Interprofessional communication in education: a case study

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Abstract

This thesis is concerned with communication in interprofessional practice, an issue which is identified as a ‘difficulty’ but ‘essential’ in the literature. The research is based on a case study focusing on the communication between professionals in a series of planning meetings held to support the transition of a child with additional support needs from playgroup into the nursery class of a primary school in Scotland. The study explores the dynamics and complexities of communication through the theoretical frameworks of ethnography of communication and Dewey’s concept of communication as participative action. This joint analysis illustrates the way in which the group worked together to make something in common and the extent of commonality that was needed for them to work actively together. The findings show the interprofessional group functioning as a speech community with a bounding feature of working with the child. The soft-shell of this community illustrates a flexibility of practice and the ability of the group to expand or contract to meet the needs of the child and family. The way in which the participants worked together to agree the outcomes they were working towards is an illustration of Deweyan communication, making something in common between them. This process included the recognition of the competence and responsibility of individual professions. The study demonstrates that the doctors who were members of the interprofessional group were recognised as holding more power than the other members of the group and were bound by the outcomes and procedures of their own profession. This difference affected the dynamics of communication within the interprofessional team. The findings add to our understanding of the complexities of communication in an interprofessional team and show that

communication in a Deweyan sense can strengthen the work of an interprofessional group and develop their support for the child or family they are working with.

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This thesis is for the children of Coupar Angus Primary School whose joyful laughter and games encouraged me as I wrote and reminded me every playtime and lunchtime of why I became a teacher.

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Abbreviations

CAIPE	Centre for the Advancement of Interprofessional Education
CAMHS	Child and Adolescent Mental Health Services
CSP	Co-ordinated support plan, an inter-agency plan to support children with additional support needs
DfES	Department for Education and Science, United Kingdom Government
EAZ	Education Action Zones
HMIe	Her Majesty's Inspectors of Education, Scotland
GIRFEC	Getting it right for every child, national programme introduced from 2006 by the Scottish Executive
IEP	Individual education plan, school based planning and recording system used by teachers to plan for children with additional support needs
IPE	Inter-professional Education
NCS	New Community Schools
OECD	Organisation for Economic and Cultural Development
TAC	Team around the child, health based planning system for children with complex health issues
TLRP	Teaching and Learning Research Programme

1 Introduction

The focus of this research is communication within school-based interprofessional planning meetings where a group of people from a variety of professional backgrounds plan together the support systems for a child. This research sits within two key aspects of the current Scottish policy framework: the Additional Support Needs (Scotland) Act (Scottish Executive 2002, Scottish Government 2009) and Getting it right for every child (GIRFEC) (Scottish Executive 2006, Scottish Government 2009), a national programme which introduced formal joint planning systems across education, health and social work practice. The aim of the research is to enhance the understanding of the dynamics and complexities of interprofessional communication through a case study. The focus of the study is a group of 22 professionals, from education, health and social work, working with one child and their family during the period of one year to support the transition of the child from playgroup into nursery. The setting is a medium sized primary school in a small town on the east coast of Scotland.

In this chapter I will outline my professional background to the research (1.1) and my personal interest in interprofessional communication (1.2). This provides the impetus for the focus of the research on interprofessional communication and informed the aim, objectives and questions for my study (1.3). I will then outline the structure of the thesis (1.4) and the definitions of interprofessional (1.5) and communication (1.6) that the thesis will start from.

1.1 My professional and academic background to the research

The core of my professional practice as a teacher was as a support teacher for children and young people in a variety of settings in Scotland and England. Since 2004 I have worked in professional education in the School of Education, University of Stirling, teaching on postgraduate programmes for experienced teachers. The first part of the doctorate programme gave me the opportunity to establish connections between my professional experience as a teacher in interprofessional projects, the existing research base and the role of policy in interprofessional practice. This experience informed the focus of this research, which developed from a wish to ensure that all teachers, through initial or continuing professional education, had access to professional education to support interprofessional practice. The use of language and the theory of communication has been part of my academic interest since undergraduate studies in linguistics at Edinburgh University, while graduate studies in historical geography in early medieval Scotland, left me with a continuing interest in people and place. My academic background in history has influenced this study in various ways. It is evident in my approach to the literature review and challenged my development as an educational researcher when I began the data analysis in this study. It has added a layer of distance to my interpretation of the data in the study, in an area of practice which was a central part of my work as a teacher.

My teaching career mirrors the development of interprofessional practice in Scotland and England from 1990 to 2004 as the focus of local authority and

Government funding changed. In the early 1990s funding was available for multi-agency teams based outside schools often working in one area of a local or education authority, with admission guidelines to support children who fell within a specific category such as looked after or excluded from school. By the end of the 1990s funding had been moved to focus on interagency teams who were based in schools and worked as part of the staffing in the school, but often with line management outside schools. By the early years of the new century there was no direct funding for multi- or interagency teams and staff from each profession were expected to work together from their own professional base to provide integrated support for children and young people. This expectation has moved into legislation for children and young people with additional support needs (Scottish Executive 2002, Scottish Government 2009) and national recommendations for all professions working to support children and young people through GIRFEC.

I first taught as a primary teacher in Scotland and began support teaching when I moved to England in 1990. There I worked as part of the Humberside Traveller Education Team, funded directly by the Department for Education and Science (DfES) to support the children of Travellers. The team included eight teachers and one education welfare officer, with the aim to support families to place their children in school, and then to support the children. The teaching in this post involved working with children and young people from three to 16 years old, helping them to settle into new schools and to support their literacy skills. In 1993 I returned to Scotland to a post as a teacher in a team funded jointly by the education and social work departments in one local authority to support

looked after children, who were then referred to as children in care. The Children in Care team had eight teachers and four educational psychologists, with the teachers providing very similar support to the work I had done with Traveller children. In 1995, at the time of disaggregation in Scotland with smaller local authorities and less funding for non-core work, i.e. teaching that was not class based in school, I moved into a secondary school post as a principal teacher of learning support. This work was similar to the teaching I had done in the multi-agency teams but with less contact with other agencies or services. The development of a social justice agenda with the formation of the Scottish Parliament (Scottish Executive 1999) brought short-term funding for specific types of interagency working and I spent 1997 – 1999 working in an Alternatives to Exclusion project (Scottish Office 1997) with four staff from four professions: education, educational psychology, community education and social work. This was a very focused project, working across the transition between primary and secondary schools with two primary and one secondary school. The funding arrangements for the project enabled the four staff involved to explore the knowledge and skills base of each profession to ensure that the work we did to support individual children and their families was interprofessional. In 1999 I was appointed as integration manager for a Phase 1 New Community School (NCS) (Scottish Office 1998). In that project I led a team consisting of me as a teacher, four social workers, one community education worker and one health worker. I was not employed to work as a teacher in that role, but to co-ordinate the interagency support offered by the team. When the funding for the project ended I returned to the school post I left in 1997, this time as a principal teacher of support, providing learning and

behaviour support. The core of the teaching that I did in all these projects was to teach basic skills in reading, writing and maths, and support the child or young person to access the wider curriculum. It was interagency practice because it was planned with the children and young people concerned and the other supports that they had. My professional role as a teacher remained the same, but the structural system in which teaching was delivered changed. A key challenge facing me in each of these posts was to communicate and work with the other professionals working with the same children and young people. This experience has left me with historical knowledge of struggles to create interagency working and a desire to inform current interprofessional practice. The terminology has changed with the polity to focus on interprofessional, between the individual professionals involved, rather than between the agencies but the challenge remains the same.

1.2 My interest in interprofessional communication

A critical incident (Tripp 1993) as I left my school post to move into Higher Education brought into sharp relief the communication issues facing interprofessional practice. The incident took place after a planning meeting for one child. This child was in his first year in secondary school and throughout the year had a variety of support for language difficulties. The planning meeting involved the child, his mother, an educational psychologist, a speech and language therapist and myself. The aim of the meeting was to discuss with the child the work he was doing in different subject areas and review his individual education programme (IEP). The child was happy in the school and talked

about the subjects he enjoyed most and his mother was pleased to see him settled in the school and happy with the support he was receiving. The educational psychologist described the work she had done with the child and the support he needed in different subjects to fully participate in each class. The speech and language therapist talked about the work she had done with the child to establish key learning strategies for him to use. I gave an overall report on the child's general progress in the school and specific information about his IEP. A new programme was agreed for the next term and the meeting ended. The meeting was informal, there had previously been considerable contact between everyone taking part, and anyone listening in would have heard a discussion focusing on positive achievements. As I reflected on the meeting afterwards I thought about that meeting as the focus of reporting and planning for the child. The reports were positive and the child was happy but I knew there were underlying questions about the difficulties the child had in using language. I had struggled as his teacher to support him to retain in his memory knowledge for each subject area and his experiences in each of his classes. To support his retention of knowledge and experience the speech and language therapist had devised with his mother a complicated system of recording learning outcomes that none of us were able to sustain the use of. This was referred to in the meeting but not discussed. It was 'the elephant in the room'; we all knew that it had not worked for the child but no one was willing to discuss why. It made me wonder how much I had actually communicated to the group of professionals involved about the learning difficulties that the child had. Did they really understand the problem of going into a science class and not remembering any of the details from the previous lesson? Similarly what had I understood / taken

in / acknowledged from the disciplines of speech and language and educational psychology? Did I understand enough of the language processing difficulties the child had to be able to support him in school? What had we communicated to each other in the meeting? How had the meeting structure impacted on the content of the discussion?

The analysis of the incident above provides a summary of some of the communication issues I experienced working in interagency or multi-agency teams and in co-ordinating interagency support. These communication issues have motivated me to focus this research on gaining a better understanding of the dynamics and complexities of communication in an interprofessional planning meeting with the hope that a better theorised understanding of the complexities of such communication processes can lead to improvements in the communication itself.

1.3 The aim, objectives and research questions

Aim: To enhance understanding of the dynamics and complexities of interprofessional communication through case study.

Objectives:

- To observe and record communication in a series of interprofessional planning meetings
- To analyse the ways in which the participants worked together to make something in common between them

- To examine the ways in which professional 'languages' are used in the way that the participants worked together

Research questions:

- What are the dynamics and complexities of communication in an interprofessional planning meeting?
- In what ways is the communication process in interprofessional planning meetings affected by the professional knowledge of the participants?
- Do professional languages have a particular role in the communication processes in interprofessional planning meetings?

1.4 The structure of the thesis

The thesis is presented in seven chapters. In this introduction I have established my professional interest in interprofessional communication and identified the aims, objectives and research questions for the study. I will end this chapter with the definitions of interprofessional and communication that were used to establish my research.

In chapter two I provide the policy setting for interprofessional practice and a review of the literature focusing on communication in interprofessional professional practice. This chapter begins with a chronological account of the policy development of interprofessional practice in the United Kingdom and in Scotland and an introduction to the literature relating to interprofessional practice. I then present a review of the literature in three sections collated

around three key texts which address: the conceptualisation of practice, multiprofessional teams and interprofessional learning. In the conclusion I summarise the gaps the in the literature and identify three areas for my research to consider: the use of communication theory, the identification of communication as a skill and the role of professional languages.

In chapter three I introduce sociolinguistics and justify the use of ethnography of communication as the theory for the research. I then consider Dewey's concept of communication as a practical activity between partners that requires the active involvement of all participants. I relate this focus on partnership working to my literature review and demonstrate the relevance of Deweyan communication to a study of communication in interprofessional practice. Chapter three ends with a discussion of the influence of pragmatism on the design of this study.

The theoretical framework informs the design of the study which is described in in chapter four. In this chapter I discuss the use of a case study for the research, the validity of the study, the setting for the research and the ethical considerations. This is followed with a section on the data collection and a note of the time period of the research, the meetings recorded and the participants involved in the study. The chapter concludes with a discussion of the use of ethnography of communication as the methodology for analysis and the establishment of an adapted framework for the data analysis.

Chapter 5 provides an analysis of the research data. The data analysis is

presented in six sections, which were established from the terms and concepts of ethnography of communication. The sections are: the participants, the meetings, roles and responsibilities, professional information, power and the medical letter.

In chapter 6 I consider the themes identified in the data analysis and interpret them in relation to the conceptual and theoretical frameworks of the study. This interpretation of the data themes in relation to the theoretical frameworks supports the identification of findings from the study which are then considered in relation to the research questions.

I conclude in chapter 7 with a discussion of the limitations of my study before moving on to discuss the implications of the findings for practice. These implications are then discussed in relation to the developing policy situation in Scotland in relation to interprofessional practice. The chapter ends with a discussion of future areas of research.

1.5 Definition of interprofessional

A range of terms are used throughout the literature to describe interprofessional working. Leathard (1994) described the range of terms used as a 'terminological quagmire' (1994: 5) and proposed that there were three different bases for interprofessional working: (a) terms which are concept-based; (b) terms that are process-based; and (c) terms that are agency-based, and provided a table of 52 different terms used to label or describe interprofessional practice. She also

discussed the differences between the use of ‘inter’, which indicates that only two groups are involved and ‘multi’ which usually indicates more than two groups or individuals coming together. Wilson and Pirrie (2000) took this work further and listed specific activities which could be described as ‘inter’:

> ‘Inter-‘ used when the activity enables members of the team to
>
> - Develop an inter-professional perspective which is more than the sum of the parts
> - Integrate procedures and perspectives
> - Learn from and about each other
> - Share knowledge
> - Develop a common understanding
>
> (Wilson and Pirrie 2007: 7, selected bullet points)

The range of terms used has led a number of writers to comment on the difficulties this causes for research and practice. Atkinson in a literature review of interagency working concluded that there would, ‘be value in refining descriptors and vocabulary associated with inter-agency activity to advance general awareness and understanding of its processes and outcomes’ (Atkinson *et al*. 2002: 8). The range of terms and the differences in the practice and structure of interprofessional practice is such that each project report and research analysis begins with a definition of the particular term they had selected to use for the paper, for example:

> In this paper the term inter-agency working refers to the joint/collaborative discussions and planning that take place in school based inter-agency meetings. ‘Joined up’ is used to refer to deliberately conceptualised and coordinated planning and working, which takes account of different policies. ‘Joint working’ means professionals from more than one agency work (not just discuss) together on a project (Stead *et al*. 2004: 43).

Warmington and colleagues (2004) in a literature review for the Teaching and Learning Research Programme (TLRP) project 'learning in and for interagency working' commented on the 'plethora of terminology' used to describe collaborative working practices, noting that what he described as 'portmanteau terms' such as 'interagency' and 'multiagency' covered a range of structures, approaches and rationales (Warmington *et al*. 2004: Introduction). He referred back to the work of Lloyd *et al*. (2001) and the following working definitions:

> Interagency working*:* more than one agency working together in a planned and formal way, rather than simply through informal networking (although the latter may support and develop the former). This can be at strategic or operational level.
>
> Multiagency working: more than one agency working with a client but not necessarily jointly. Multiagency working may be prompted by joint planning or simply be a form of replication, resulting from a lack of proper interagency co-ordination. As with interagency operation, it may be concurrent or sequential. In actuality, the terms 'interagency' and 'multiagency' (in its planned sense) are often used interchangeably.
>
> Joined-up working, policy or thinking refers to deliberately conceptualised and co-ordinated planning, which takes account of multiple policies and varying agency practices (as cited in Warmington 2004: Introduction).

Frost and others (2005) provided a hierarchy of terms used in partnership working such as co-operation, collaboration, co-ordination and merger or integration. Anning and colleagues (2006) in their analysis of multi-agency teamwork chose to use the term 'multi-professional'.

> (W)e have chosen to use the term multi-professional as the most fitting construct to describe the coming together of workers from the traditional services for children of health, education, social services, crime reduction and family support into new configurations for delivering variations of joined-up services (Anning *et al*. 2006: 9).

Brown and White (2006) in a review of the evidence base for integrated children's services in Scotland stated that interagency terminology:

> . . . raises a number of challenges for clearly communicating what the integration agenda is about, gaining a shared understanding among professionals about what it means and for measuring the outcomes of integrated services. A clearly articulated definition of integration may contribute to enhancing communication and understanding (Brown and White 2006: 2).

Atkinson and colleageues in a further literature review in 2007 proposed that there were three dimensions which all the models and classification systems came from:

- Multi-disciplinary working: Among individuals working within a single agency.
- Inter-disciplinary working: Individual professionals from different agencies separately assess the needs of child and family and meet to discuss findings and set goals.
- Trans-disciplinary working: Members of different agencies work together jointly, sharing aims, information, tasks and responsibilities (Atkinson *et al.* 2007: 21).

This wide range of definitions and working structures has challenged both research and practice. Forbes and Watson (2012) in their recent examination of the complexities of interprofessional practice in integrated children's services

present ‘inter/professional’ as a term. In this text they explore what they refer to as the seamless qualities of integration and the gaps that exist in such policies and practices. They suggest that the use of a hyphen in inter-professional emphasises the differences between services, whilst without a hyphen, interprofessional implies that there are no differences between services. Their proposal is a forward slash to represent the space and time between the professions, inter/professional, which they reference to Watson’s earlier work on Deleuzian folds (Watson 2008). The idea that the term itself can illustrate the ways in which professions work together appeals to my professional experience of interprofessional working as I experienced in practice what they label as spaces between professions, and time is often a difficulty in planning interprofessional support. For my research, where the focus is on communication and not on the terms used to describe practice I intend to use the term of ‘interprofessional’ as it appears in current legislation and policy documents (Scottish Executive 2002 and 2006, Scottish Government 2009).

1.6 Definition of communication

McQuail defines the verb to communicate, “(as) an action of ‘sending a message’ about ‘something’ to someone who is a ‘receiver’” (McQuail 1984: 2). He writes about a channel of communication between individuals or between roles, and argues that,

> all communication involves change. Wherever there is communication there is a change of state – something happens in the course of communication which alters the situations of participants in relation to each other, or to the external environment (McQuail 1984: 24).

