themselves, that is the history and examination of the patient and the results of investigations and a review of treatment, and may continue with physical examination and questioning of the patient. Where patients are physically examined, the screens may or may not be drawn.

These physical matters may involve a 'medical' aspect of the patient, such as listening to their chest, but they may also include testing more functional aspects of patients, such as their limb movements or ability to walk.

On a ward round, practitioners typically stand around the notes trolley or move to the end of the patient's bed, sometimes talking together, sometimes watching and listening. If it is a case conference, then the doctor has the notes in front of them and reads/checks through them, frequently out loud. As the case progresses, whether on the ward or in an office, the doctors write in the notes.

Public/private: making patients visible

These processes can make many of the aspects of patient diagnosis, treatment and assessment a matter of *public* display. The ways in which the patient is treated themselves during this display is very varied, and ranges from an inclusive mode, where the patient is brought into the public discussion as a participant, to the patient being constituted as an object: they are excluded from any discussion, or, where their participation is elicited, it is only to report on or, in the case of limb function, demonstrate, their symptoms or situation.

However, the nature of patient participation on ward rounds is problematic: occasionally patients are expected to discuss extremely personal matters in front of a group of people, such as where they should go to after discharge. Many practitioners expressed views that indicate that they are unhappy with this situation, and that these matters should be left to a more private, one-to-one situation. Some also expressed suspicion over the precise context in which a patient is included: usually patient participation is elicited only on those occasions when discharge is being discussed. Some practitioners suspect that, through the public and exposed situation in which they are placed, the doctor intends to coerce a patient into agreeing to a particular course of action.

Where the ward round is a *medical* round, involving nurses and doctors alone, the senior doctor was seen to move into a much closer position in relation to the patient, such as sitting on the bed, or kneeling down beside them, to talk in a more confidential manner.

The division of labour: who is responsible for what?

The review process at multi-disciplinary ward rounds extends to a patient's 'social' situation, that is their home circumstances and the level of resources and care used by them prior to the current illness, as well as the availability of family care or progress with regard to supplying resources in preparation for discharge. The level of detail entered into varies, with each consultant, and with the period of time since the patient was admitted or with the possibility of discharge.

This review brings the different practitioners into the round, and can be seen to help produce the ways in which the patient and their care are 'divided' up. For example, matters of discharge which are to do with ability to function or mobility in the home may be referred to the occupational therapist, while matters of mobility to do with recovery of function may be referred

to the physiotherapist. When it is the patient's social situation which needs closer investigation, it may be the nurses or the social worker who are referred to.

This is a very simplistic version of how the division of labour gets produced and reproduced through multi-disciplinary occasions, but it does give some idea of one of the things that the ward round accomplishes: it helps to mark who is responsible for what, and to some extent, implicitly at least, clarify who is accountable for what.

Here is an example:

Dr: He has got a right hemiparesis. Are you seeing him? (looks at physiotherapist)

Physiotherapist: Just regularly walking him really, he is getting a little better, last week he needed a little bit of assistance, whereas now he is getting a bit more....

Dr: Yes.

Here the doctor asks the physiotherapist whether she is seeing a patient, by referral to the physiotherapist the doctor confirms that the recovery of function is her responsibility. The doctor's query elicits the physiotherapist's account: yes, she is treating the patient, and her treatment seems to be working - the patient is needing less assistance. Note how this particular doctor cuts the physiotherapist off - he has made the check and he is satisfied, he does not need to know the details of her work. This is not then a dialogue of equal experts, but an audit.

These multi-disciplinary occasions serve a multiplicity of functions in relation to keeping medicine and rehabilitation moving along. How they are conducted in relation to the different practitioners is now discussed in more detail.

Bearing witness

Doctors initiate the inclusion of other members in the medical process of diagnosis and decision-making: they call upon other members as 'witnesses'. Practitioners' observations are elicited as part of the medical process of diagnosis. Here is an example of the technique:

Doctor: (to the staff nurse) Is he confused?

Nurse: No.

Doctor: Can he eat or drink?

Nurse: He is vomiting a lot.

Doctor: He is on IV fluids at the moment?

Nurse: I think he has just been started on them now.

The technique involves closed or leading questions. Through this method the questioner narrowly defines the space in which the respondent can answer. It is commonly thought of as a mode of talk which is closely related to service institutions (Schlegloff 1991).

In the present example it involves calling the nurse to bear witness, over both a patient's symptoms and signs (can he eat or drink? is he vomiting a lot?) and over the ways in which these things are being dealt with (He is on IV fluids at the moment?). The doctor is proceeding in a way which implies that there are facts to be uncovered, which relate directly to a particular diagnosis. The doctor is massing the evidence and reviewing the case. The end result of this line of questioning is to review the patient's medication, with a view to prescribing an anti-emetic.

The extent to which the other disciplines feel it is necessary to witness, or feel able to contribute to this aspect of the medical process, varies amongst practitioners: for nurses it is undoubtedly part of their job - they are the doctors' eyes in their absence - and as discussed earlier they also help keep tabs on what the junior doctors are up to. Other practitioners feel that

they appreciate the detail, while others feel that it is a waste of time in already hard-pressed agendas.

In contrast some doctors, do very little of this medical process in their case conferences, but leave it for the medical ward round itself, where it is the nurses and doctors, as well as the patients, who go through these routines. The difficulty here is over how the doctor decides what to include in the case conference over the medical aspects of patients: it raises the issue of whether they are able to know what other practitioners need to know. This is a point for real debate.

Calling people to account

On some occasions doctors extend their questioning to matters which are increasingly being constituted as *outside* the medical domain. It is under these circumstances that problems may arise, as it appears that the doctor is explicitly or implicitly calling other practitioners to account in relation to work for which they, not the doctor, is accountable.

Under these circumstances, the doctor can appear not just to be getting information about what others have observed or done, but actually setting themselves up in the position of making other practitioners accountable *to them*. That is they take on a managerial role over other disciplines.

Here is an example:

Doctor: I presume she did have a strap on the wheel chair?

Nurse: No.

Dr: Oh.

Physiotherapist: She should have had, she has got a chair now but it hasn't got a strap on.

Occupational therapist: It is because it is the only one from the joint equipment store, because the chairs from the Brisbane are taking such a long time.

Physiotherapist: We can give her a belt.

Doctor: If she slides while he is pushing her outside we would be in trouble.

Because we know she has a tendency to slide out of the chair, got no reason why she wouldn't do it out of a wheelchair.

The doctor's innocuous query about the strap sets off a chain of accounts and justifications. But the doctor persists. In this particular example, the doctor distributes the responsibility in the last passage: 'we would be in trouble'. The implication is a legal one: they are all accountable and could be accused of negligence because they know this patient has a tendency to slide out of the chair.

However, this approach, as inclusive as it is, still puts the doctor in a position where they appear to have the authority to call the others to account for their practices. This role is never reversed.

Medical Orders

Some doctors exclude other practitioners from decisions about treatment and care, even though it may be over an aspect of the patient's situation which would normally be considered as in their domain of responsibility. At the same time they enrol the other practitioner in a way which makes it impossible for them not to follow doctor's orders.

For example, on the following ward round the consultant, the physiotherapist, social worker, staff nurse, junior doctor and house officer are all present.

Doctor: (He is standing over the patient who is sitting in a chair. He does a sitting and standing blood pressure). Are you giddy when you stand up at all?

Patient: I'm frightened of the fall.

Doctor: You'd be better with a frame? (sees a frame across from the patient, and takes it, puts it in front of the patient) Or do you mind?

Patient: ?On this floor (cannot quite hear).

Doctor: It'll help you get about a bit more. If you don't get about you'll get weaker.

Physiotherapist: You'll be better with this frame (brings another frame over).

Now we have seen in the previous section that walking and mobility are very much considered the domain of the physiotherapists. The doctor here does not refer to the physiotherapist over the matter of whether the patient should or should not use a frame, nor does the doctor directly call her to account over why the patient is not being mobilised, but questions the patient and supplies the frame.

This move can be considered in a number of ways: as excluding the physiotherapist and undermining her position as the authority on mobility; as an *implicit* charge, that neither the nurses nor the physiotherapist have sorted out the patient's mobility; or as simply one practitioner helping a patient in an ideal world of no domains and divisions over who is responsible for what!