He lists communication as involving five choices; sending and receiving, intention, cause and effect, linear or circular, order or change and draws attention to the fact that the effects of communication would not necessarily be those intended by the communicator. This definition of communication, as a process of change, illustrates the complexity of the term which in general usage today refers both to the way information is sent and to the content of the message that is sent and received. The Oxford English Dictionary (OED online 2011) has 46 current definitions of communication, most connected to the technology which is used to send and receive information. It is a word where the meanings have changed considerably across the last century. Kress (1988) comments on the fact that the it was first used in Europe in the 19th and early 20th centuries to refer to roads, railways and shipping, the actual means by which goods and people were moved around. He goes on to suggest that in the late 1980s communication still retained vestiges of this definition in the understanding of things moving from place to place.

The academic study of communication has focused on the development of models used to analyse communication as a process of sending a message. McQuail and Windahl (1993) followed the history of this development, beginning with research in the United States of America in the 1940s. They begin with the Lasswell formula, 1948, and the mathematical model developed by Shannon and Weaver in 1949. In this model communication is described as a 'linear, one-way process' (McQuail and Windahl 1993: 17). DeFleur added a feedback loop to this model in 1970, while Osgood and Schramm had produced a circular model to illustrate the route of the message sent in 1954. That model was

refined by Dance in 1967 who proposed a helical model:

> The helix provides understanding in some cases where the circle fails. It directs one's attention to the fact that the communication process moves forward and that what is communicated now will influence the structure and content of communication coming later on (McQuail and Windahl 1993: 21).

McQuail and Windahl comment on the dynamic nature of this model as the helix could expand or contract relative to the situation and individuals involved. They then describe the Newcombe ABX model, also from 1953, which is represented as a triangle with points A and B being the communicators and point X an object in their environment. This model, 'lies at the heart of a wide-ranging body of ideas about attitude change, public opinion formation and propaganda' (McQuail and Windahl 1993: 27). This was later developed as a kite model, with further points of interaction, and has informed more recent theories of mass communication. Gerber's model of communication, also from 1953, is perhaps most pertinent to interprofessional communication as it includes a series of steps starting from the sender, which could be structured in different ways. It was represented graphically, and verbally as a list:

- someone
- perceives an event
- and reacts
- in a situation
- through some means
- to make available materials
- in some form
- and some context
- conveying content
- with some consequence (McQuail and Windahl 1993: 23).

The emphasis in all the above models of communication is on the transmission of information. This has been argued against in the separate area of literature which addresses communication theory. In a review of this literature Craig writes:

> that the transmission model is philosophically flawed, fraught with paradox, and ideologically backward, and that it should at least be supplemented, if not entirely supplanted, by a model that conceptualizes communication as a constitutive process that produces and reproduces shared meaning (Craig 1999: 125).

He in turn proposed a meta-model, 'that opens up the conceptual space in which the many different theoretical models can interact' (Craig 1999: 126) and went on to discuss that proposal in relation to phenomenology and sociocultural communication theories. His definition of communication theory as 'a field of discourse about discourse with implications for the practice of communication' (Craig 1999: 126) provides a 'space' for models of communication to be debated and refined but does not offer a definition of communication that can be applied to research and inform a better understanding of communication in interprofessional practice.

The models described by McQuail and Windahl (1993) represent communication as information that is sent and received with no distortion of the information. The model proposed by Gerber (McQuail and Windahl 1993: 23) introduces an element of 'consequence' or possible change at the receiver end of the model but does not indicate if this is good or bad. The helix model introduced by Dance (McQuail and Windahl 1993: 21) provides for a number of participants influencing the communication and the idea that change will happen

through communication.

Dewey (1958) provides a conception of communication which defines the dynamics and complexities of communication beyond the transmission of information. He defined communication as the process of making something in common, ‘as the establishment of cooperation in an activity in which there are partners, and in which the activity of each is modified and regulated by partnership’ (Dewey, 1958 [1929], p.179 as cited by Biesta 2006: 25). Or as Biesta states:

> The crucial point for Dewey is that common understanding is not a condition for cooperation. For Dewey it is precisely the other way around: common understanding is produced by, is the outcome of successful cooperation in action (Biesta 2006: 30).

The emphasis in Dewey is on communication as a participative action, ‘a process of sharing experience till it becomes a common possession’ (1916 MW.9.12 as cited by Biesta 2006: 30). Dewey sees communication as a creative process of collective meaning making. This is in direct contrast to the models of communication cited above where communication is the information that is sent and received between people and is in effect a reproductive process of meaning taking.

The aim of this research is to begin to understand the dynamics and complexities of interprofessional communication through a case study. To support this aim I need to work from a definition of communication which will enable me to follow and analyse the ways in which participants communicate and through that plan the support for the child. The models of communication

discussed above offer structures to analyse the circulation of information. A case study focusing on the circulation of information will allow me to follow information as it moves between the participants but I will not get a sense of the ways in which the information is interpreted as it is sent and received between them. The use of Dewey's concept of communication offers a more complex understanding of communication that recognises communication as productive and creative process, rather than just receptive.

2 The policy setting and literature review

Interprofessional practice has developed rapidly since the late 1980s in the United Kingdom across a number of professional roles in health, welfare and education. The structure and roles of interprofessional practice have been led by a focus in Government policy in the period from 1990 to 2010 towards what has become known as 'joined up thinking', from a comment made by Tony Blair when Prime Minister, that 'joined-up problems demand joined-up solutions' (Blair 1997). This policy imperative led directly to the commissioning and publication of five major literature reviews since 2000, three in England (Tomlinson 2003, Atkinson *et al*. 2007, Warmington *et al.* 2004) and two in Scotland (Wilson and Pirrie 2000, Brown and White 2006). Related to this are a large number of project reports about interprofessional practices in Government funded initiatives, contributing to a substantial body of literature published across the period including empirical research studies, theoretical analyses and the reports of two major Economic and Social Research Council (ESRC) projects (Edwards *et al*. 2009 and Anning *et al*. 2006, 2010). In relation to this case study it should be noted that the majority of the literature available is from empirical research carried out in England and, with the exception of the ESRC projects, much of it is directly linked to changes introduced through policy initiatives. It is because of the strength of these connections between policy and the research literature that this chapter addresses them together.

In the first part of this chapter I will use the policy and related literature to present a chronological account of the development of interprofessional practice in the United Kingdom in health and welfare (2.1) and child welfare and

education (2.2) to the year 2000. I will then review the policy literature relating to key changes in education based interprofessional practice in Scotland (2.3). The second part of the chapter begins with an introduction to the wider literature on interprofessional practice (2.4) and then focuses on current interprofessional practice and the research literature published from 2000. This will be reviewed in three sections: the conceptualisation of interprofessional practice (2.4a), multi-professional teams (2.4b) and interprofessional learning (2.4c). These divisions relate to practice developments in that period and three key texts which have influenced research and practice. Firstly the work of Eason *et al*. (2000) who were among the first to address the conceptualisation of interprofessional practice, secondly the ESRC funded project led by Anning *et al.* (2006, 2010) which focused on multi-professional teamwork and thirdly the work of Edwards, Daniels *et al*. (2009) on interprofessional learning. Throughout these sections the review will focus on the issue of communication in interprofessional practice. This will inform the final two sections of this chapter interprofessional communication (2.5) and a summary of the review (2.6), which links to the aim, objectives and questions for this research as outlined in the introduction. The terms used in this chapter for interprofessional working are those of the original authors.

2.1 Interprofessional practice in health and welfare

In the UK welfare services were part of the National Health Service (NHS) from 1942 to late 1960s, when following the Seebohm Report (1968) generic social services departments were created in local government. These departments

took on increasing roles in the community following the reorganisation of the NHS in 1974 (Pietroni 1994). Interprofessional co-operation in health and welfare was first identified as part of professional practice by Hallet and Stevenson (1980) in their work on child abuse and was then noted in Government publications by Hallet and Birchall (1992) in a literature review on child protection and by Hallet (1995) in a study of interagency work in child protection. Challis and others (1988) discussed the policy implications of what they referred to as inter-agency and inter-professional co-ordination in their work on the co-ordination of services for the elderly and the under-fives. They described the development of interprofessional policy as 'the manic-depressive cycle of the policy debate about co-ordination with fits of enthusiasm yielding to bursts of disillusion' (Challis *et al*. 1988: 267). This policy debate in the 1980s should be seen against a series of child neglect and child abuse inquiries all of which commented on the lack of collaboration between medical, nursing and social work staff, and linked this issue to a lack of education and training (Pietroni 1994). In health this led to the development of interprofessional education, which was referred to as IPE, supported through the establishment of the United Kingdom Centre for the Advancement of Interprofessional Education (CAIPE) across medical, nursing and allied health professions. This was founded in 1987:

> To promote and develop IPE whenever and wherever professions need help in responding together to complex needs beyond the capacity of any one of them alone, most poignantly when lapses in communication and trust contribute to undetected abuse of children or clinical errors' (CAIPE 2002).

The work of this organisation was actively supported by the Higher Education Academy for Health who published a series of occasional papers from 2001 to 2007 which addressed IPE in health and welfare. The series included the findings of a systematic review of interprofessional education in health and social care (Barr *et al.* 2006), a position paper on IPE (Barr and Ross 2006), and a history of IPE In the United Kingdom from 1966 to 1997 (Barr 2007). A summative text *Going inter-professional, working together for health and welfare* edited by Leathard in 1994 presents a series of papers that demonstrates interprofessional practice in health promotion (Beattie 1994), child protection (Stevenson 1994), mental health care (Lieba 1994) and work with the elderly (Evers *et al*. 1994). Further health based publications addressed interprofessional practice in collaborative care (Hornby 1993) and teamwork (Øvertveit *et al*. 1997 and Payne 2000).

2.2 Interprofessional practice in welfare and education

The development of interprofessional work between welfare services and education was given impetus through policy and legislation across the United Kingdom in the late 1990s. This can be seen in the Organisation for Economic Cooperation and Development (OECD) (1998) report on the co-ordination of services for children and youth at risk and a range of Government funded initiatives. These initiatives included Sure Start which worked with children and their families from birth to five (Glass 1999), the Children's Fund which established local partnerships across agencies to work with children aged five to thirteen (Edwards *et al*. 2006) and in England extended schools, which

brought together support structures for families (Cummings *et al*. 2006). This period of development led to the publication of the Green Paper Every Child Matters (DfES 2003) and the Children's Act (DfES 2004). It also brought changes in the structures of services within local authorities to support interprofessional work with children and young people. This led to the commissioning of a major literature review (Atkinson *et al*. 2007) focusing on the range of multi- agency activities and best practice. This built on an earlier review (Tomlinson 2003) which had identified the challenges and potential impact of multi-agency working.

Research analyses of many of the initiatives established through the introduction of Every Child Matters (DfES 2003) will be addressed in the sections on research literature below.

2.3 Interprofessional practice in Scotland

The policies leading towards interprofessional practice in Scotland were informed by the United Kingdom Government but sit within a separate legislative framework. The National Health Service is a separate organisation, NHS Scotland, subject to the legislation of the Scottish Office to April 1998 and from May 1998 to that of the Scottish Parliament. Welfare and education services are managed by local authorities, and subject to Scottish legislation. Joint working between agencies has a longer history in Scotland and was first proposed in the Kilbrandon Report (Scottish Office 1964). The social education departments suggested by Kilbrandon for young people in difficulty were never

established, but collaborative strategies for youthwork have been in place since the early 1980s (Pickles 1992). The more recent developments of interprofessional work in Scotland mirror the developments across the United Kingdom due to the impact of the political ideologies of the Governments led by Conservative and Labour politicians in the 1980s and 1990s (Anning *et al*. 2010). The Scottish Executive set policy targets for social inclusion and sustainability as 21 milestones in 1999, many of which necessitated interprofessional working. To support the development of this policy the Scottish Executive commissioned a literature review of multidisciplinary working in 1999 to, 'draw out the implications for policy and practice in Scottish Education' (Wilson and Pirrie 2000: v). The reviewers commented on, an 'increased demand for multidisciplinary teamworking' and recommended the development of 'appropriate models for education' (Wilson and Pirrie 2000: 20). This review was published as the first phase of New Community Schools (NCS) were established in Scotland. These innovative projects brought together the interprofessional agenda for health, welfare, education and voluntary agencies in Scotland (Scottish Office 1998). There were three phases of funded development leading to a 'roll out' across all Scottish schools in 2002 (SEED 2003). A review of the initiative by HMIe (2004) reported examples of good practice but suggested that there was a need to refocus the 'roll out'. In response to this the Scottish Executive Education Department (SEED) commissioned a review of the evidence base for integrated children's services (Brown and White 2006). The aim of the review was to consider the evidence for integrated services and the implications for policy development. The review focused on a lack of definitions of integrated working and linked that to,

‘challenges for clearly communicating what the integration agenda is about’ (Brown and White 2006: 2). The authors found that the ‘difficulties in the language around integration’ (Brown and White 2006: 8) made it more difficult to collect evidence of integrated working. In a discussion about the benefits of integrated working they identified ‘good systems of communication . . . as one of the key success factors in integrated working’ (Brown and White 2006: 17).

The Scottish Executive was renamed the Scottish Government in 2007, following the election of a parliament led by the Scottish National Party. The new administration continued to follow the agenda for integrated services set by the Scottish Executive (Scottish Executive 1999) in the first session of the new parliament. This included the development of a national programme Getting it right for every child (GIRFEC) that aimed to improve outcomes for all children and young people in Scotland (Scottish Executive 2006). This programme provided a framework, ‘for all services and agencies working with children and families to deliver a co-ordinated approach which is appropriate, proportionate and timely’ (Scottish Government 2009: v). An evaluation of the development and implementation of pathfinder projects for GIRFEC was published in 2009. The title of the review: Changing Professional Practice and Culture to Get it Right for Every Child (Scottish Government 2009) sets the current agenda for interprofessional working in Scotland. In their evaluation of the pathfinder project in Highland (2006 – 2009), the authors noted evidence of the ‘convergence of stronger shared multi-agency thinking and use of language across agencies at each stage of support provision’ (Scottish Government 2009: ix).

2.4 The literature on interprofessional practice

By 1990 a number of health-based authors had begun to publish on interprofessional practice (∅vretveit 1990 and 1993; Horder 1991; Leathard 1991 and 1992; Anderson *et al.* 1992; Pietroni, 1992 and Barr 1993). As noted above Leathard brought many of these authors together with others from welfare in a 1994 collection of papers *Going Inter-Professional* (Leathard 1994) which presented the key issues in the theory and practice of interprofessional working in the early 1990s. The aim of the text was 'to map out relatively new territory . . . and present a springboard for future activity' (Leathard 1994: 4). These papers, grouped in three sections: theory, practice and learning together, established the three key areas in which the literature on interprofessional practice developed across the next decade. There was a slow start to publications relating to the theory and the conceptualisation of interprofessional practice. Loxley addressed interaction between practitioners through social theories in 1997 but it was the development of a model of interprofessional practice by Eason *et al*. in 2000 which provided a framework used by later studies to analyse the data from interprofessional practice e.g. Webb and Vulliamy (2001), Vulliamy and Webb (2003a). The majority of papers and texts published from 1994 to 2004 concerned the analysis of a wide range of interprofessional practice. There was a considerable focus on teamworking and networking (Payne 2000), collaboration (Coulling 2000) and the barriers to interprofessional collaboration (Tett *et al*. 2003). Other studies considered the structural differences between organsisations (Freeth 2001) and the way in which the needs of different groups of people e.g. the elderly (Stewart *et al*. 2003) were met through interprofessional practice. Riddell and Tett published a

key collection of papers in 2001 which focused on the implementation in practice of interprofessional policy initiatives designed to aid social change. The editors asked if 'joined up working' (Blair 1997) could achieve this and concluded that there was little evidence of social change being achieved through interprofessional practice. Balloch and Taylor (2001a) asked a similar question in their focus on partnership working in an edited volume which considered partnership in relation to practice in regeneration, health and social care. Another edited volume to address this connection was that of Glendinning, Powell and Rummery (2002) who focused on the role of partnership in the governance of welfare.

The period 2000 to 2006 brought a focus in the literature on changes in professional practice and the development of multi-disciplinary teams or co-working (Robinson and Cottrell 2005, Shucksmith, Phillip, Spratt and Watson 2006). The papers in this period addressed models of professional practice, status and power, confidentiality and information sharing and relations with external agencies e.g. Frost and colleagues (2005). The last six years have brought a change in focus to interprofessional learning and the need to learn through role change (Worrall-Davies *et al.* 2009) and the publication by Edwards, Daniels *et al*. (2009) of the outcomes from an ESRC and TLRP funded study which considered what and how professionals learned as they developed new ways of working together.

The literature review of communication in interprofessional practice in the following three sections (2.4a, b and c) is structured around three key texts

which have influenced the range and scope of research into interprofessional practice since 2000. Coincidently these texts echo the structure that Leathard (1994) gave as editor to the first major collection of papers on interprofessional practice: the conceptualisation of practice (Eason *et al*. 2000), multi-professional teamwork (Anning *et al.* 2006, 2010) and interprofessional learning (Edwards, Daniels *et al*. (2009).

2.4a The conceptualisation of interprofessional practice

The study by Eason, Atkins and Dyson (2000) was the first to address the issue of the conceptualisation of collaborative interprofessional practice. The premise for the study was that the differences between the ways in which each profession conceptualised 'their roles, purposes and practices' (Eason *et al*. 2000: 357) would hinder the development of interprofessional practice. They found differences in conceptualisation between the professions, in particular cultural differences but were unable to further define conceptualisations due the range of other factors involved: working conditions, the extent of shared values or purposes, the locality, resources and the individuals involved. This led them to propose a mapping of collaboration across *boundedness*: relating to outcomes, timescales and procedures and context: the individual or community focus of the work. From this they established a model of the context for collaboration, which is presented in a nested structure with people, conditions of practice, conceptualisations of practice, specifics of locality and resources connected in the centre by a series of two-way arrows. This context for collaboration sits within the policy milieu, and both sit within the 'nature of the political economy' (Eason *et al*. 2000: 365). In the discussion of this model they

recognise the need for both policy and joint professional training to develop such practices. Although the analysis identifies poor communication as a difficulty in interprofessional collaboration, where it was seen, ‘as essential for understanding both differing perspectives and different expectations’ (Eason *et al*. 2000: 358), it is absent from the proposed model.

This model was used by Stead *et al.* (2004) in the analysis of interagency work to prevent exclusion from school in three Scottish Councils. In this paper they refer to the conceptualisation of ‘joined up working’ as co-ordinated planning, ‘which takes account of different policies’ (Stead *et al*. 2004: 43). The writers welcomed the typology proposed by Eason and colleagues (2000), as it enabled ‘significant differences in the conceptualisations of difficulties between different levels and branches of the same service to be acknowledged’ (Stead *et al*. 2004: 43). The analysis in this paper recognises the difficulties in the conceptualisation of practice but does not take the issues further. The focus in this paper is a comparative analysis between the ‘bounded’ and ‘less bounded’ (Stead *et al*. 2004: 51) nature of the interagency work in the three council areas. The ‘benefits of better communication’ (Stead *et al*. 2004: 48) is noted as one of the outcomes of joint planning meetings.

A wide range of papers published between 2000 and 2011 note the issues around the conceptualisation of interprofessional practice, each research project and related publications providing different definitions but no further conceptualisation of practice. The breadth of issues to be addressed in the area of interprofessional research is illustrated in the variety of approaches to the

analysis of research data. Nixon *et al*. (2001) in a paper addressing the NCS initiative in Scotland consider institutional and professional boundaries with a particular focus on 'professionals working *together* and working *with* communities (Nixon *et al*. 2001: 330 their emphasis). Their emphasis on working *together* and *with* is an expectation linked to interprofessional practice (Sinclair and Franklin 2000). In 2002 Farmakopoulou presented a framework for the analysis of collaborative activity between education and social work, based on data collected in Scotland. This framework looked at the complexity of inter-organisational relationships and proposed the interaction of a social exchange and a political economy model in the analysis of interprofessional practice. This study identified structural differences, lack of joint training and scarcity of resources as factors inhibiting collaborative practice. Glenny (2005) published an analysis of the factors contributing to the success and difficulties of three case studies of interdisciplinary working using complexity theory. In the conclusion it is suggested that a managed communication system was an essential part of information sharing, 'inter-agency collaboration is not about collaborative activity as such, but about communicating effectively with regard to individual pieces of work' (Glenny 2005: 174). She followed this with a larger study, also framed through complexity theory, which considered the 'free flow of information and feedback' between practitioners, children and young people (Glenny and Roaf 2009: 10). Forbes (2006a and 2006b) used the theories of dimensions of power and social capital to analyse the interprofessional relationships between teachers and speech and language therapists. The discourse analysis in the first paper illustrated the way in which the language used by individuals was 'shaped by specific disciplinary and professional

knowledge bases' (Forbes, 2006a: 101). Allen (2006a and b) addressed the role given to interprofessional practice in policy and proposed the 'deterritorialization' of professional training for health workers, social workers and teachers:

> 'Deterritorialization has the potential to attack the rigid, striated – or territorialized – spaces of teacher education, replacing these with ones which are smooth and full of creative possibilities' (Allan 2006b: 60).

Warin (2007) argues for the use of a theoretical rationale for integrated services from the socio-cultural approach to child development. Whilst the need for a theoretical rationale for interprofessional work in extended schools is advocated by Cummings *et al.* (2006) in an analysis of the professional understandings of 350 professionals. Harris and Allen (2011) used the theoretical framework of communities of practice to analyse the impact of multi-agency work on young people and their families. In this research differences in professional language, particularly in the forms used to discuss young people, 'symbolised strong demarcations of professional identity and orientation' (Harris and Allen 2011: 415). In the papers discussed above communication is not addressed as part of the theoretical frameworks used for analysis but is identified as a difficulty (Eason *et al.* 2000) and as an essential part (Glenny 2005) of interprofessional practice.

2.4b Multi-professional teamwork

In 2010 Anning and colleagues issued a new edition of *Developing Multi-professional teamwork for Integrated Children's Services*. This text was first

published in 2006 as the outcome of research carried out with five multi-agency teams working across health, welfare and the voluntary sector, in 2002 – 2004. The research used communities of practice (Wenger 1998) and activity theory (Engeström 1999) to analyse the knowledge and practices that each professional brought to the teams involved. The theories used for analysis highlight tensions in these teams between the need to reach agreement (communities of practice) and the need to confront conflict (knotworking in activity theory). The conclusions reached acknowledge the ways in which professional knowledge was shared in multi-professional teams and the importance of distinctive specialist knowledge as well as a general knowledge about the work of the team. In the analysis they identified professional language as a 'one stumbling block' in interprofessional practice but concluded, that 'professionals can and do learn the skills of being able to communicate with each other about their specialist knowledge and skills' (Anning *et al*. 2010: 85). The imperative for this research was, 'a confusion at both conceptual and practical levels in the implementation of government reform of public services' (Anning *et al*. 2006: 7). This confusion is reflected in the range of papers addressing various foci in multi-professional teamwork since 2000.

Payne (2000) wrote about teamwork in multiprofessional care, arguing for a combination of teamwork and networking to build relationships into the wider community. This followed the agenda set by Øvertveit (1997) who made a distinction between the individual role and the collective responsibility of teams. The research focus in publications changed in 2001 to reports from projects researching the methods of interprofessional teamwork and the outcomes for

children and their families. Webb and Vulliamy (2001) and Vulliamy and Webb (2003a, b) analysed the role of home-school support workers based in and outside secondary schools. Their analysis focused on the constraints and benefits of co-operation, finding that, 'support workers were able to initiate and improve communications between agencies' (Webb and Vulliamy 2001: 330). In 2002 Band and colleagues published a report on the outcomes of a multi-centre study on the perspectives of parents whose children had speech and language needs. This study examined collaboration between a range of health and education professionals. It reported that parents assumed professionals were communicating with each other but that they had no actual evidence of that communication. The authors also highlighted duplication in the content of reports given to parents, caused by a lack of communication between professions. Freeth identifies, 'more complex communication demands' (Freeth 2001: 44) as one of the organisational challenges in interprofessional practice in an article addressing the issue of sustaining interprofessional collaboration. A study of collaboration between community education workers and partner agencies in Scotland discussed the 'voices of excluded communities' (Tett *et al*. 2003: 50) but did not address the role of communication. A number of studies published at this time explored partnerships and joint working in specific interprofessional groups but did not address communication (Milbourne *et al.* 2003, Worrall-Davies *et al*. 2004, Frost *et a*l. 2005, Illsey and Redford 2005, Harrison and Bulllock 2005, Dhillon 2005). Pettit (2003) in a report commissioned by the DfES for the Mental Health Foundation recognised 'good communication' as a tool to address difficulties caused by different organisational and professional cultures. This report explored joint working

between schools and Child and Adolescent Mental Health Services (CAMHS) in England:

> Good communication was deemed as essential for good practice. This was on many levels, good communication within teams, communicating clearly between health and education staff and communicating with clients (Pettit 2003: 62).

The analysis of a similar study in Scotland into the collaboration between schools and other professionals to promote young people's mental health focused on the tensions between professional knowledge and identity, with an exploration of why teachers are 'resistant to changing practice' (Shucksmith *et al*. 2006: 28). The study did not address communication in these interprofessional collaborations. A key paper by Percy-Smith (2006) on partnership working provides a summary of factors which contribute to effective partnerships; communication is not one of the factors listed. Murphy and Stewart (2006) in a detailed study of partnership working in communities responding to trauma in Northern Ireland named communication as the first of four key processes in a system offering direct therapeutic support and support for the systems surrounding the young people receiving the support. In a smaller study (Sloan 2006) of the experiences of two individual young people with additional support needs between 1999 and 2006 the study concluded with a list of five factors that the writer felt are needed for multi-agency working to benefit children and young people. The fifth and final factor is:

> 'A Common Purpose - collaborative practices and projects have been seen to work if all the professionals have a common and efficient system of communication and a common goal' (Sloan 2006: 214).

Hughes and Beirens (2007) did not address communication directly in an analysis of six school or education-based support services for young refugees and asylum seekers in two English education authorities funded through the Children's Fund (Children's and Young Peoples Unit, 2001). However in this paper they discussed the development of a 'multi-levelled and multi-faceted approach' (Hughes and Beirens 2007: 270) and recognised the importance of liaison between home, school and community. Dhillon (2007) in a study of partnership in post-16 education and training providers considered the role of trust and shared goals. The process of service integration was explored by Hingley-Jones and Allain (2008) in an analysis of the creation of integrated support services for disabled children in two inner city authorities in England. In this study communication between services was found to be 'excellent' (Hingley-Jones and Allain 2008: 540) in one authority, but not commented on in the second. In both areas, 'differences in professional language' (Hingley-Jones and Allain 2008: 540) was a recurring difficulty in the creation of agreed support plans for children. A quantitative study of 35 Children's Trust Pathfinders in England (O'Brien *et al*. 2009) asked if integrated services improved the outcomes for children. The authors concluded that the complexity of the background to changes in services and inter-agency working prevented the data from showing improved outcomes for children. They found evidence that integrated services, 'can reasonably be expected to increase their effectiveness and so lead to better outcomes for children and their families' (O'Brien *et al*. 2009: 334). The data examined here focused on outcomes for children and not the processes of integrated working. Worrall-Davies and Cottrell (2009) in a study of multi-agency working in child and adolescent mental health (CAMHS)

examined the way in which evidence based practice related to the outcomes for individual patients. The authors contrasted the health service expectation of evidence from controlled trials with other agencies, who 'may prioritise the direct experience of service users and carers' (Worrall-Davies and Cottrell 2009: 338). They discussed the evidence base for the most common interventions used in CAMHS work and concluded, 'that all too often professionals and services offer treatments that they are comfortable with and have available, rather than those for which there is evidence' (Worrall-Davies and Cottrell 2009: 343). They recommended flexible arrangements between agencies, 'to facilitate communication, understanding and training' (Worrall-Davies and Cottrell 2009: 343). Frost (2012) in a chapter which addressed interprofessional working with looked after children noted that there was a need for effective communication between team members and partner agencies. Eccles (2012) in an analysis of the growth of partnership working across the United Kingdom noted that:

> In a very obvious sense partnership working which enhances communication and the exchange of ideas is a positive development, especially if it leads to speedier decision-making and more effective engagement with service users (Eccles 2012: 24).

The literature relating to multi-professional teamwork is also presented in three literature reviews (Atkinson 2002, 2007; Tomlinson 2003). Atkinson and others published a report of a study of multi-agency working for the Local Government Association in 2002, where communication was 'a challenge at all levels of working' and identified as a skill that was 'beneficial for multi-agency working' (Atkinson *et al*. 2002: 9). This material was referred to again in 2007 in a multi-agency literature review for the CfBT Education Trust (Atkinson *et al*. 2007).

This review examined in detail the models and terminology of multi-agency teams, the impact of such work and the factors effecting practice. The review listed communication as a key multi-agency process along with clarity of purpose. It cited three studies which found that multi-agency working, 'led to improved communication between professionals' (Atkinson *et al*. 2007: 34). The Tomlinson review in 2003 was also undertaken for the Local Government Association, it was designed to collate examples of good multi-agency practice for practitioners, and identified 'effective and appropriate communication' as one aspect of good practice (Tomlinson 2003: 2).

In the area of multi-professional teamwork communication is identified as a skill that professionals need (Anning *et al*. 2010) and as a method to address cultural and practice difficulties (Pettit 2003). It was noted as a challenge by Atkinson (2002), as an issue in multi-professional teamwork (Band *et al*. 2002) and as a way to improve services (Webb and Vulliamy 2001). Two case studies (Murphy and Stewart 2006, Sloan 2006) identified communication as a key process in multi-agency working. In these studies professional language was seen as a barrier to multi-professional teamwork by Anning *et al* (2010) and as a cause of difficulty in interprofessional practice by Hingley-Jones and Allain (2008).

2.4c Interprofessional learning

In 2009 Edwards and colleagues published *Improving Inter-Professional Collaborations*, with the sub-title *Multi-agency working for children's wellbeing*.

This text was one of a series of publications about the findings of projects in the ESRC's Teaching and Learning Research Programme. It is an account of professional learning in inter-professional collaborations in five English and two Northern Irish local authorities as they developed inter-agency responses to the problems of social exclusion between 2004 and 2008. The professions involved in the study included education, health and social care and in some areas, voluntary and community services. The research was framed by Cultural Historical Activity Theory (CHAT) and concluded with, 'some useful principles that can lead to inter-professional work being an enriched form of professional practice' (Edwards *et al.* 2009: xiv). The research team developed specific tools to analyse talk within developmental work groups and the learning taking place in those groups. The project used a specific definition of communication (Edwards *et al*. 2009: 108) drawn from the work of Engeström and others (1997) to analyse 'the communicative action of participants engaged with the transformation of the institution' (Edwards *et al*. 2009: 58). This definition of communication described a level of collaboration:

> Where practitioners co-operate, but also question the rules that shape how they work on the problems of practice with others and so develop new scripts and understand their implications (Edwards *et al*. 2009: 108).

The study made recommendations for the training and professional development of staff, the organisations involved and the use of CHAT. The focus in the recommendations for staff and organisations is on the use of knowledge and learning in developing interprofessional practice.

The sharing of knowledge and joint learning opportunities is a key strand in publications focusing on interprofessional practice. The development of interprofessional learning was led by health professions through CAIPE and this is reflected in the publications by Barr (2001), Barr et al. (2006), Barr and Ross (2007), Freeth (2002) and Freeth and others (2005). In 2001 Barr published a review of interprofessional education entitled *Today, Yesterday and Tomorrow* which traced the development of interprofessional education from the 1960s to 2000 in all countries within the United Kingdom. The areas identified for future research and development ranged from establishing standards and programmes for interprofessional education to researching interprofessional education in different fields and, 'Designing a continuum of professional, multiprofessional and interprofessional education' (Barr 2001: 5). The development of communication skills is noted in national policies for the NHS (Barr 2001: 7) and as part of a competency-based model of professional development (Barr 2001: 16). An appendix to the review lists the benchmarking statements for social policy and health care subjects from the Quality Assurance Agency for Higher Education (QAA). In both subject areas communication is a required skill e.g. to 'Have effective skills in communicating information, advice, instruction and professional opinion to colleagues, patients, clients, their relatives and carers" (QAA as cited in Barr 2001: 46). Freeth published a critical review of evaluations of interprofessional education in 2002 which found that most studies focused on continuing professional development, where interprofessional education was offered in the workplace as in the TLRP study above. This review grouped the outcomes of interprofessional education into six categories: 'learners' reactions, changes in attitude or perception,

changes in knowledge or skill, behavioural changes, changes in the organisation or delivery of care, benefit to patients or clients' (Freeth 2002: 55). In this structured analysis communication skills and interprofessional communication were noted as changes in knowledge or skills and in some studies as changes in behaviour. Freeth was the lead author of a self-help guide for evaluating interprofessional education, published by the Higher Education Authority in 2005. This text provided examples of good practice in planning, teaching and evaluating interprofessional education with a particular focus on enquiry and evaluation. The evaluation of communication between the teacher and participants is noted but not addressed as a topic in the guide. It is also not addressed in the position paper *Mainstreaming Interprofessional Education in the United Kingdom* (Barr and Ross 2006). This paper was written partly in response to policy imperatives in interprofessional education at that time. In it the authors recognised the use of different theoretical perspectives to analyse interprofessional education and suggested ways to sustain and embed practice. Barr (2007) edited a series of case studies in interprofessional education which presented an evaluation of interprofessional learning in four areas of England. In those studies communication skills were a key part of the programme in each area. A further publication in the same series (Colyer *et al*. 2007) addressed the relationship between theory and practice in interprofessional education in health and welfare. In this booklet a group of papers and short contributions from 22 authors have been collated and presented together to connect the theorisation of interprofessional practice to initial training in health and social care. In the introduction Colyer and colleagues (2007: 21) ask, 'whether exploration of the choices of theories that

people make in describing their experience and practice of interprofessional education can illuminate IPE (interprofessional education)?' The editors proposed:

> That the current move towards interprofessional learning and teaching should be considered a "paradigm shift: in professional education, analogous to a scientific revolution (Kuhn 1979) rather than a cumulative development or extension of how different health and social care professionals have been taught for the last fifty years' (Colyer *et al*. 2007: 14).

The papers included in the publication addressed IPE in relation to theories of learning, identity, social practice, boundaries, complexity, activity systems and adult learning. In the concluding chapter Sills suggests that the range of theories presented moves IPE In health and welfare, 'towards synergy inbetween theory and practice' (Sills 2007: 93). However she ended with 14 questions for IPE, including: 'How important is language development, the understanding of discipline languages and that of education?' (Sills 2007: 97). This set of papers demonstrates the range of theories which have been applied to interprofessional learning and practice in health and welfare. None of the theories used address communication, although acts of communication are used as part of the analysis of interprofessional practice in relation to complexity theory (Price 2007: 87).

The range of theoretical approaches discussed above demonstrates the different development trajectories of interprofessional practice and research between health and welfare, welfare and education, and practice incorporating all three professional areas. As can be seen in section 2.4b above the emphasis

in papers addressing education based interprofessional practice is on practice development rather than on interprofessional learning.

Robinson and Cottrell (2005) drew on research from the ESRC project noted in 2.4b above (Anning *et al*. 2006, 2010), to present an analysis of work in multi-disciplinary and multi-agency teams, in particular, 'on how professionals work, communicate, and learn together' (Robinson and Cottrell 2005: 558). This analysis used the theories of communities of practice (Wenger 1998) and activity theory (Engeström 1999) to analyse the project data. The writers found, "that 'joined-up' working has profound implications for professionals working in teams, and for the agencies that commission services" (Robinson and Cottrell 2005: 550). They identified issues in relation to professional identity and what they termed, 'the blurring of knowledge boundaries' (Robinson and Cottrell 2005: 550) between professions. In this analysis communication was seen as information sharing and addressed within a discussion of issues of confidentiality and record keeping. The authors recommended, 'transparent lines of communication within and between partner agencies' (Robinson and Cottrell 2005: 557) and that team members with different professional backgrounds, including different 'language(s)' (Robinson and Cottrell 2005: 557) cannot be expected to work together immediately.