However, this exchange takes place in the context of a ward round where the doctor has repeatedly called the nurses and junior medical staff to account over such things as the medication sheet and blood sugar levels. The doctor has also been ordering other people to get things. Notes, charts, x-rays, forms, scans were all asked for and brought to the doctor at the notes trolley, by the nurse or the junior doctor. When the notes were to be filled in the consultant dictated what was to be written, but the junior doctor did the writing.

While the doctor is more explicit in calling nurses and doctors to account over what might be considered medical matters and over giving orders, he manages his relations with the physiotherapist and the social worker less directly: he gives them instructions *implicitly*. In the extract above the instruction is implicit and given through the doctor's performance around the patient. After the doctor moves away the physiotherapist takes over, labels the new frame and helps the patient up, who then goes off up the ward with his frame. The physiotherapist's activities have been defined by the medical orders.

This form of conduct is significant. It represents a particular way of managing. Through the doctors conduct, other practitioners are constituted as potentially unreliable and to be kept in order. The idea presumably is that they will make sure that they do things right, to avoid losing face on the ward round. But it is not just, as one practitioner put it to me, a performance through which the doctor puffs themselves up. However much the conduct grates on one's democratic sensibilities, it is a performance through which highly significant matters are being accomplished. These involve the fact that the ward round is a public performance. The doctor is *performing* a form of medicine, which is primary and which, presumably, leaves no stone unturned. It is virile and active and confident, the other disciplines are merely adjunct to the medical domain. As one doctor put it:

I have my people on my ward round.. so that they know what we are talking about medically.. and they will be fully equipped, not ignorant, and things can fall into place

In this view, patients are cared for and then rehabilitated, but the method is for the medical to order the ways in which the patient is seen and their problems are defined, not just by the doctors themselves, but by all the other disciplines. But the situation is not reciprocal: the doctor does not give the other practitioners space to give their view of the patient, so that their views do not help define the medical view. As we have seen in the extract above, even the patient is told:

he should walk, to stop from getting weak.

Checking up

A much gentler approach to ordering and checking may be used than that described above, but the effect, to check that things are going along as they should, seemed to be more or less invariant. For example, a doctor, when asking a nurse 'what prophylactic measures are we using with regard to pressure areas?' Is not just making a query, they are also making a check. While on another occasion a doctor said to a physiotherapist 'I presume she is wearing a neck collar' the physiotherapist said that it was on order, the doctor responded, 'What do you mean, it's 'ordered'?'.

It would appear that all the ward rounds and case conferences to some extent constitute a form of audit: these occasions are used to check up that things are moving forward and that matters are proceeding as they should. And it has to be emphasised, practitioners do take this aspect very seriously: some of those practitioners who come to these occasions, mentioned how they work to make sure that they are prepared, that they have done their assessments, or arranged things, for 'the round'. The checking up, after all, goes on in front of not just the doctor, but in front of other colleagues and, sometimes, in front of the patient themselves, as in the example above.

Mostly practitioners are acquiescent and respond to these checks. However, some practitioners may be protesting with their feet: their non-presence at multi-disciplinary occasions or the sending of junior practitioners to them, may be a form of resistance.

While there was very little adversarial exchange observed in the case conference and ward rounds, practitioners reported how they had had confrontations with other practitioners on a number of occasions in the past. These stories seemed to all revolve around occasions where doctors were refusing the community view of the patient: they were stories about how patients were to be discharged to environments which they did not want to go to. It would appear that on these occasions practitioners might talk outside the round or conference, and then launch a collective effort to persuade the other members of the multi-disciplinary team to keep the patient longer to allow them further rehabilitation, so that they could return home.

Now in an ideal world, checking carefully on each other would be unproblematic, if it were a reciprocal process. The question arises as to whether nurses, physiotherapists, occupational therapists and social workers ask such questions of the medical staff. The answer is very rarely at these ward rounds and case conferences do practitioners check that a consultant has done something, or what their reasons are for having done something.

There is one exception, a case conference, during which a social worker questioned a consultant with regard to systems for informing patient's relatives of a discharge arrangement: the social worker was concerned and questioned whether it was clear that the patient was to be transferred, the doctor explained and gave an account of the situation. What emerged from this exchange was that it was unclear as to whose responsibility it was to make such arrangements clear to relatives. This Consultant was the most supportive of collaboration and multi-disciplinary team working - he partly saw it is helping to unburden himself of a lot of work, but he also had respect for and promoted the contribution each discipline could make in terms of helping patients.