Communication was identified as a key part of inter-agency training and one of the, 'core dimensions of effectiveness in interprofessional working relationships' by Glennie (2007: 171). In this paper Glennie provides an analysis of the inter-agency training needs in response to the creation of Local Safeguarding Boards for Children in England and Wales (DfES 2006). It focused on the need for

trainers to work beyond models of collaboration, with 'the fine grain, of human behaviour that makes the difference between professionals working effectively across boundaries, and not doing so' (Glennie 2007: 181). Inter-agency training is identified as a necessary catalyst to improve 'the *nature and quality of interactions* between professionals' (Glennie 2007: 175 emphasis original). Charles and Howarth (2009) reviewed interagency training in relation to the safeguarding of children. The authors questioned the evidence base for the value of such training concluding that, 'belief in the value of training different disciplines together persists, despite little being known about the way in which interagency training improves practice' (Charles and Howarth 2009: 364). In their analysis of this training, formal and informal communication channels are identified as part of the knowledge base in interagency relationships.

In the work published in the area of interprofessional learning communication is less evident as a subject area than in the papers addressed in 2.4b. It was used by Edwards *et al*. (2009) with a specific definition drawn from the work of Engeström and others (1997). In the wide ranging series of papers from CAIPE communication is labelled as a required skill and listed in competency lists (Barr 2001) and a key part of existing interprofessional education programmes (Barr 2007, Glennie 2007). Robinson and Cottrell (2005) saw communication as information sharing and linked it to issues of record keeping and confidentiality. The concluding paper in those presented by Colyer *et al*. (2007) asked about the understanding of discipline language. Communication is not used as a theoretical application in interprofessional learning but is acknowledged in some papers as skill required in interprofessional working.

2.5 Interprofessional communication

Since 2000 one research paper has been published which addressed communication directly. Simpson and Cieslik published a paper in 2002 about the use of discourse in three Education Action Zones (EAZs). EAZs were introduced from 1998 in England, with the aim to improve educational standards in areas of social deprivation through a partnership of schools, local business, local education authorities and parents. This paper focused on issues relating to the empowerment of parents through the EAZ structures and their involvement in policy-making. The data that informed the research analysis came from the documentary records of meetings, interviews with stakeholders and observation at EAZ forums. In the analysis the authors defined discourses as 'simply ways of talking and thinking about issues' (Simpson and Cieslik 2002: 124). Discourse was used as a general term to illustrate the way in which agreements were reached and power held within the management structures of each of the zones. The authors concluded, "that many of the 'voices' that make up the divers and complex communities that EAZs serve remain 'locked out' of the policy-making process" (Simpson and Cieslik 2002: 126). The use of discourse here relates to what was said in the meetings and interviews where data were collected, the focus is on the way in which parents were included and excluded in the EAZ. The paper illustrates one of the ways in which the content of discourse, as defined by Simpson and Cieslik, can inform the analysis of projects where different groups are working together.

Prior to 2000 one influential paper was published about the languages of health and social care. Pietroni (1992) identified eleven types of professional

languages used in health and social care. He used this framework to discuss the complexity of interprofessional communication and the implications for joint work. At the time the article was written Pietroni was a Senior Lecturer in General Practice at St. Mary's Hospital Medical School in London and the 'languages' he identified relate directly to interprofessional practice in health and social care:

1. Medical / molecular / material
2. Psychological / pyschomatic / psychoanalytical
3. Social / Cultural / epidemiological
4. Anthropology /ethology/ ethnology
5. Symbolic / metaphorical / archetypal
6. Natural / energetic / spiritual
7. Prevention / promotion / education
8. Environmental / ecological / planetary
9. Legal / moral / ethical
10. Research / evaluation / audit
11. Economic / administrative / political (Pietroni 1992: 8 - 14).

In each section he identified the impact of the language on the way in which practitioners worked and the implications for practice. In the conclusion he made the point that, 'it is not only the language and words used that separate us, but the mode of thought made possible by the different languages' (Pietroni 1992: 14) and went on to argue for the introduction of reflective practice in professional training to support different professions to reflect on practice together. This paper was written just after the establishment of CAIPE and prior to the development of interprofessional training in health and welfare. It is often cited in later works because the author brings together examples of 11 different

professional languages, knowledge bases and practice to illustrate range of issues in interprofessional communication.

These two papers represent the sum of research focusing on communication in interprofessional practice apart from the very specific contribution of Edwards *et al.* (2009) to communication in interprofessional learning as defined through CHAT. The theoretical approaches to research in interprofessional practice range from communities of practice, activity theory (Anning *et al*. 20010) to very specific applications of discourses of power and social capital (Forbes 2006 a, b). However, communication is seen as an *essential* or *key* part in the processes of interprofessional practice (Glenny 2005, Murphy and Stewart 2006, Sloan 2006) and as a *skill* (Barr 2001, Anning *et al*. 2010) that professionals need. It is identified as a *challenge* (Atkinson 2002) and as an *issue* in interprofessional practice (Band *et al*. 2002). In some literature communication is identified as *information sharing* and linked to joint record keeping and issues of confidentiality (Barr 2001, Robinson and Cottrell 2005, Barr 2007, Glennie 2007). Individual professional or discipline *languages* is seen as a barrier to interprofessional practice and as a cause of difficulty in interprofessional teamwork (Hingley-Jones and Allain 2008, Anning *et al*. 2010). The identification of professional languages is connected to different *knowledge* bases in each profession and the knowledge that is communicated in interprofessional practice (Pietroni 1992).

2.6 Summary

The interprofessional literature reviewed above highlights that communication is an identified issue in interprofessional practice. The research papers discussed in 2.4a provide different definitions of interprofessional practice but no conceptualisation of the practice. In that group of papers communication is recognised as a difficulty but also as essential for understanding. Theories of social exchange, political economy, dimensions of power, social capital and communities of practice have been used to analyse interprofessional research but not theories from communication or linguistics. The papers in section 2.4b presented research from a wide range of multi-professional teams. In these analyses professional language was seen as a *stumbling block* (Anning *et al.* 2010) and differences in professional languages recognised. In this section communication was identified as a key factor in multi-professional processes and as a skill to be learnt. Section 2.4c grouped papers around interprofessional learning and the work of Edwards *et al*. (2009), which used a specific definition of communication. Other work reviewed in 2.4c identified communication as a required skill to be taught in interprofessional education or training. In this context communication was seen as one of the core dimensions of effectiveness in interprofessional working relationships. One paper in this section asked about the development of professional languages and the need to understand the languages of different disciplines. The key paper in section 2.5 identified 11 different types of language in health and the mode of thought made possible by those languages.

The review demonstrates that communication is an issue in interprofessional practice. There are gaps in three areas of the research: firstly the use of communication or linguistic theories, secondly the issue of communication as a skill to be learnt and thirdly the need to understand different professional languages. This research offers the opportunity to examine the use of communication theory in interprofessional practice, to discuss the identification of communication as a skill and to investigate the role of professional languages.

3 Theory

The purpose of my research is 'interpretation' (Biesta *et al*. 2011: 226), as my aim is to investigate and enhance our understanding of the dynamics and complexities of communication in interprofessional planning meetings. Biesta and colleagues describe the role of theory in interpretative research as one which:

> . . . lies in deepening and broadening the understanding of everyday interpretations and experiences. The task for theory here is not to describe *what* people are saying and doing, but to make intelligible *why* people are saying and doing what they are saying and doing (Biesta *et al*. 2011: 229, emphasis original).

This approach involved the collection of empirical data which I have analysed and re-presented with a layer of interpretation. I have focused my study through two theories: a sense-making theory, ethnography of communication which I used to inform the design of my study and to analyse my empirical findings; and an 'object theory' (Biesta *et al*. 2011) which I have used to conceptualise communication through the work of Dewey. Deweyan pragmatism informed the structure and analysis of the research. In this chapter I will present each of these theories and describe the ways in which they contributed to the structure of the research and the areas identified for investigation in the introduction. I begin with sociolinguistics (3.1) and ethnography of communication (3.2) as the theoretical framework for the collection and analysis of the data. I will then consider the concept of communication in Dewey (3.3) and the role of pragmatism (3.4) in the structure of the research and practical implications of the findings.

3.1 Sociolinguistics

The communication I will research for this study will focus on 'speech and language', the discussions that professionals hold in a planning meeting. Sociolinguistics, as '*the study of language in relation to society'* (Hudson 1996: 1, emphasis original) provides a theoretical framework for the design of a study of speech in this context. Coupland and Jaworski (1997: 71) describe sociolinguistics as 'empirically grounded approaches to the study of language in society' and '(as) our best and systematic and explanatory accounts of how people position themselves and their social worlds through language' (Coupland 2002:116). Blommaert (2007: 682) defines it as 'what could be known about language' in a 'particular setting', which fits well with the focus of my research on 'language' as it is used within communication in a particular interprofessional setting. Although sociolinguistics provides a theory to support the study of 'language', it is an umbrella term for a range of different theoretical approaches to the study of language in society such as ethnomethodology, ethnography of communication, discourse analysis, conversation analysis and stylistics (Finch 2005).

Sociolinguistics developed from the work of William Labov in the United States of America and that of Peter Trudgill in the United Kingdom, both of whom worked from the traditions of dialectology and used them in analyses of urban and contemporary speech in the 1960s and the 1970s. In the same decades, Dell Hymes and John Gumperz led developments from the American traditions of fieldwork based linguistic and anthropological studies to examine the ways in which language was used in specific cultural settings. Figueroa (1994) in an

analysis of the development of sociolinguistics reviewed the corpus of Hymes, Labov and Gumperz in a search for a sociolinguistic metatheory. She concluded that all three writers located language in society in different ways:

> For Gumperz, social meaning does not adhere in a text, or in an institution, but is negotiated in interaction. For Labov, langue is a social fact which is imposed on the individual in concourse with other social institutions such as class or gender. For Hymes, social meaning is to be found in the culturally defined patterned use of language (Figueroa 1994: 178).

The work of Hymes (1962, 1972) led to the development of ethnography of communication as a distinct theory within sociolinguistics. Gumperz and Cook-Gumperz (2008: 536) describe it as, 'comparative research on language use that combined ethnographic fieldwork with linguistic analysis'. Figueroa (1994: 66) saw it as an unfinished theory that was 'weak in detail', but one that addressed 'communicative competence' and 'the relationship between language functions and social functions' (Figueroa 1994: 178). Saville-Troike (2003: 1) refers to it as, 'a new synthezising discipline which focuses on the patterns of communicative behaviour'. Ethnography of communication offers a theoretical framework for my research which will support the analysis of communication in interprofessional settings:

> Ethnography of communication extends understandings of cultural systems to language, at the same time relating language to social organization, . . . role-relationships, values and beliefs, and other shared patterns of knowledge and behaviour' (Saville-Troike 2003: 3)

This wide-ranging description of ethnography of communication offered a theoretical framework in which to design my study and support the analysis of

the data in the sense-making phase of this research. It provided a structure through which I could focus on language in a series of planning meetings and consider professional, rather than cultural systems. In my study I used ethnography of communication to address the interprofessional structure of the meetings, rather than social organisation, and the relationships between the professionals involved, rather than social relationships. The theory also provided a framework to consider 'other shared patterns of knowledge and behaviour' (Saville-Troike 2003: 3) as they appeared within the dynamics and complexities of communication in the series of interprofessional meetings in this study.

3.2 Ethnography of Communication

There are three aspects to the framework of ethnography of communication that I used to develop my case study. Firstly the consideration of the idea of a *speech community* and the *communicative competence* of those who are members of the community, which was first developed by Hymes (1972). Secondly a system of analysis, also created by Hymes (1972), to identify the *speech community* and the *communicative competence* of the members through the framework of *situation*, *event* and *speech act*. The third aspect is that of *cultural knowledge,* which considers social structure, values and attitudes, cognitive maps and the transmission of knowledge in skills. This third framework was developed by Saville-Troike (2003) in a synthesis of the work of Gumperz (1984), Hymes (1987) and Duranti (1988). I will now consider these three areas of ethnography of communication and define the way in which these

aspects of the theory were used to inform the design of my study.

Ethnography of communication was established as a theory within sociolinguistics when Hymes defined the principles of the terms *speech communit*y and *communicative competence* in 1972. The term *speech community* was adapted from the work of Bloomfield in the 1930s, when *speech community* was use to describe a group of people who shared the same language. Hymes redefined the term to mean, 'a community sharing rules of conduct and interpretation of speech' (Hymes 1972: 54). In ethnography of communication *speech communities* are, 'a matter of ethnographic investigation and should not be presumed' (Figueroa 1994: 57). It is also not likely to be 'a static entity which necessarily encompasses the same membership over time or situations' (Saville-Troike 2003: 15). The definition of *speech community* varies between studies and can encompass a range of foci, including, 'shared contexts for interaction' and 'shared sociocultural understandings' (Saville-Troike 2003: 15). In this study it is a group of professionals with, ' a shared context for interaction' (Saville-Troike 2003: 15). It is also possible to consider a group of *speech communities* as nested speech communities, 'reflecting expanding fields of individuals' interactions and networks' (Saville-Troike 2003: 17) which is particularly relevant for my research with a group of different professionals planning together.

Communicative competence is the counterpart to *speech community* in ethnography of communication and provides a structure to analyse the role of individuals in the *speech community*. Saville-Troike defines *communicative*

competence as what a speaker needs to know, 'to communicate appropriately with a particular speech community, and how does he or she learn to do so?' (Saville-Troike 2003: 2). In other words, the rules and expectations of the speech community which enable participants to communicate within it.

The principles of *speech community* and *communicative competence* establish the 'language' that is the focus of the research and provide a framework to structure what has been said. Hymes developed an analytical framework to support the analysis of data in relation to these principles. This framework covers three areas described as: *situation*, *event* and *act* (Hymes 1993). The areas are embedded within each other and can overlap. Figueroa described this analytical structure in the following way:

> The speech act is embedded in the speech event which in turn is embedded in the speech situation. The speech situation is the genre in which the discourse takes place. It bounds the event and may be associated with a particular speech genre but is itself not governed by rules of speaking (Figueroa 1994: 49).

In this study the *situation* is the policy *situation*: changing interprofessional practice as developed in a particular local authority and health board area. The *situation* provides boundaries for each speech *event*, the meetings; and the *speech act* is what each individual says in the meetings.

As with the definition of the *speech community*, the *situation*, *event* and *act* are 'not discrete units (and) will vary according to relationship with other units (Figueroa 1994: 50). Saville-Troike describes them simply as follows:

- The *communicative situation* is the context within which communication occurs.
- The *communicative event* is the basic unit for descriptive purposes.
- The *communicative act* is generally coterminous with a single interactional function (Saville-Troike 2003: 23 – 25, emphasis original).

The *situation*, *event* and *act* sit within three areas: linguistic knowledge, interaction skills and cultural knowledge. Saville-Troike (2003: 20) provides the detail of this as in a list, which demonstrates the range of linguistic, interactional and cultural knowledge, that ethnography of communication addresses:

1. Linguistic knowledge
   (a) Verbal elements
   (b) Non-verbal elements
   (c) Patterns of elements in particular speech events
   (d) Range of possible variants (in all elements and their organization)
   (e) Meaning of variants in particular situations

2. Interaction skills
   (a) Perception of salient features in communicative situations
   (b) Selection and interpretation of forms appropriate to specific situations, roles, and relationships (rules for the use of speech)
   (c) Discourse organization and processes
   (d) Norms of interaction and interpretation
   (e) Strategies for achieving goals

3. Cultural knowledge
   (a) Social structure (status, power, speaking rights)
   (b) Values and attitudes
   (c) Cognitive maps/schemata
   (d) Enculturation processes (transmission of knowledge and skills) (Saville-Troike 2003: 20).

The focus of my research is not on the linguistic knowledge or interaction skills of participants, as defined above, but the four areas identified under C*ultural Knowledge*; social structure, values and attitudes, cognitive maps and enculturation. This list contributed to the process and structure of my data analyses and my interpretation of communication in an interprofessional setting.

3.3 Dewey

In the introduction I noted the key aspects of Dewey's definition of communication (from Biesta 2006) as a co-operative activity, something that is made between participants and as a process providing the cooperation to produce something that is shared by those creating it. For Dewey the purpose of language was to communicate:

> it (language) compels one individual to take the standpoint of other individuals and to see and inquire from a standpoint that is not strictly personal but is common to them as participants . . . it (language) first has reference to some other person or persons with whom it institutes *communication* – the making of something in common (Dewey 1982 [1938] emphasis original: 46).

In Democracy and Education (1916) he wrote of society existing because of communication:

> Men live in a community in virtue of the things which they have in common; and communication is the way in which they have come to possess things in common (Dewey 1916: 5).

He went on in the same text to write of the experience of receiving a communication:

> To be a recipient of a communication is to have an enlarged and changed experience. One shares in what another has thought and felt and in so far, meagrely or amply, has his own attitude modified. Nor is the one who communicates left unaffected. . . . The experience has to be formulated to be communicated. To formulate requires getting outside of it, seeing it as another would see it, considering what points of contact it has with the life of another so that it may be got into such a form that he can appreciate its meaning (Dewey 1916: 7).

For Dewey communication was an important part of the human experience and the way in which men or humankind shared and understood experiences. Biesta, as I noted in the introduction, wrote about Deweyan communication as a practical activity between partners, where 'the activity of each is modified and regulated by partnership' (Dewey, 1958 [1929]: p.179 as cited by Biesta 2006: 713) defining communication as process where something is made in common between the partners. It is the role of partnership or working together in Dewey's concept of communication that makes it particularly relevant to my study of interprofessional communication. There are connections between Dewey's concept of communication and some of the extensive range of models developed to analyse communication processes, in particular the Newcomb ABX model (McQuail and Windahl 1993) where X is used to illustrate the point around which the actions of A and B are co-ordinated. What Dewey emphasised that is not evident in communication models is the shared ownership of the communication that is created between the partners A and B. For Dewey communication is something that is made by both participants together towards a common end and is shared by both. It is only when all participants are interested and understand the common end, that there is the

type of the participation ‘which modifies the disposition of both parties who undertake it’ (Dewey, 1916 MW.9.12 as cited by Biesta 2006: 30).

Dewey’s concept of communication defines communication as a process of change that requires the active involvement of all parties working towards an agreed and understood common aim, a definition that underlies many aspects of interprofessional working as demonstrated in the literature review in chapter 2. The words used by Dewey to describe the process of communication can be seen throughout that chapter, but it is important to note that the use of the words in the literature are drawn from practice and recent research projects, and do not necessarily relate to the Deweyan concept of communication. ‘Co-operation’ appears early in the canon in the reports of Hallet and Stevenson (1980) and the analysis by Challis and others in 1988. ‘Partnership’ is much debated as a term (Balloch and Taylor 2001a, Glendinning *et al*. 2002, Dhillon 2005, 2007 and Eccles 2012) but is established in the last decade as a particular approach to interprofessional practice (Edwards *et al*. 2006). Eason and colleagues (2000) addressed the issue of ‘shared values’ and Nixon and colleagues used the term ‘working together’ in their analysis of NCS practice in 2001. Sloan wrote in 2006 of the need for a ‘common purpose’ and a ‘common goal’ (Sloan 2006: 214). While the TLRP research into interprofessional collaborations used the term ‘communicative action’ (Edwards *et al*. 2009: 58). Of the factors effecting interprofessional practice Atkinson and colleagues (2007) listed the following: ‘Ensuring parity amongst partners, securing commitment, engendering trust and mutual respect, and fostering

understanding (Atkinson *et al*. 2007:3). They went on to identify three areas as particularly important:

> Ensuring effective *communication* and information sharing (e.g. by having transparent lines of communication, creating opportunities for *discussion*), developing a *shared purpose* (e.g. by agreeing *joint aims*, conducting a needs analysis) and effective planning and organisation (e.g. by developing *shared protocols*, having a clearly defined structure (Atkinson et al. 2007: 4, emphasis my own).

This quotation, from a recent literature review of interprofessional practice demonstrates the tensions and contradictions that exist in the current interpretations of communication in interprofessional practice. The words used by Dewey may be reflected in the literature, as I illustrated above, but the understanding of communication as a process is quite different. In the above quotation the description of communication in the brackets is seen as a 'line' that is visible between people, supported by 'opportunities for discussion'. Dewey's concept of communication as a '*meaning-generating* process' (Biesta 2010: 713, emphasis original) is very different to the 'transparent' transfer of information; it is about the creation and generation of meaning between different centres of behaviour. The use of Dewey's concept of communication supported my focus in this study on what happens between professionals who are 'communicating' with each other in interprofessional meetings.

3.4 Pragmatism

Dewey was one of the founders of a philosophical movement called pragmatism

which developed in North America in the late nineteenth and early twentieth centuries principally from the work of Charles Pierce (1839 - 1914), William James (1842 -1910) and John Dewey (1859 - 1952). There were differences between the ideas of each of the pragmatists and the range of philosophical topics they were interested in, so there is no single definition of pragmatism. Biesta and Burbules (2003) defined Dewey's pragmatism as 'transactional realism' because Dewey focused on the 'transactions' between 'the living human organism and its environment' (Biesta and Burbules 2003: 10). They further defined it as 'transactional constructivism' (Biesta and Burbules 2003: 11) because the knowledge is constructed in and based on reality. In this research the 'transactions' I am focusing on are those that take place between the contributors in an interprofessional planning meeting. In Dewey's terms each professional is the 'living human organism' (Biesta and Burbules 2003: 11) and the meeting the 'environment' (Biesta and Burbules 2003: 11) in which the transaction takes place. In their analysis of Dewey's concept of communication Biesta and Burbules (2003: 12) define it as a process where 'partners in interaction create a shared intersubjective, world'.

> Communication is not the simple transfer of information from one mind to another, but the practical coordination and reconstruction of individual patterns of action, which results in the creation of a shared, intersubjective world (Biesta and Burbules 2003: 12).

Dewey's pragmatist theory of knowledge is not an epistemology in the traditional sense as Dewey did not divide mind and matter but focused on interactions between 'human organisms' and their environment, 'a moving whole of interacting parts' (Dewey 1929a, 232 as cited by Biesta and Burbules, 2003: 10). His naturalistic approach to knowledge meant that he saw social

sciences as ‘branches of natural sciences’ (Dewey 1938a, 481 as cited by Biesta and Burbules, 2003: 72). This meant that he saw the social world as, ‘the most inclusive level of natural transaction and not a different ontological realm’ (Biesta and Burbules 2003: 73). His theory of knowledge is something that people use to act in the world. It is this practical aspect of Deweyan pragmatics that makes it relevant to my research where the initial impetus and aim for the study was to develop understanding of interprofessional communication in order to inform future practices. Biesta and Burbules (2003) list four areas in which Deweyan pragmatism contributes to educational research: a way to conceive the relationship between knowledge and action; a different way to think about the relationship between theory and practice; a different way to think about objects of knowledge and how to view objectivity and relativity. The first two of these points have informed the way in which I designed this study and the way in which I would like to use the findings of the research.

A focus on the relationship between knowledge and action sits at the centre of this study, how professionals use knowledge within the communicative process and how that then informs action. The inter-relationship between knowledge and action is equally relevant to the role of knowledge (Saville-Troike 2003) and the communicative act (Hymes 1972) in ethnography of communication. The research questions bring both aspects together in a quest to develop understanding of the dynamics and complexities of interprofessional communication.

The recognition in Dewey’s pragmatism that educational theory and educational

practice are separate but inform and influence each other is an important personal aspect of this study. Biesta and Burbules (2003: 108) defined the relationship between theory and practice in Dewey as one of 'co-operation and collaboration'. As someone who leads and co-ordinates professional learning and development for education the 'co-operation and collaboration' between theory and practice is one of the most challenging aspects of my role. This study was designed to develop the relationship between theory and practice in interprofessional communication and to support the way in which relevant findings can be used to inform practice.

Denzin and Lincoln (1994: 185) described pragmatics as providing 'the basic set of beliefs that guide (the) action'. In this study Deweyan pragmatics have guided the way in which I have worked with ethnography of communication and informed the design of my study. This research sits within Denzin and Lincoln's definition of qualitative research:

> Qualitative research is multimethod in focus, involving an *interpretive, naturalistic approach* to its subject matter. This means that qualitative researchers study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (Denzin and Lincoln 1998: 3, emphasis my own).

Flick (2006) in an historical account of the development of qualitative research refers qualitative research as 'the study of social relations' (Flick 2006: 11) and 'the empirical study of issues' (Flick 2006: 12), which seems particularly apt for a case study focused on the process of communication in an interprofessional meeting. What is key for this study is that the strength of qualitative research is,

‘its ability to analyse what actually happens in naturally occurring settings’

Silverman (2006: 351).

4 Design

The design of this study began with ethnography of communication and the frameworks provided by Hymes (1972) and Saville-Troike (2003). A case study design (Bassey 1999) provided a structure to work with the frameworks from ethnography of communication in order to investigate communication as a something that people created together (Dewey 1916). The design of the case study was influenced by the timing of my research and the agreement reached with the group of professionals who agreed to take part in the study. It was challenging to find an interprofessional group willing to take part in a study at a time of change in their professional practice. The access agreement with the participants informed the data collection structure of the study.

In the first part of this chapter I discuss the choice of a case study approach for the research (4.1) and the validity of qualitative research (4.2). I then describe the setting for the research (4.3) the ethical considerations (4.4) and data collection methods (4.5). This concludes with a section which outlines the period of research, the meetings and participants (4.6). In the second part of the chapter I discuss the proposed structure for the data analysis (4.7) and the way in which I worked with the frameworks from ethnography of communication and Dewey's concept of communication to adapt the data analysis structure (4.8).

4.1 Case Study

Case study was first defined as a methodology in the social sciences by Robert Stake in 1978 as, 'the study of the particularity and complexity of a single case,

coming to understand its activity within important circumstances' (Stake 2000: 25). In this study the particular event is a series of interprofessional planning meetings held for one child to support the transition from playgroup into the nursery class of a primary school. The general setting for this is the Scottish policy agenda (Scottish Executive 2002, 2006, Scottish Government 2009) and the introduction of planning procedures through GIRFEC. These circumstances are of importance to the child and family at the centre of the process and entail complex changes in planning and working procedures for all the professions involved. Research into a single case of interprofessional planning meetings offers the opportunity to examine in detail communication within those meetings.

The structure of case study methodology used in this research is that defined by Bassey who provided a reconstruction of the use of case study in educational research in 1999. In that work Bassey proposed a structure for case studies, 'as a prime strategy for developing educational theory which illuminates educational policy and enhances educational practice' (Bassey 1999: 3). This is a structure which connects with the practice focus of research undertaken in part completion of this professional doctorate programme and provides a form of case study through which my research can investigate aspects of interprofessional communication and from the findings make recommendations which could enhance educational practice.

In his analysis of case study methodology Bassey (1999) identified three types of educational case study: theory-seeking and theory-testing, story-telling and

picture-drawing, and evaluative. This research project sits in Bassey's definitions as a 'theory-testing' case study, a case study which is one of:

> . . . particular studies of general issues – aiming to lead to fuzzy propositions (more tentative) or fuzzy generalisations (less tentative) and conveying these, their context and the evidence leading them to interested audiences (Bassey 1999: 58).

He proposed that the outcomes of each case study as 'fuzzy generalisations' are, 'a valuable way of bringing educational research findings into professional discourse' (Bassey 1999: 56). He went on to list the requirements of an educational case study (Bassey 1999: 58 - 62) and I have annotated these for my research below:

- *Empirical data*

The data was collected from a series of planning meetings in one school setting, relating to one child, in one family. The meetings had both an education focus through school planning meetings (staged intervention meetings) and a health focus (team around the child meetings). The data was collected within a localised boundary of time and space: one local authority, one health board, across one calendar year. The data itself was a series of digital audio recordings of the professional discussion in the meetings and interviews with the professionals involved, sections of which I transcribed for analysis.

- *A singularity*

The study is of one group of professionals working with one child and their family in the transition between playgroup and nursery. It was selected because it is a developing area of professional practice in an area of changing national and local policy. The collection and analysis of data in this geographic area will support the interpretation of the overall study in relation to the implementation of national and local policy in practice.

- *Interesting aspects*

The location of the study is in a geographic area which was not part of pathfinder development work for GIRFEC. The case study was carried out as the professionals involved began to work together within the local policies developed from new national systems. This included the gradual introduction of joint processes through GIRFEC across health, education and welfare and existing school planning systems developed from the legislation for Additional Support Needs (Scottish Government 2004, 2009). At the same time the local health board expanded the team around the child (TAC) planning system from pre-school to include children in school. This case study was carried out at a time of change for all and provided evidence of interprofessional communication within these new systems.

- *Educational system*

The study followed the planning meetings which supported the transition of a child with additional support needs, as defined in Scottish legislation (Scottish

Government 2004, 2009) from playgroup to a nursery class in a state primary school in Scotland.

- *Natural context, ethic of respect*

The context is 'natural' to education, health and welfare services, but changing, as what would have previously been a series of separate meetings for the family with each profession were held together. As the meetings were held in a school and were for transition from private playgroup into the school nursery class permission was first sought from the Director of Education in the local authority, the headteacher of the school, and the family, prior to asking permission from the professionals involved. The methods of data collection were agreed in consultation with the family and professionals working with the child and family, and conducted with the minimum disturbance to the proceedings. The participants were informed by letter of the purposes of the research and that the data would be stored in password encrypted files and anonymised for use in my study.

- *In order to inform the judgements and decisions of practitioners or policy-makers or of theoreticians who are working towards these ends*

The aim of the research is to inform practice, through an analysis of the dynamics and complexities of communication in a series of interprofessional planning meetings. The 'fuzzy propositions and fuzzy generalisations' (Bassey 1999: 56) from this case study will contribute towards the future decisions of policymakers in this area and inform practitioners and theoreticians who are working in the area of interprofessional practice.

- *In such a way that sufficient data is collected*
    - *To explore significant features of the case and to create plausible interpretations of what is found*
    - *To test for trustworthiness*
    - *Triangulation of data through the meetings, professional reflections and outcomes of meetings*
    - *To relate the argument or story to any relevant research*
    - *To provide an audit trail by which other researchers may validate or challenge the findings*

Two interconnecting layers of data were collected in digital audio files. The first layer is a recording of the whole of each of the planning meetings held to support this transition. The second layer is a series of semi-structured, individual interviews with the professionals who take part in the meetings. All the professionals who attended the meetings were invited to take part in an individual interview. The data from the meetings provided material to analyse the significant features of communication between the professionals in the meetings. The data from the individual interviews added personal interpretations to the analysis of the data and in doing so provided a test of the 'trustworthiness' of the content of the data. This provided triangulation of data through the meetings and personal reflections of the participating professionals. It was planned to structure the data analysis through the frameworks of *speech community*, *communicative competence*: *situation*, *event* and *act*, and *professional knowledge* from ethnography of communication as outlined in chapter 3. However in this case study the use of *speech act* to inform the data

collection was not appropriate for two reasons. Firstly because s*peech acts* are the individual contributions of each member of a speech community and all of those contributions were not available in this study. The access agreement to collect the data for my study precluded the use of the parts of the meetings which were discussing the detail of support for the child, which meant that the entire *speech acts* of each professional were not available for analysis. Secondly the focus of the study was on the dynamics and complexities of communication between the professionals in the meetings rather than on their own individual *communicative competence* in that setting.

This provided data to consider the role of communication as conceptualised by Dewey as a meaning making process between people. The outcomes of the data analysis were then interpreted against the three research questions for the study:

- What are the dynamics and complexities of communication in an interprofessional planning meeting?
- In what ways is the communication process in interprofessional planning meetings affected by the professional knowledge of participants?
- Do professional languages have a particular role in the communication processes in interprofessional planning meetings?

The structure of the thesis from the introduction, the review of relevant literature, the establishment of a theoretical framework for the research, an outline of the design of the study, the analysis of the data, the interpretation of the data and a conclusion which relates the outcomes of the research to

practice provides an audit trail through which other researchers may challenge the findings as proposed by Bassey (1999).

4.2 Validity

Flick (2006) proposed that the validity of the findings in a qualitative study are directly related to the design of the research. In his discussion of validity he identified the key problem as how to specify the connections between what is studied and the version of that provided by the researcher: 'And is the researcher's version grounded in the field?" (Flick 2006: 371). In Flick's terms my research is valued through the structure of the case study (Bassey 1999) which makes explicit the connections between the two strands of data collected. In particular the way in which the data from the meetings was cross-checked through the semi-structured interviews with some of the professionals involved in the meetings. These interviews with the co-ordinator, early years worker, headteacher, resource worker, support worker and the teacher additional support needs pre-school provided their interpretation of the meetings to be analysed with the data from the meetings. This grounded the study in the practice of interprofessional meetings in the area the research was carried out in and provided a test of the trustworthiness (Lincoln and Guba 1985) of any interpretations. Silverman (2006: 282) recommends that the validation of qualitative research is supported by ensuring that, 'the research process is transparent'. In terms of Silverman's definition this study is partially transparent. The structure of the study and the data collection methods are transparent but the analysis of the data, through the theories of ethnography of communication

and Dewey's concept of communication (4.7) and the development of units of analysis (4.8) is less transparent. This is due to the adaptation of the planned framework for analysis. The connections between the units of analysis and each theory are outlined in each section of the data analysis (5.1 – 5.6) in order to make the data analysis as transparent as possible. It is also possible to consider the validation of research through the outcomes of the study, what Mishler (1990: 417) described, 'as the social construction of knowledge' suggesting that the knowledge created from the research provides the Justification for the overall study. In this research the use of the educational case study methodology established by Bassey (1999) provided outcomes as, 'fuzzy generalisations' (4.1, 6.5 and 7.2) to take the findings of the research into the professional discourse. In Mishler's definition of validation it is these fuzzy generalisations that will provide connections to practice and the validation of the design of the study.

4.3 The setting for the research

This study followed a series of four planning meetings with professionals from education, health and children's services, working together with a family across one year to support the transition of one child from playgroup to nursery education. The meetings took place in the primary school that the nursery class was in and were chaired according to education and health guidelines for that area. Individual interviews were held in the school and in the social care offices. The boundaries of the setting were established and maintained, as recommended by Hammersley and Atkinson (1995) through the education and

health procedures which created the meetings. This meant that the research began following two series of meetings, one education led and chaired by the headteacher of the primary school and one health led chaired by the health care and co-ordinator manager for children with additional support needs. These involved the same participants and were merged by agreement in the third meeting.

4.4 Ethical considerations

The focus of this research, with the involvement of a number of professions in an area of changing policy and practice, made it a difficult study to establish. A conversation with the headteacher of a primary school led to the opportunity of conducting a case study with an interprofessional group supporting a child and family through the transition from playgroup into the nursery class of the school she leads. The research was conducted according to BERA (2009) guidelines. I first approached the Director of Education of the local authority for permission to undertake research in a primary school in the authority. Permission was granted and the headteacher then discussed the proposed research with the family concerned. The family agreed that the discussion between the professionals taking part in the meetings for their child could be studied. It was not appropriate in the setting to seek permission to include information about the child the meetings were to be held for. I then requested and received agreement from all those taking part in the meetings to be part of the research. In this initial information all participants were made aware of the reasons for the research and my interest in this area from my practice background as a teacher.