Consultation and conference

As stated earlier, doctors are more or less in control of the direction of the case conference or ward round, and control not only who speaks but to some extent what is spoken about. All doctors extend discussion of the patient to other areas of the patient's circumstances, which practitioners constitute as the non 'medical' aspects of patient care. The ways in which they do this, and whether they include others' views on the patient and their particular

assessments and care of patients, varies.

Some consultants, while still leading the conversation, give others the space in which to express their views. They do this through a number of different approaches, by asking open questions or by commenting on matters pertaining to the patient's condition or situation to which others respond. In these situations, while the consultant is still to some extent directing the matters upon which people are conferring, other practitioners are not put in the position of simply answering a question, but are being given the space to talk about their view of the patient. There is more of a dialogue. Take the following passage as an example:

Doctor: So from your point of view what is he like?

Nurse: He is a very stiff gentleman. He does stand quite well between two, but it is actually getting him up, he is quite rigid in the middle and you can't sit him up in bed; he appears confused to me, but the wife, not the wife, the partner, says he isn't; but if not confused, disoriented; he is adamant he is going home, although he has gone to sleep in his bed now.

Doctor: What does she say?

Nurse: She seems a quiet lady, sort of whatever he says, fine. He says that he washed himself and sorted himself out, yet when I spoke to the partner she says she did it all for him, so I mean it appears to me as if there is some confusion there. We sent the MSU off this morning, he was pyrexial when he came up and he was on oral augmentin (an anti-biotic) I think it was; we were querying basically for us, UTI (urinary tract infection) or another CVA (stroke).

Doctor: Is his urine offensive or anything at the moment?

Nurse: I don't think so.

Doctor: And what is he like in terms of, once, he is helped to stand, he can walk?

Physiotherapist: When I came to see him it was early on this afternoon, and he had been sitting out and he was just putting himself back to bed and I got him to get up again, he's having trouble with his bed mobility, but once he was sitting he stood up and went off by himself with me, just a hand under his arm.

Nurse: He has got two sticks.

Physio: He's on two sticks normally.

Doctor: So he can walk with one and his two sticks.

The doctor asks an open question - 'In your view what is he like?' In this way the doctor is leaving it to the nurse to define the space of her reply. The doctor could, for example, have asked 'How is he at walking'. Thus narrowing the possible context for the nurses' response. The nurse would have had to *create* a space to bring in the other aspects of the patient which she feels are worth commenting on. And the doctor's clarification, 'So he can walk with one and his two sticks', helps indicate that the nurse and the physiotherapist are being listened to, that what they have to say is important in some way. Obviously those techniques can go astray if, once they have opened up another practitioner's view, the doctor's response is then dismissive.

In this example, the doctor gives the nurse and the physiotherapist some space to give their view. This does not just allow many important bits of information to come out, but also allows other practitioners to contribute to defining what is, or could be, important about the patient.

In this particular case, through their discussion, the practitioners pinpoint the exact area of difficulty the patient is having with his mobility: it is not just how he walks, but, getting up out of a chair or bed which is difficult, he's stiff and doesn't bend. The physiotherapist moves the analysis of the patient's problem even further forward: the nurse said the patient could stand with

two, whereas the physiotherapist states that she got him up and walked him alone. The doctor clarifies: he can walk with one and two sticks.

This method of conducting ward rounds and case conferences is *inclusive*, it is still directed by the doctor, but by a doctor who has an *extensive* view of what medicine is about and about the nature of their responsibility for patient care. Here, rehabilitation and the details of assessment and care from others' points of view, are as much a part of the processes of medicine, as any other. Also it is conducted in a way which suggests that there is an acceptance that some aspects of patient care are contextual and specific, that is less *predictable*, than others. This aspect is now discussed.

The constituting of evidence and relevance

There are a variety of views expressed in interviews and which emerge through participant's interactions over what constitutes 'evidence', and what can be taken as relevant, in the assessment of patients' needs and decisions over their care.

In one view, while there are general areas which it is important to cover in any assessment, what exactly will emerge as relevant or salient cannot always be predicted. In this view, evidence is frequently tentatively constituted, and interpretations are open to suggestion or change.

For example, in extract in the previous section, the nurse mentioned the patient's partner, and the discrepancy over her and their views of the patient's mental state. To the nurses he appears confused, or at least disoriented, whereas the partner says he is not confused. The nurse's evidence is not in any way conclusive, indeed it is ambivalent, but it does point to a possible set of connections and a possible area of concern. The doctor does not appear to take up these observations explicitly, but may be taking up the staff nurse's diagnostic connection between the possibility of UTI or stroke as the cause of the changed mental state in the patient. The nature of what may be significant is to some extent being established between them, but it is left as inconclusive.

Now critically, other practitioners of the group may not have known the patient had a partner, or about the issue of the patient's mental state, or the specificity of his difficulties. This making explicit any or all of these matters may alert them to considering the patient differently. Or these matters may emerge as significant latterly, as other matters come to light. For example, the occupational therapist, who has not yet seen the patient, may bring this ambiguity to bear when assessing the patients ability, it may help inform her view of the patient, she may decide to include the partner in treatment programmes, over helping the patient to get up, out of a chair or bed, and she may take into account the patients mental state in her approach in some way.

The ways in which these matters get interpreted and used cannot be controlled: for example, some would argue that in certain contexts, the patient may get labelled as confused, and all their treatment may get contaminated by this label. For example, the way the occupational therapist looks at the patient could be prejudiced by the conversation between the doctor and the staff nurse. This is always going to be a problem with a sharing of views.

It is here that issues of balance emerge: for some participants, expressed in their interviews, the balance is instituted through each participant making their own independent assessment of patients and through allowing a variety of views to emerge over the patients needs. This is very different from each discipline working in isolation, but it is a protection against the patient being seen only one way. In other words, from the point of view of participants, it is not always consensus which is the objective of multi-disciplinary working, but an exchange of views. But of course, practitioners have to be given the space in the first place to express their views openly!

The one complaint about this method was that it takes up a lot of time. For example, one

practitioner expressed the view that they hoped the collaborative care planning project would mean that everyone worked together better in the day to day so that they would no longer need such conferences! This comment is of some relevance. The question which must be asked is: why is the doctor having to do so much work to get people to speak and share their views, is this kind of conferring not possible at earlier rather than later moments? We will return to this issue in the final discussion.

It should be noted that the consultative method described is not any more or less involved in the global view than any other. On analysis, it is the production of throughput which in many ways drives all the ward rounds and case conferences, but with this method, in theory at least, all the views should be able to emerge, within certain constraints: the local view, the community view, and the global view. Each has their contribution to make. A balance is kept in play, partly by the level of detail and partly by the ways in which each practitioner is given at least some space in which to speak. Needless to say, practitioners were mostly happy with this method of conducting ward rounds/case conferences.

Discussion

In summary the ways in which multi-disciplinary occasions are conducted can be seen to help practitioners accomplish a variety of matters. These include the following:

- *Making it visible.* Through these occasions the ways in which patients needs are established and their care directed is made visible. However, this can be overtly directed by medical orders or it can occur through a consultative method. In this latter case there is potential for this method to balance all the value systems and for assessment and plans to be responsive to an individual patient's case.

- *The division of labour and responsibility.* During the ward round/case conference there is confirmation of the division of labour over patient treatment and care.

- *Surveillance and accountability* - Through a variety of methods practitioners are called to account or their work is checked on. These occasions can be considered an on-going audit process and as such a critical part of the self-regulation of practice in patients' interests.

One important issue is over the matter of reciprocity. Some participants mention how they feel that the doctors are holding on to the power. In this respect, a lack of reciprocity could be seen as signifying an asymmetry in the relations of power. The question arises as to why do participants acquiesce. The answer may be that as an on-going audit process they are deeply embedded in practitioners methods for self-regulation. That is, they help support practitioners on their toes, and if properly conducted, they help to balance the different value systems: the global, the local and community agendas.

Summary and Conclusions

The paper described how members of different disciplines organise and interact over patient assessment and care in Hope Trust Elderly Care Directorate. The aim of the research was to provide a detailed picture over how practitioners of different disciplines work together.

Issues cluster around two different matters:

- assessing patients' needs and planning how best to serve these
- balancing professional autonomy with the interests of patients.

The following sections present the main research findings.

Organisation of patient assessment

Assessing patients' needs and planning how best to serve these is one of the most complex things that practitioners do. Currently patient assessment and care is organised at the level of the disciplines.