All involved were assured of the confidentiality of their contributions and the anonymity of the school, local authority and health board area in which the research was carried out. Participants were assured that the recordings made during the study would be saved in password-encrypted files. The professionals were asked for permission to study the conversation that took place between them in the meetings and all were asked to participate in an individual interview. Seven of the professionals agreed to take part in an interview.

The permissions for this research were sought in the months prior to the first meeting, following a pre-meeting, which had established the group of professionals working with the child and family. It was an important aspect of the research that I was undertaking it in what was a new process for all the participants. This meant that as a researcher I was particularly aware of conducting the research with respect for the participants as they worked together in a new planning process. This directly informed the way in which I collected the data, as the chairs of the meetings requested that I attend each meeting to record the discussion and did not take notes during the meeting. The data collection methods were discussed and agreed to by all participants. The content of the meetings relating to the child and family were not to be part of the study, so transcriptions were only made of the data to be analysed. I did not collect as data for this study the written records from the meetings, which for both health and education were structured plans for the child and family. The permissions for the research were only for communication between professionals in the planning meetings.

4.5 Data collection methods

As noted in the discussion above data was collected from four meetings by digital audio recorder and stored electronically. Each of the meetings was held with participants sitting in a circle and the data recorder was placed on a stool in the centre of the circle. As requested by the chairs of the meetings and agreed with all the participants I attended the meetings and did not take notes. At the final meeting, as I switched off the recorder one of the group commented, 'We're so used to that as part of the meetings we've all forgotten about it'. The data was listened to and selected extracts of the data transcribed for further analysis. Selected transcription was used because only the discussion between the professionals was to be part of the research. Seven of those taking part in the meetings agreed to individual interviews, these were held by agreement in the workplaces of those who chose to take part. As with the meetings the interviews were digitally audio recorded and selected sections transcribed. The interviews themselves were semi-structured and addressed the following themes:

- Their role in the meetings
- Their professional language and use of specific vocabulary
- Communications within and across the group
- What knowledge was shared and related planning systems
- Their own professional training and development

4.6 The period of the research, meetings and participants

I recorded the data in this study over one calendar year, February 2010 to February 2011, following the interprofessional meetings arranged for a child who was moving from playgroup into nursery. The research study was arranged after a pre-meeting for professionals had taken place (November 2009). I attended and audio recorded meetings 1, 2, 3 and 4, with the agreement of the all the participants who were present at those four meetings.

- Pre-meeting: Professionals working with the family (November 2009)
- Meeting 1: Team around the child (February 2010)
- Meeting 2: School stage 2 meeting (February 2010)
- Meeting 3: Co-ordinated support plan (September 2010)
- Meeting 4: Joint school stage 2 and team around the child (February 2011)

The participants are listed alphabetically by title. Those who agreed to provide an individual interview are indicated by an *. Those interviews took place in May and June 2010.

- Care and co-ordinator manager for children with complex needs known as Co-ordinator team around the child*
- Early years worker, education *
- Headteacher*
- Health visitor
- Nursery teacher
- Parent – Mum
- Parent – Dad
- Principal teacher additional support needs (ASN)
- Principal teacher (ASN) pre-school
- Secretary for child and family and public health*
- Speech and language therapist

- Support worker, children's services*
- Resource worker, children's services*
- Teacher, additional support needs (ASN) pre-school*
- Trainee social worker
- Trainee social worker, disability support team

Other professionals who submitted written reports and / or were referred to in the meetings:

- Dietician
- Doctor – audiology specialist
- Doctor – General Practitioner
- Doctor – genetics specialist
- Doctor – metabolic specialist
- Doctor – paediatrician
- Physiotherapist
- Professor of Genetics

4.7 The proposed structure for data analysis

The setting of my research provided access to two strands of data, recordings of the planning meetings and individual interviews. As noted in my discussion of case study above (4.1) I intended to use the frameworks from ethnography of communication to analyse the data from the meetings and interviews together against *speech community*, *communicative competence* (Hymes 1972), *situation* and *event* (Hymes 1993). The record of the interprofessional meetings provided data to analyse in order to understand how and in what ways the participants in this series of meetings acted as a *speech community* (Hymes 1972). The data from both the meetings and individual interviews provided

material for the analysis of the data against the principle of *communicative competence* (Hymes 1972), which addressed the ways in which members of the community understood and used shared rules for speaking and how shared knowledge was created in the meetings. The data reflected the policy *situation* in this locality and the meetings themselves were the *events* in my study. An analysis of the data should illustrate any relationships between the *situation* or policy context and *events* or meetings. This was to be supported by a separate analysis of the data against the social structure, values and attitudes, cognitive maps and enculturation process as defined within a heading of cultural or here *professional knowledge* by Saville-Troike (2003).

I felt confident in planning the data analysis that this approach would support me to understand what communication was in my study and the way in which it worked. Ethnography of communication provided the structure to analyse each part of the processes of communication. The focus of my analysis of the data was to discover if there was evidence of communication as a practical activity between partners (Dewey 1916). Did the way in which the participants shared knowledge or information in the meetings make something that was shared between them as they worked towards a common aim? I was looking for an inter-relationship between knowledge and action that sits at the centre of Dewey's educational philosophy and from my experience is found in interprofessional practice. However in planning the analysis I had perhaps relied too heavily on the frameworks of ethnography of communication rather than searching for what the interprofessional group created together and analysing that in relation to the theoretical frameworks.

4.8 An adapted framework for the data analysis

I began the data analysis from Hymes' definition of *speech community*:

> A speech community is defined, then tautologically but radically, as a community sharing knowledge of rules of the conduct and interpretation of speech. Such sharing comprises knowledge of at least one form of speech, and knowledge also of its patterns of use. Both conditions are necessary (Hymes 1974: 50).

From that definition I asked the following questions of the data:

- Is there evidence of rules about when, how and who to speak to?
- How was knowledge of such rules shared?
- Is there evidence of shared understanding of what was said?
- Is there evidence of a lack of understanding of what was said?

These questions linked the data directly to the definition of *speech community* but did not open the data up to support an analysis of communication in the meetings. As I moved on to consider *communicative competence*, the 'ability to participate in its society as not only a speaking, but also a communicating member' (Hymes 1974:75), I realised that I was using the same extracts from the data to evidence *communicative competence* as I had done to define *speech community*. It was evident that in structuring the analysis directly from ethnography of communication I could justify the relevance of the methodology to the data but not analyse the data beyond the surface level. This initial analysis did emphasise the connections between the frameworks of ethnography of communication and the data. For example the data sets were entirely focused through the *situation* (Hymes 1974): the roles and responsibilities each professional took, the way they shared understanding and

their lack of understanding. Each of the meetings, the *event* (Hymes 1974), included the discussion of individual responsibilities and the contribution by letter and reports from professionals who did not attend in person. In the data from individual interviews the participants discussed their own contribution in the meetings, the *speech act* in Hymes' framework (1974), and their understanding of the interprofessional meetings. That data included comments about individual values and attitudes, and the ways in which knowledge was shared which linked to Saville-Troike's structure of *cultural knowledge*. My choice of ethnography of communication as a theoretical framework provided a starting point for the analysis of the data, and what Silverman refers to as a 'toolbox' (Silverman 2006:194) to inform the selection and analysis of the data. I will return to the use of ethnography of communication as a theoretical framework for analysis in chapter 7.

I felt at this point in the study that I had lost ethnography of communication as a framework for the data analysis but as I began to work through the process of finding a new analytical structure I realised that I could still use the most relevant areas of ethnography of communication. Although I could not implement my original design for the data analysis I could use the most relevant parts of the theory in an adapted framework.

My initial work through the frameworks of ethnography of communication provided a series of aspects related to the dynamics of communication that occurred across the data. I began the process of restructuring the data analysis by working directly with them to establish a new framework for analysis but

found myself returning within each of them to the context of the data. At this point I took some time to reflect on my approach to the data. I was aware that it was directly influenced by my work with ethnography of communication, where the *situation* (Hymes 1974) had directly informed the design of the study, but also recognised that there was a connection with my academic background in history and place-name research. It seemed that my background in historical research had a stronger influence on my 'voice' (Finlay and Gough 2003: 32) as a researcher than I had previously realised. The 'source' of the data, in this analysis the context, was of particular importance to me as a researcher because of my historical and practice-based experience. The policy background and meeting structure which provided the data were important to me as the researcher, so I could set the data in context and work with it in that context. It was not that I wished in any way to present an historical analysis of the data, but I found that I needed to include the context in the analysis in order to work with the data. In his work on cases studies Bassey wrote about the process of data analysis, as

> an intellectual struggle with an enormous amount of raw data in order to produce a meaningful and trustworthy conclusion which is supported by a concise account of how it was reached (Bassey 1999: 84)

I was not concerned at this point in the study about the amount of data that I was working with, nor the conclusions I might reach in relation to the research questions, but in order to work with the historian within me I needed to be confident of the relationship between the process of analysis and any conclusions I drew at the end of that process.

In an historical analysis the key primary source frames the first analysis of the data. In the data collected for my case study the first meeting provided the widest range of data and established the context of the research. This meeting was attended and contributed to by the largest number of participants. It included examples of the majority of the different aspects of the dynamics of communication that appeared across the data and was referred to by participants in the individual interviews to explain particular aspects of their work. I decided that if I approached the data analysis from that first meeting I would meet both my personal need to establish the different aspects of communication in context and develop a framework to examine the data. At this stage in the analysis I wanted to include a broad range of evidence related to as many aspects of the dynamics and complexities of communication as possible and returned to ethnography of communication to group these into units of analyses, the titles of these units were directly informed by the frameworks from ethnography of communication. I began this second analysis by working through the first meeting chronologically and established the following units of analysis (Saville-Troike 2003):

- The participants
- The meetings
- Roles and responsibilities
- Professional information
- Power
- The medical letter

I then worked again with the remaining data to build it into this framework and ensure that I had addressed all the different aspects of communication which arose in later meetings or individual interviews. This process gave me

confidence that I had considered all the data and selected for analysis that most pertinent to my research questions.

I found it particularly challenging to move away from ethnography of communication in this analysis, as can be seen in the titles for the units of analyses listed above, which are developed from the work of Saville-Troike (2003). The theory has not allowed me to neatly present an analysis which directly relates to the questions I identified from the literature review but it has supported an analysis focused solely on the linguistic content, what was said, in the meetings. This is a new approach to the research of interprofessional communication and my study demonstrates the relevance of a sociolinguistic approach to understanding such communication.

The reframing of the data analysis through units of analyses developed from ethnography of communication presented a further challenge in deciding what to name the outcomes of my analysis. Was I justified in naming them as emerging themes? I was very aware from my struggles to find a relevant structure for the data analysis that I was working across a range of academic fields and had blended my research methodology to suit the research questions. The use of research methodologies from different disciplines was noted as a particular issue in the development of nursing science, where a number of research methods from other disciplines were adapted for use in qualitative nursing studies. DeSantis and Ugarriza (2000) discussed this in relation to the definition of the term theme in qualitative research studies in nursing. In their exploration of the use of theme, they began from the premise

‘that a basic definition of the term theme is applicable to all qualitative research methods and will bring increased rigor to data collection and analysis’ (DeSantis and Ugarrizza 2000: 352). From a review of the literature, qualitative research texts and a consideration of interdisciplinary concepts of theme they reached the following definition:

> A theme is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole (DeSantis and Ugarrizza 2000: 362).

They added four criteria to this definition: that themes emerge from the data; that they are abstract and are extracted from the data by the researcher; that a theme is a recurrence of experiences expressed in various ways and that, ‘the unifying and explanatory functions of a theme occur at multiple levels’ (DeSantis and Ugarrizza 2000: 363). In this study I have worked with this definition of theme and in the data analysis identified emerging themes as I worked through each unit of analysis.

5 Data Analysis

In this chapter the data are presented in six units of analysis, which were established from the terms and concepts of ethnography of communication as I discussed in chapter 4. The presentation of the data in these units has enabled me to structure my analysis in a way which supported the analysis of the dynamics of communication in the data and connected directly to the implications for practice, which I will discuss in chapter 7. The units of analysis are:

(5.1) The participants
(5.2) The meetings
(5.3) Roles and responsibilities
(5.4) Professional information
(5.5) Power
(5.6) The medical letter

The data extracts are numbered and the source identified in the final line of each extract. The material is presented in a tabular format with the speaker indicated by profession in the first column. In each extract the name of the profession or a parental title has been inserted in italics in the place of the first names, which were used by participants throughout the meetings and interviews. Medical professionals who were referred to by their title and surname during the meetings are here referred to by their title and area of expertise.

The following conventions have been used to present extracts from the data:

- *a role in italics* replaces the name of any person referred to
- . . . indicates a pause in the speech
- underlining shows emphasis in speech
- { } to insert a word to aid understanding of the quotation
- [ ] are used to indicate a gap where direct information about the child, which is not part of this study, has been removed
- a blank line in a table indicates space between a series of extracts from one interview

The units of analysis which follow are each structured in the same way: they begin with an explanation of the way in which ethnography of communication has informed the naming of the unit, followed by an explanation of the relevance of the unit to the dynamics of communication, extracts from the data and an analysis of the data in relation to the theoretical frameworks of the study. Each unit concludes with a discussion of the ways in which the theoretical frameworks supported or challenged my understanding in this sense-making process and the identification of emerging themes in the data.

5.1 The participants

The choice of participants as a unit of analysis relates to two areas in ethnography of communication: the *situation* (Saville-Troike 2003) and *speech community* (Hymes 1974). The term *situation* was defined by Saville-Troike (2003: 23) as, 'the context in which communication occurs'. In my study the *situation* is GIRFEC, the national programme that was being taken forward through the education planning structures in this local authority. GIRFEC had

also informed the developments introduced by the area health board and the introduction of the team around the child and the post of co-ordinator for that process. This *situation* led both the headteacher and co-ordinator, as chairs / organisers of the meetings, to spend time in the meetings identifying which professionals were supporting the child and who should be included in the meetings. The focus of the *situation* on the development of a team of professionals connects to the idea of *speech community* (Hymes 1974) as a social, here a professional, structure which can be used to study the interactions between a group of people (Gumperz 1962, 1971). Saville-Troike (2003) noted that the membership of a *speech community* was not likely to be static.

When I examined the data through Dewey's definition of communication I found that the participants, the professionals attending these meetings, were the key part of the study. The participants were in effect the partners who, to communicate, would work together towards a common aim. Indeed the three participants who attended all the meetings: the co-ordinator, early years worker and the teacher (ASN) pre-school formed a small group who, with the child's mother, did communicate with each other to achieve a common aim. It is interesting that the participants themselves also placed importance on knowing who was working with the child and from which professions. This is in direct contrast to the findings of some earlier studies of interprofessional practice which suggested that professionals often did not know which other professions were working with a child (Band *et al* 2002) or were aware but did not communicate across services (Sloan 2006).

The first meeting began with a long discussion about which services and staff should be at the meeting. The purpose of this was to establish a core list of participants, but such was the variation in attendance that each of the meetings began with a series of introductions, apologies and a note of reports in lieu of attendance. The role of the chairs was crucial in this list of participants as can be seen in this first extract from meeting 1 where both chairs debated the involvement of the early years worker:

Co-ordinator	Are you aware of anybody I should add on? I just wanted to check that we had everybody up to date on it. I've got you *health visitor, early years worker*
Headteacher	She's going to be late
Co-ordinator	But will she be on the list?
Headteacher	I think she will be
	Extract 1: meeting 1

The co-ordinator was more concerned about the inclusion of the early years worker 'on the list' than her actual attendance at the meeting. The headteacher knew that the early years worker was coming to the meeting, but her reply also shows her uncertainty about the role of the early years worker in the meeting, and she doesn't know if the early years worker should be on the list. She explained some of the background to that in her individual interview where she commented on the changing group of professionals who were working with the child and the size of the group.

Headteacher	This person was contacting us and that person was contacting us and we got to the stage we didn't know who was involved with this family.
	The social worker involved has changed and two new people arrived at the meeting last week so it's very difficult to keep track of it because I didn't know that had changed and social work didn't inform us that it was changing . . . You're accustomed to going to child protection case conferences and sometimes the health visitor is there but not to this extent and this size of a meeting
	Extract 2: headteacher interview

The final comment in extract 2 illustrates the change in practice that the headteacher was experiencing through the implementation of GIRFEC. She contrasted the number of professions working with this child with her previous experience of 'large' interprofessional meetings, which were usually child protection case conferences. The final comment from the headteacher in extract 2, 'and sometimes the health visitor is there' emphasises the difference for her in this series of meetings compared to her previous experience; namely the involvement of a much wider range of health professionals. It was however involvement at a distance, as the health visitor was the only health professional to attend these meetings and the first meeting included considerable discussion about which health professions were supporting the child.

Co-ordinator	*Dietician?*
Mum	I don't know when I'm next seeing her [ ] she's not
Co-ordinator	But you are still working with her?
Mum	Yes supposed to be. I don't know when she's coming next
Resource Worker	That's not on our list
	General nervous laughter
	Extract 3: meeting 1

The co-ordinator, who was a health professional, suggested that a dietician should be part of the group but the Mum was not sure whether the dietician was still working with the child. The comment from the resource worker, which was immediately followed by nervous laughter across the group, shows the concern that was felt by some of the professionals that they did not have a complete understanding of the support this child was receiving from different services. The reason for calling the meeting was to support the transition of the child from playgroup into Nursery, yet no one from the playgroup had been invited to the first meeting.

Headteacher	Sorry . . . it's really just dawned on me they just haven't been invited so maybe next time . . . playgroup
	Several voices talking at once about which playgroup
Coordinator	What playgroup is it?
Mum	Only there until the summer
Headteacher	If it's before the summer holidays they should be invited, it's good for transition as well . . . who would it be?
Teacher (ASN) pre school	It would be *playgroup leader*
	Extract 4: meeting 1

The confusion felt in the meeting about who should be there and why, can be seen in the conversation in extract 4. The headteacher realised that someone from the playgroup should have been invited to a meeting planned to support transition of a child from playgroup to nursery. A number of the participants then started to talk about which playgroup the child attended and the co-ordinator, who was still compiling her list at this point, immediately responded. The child's Mum was confused because the child was leaving the playgroup in the summer and for her this meeting was about the move into nursery. The teacher (ASN) pre-school had the knowledge of the local playgroups and provided the name of the playgroup leader. This extract demonstrates the level of uncertainty about

who should be participating in the meetings and also the need for local knowledge to ensure that all relevant participants were invited.