- Each discipline has a practitioner who assesses and devises a treatment or care plan for each patient.
- For all disciplines there are proforma and methods of assessment specific to them.
- For some disciplines there are also protocols and clinical guidelines over treatment and care plans.

Within discipline management

There were strong feelings that discussion about patients within disciplines is as important as discussion between disciplines for two contrasting reasons.

First, work is organised through processes of delegation. Assessment and planning work is often undertaken by practitioners who do not necessarily carry out care or treatment themselves, this is delegated to junior or unqualified personnel.

Second, team nursing has been introduced, and the senior nurse role at ward level in each unit is being increasingly developed into a managerial role. There is much emphasis on staff development backed by the introduction of standards, protocols and audit of the adequacy of practitioners' practices.

Occasions which result from these different methods of organisation include medical ward rounds, or team meetings, which each incur demands upon disciplinary practices. They enable evaluation and reassessment of patient care, reporting and supervision work, as well as education and staff development.

Across discipline interaction

The main occasions for formal discussion over patient assessment and care are multi-disciplinary ward rounds and/or case conferences. The exception here is the Day Hospital, which operates a different model from the other sites.

Most practitioners stress the importance of informal encounters to their own assessment of patients' needs. Practitioners from each discipline interact on a daily basis as they go about their work. However, access to each other is variable and is itself managed.

Structural constraints on interaction

Structural constraints on ways in which different groups of practitioners interact include:

- Methods of patient allocation means practitioners can find themselves working with different sets of practitioners over different groups of patients.
- Part-time working, and inflexibility over hours as well as shortages of staff (particularly in physiotherapy and in medicine at The Outlying Hospital) can lead to additional constraints over cross-disciplinary communication.
- Limited access to assessment and care plans of other disciplines
- Where there is access, the use of disciplinary jargon can limit understanding
- Demands of within discipline organisation (e.g. team working, delegation)

Balancing professional autonomy with the interests of patients

At trust level, difficulties arise in ensuring processes of assessment and care delivery balance professional autonomy with patients' interests. Several issues arise here.

Inclusion of multiple perspectives

The view that the assessment of patients' medical needs can be made in isolation from

the views of practitioners of other disciplines was held by the majority of the doctors: for them the views of other disciplines are additional to the medical view. Views from other disciplines have to be fitted into such categories as a patient's mobilisation, function, mental/emotional state, resources and future care.

Other groups of practitioners indicated that this is a difficult position to defend in an elderly care context. All of these other groups said they incorporate the medical assessment of the patient into their own. Some claimed that they do not necessarily need to witness that assessment, or diagnostic process, as on ward rounds. In contrast other participants felt it was valuable to be present at the medical assessment, but only where this was conducted in a manner respectful of their own contributions.

Social workers, occupational therapists and nurses stressed that their own assessments of patients' needs, and their decisions over what they are going to do about these, partly arise from being informed by the assessments and understandings of all the disciplines. These practitioners are very aware that this flexibility and regard is not necessarily reciprocated.

Value systems

Different value systems informing practitioners' methods may be summarised in the following ways:

- * the **local**, or custodial view, which can be said to be protective of the 'ill' as having diminished ability and autonomy
- * the **global**, or service oriented view, where the organisation is oriented to populations of patients rather than individuals
- * the **community** or person-oriented view, which considers patients not just as ill, but each as a *person* with a future and as someone to whom professionals are also accountable

Each value system implies different forms of accountability.

Ideally multi-disciplinary working should involve discursive practices which represents discussion between different occupational groups with different views of the subject (the patient). This type of discursive practice is identified by Saferstein (1992) in his discourse analysis of sound effects spotting sessions and script meetings in the film and television industry. In Saferstein's study this type of meeting, between persons of differing occupational disciplines, is characterised by discussion. There are interruptions and turn-taking rather than questioning. A form of discursive practice emerges through which each member attempts to enable other members' understanding of how the script can be operationalised (to enable filming). This is done through visualising the script through their particular conceptual models to pinpoint and anticipate difficulties. This Saferstein characterises as "collective" cognition and is the basis of truly collaborative work. This is critical because film time is so expensive and wasting time on location or on the set is to be avoided. For example, the cameraman's visualisation of a scene may reveal problems with the script. As he visualises the script in relation to the positions of the actors and the possibilities of the camera's access to them he can see that as scripted the scene in question is not workable. This may then lead the script writer to change the script. The meeting enables each member of the film production team to have some insight into each others' perspectives (a "sharing of mental models"):

Participants have organised their respective concerns about the scene into a shared model. (p77)

Saferstein argues how these meetings, as forms of discursive practice, are constitutive of forms of power relations which "refract hierarchical domination of the work processes" (p83) and institute more than economic efficiency: they give each member some control over the overall production of the film. Through interactive cognition and communicative processes they institute a collaborative approach which produces a different form of organisation. In the current context, an immensely hierarchical organisation in which different kinds of knowledge practices have very different kinds of value, there is a very different kind of organisational process.

Checking and Accounting

As we have seen the importance of cross-disciplinary occasions is rarely primarily concerned with a 'sharing' of views. These occasions are not, in Bakhtin's phrase, dialogic. On these occasions there is affirmation of who is responsible for which aspects of patient care, a process which continuously confirms arrangements for a 'division of labour' over patient assessment, treatment and care. However, such work automatically involves aspects of surveillance, e.g. that what needs to be done over patient care is being done. In this sense multi-disciplinary occasions can be seen to be an *on-going* process of audit.

Difficulties arise here over the *ways* in which multi-disciplinary occasions are conducted. There seems, however, to be a great deal of variation. Methods range from an asymmetrical hierarchy, in which practitioners are called to account and are virtually given orders, to a more consultative model. The research did not observe a model which compares with that offered by Saferstein or Øvreit - a 'truly collaborative model'.

Two things must be emphasised. First, when a senior doctor is present, *they* conduct the occasion. This means that the doctor almost exclusively stays in control of when other participants contributions are permitted to enter the proceeding. Second, this checking on other groups of practitioners, and calling other people to account, is not reciprocal. It is the doctors who check on or call practitioners of other disciplines to account, these others do not check on or call doctors to account.

While no management audit could be as effective as the 'self-regulation' accomplished through these across-disciplinary occasions, the question arises as to the extent to which to be effective as a form of audit, these occasions depend upon a 'hierarchical domination of the work process'. Thus while the perpetuation of these practices in some form is of paramount importance because they are *potentially* so responsive to the complexity of practice and specificity of each patient there are clearly difficulties. Asymmetries over 'who is regulating who' need to be opened up in order to explore, if not settle, the question of hierarchies, particularly to check the best way to balance the multiple agendas discussed above. In a sense this means shifting to an appreciation of how collaboration can offer complementary rather than competing knowledge practices and world views to accomplish a balance of interests which centre the patients and their futures.

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¹ Some practitioners from other groups support this insistence, while others feel that these decisions could be made in a nursing home - they insist that patients should be discharged to the first available nursing home place which becomes available. In these circumstances, as one social worker put it: the patient may end up living in a place which they have never seen let alone chosen, for twenty years of their life, just because someone needs a bed.

According to some practitioners, the difficulty over transferring patients to nursing homes for multi-agency assessment is that the nursing home staff are not 'doing assessment', they look upon the patient, once admitted, as there permanently. The concern over discharging people to nursing homes to give time for proper assessment is that it is not going to work under these circumstances. Other practitioners do not hold this view, and would like

to move patients out to homes to clear the beds for people who are ill or who need rehabilitation.

² Throughout the report nurses refers to the qualified nurses. Health care assistants are included as nursing personnel, but it was clear from many nurses interviews that they consider these assistants as adjunct to rather than as part of the nursing profession.

³ The day hospital has one Sister and two health care assistants, so does not operate team nursing, rather work is done more along a task allocation model, to cover clinics and day hospital patient's needs. The ward manager role is more that of an organiser of the workplace, on both the clinic and the day hospital sides, a co-ordinator and liaison person between the patients home and the day hospital, and also between the disciplines involved. She also takes bloods and does dressings when necessary.

⁴ These occasions apparently used to occur at least once a week in the four different sites. Now they only occur in the Day Hospital, at The Outlying Hospital. Practitioners said that they have fallen by the way side because of staff shortages and pressure of time. Most practitioners concerned said that these meetings had been very helpful in the past. Observation of these meetings are not therefore included in the analysis as at the time of the research they were not functioning.