This unit of analysis shows the way in which the group of professionals worked together to agree who would be part of this speech community, through being listed as a member, 'But will she be on the list?' (co-ordinator, extract 1). The 'bounding features' (Saville-Troike, 2003:16) of this *speech community* are defined through the statement that each professional, is 'still working' (co-ordinator, extract 3) with the child and / or family. The boundary itself can be described as 'soft-shelled' (Saville-Troike, 2003: 17) with movement across the boundary possible: 'two new people arrived at the meeting last week' (headteacher, extract 2). These two aspects of the *speech community*, with one bounding feature and a soft-shelled structure, with the associated changes of participants, illustrate one of the key difficulties facing communication in this speech community. There is no established partnership in which members can work together towards a common aim. An agreed aim can be seen in the extracts above: to identify members of the *speech community*, but it is apparent that there was more than one list of members, 'that's not on *our* list' (resource worker, extract 3, emphasis my own). It seems from that statement that there was more than one *speech community*. Although this should be considered with the statement from the headteacher, 'This person was contacting us and that person was contacting us' (headteacher, extract 2) which suggests that the meetings in this study were the first opportunity for the creation of a *speech community* around the support for this child.

In this unit of analysis the frameworks from ethnography of communication were key in supporting my analysis of the participants and their attendance at the series of meetings in my study. The definition of a *speech community* (Saville-Troike 2003) provided me with a way to consider the data beyond patterns of attendance and to search in the data for the reasons given by each professional for their participation in the meetings. The identification of 'still working' as the rule or 'bounding feature' for being included in the meetings demonstrated the way the membership of the planning group was formed and how new members were admitted; it also let me see that there were a series of different groups of professionals working with this child and his family. This provided an indication of what seems to have been a series of inter-connected groups of professionals working with the child who in the meetings in this study were being pulled together for the first time. This was an important step in developing my understanding of the way in which this series of meetings was a new development in the policy *situation*. It was particularly useful to consider the group as a *speech community* with flexible edges, that Saville-Troike (2003) described as a soft shell, to identify the core participants and understand the way in which the different professionals moved in and out of the series of meetings.

The two themes which emerge from this unit of analysis relate to the definition of the members of this series of interprofessional meetings as a *speech community*: first that the definition of the bounding feature of the *speech community* as 'working with the child' and second that the boundary of the *speech community* itself was soft-shelled and participants could join or leave at

any time. The second theme is related to the way in which the participants perceived the community and the different understanding they had of who they were doing what with, which is likely to have had an impact on the dynamics of communication. The data in this unit developed my understanding of the movement of the participants but challenged my use of Dewey's concept of communication and left me questioning the relevance of the concept in a data set where the membership of the partnership or speech community varied. How could the group communicate (Dewey 1916) when there was no consistent partnership although there appeared to be a common aim of working with the child at the centre (Scottish Executive 2006).

5.2 The meetings

In ethnography of communication these meetings would each be classed as an *event* (Hymes 1974) which sat within the speech *situation* (Figueroa 1994). The *events* were arranged in response to the *situation,* as outlined in 5.1 above. The discussion in the data about meetings connects to what Saville-Troike (2003) defined as *cultural knowledge*, perhaps more appropriately labelled *professional knowledge* here. This relates to the structure of the meetings and the way in which knowledge and skills were shared in this *situation*. I will return to the role of professional knowledge when I discuss professional information (5.4).

This unit of analysis is linked to that of participants as, with the changes in participants between the meetings, much of the professional discussion in the meetings was about arrangements for future meetings. This appeared in two

ways in the data: what each meeting was called by the different professions and why the meetings were being held. These discussions can be seen in Deweyan terms as the *speech community* working to create a common understanding of the meetings.

The way the meetings were named concerned the headteacher and the co-ordinator who chaired the meetings but was of less interest to the other participants. This illustrates a difference in perception across the group about the common purpose of the group, which indicates that the common activity was less common than it perhaps appeared externally. The naming of the meetings related directly to the policy *situation* which influenced the structure and content of the meetings. This indicates uncertainty at practice level in the implementation of national policy (Anning *et al*. 2006), which was also seen in the difficulties the meetings had in agreeing which professionals should be participating discussed in 5.1 above.

The way in which the meetings were named by the headteacher and the co-ordinator illustrates the movement between national and local policies as they worked together to implement policy in practice. The table below gives the names they each used for the meetings.

	Headteacher	**Co-ordinator**
Pre-meeting (not part of the study)	Dialogue meeting	Professional planning meeting
Meeting 1	Team around the child	Team around the child
Meeting 2	Stage 2	Stage 2
Meeting 3	Stage 3 / co-ordinated support plan	Co-ordinated support plan
Meeting 4	Stage 3	Joint meeting for health and education

Table 1

The names used by the headteacher for the meetings are mainly from the local authority planning process for additional support needs: dialogue meeting, stage 2 and stage 3. The co-ordinated support plan meeting is a name from the additional support needs legislation (Scottish Executive 2002, Scottish Government 2009) that can be seen sitting as an alternative with the stage 3 meeting. The co-ordinator uses terms from health for the first two meetings, education terms for the next two and then brings the two together in meeting 4 and refers to it as a joint meeting for health and education. The table illustrates the way in which the education planning structure adapted to work with health, and likewise the way in which the co-ordinator worked with the education structure to ensure that the team around the child was in place. She discussed this in her interview when she commented on the lack of knowledge in education about the health planning structures.

Co-ordinator	Well we suggest the meeting often, but it's actually different though pre-school and once they're in school, . . . because if the children are actually in school I try and tie it up with an IEP {individual education plan} meeting and a CSP {co-ordinated support plan} meeting, trying to reduce the amount of meetings that people are attending. I hadn't realised it was such a step in the dark for people. I phoned a secondary school today and she said, 'What? you do what?'
	Extract 5: co-ordinator interview

This lack of understanding was also seen in meeting 3, which was chaired by a newly appointed principal teacher (ASN) who had not attended the earlier meetings and asked at the start of meeting 3 what the joint team around the child was. In her reply the co-ordinator explained the way that education and health had been working 'alongside' each other through the meeting structure.

Principal teacher (ASN)	Joint team around the child, I don't know what that means
Co-ordinator	It's just like what we've tried to do today, a team around the child meeting alongside the CSP meeting
Principal teacher (ASN)	I'll be happy to just say to *headteacher* because I think there has been a huge misunderstanding of what the meeting was actually for
Co-ordinator	A joint team around the child, CSP meeting … about January, we can set a date now if you want? . . . It makes no difference to the support *child* is getting, it's a piece of paper that collects that information but there's no-one who will say *child* doesn't have a CSP so he won't get that. Your IEP documents that and that won't change …
	Extract 6: meeting 3

The comment from the co-ordinator at the end of extract 6 illustrates the emphasis given by the headteacher and the co-ordinator to make both health and education planning systems work together for the child, and to make no difference to the support the child received. It highlights the challenges felt in joining the two systems but also that the systems were viewed separately from

the work that the different professionals did with the child. In extract 7 the meeting moves from the headteacher explaining why meeting 2 was called to three of the professionals reassuring the child's mother about the support.

Headteacher	Last . . .we had a dialogue meeting with all the professionals just about, oh, November time and we decided that we would have an education meeting, which is called a stage 2 meeting just to share where we are with *child*
Mum	That'll help *child* when he's older [ ] doing this now is hopefully . . .
Headteacher	Is giving him the support
Teacher (ASN)	Absolutely
Principal teacher (ASN) pre school	And that's why we're all here, we're very much on your side to make sure, it's part of our role to make sure that *child* gets everything he's entitled to and in a place that he's comfortable and happy
Mum	Uh uh
Headteacher	Every child is an individual and that's what we work to
	Extract 7: meeting 2

In this discussion the principal teacher (ASN) pre-school described how she saw the connection between the meetings and the support the child received, 'to make sure that child gets everything he's entitled to' (principal teacher (ASN) pre-school). She made this statement in a stage 2 meeting which was part of the education support structures that she worked within and was familiar with. She was the only participant to comment in this way on an overall aim of the planning meetings.

The lead services in planning the support for this child were education and health, which provided the two planning systems that can be seen in the series of meetings. Children's services staff working with the child and family took part in the first two meetings. The resource worker was direct in her comments

about the joint meetings, which she viewed as outside children's services planning structures.

Resource worker	I don't know how that will work because team around the child doesn't take over from a case conference, or that type of thing.
	Extract 8: resource worker interview

For education and health the impetus in working together to establish the series of meetings followed through to the final meeting in this study. The headteacher talked about this in her individual interview when she acknowledged the challenges she faced in making the support systems, legislation (Scottish Executive 2002, Scottish Government 2009) and policy (Scottish Executive 2006) work for the child.

	It's taken another dimension from now on, because at the stage 3 meeting there were changes in staff. The next meeting is the beginning of September {meeting 3}, we're just going to call it team around the child, because it's now going to take on …because so many agencies are involved we think it's going to be a co-ordinated support plan .. we're trying to do it all at the same time and do it as a family but I don't know if we can. I've never been in a CSP meeting, it's new territory for me.
	Extract 9: headteacher interview

The headteacher began meeting 4 with an explanation about what the meeting was called, why it was being held and which service was responsible for it.

Headteacher	This meeting is a stage 3 meeting, it's not a CSP meeting as there are certain reports *Mum,* that we need, to see if it is able to be, to go to *main town* to see if it will be a CSP meeting. Co-ordinator and I had a wee discussion to see if she is leading this meeting or I am and the agreement is that I am leading it because it's a stage 3 meeting and that really just means bring the home and agencies together for *child.*
	Extract 10: meeting 4

This meeting ended with the following exchange:

Co-ordinator	We'll need to have our joint meeting?
Headteacher	Oh yeah I don't think this should stop, it's maybe the wrong way to say it but to say it as a positive thing is to say that what is making this all work very well together is the fact that all the agencies are coming together and everybody is then hearing what everybody is saying. Is everything working well, if not is there a problem and how can we solve it. As far as I'm concerned we're going to carry on, we'll still call it team around the child, or getting it right for every child, we'll still call it that
	Extract 11: meeting 4

This final comment from the headteacher, 'we're going to carry on' illustrates the determination of the headteacher and the co-ordinator to ensure that the interprofessional practice they had begun would continue. The final question from the co-ordinator and the headteacher's reply show them convincing each other that the joint system they had developed was bringing agencies to work together to provide support for the child. There is less certainty in the headteacher's remarks about what the meetings should be called or where they fitted into local or national policies.

The data extracts in this unit of analysis illustrate the boundaries and interactions between the concepts of *situation*, *event* and *speech community* in this study. In particular the extracts illustrate the way in which the *situation* informs the definition of *events*. Saville-Troike described the concept of *situation* as:

> A single situation maintains a consistent general configuration of activities, the same overall ecology within which communication takes place, although there may be diversity in the kinds of interaction which occur there (Saville-Troike, 2003: 23).

The *situation* is referred to in the extracts above only in relation to the changing of the name of an *event*, 'we think it's going to be a co-ordinated support plan'

(headteacher, extract 9), a co-ordinated support plan is part of the legislative structure to support children and young people with additional support needs. However the overall aim and 'general configuration' (Saville-Troike, 2003: 23) of the meetings remains the same throughout. This can be seen in extract 5 when the co-ordinator discussed pulling meetings together, 'I try and tie it up with an IEP {individual education plan} meeting and a CSP {co-ordinated support plan} meeting, trying to reduce the amount of meetings that people are attending' (co-ordinator, extract 5). The resource worker commented on the role of the meetings and drew attention to the meeting structures in children's services, which existed alongside the meetings in this study and said, that the 'team around the child doesn't take over from a case conference' (resource worker, extract 8). In the same way the headteacher referred to the introduction of a CSP plan as 'another dimension' (headteacher, extract 9) and not a change to the *situation*. This demonstrates 'diversity in the kinds of interactions' (Saville-Troike, 2003: 23) which took place within this *situation*. This diversity of practice was also seen in the naming of the *events*, although each meeting retained the following key features:

> the same general purpose of communication, the same general topic, and involving the same participants, generally using the same language variety, maintaining the same tone or key and the same rules for interaction, in the same setting (Saville-Troike, 2003: 23).

Or as the headteacher described it, 'all the agencies are coming together and everybody is then hearing what everybody is saying' (headteacher extract 11). The lists in Table 1 (p.104) show the change in focus of attention between the different *events*, which remain part of the overall aim of the *situation*: 'to make

sure that *child* gets everything he's entitled to and in a place that he's comfortable and happy' (principal teacher (ASN) pre-school, extract 7). This aim adds to our understanding of the role of the *speech community* and the dynamics of communication within that community. The comment from the principal teacher (ASN) pre-school (extract 7) about entitlement sits with the statements from the headteacher in extracts 10 and 11 to illustrate the aims of the group. In particular what she described in extract 11 as:

> . . .all the agencies are coming together and everybody is then hearing what everybody is saying. Is everything working well, if not is there a problem and how can we solve it' (headteacher, extract 11).

In this unit of analysis the focus provided by the use of *event* and *situation* from ethnography of communication developed my understanding of the fluidity of ways in which the local policy *situation* influenced and informed the series of meetings. An analysis of the meetings as *events* demonstrated an underlying issue of the meetings, to use this new series of meetings to replace others. This tension was visible in the data in the naming of the meetings and the contrasting comments from participants about the other planning meetings, which they seemed to expect to hold alongside the interprofessional *event*. This process of sense-making about the meetings revealed that the participants were working together towards an agreement of what the meetings were for. This was in effect working together to agree the role of speech community and is one of the emerging themes from this unit of analysis.

The work towards a common understanding of each *event* can be seen in Deweyan terms as making something in common and an emerging theme from

this unit of analysis, although the extracts also show that they struggled to reach a common understanding of what the meetings were for. As I considered this in relation to Deweyan communication I felt that perhaps the variation in membership of the speech community was not a limiting factor in the way that it seemed in relation to the data concerned with participants (5.1). For as a group they were working in partnership to agree what the meetings were for.

5.3 Roles and Responsibilities

My grouping together of extracts in this unit of analysis relates directly to the *cultural knowledge* framework proposed by Saville-Troike (2003) within ethnography of communication. In that area of her framework she identified four areas as contributing to the *communicative competence* of a *speech community*: social structure, values and attitudes, cognitive maps and the transmission of knowledge and skills (Saville-Troike 2003: 21). Roles and responsibilities are part of the professional, rather than social, structure of this community and professional knowledge and skills appear in the data in the discussion of roles and responsibilities. The analysis of the data in this unit of analysis will focus on the ways in which *communicative competence* is demonstrated in these extracts. The way in which the speech community defined and redefined roles and responsibilities in order to reach agreement is an example of working together to make something in common.

Roles and responsibilities was selected as a unit for the analysis because of the debate which ran within and between this series of meetings as to who should

be a key worker for the child and family. The structure of the team around the child system required one professional working with the child to act as a key worker and first point of contact for the family. This person had the responsibility to ensure that the action plan, and professionals linked into it, was kept up to date. This was referred to in the meetings and discussed in the individual interviews, although nobody commented on the fact that in looking for a key worker they were identifying a person to take on a role defined in the GIRFEC framework as: a named or lead professional, 'responsible for making sure that the child has access to the right help to support his or her development and well-being' (Scottish Government 2009, ix). The on-going discussion about the key worker and the different responsibilities held by each profession working with this child were also commented on in the individual interviews.

The role of a key worker is defined in national policy (Scottish Government 2009) as a central role to support communication and partnership working. The secretary to the team around the child, described the key worker as:

> a point of contact for everybody really, so if they wanted to get in touch with the family they can go through this key worker person as well (secretary to the team around the child, interview).

The conversation in extract 12 shows the concern felt by the co-ordinator and the Mum about the lack of a key worker. The following comments from four of the other professionals in the meeting show the variation in understanding across the meeting of the need for a key worker and what a key worker would do.

Co-ordinator	I know *Mum* I caught up with you last week or the week before because you were really worried about the key worker for this piece of work. And what Mum and I agreed is that she's not alone in not having a key worker, obviously best practice is to identify one and that's ongoing. We'll keep our eyes open for a key worker, and see if we can find somebody to do it but it doesn't stop any of this happening. We'll still run, we'll still have your meetings, we'll still develop the action plan which we'll still all run through. What we don't have is that central point of contact which the key worker gives us but we are working towards it. Is that okay?
Mum	Yeah
Co-ordinator	But don't panic because I know when I spoke to you on the phone you were saying, ' I don't have one of those'. That's okay, it's more my job than your job.
Health visitor	But what you do have now is people sitting down and people who're involved working together
Teacher (ASN) pre-school	You've got lots of key workers
Resource worker	You've got better communication than it's been in the past
Teacher (ASN) pre-school	It's much much better
	Extract 12: meeting 1

For the health visitor, what was important was that the group of professionals working with the child were now 'sitting down . . . working together'. The comment from the teacher (ASN) pre-school appears to indicate that she felt all the professionals could be seen in the role of key workers. The brief comment from the resource worker about communication does not show the concerns that she felt about the role of key worker. She reflected on this in her individual interview, where she listed a number of issues that arose from being asked to be the key worker.

Resource Worker	They wanted to identify a key worker . . the expectation would be the person that they know the best and they get on well with and have a relationship, which would be me, so I said no because I didn't have the assessments done that I needed to have done and it wasn't social work issues. If somebody gets on with a profession it doesn't mean to say that that profession should always take the lead, because it would always be social work
	One of the good things about that meeting, regardless of why the meeting was held, folk have taken more responsibility I think. … I think saying no, it's not just social work's job to be the key worker here. I thought it was just my saviour that this team around the child was going to come and everybody was going to sit and talk about it. I just don't want to be the lead, the key worker. I didn't need any more at that point.
	I couldn't take on being a key worker when it wouldn't take priority because of {my} child protection work
	Extract 13: resource worker interview

The comments at the beginning of this extract refer to the dialogue or pre-meeting that was held before this study began. At that meeting the resource worker had been asked to be the key worker but had refused to do so because, 'it wasn't social work issues' (resource worker, extract 13). She clearly felt that she could only take the role on if the child was assessed through social work procedures for support and that the support the child required would not have a high priority in her workload. In the interview she acknowledged the opportunities the meeting provided to enable discussion between services and that work was being shared, 'folk have taken more responsibility' (resource worker, extract 13).

The early years worker commented on the need for each professional working with the child to ensure that each of them knew who was working with the child.

Early years worker	We need to be aware of each other and what our roles are, so we're not all descending on these families and overwhelming them
	Extract 14: early years worker interview

The early years worker, the student social worker and the teacher (ASN) pre-school were all aware of the connections and possible cross-over or duplication of support that each of them offered to this child. They each identified a need to agree the focus of support that they were separately offering the child and family. This was commented on in the first meeting.

Student social work	I don't know what to say, we didn't want to duplicate any work
Early years worker	Yeah so we're kind of doing opposite things that complement each other
	Extract 15: meeting 1

In this exchange the student social worker and the early years worker recognised the work that each of them were doing with the child and how it fitted together. They had begun to modify their own activities to fit with the two areas of support, but were the only two professionals to comment on this or make changes to the support they were giving to the child.

The teacher (ASN) pre-school commented in her individual interview about the range of professions working with children and what she identified as a need to explain her role to other professions.

Teacher (ASN) pre-school	There's early years workers in education, there's now early years workers in health and then there's the social work, speech and language workers …. It would be useful for our team to explain our role
	We work alongside and we network but sometimes I've gone into school and there's another worker there and I've thought why are you here when I'm here?
	Extract 16: teacher (ASN) pre-school

Extracts 15 and 16 indicate that each worker seemed to feel some form of responsibility to their own professional role and their own planning and referral systems. The effects of this on the ability of the group to work in partnership can be seen in meeting 4.

Co-ordinator	*Early years worker*, we discussed if you could be the key worker.
Early years worker	Unfortunately, or fortunately, all the things that were on the referral have been achieved, so I would close {the case}.
Co-ordinator	I discussed it with {line manager of early years worker} and she was supportive, so I think it is really important to note that your line management was supportive of that
Early years worker	I spoke to *headteache*r about this yesterday as well. *Child* has another year at nursery, so if in the period prior to transition as to whether it's *this school* or *different school*, then I would look at re-opening then and doing another piece of work with *child*.
	Extract 17: meeting 4

In this final meeting in the study the early years worker had received approval from her line manager, within her own system, to take on the role of key worker for the child, but child had transferred successfully to nursery and her support was no longer needed. The final comment from the early years worker, where she suggests that she would work with the child in the future emphasises one of the issues for interprofessional teams in identifying key workers, that the workers and the support they offer varies over time.

The data extracts in this unit of analysis illustrate aspects of *communicative competence* in this speech community. In ethnography of communication *communicative competence*, 'refers to the communicative knowledge and skills shared by a speech community' (Saville-Troike, 2003: 21). The extracts above

illustrate the way in which knowledge and skills are held by individuals and shared. For example the teacher (ASN) pre-school talked about the need to explain her support role to others and the student social worker referred to not wanting, 'to duplicate any work' (student social worker, extract 15). In extract 12 the conversation shows three of the professionals: the health visitor, the teacher (ASN) pre-school and the resource worker using interaction skills and their knowledge of practice to reassure the Mum that professionals are working together. In extract 17 the co-ordinator and the early years worker use their knowledge of the support system to create a way in which the early years worker could be the key worker for the child in the future 'I would look at re-opening then and doing another piece of work with *child*' (early years worker, extract 17). This extract demonstrates the way in which the group returned to the issue of a key worker and worked with that until there was agreement reached as to who might be the key worker. This can be seen in Deweyan terms as a further example of making something in common and as an emerging theme from the data, that the discussion in the meetings was used to define and redefine the issues they were working with in order to make something in common between them. The converse of this also illustrates an emerging theme in the data as the starting points for the discussion about the role of a key worker show the variation in understanding between the participants about a role that was part of their work together.

My analysis of the data in relation to the role of the key worker highlights an emerging theme of professional competence in the study. This can be seen in the comments made by the resource worker that it was not part of her

professional role to be key worker for this child. It is also evident in the comments the teacher (ASN) pre-school made about the number of early years workers and the role of pre-school team in extract 16. There is also an emerging theme about professional responsibility, what each professional was expected to undertake by her own profession, and the way in which that impacted on the work that each professional did with the child and family. As the early years worker commented in relation to the work of the student social worker with the child, ‘so we’re kind of doing opposite things that complement each other’ (early years worker, extract 15).

The use of Dewey’s concept of communication to analyse the development of the agreement about the key worker in this unit of the analysis provided a structure to follow the discussion across and between the meetings. A focus in the analysis of the way the role of key worker was revisited and by whom illustrated the way in which developments between the meetings supported the partnership to reach a joint agreement. It also highlighted that in this *situation*, in a new interprofessional process, what was communicated in a Deweyan sense was agreement about how the group worked in partnership and the different roles of that partnership. Analysis through Dewey revealed the complexities of what could be considered the initial stages of communication, as the participants worked together to establish a partnership and agree roles within that partnership. This relates directly to analysis of the data against *communicative competence*, which confirmed for me the limited amount of knowledge and skills that were shared in this *speech community* and supported the results of the Deweyan analysis that in relation to communication this

partnership was working together to understand the *events* themselves and their individual roles within them.

5.4 Professional information

My identification of this unit of analysis as professional information is linked to the *cultural knowledge* framework in ethnography of communication (Saville-Troike 2003). As I noted above in roles and responsibilities (5.3) Saville-Troike identified four areas which contribute to the *communicative competence* of a *speech community* and grouped these together as *cultural knowledge* (Saville-Troike 2003: 21). This unit of analysis relates to professional rather than *cultural knowledge* and the data illustrates the, 'transmission of knowledge and skills' (Saville-Troike 2003: 21). The participants referred to this as sharing information about their work with the child and family and regarded it as part of their professional knowledge. It should be noted that the professional reports, which were orally reported in the meetings, were by agreement not included in this study.

The data from the meetings and interviews raised issues about the permission to share professional information; who could access that information; the ways in which professional information was gathered and how different professionals worked with that. These are all examples of the way in which the participants in the meetings worked together to agree a common aim for their actions, or worked towards an agreed action. All of these issues can be seen in extract 18 from meeting 1.

Headteacher	Can I ask that you share that with *Nursery Teacher* so we can look at diet in the snack we're offering in Nursery?
Dad	I think we're going to start that from Saturday
	Several voices speaking together
Trainee social worker	But *child* is not at Nursery now?
Nursery teacher	It'll have implications for next year
Resource worker	Can I ask that you maybe talk to *health visitor* or *dietician* about that as some of the other children that I've worked with maybe need to go on a . . . you maybe need a wee bit of advice. The *dietician* will be able to
	Several voices talking together
Resource Worker	I think it's a good idea
	Several voices speaking together
Co-ordinator	As I understand it *dietician and Doctor GP* will be working quite closely together if there is anything additional you need to know. If there is anything additional you need to know. Have you discussed . . . with *dietician* ?
	The following voices talking at the same time
Resource Worker	I think it's a good idea . . . you can talk to *trainee social worker*
Health visitor	To make sure that you know
Mum	We've started . . . unless you've any suggestions . . .
Resource Worker	You can talk to *trainee social worker* about that
Health visitor	It may well be fine but we'll need to check it out
	Then individual voices
Co-ordinator	But one thing I wouldn't want you to do is to start it and find [ ] but if you plan it right and get *dietician* and *GP* involved and
Resource worker	I think it's good because you are thinking about it . . . but *trainee social worker* and *health visitor* can contact *dietician*
Health visitor	I can do that . . . I'll do that.
	Extract 18: meeting 1

Extract 18 illustrates the way that this group of professionals and the parents of the child worked together in the meeting structure. In the gap between the discussions about the change in diet almost everyone in the meeting was speaking at the same time, either adding to or interpreting the information about diet. At the start of the discussion the headteacher asked the parents to share

the information about the child's diet with the nursery. The nursery teacher then explained the reason for the request to the trainee social worker, who did not understand why the nursery needed to know about individual diets. This was followed by the resource worker adding her own concern that the parents did not have access to relevant information about this change to the child's diet and asked them which professions they had contacted to discuss this. The co-ordinator connected this remark back to the two professionals she saw as most relevant to the request, the dietician and the GP. At the same time the resource worker offered the support of the trainee social worker to the parents to access further information. The discussion ended when the health visitor offered to support the parents and get in touch with the dietician. Until that point the concern voiced by the resource worker, that more detailed professional support about diet was needed, was handed around the meeting from profession to profession. This movement of information from the parents, who had not requested more knowledge about the dietary change they were about to make, illustrates the concern of the different professions to ensure that a connection was made to the most relevant profession. This allotting of information to a particular professional area is similar to the way in which individuals depended on the planning systems of their own agency, discussed in 5.2 above.

The professionals attending the meetings held different views about the amount of information that was shared but did not comment on the content of the information which they did share. The teacher (ASN) pre-school was not sure that she needed all the information, although she indicated that she would want

access to a written record (minute) of the meeting so she could access information.

Teacher (ASN) pre-school	I don't know if we need all that information, for people to sit there at a table . . . we're spending more and more time at meetings and not working with children. You know half way through we could have left and it could have been minuted,
	Extract 19 teacher (ASN) pre-school interview

Her concern about the information is linked to a wider concern about the impact of the interprofessional meeting on the time she had to work directly with children. It also demonstrates a focus on individual work with the child rather than working in partnership as highlighted above (5.3). This is an area that the headteacher also commented on, although she felt that the amount of knowledge gained through the meeting outweighed the amount of time given by professionals to them.

Headteacher	There's a lot of professionals out of their working environment, but how else can you get that information? We now have a wealth of information about that family that if we didn't have these team meetings we wouldn't have known about, it would have only been through conversations with the mother or whatever . . .
	Extract 20: headteacher interview

The Dad expressed concern about the information that they had already given to medical professionals not being known by relevant professions when they discussed a visit to a major hospital in the first meeting.

Dad	There doesn't seem to be communication from the hospital records as to what, about what's actually been done because each time we go to *major hospital* we're getting asked the same questions and then they're questioning us as to why [ ] we're like read the notes! The we're getting told by the nurse we have no notes . . .
Mum	We went in [ ] they let him [ ]
Health visitor	That was when he was acutely unwell
Co-ordinator	They're trialling . and you're not the only family who has had issues with this, I don't know if you've seen this *health visitor.* It is about that it is a summary of the child , so that when they get admitted or discharged from *major hospital*. And you hold the records, which is what I like about it as well and it's all updated each time you go to the hospital and the most recent information is on it. I know they're trialling that and if you're happy with that, we can see if you can join that or we can say that when they roll it out that you would like one
Dad	It would make the stress, it's stressful enough each time you take *child* into hospital but when you get bombarded with questions and they're actually questioning you as a parent as to why [ ] . They then put more pressure on you
Health visitor	They should have access to records in hospital . . . they shouldn't need to . . . it happens all the time
Co-ordinator	For me if this tool makes it easier and it's just a couple of bits of paper . . . would you be happy if I take this on and have a look at that?
Mum & Dad	yeah
	Extract 21: meeting 1

In extract 21 the co-ordinator responded to the concerns of the parents by telling them about a new record keeping system, where a card or file, which summarised key health information about the child, would be held by the child and family. In the same exchange the health visitor expressed her concern that the current record-keeping system in the hospital was not working for the family. The co-ordinator discussed this in her individual interview where she commented on the need for families to consent to information being shared between health professionals.

Co-ordinator	I never ever take consent as foregone tick on a sheet, because I think there has always been an issue with how much information health professionals share. So I always go down and families say to me, but of course you all share this and I say to them, but not unless you tell me we can share it. It's interesting the assumptions that people make.
	Extract 22: co-ordinator interview

The sharing of knowledge between health professionals was a particularly challenging part of the co-ordinator's role.

Co-ordinator	I'm trying to get doctors to communicate too. And some of them think who is she and what does she think she's trying to do?
	The GPs get excluded from this as well because these children are straight into *major hospital* and their consultants, they hardly see their GPs but when they are 18 they come back and their GP is meant to have care of them and know all about them. So I always copy the GPs in. So several meetings now, GPs have attended. It ties it up for the families as well.
	Extract 23: co-ordinator interview

For the co-ordinator it was important to enable all the professions who were working with the child to access the professional information which was shared. Similarly as we saw in extract 20 above the headteacher was concerned to collect information from all the professions working with the child. The other participants in the meetings held different views about that information. In extract 19 we saw that the teacher (ASN) pre-school appeared to want the information but was unwilling to give time to the whole meeting. The resource worker commented about the use of 'jargon' which she felt limited understanding, and was not something that she wanted to give time to understanding.

Resource Worker	The parents didn't understand the jargon in the letters, the health visitor didn't understand. We have to watch that in our office because we're all at different stages and different backgrounds in what we do. We've the confidence to say to each other 'what's meant by this? What's the social work term? That's why I wouldn't co-ordinate it {act as key worker} because I didn't even understand what they were talking about. That would be really time consuming for me to work that out.
	Extract 24: resource worker

For the early years worker the meetings offered an opportunity to share information about the child, to develop a 'better understanding' of the range of support the child was receiving and to learn some of the terms used by other agencies.

Early years worker	The more that we meet and the more that we say what these things {IEP} are then everybody has a better understanding . . . probably all these meetings have helped that I think sometimes professionals do forget . . . I have to say I think professionals are becoming much more aware so that parents have an understanding . . .
	Everybody needs to be quite aware of what is going on in each child's life … I would share it on a professional basis, we still have confidentiality
	I do think that people are becoming much better at actually asking and people are aware too saying the short word and then what they meant by it.
	Even health when they're talking about the genetic clinics, I get lost. I have to ask the parents, what do they mean by that? Because they've got a better understanding of all the health side. I do think people are becoming much better at actually asking. I don't find it an issue and I don't find it an issue to say at a meeting, 'I don't know what you mean by that'. When you work within your teams you will have jargon that you use, … social workers will think what is an IEP? And probably all these agencies now meeting together and sharing has helped that . . . when you work within your teams you will have jargon that you use . . . social workers will think what is an IEP? And probably all these agencies now meeting together and sharing has helped.
	Extract 25: early years worker interview

In this extract from her interview the early years worker was supporting the sharing of information between agencies but in arguing for 'meeting together and sharing' she emphasised the strength of the relationship between individual professional roles and the control of information when she said, 'I would share it on a professional basis, we still have confidentiality'. This indicates that although she was willing to share information she could still control how it was used in the group because it was confidential information. The resource worker also commented directly on the sharing information:

Resource worker	Yes that's what's going to happen, health is going to come on board with us . . .We share information, but you've still got the data protection act. We share a lot of information, working with children, with child protection, if there is a care concern people do need to share information . . .It's clearer with statutory {responsibilities}, it's clearer with child protection because everybody has responsibilities they have to follow anyway.
	Extract 26: resource worker interview

In this comment the data protection act (UK Government 1998) was used to provide a safety structure to prevent the misuse of shared information. The resource worker linked sharing information to a 'concern' about children and acknowledges that it is much easier for all professions when it is a concern that sits within legislation, such as child protection. It seems that in this series of meetings information was shared, but still held or owned by individual professions.

The retention of information by individual professions illustrates the limited extent to which *communicative competence* is achieved in this series of meetings. *Communicative competence* is developed from the knowledge and

skills that individuals bring to the situation. It is the sharing of that knowledge or information which develops, 'the shared presuppositions and judgements of truth value which are the essential undergirdings of language structures' (Saville-Troike 1989: 22). In this professional situation the questions about the information that was shared are likely to have limited the opportunity to develop shared professional understanding within the meetings. This can be seen in the comment from the resource worker (extract 24) about her lack of understanding and that she was not going to spend time to develop that understanding. The meetings may have been working together towards sharing information, so in Deweyan terms had a common aim, but what they achieved through partnership was likely to have been limited by the way in which information was shared.

The analysis of the data in this unit of analysis through both theories confirmed for me the way in which the structure of meetings as a new series of *events* limited interprofessional communication. An examination of the data through *communicative competence* provided little evidence of the sharing of knowledge or skills in the meetings. When I then examined what was shared in the meetings the focus in the data was on what information they could share with each other. While this sat within the wider definition of *communicative competence* in a *speech community* it provided little evidence of Deweyan communication. As in the unit on meetings (5.2) the participants communicated in a Deweyan sense towards a common aim of agreeing what they could share. The picture that each unit of the analysis was providing was of a group who

were working together to agree the ‘ground rules’ which would support the partnership to communicate.

In this unit of the analysis there are two themes relating to the tension evident in the data about what information was shared between professions, and how different professions accessed and used information. The first of these themes is evident in extract 18 where tension is visible between the resource worker, who wanted the family to share a dietary change they were making with other professions and the co-ordinator who was less keen to support the family to do so. In extract 18 the resource worker pushes the case for further sharing of information about the child’s diet and brings in the trainee social worker, whose time she directs and turns to the health worker for support, who at that point says, ‘ I’ll do that … I’ll do that’ (health visitor, extract 18). In making this response the health visitor may have felt that it was more appropriate for her to take the request forward than the trainee social worker but her late intervention suggests that this was not an area that she felt she should be discussing in the meeting. This exchange shows the different layers of understanding about sharing information between each profession.

The mother and the father expressed concern about the lack of shared information in their child’s health records (extract 21), particularly in the major hospital. The health visitor is quite clear in her statement that existing systems provide for hospital staff to have access to the relevant records but also that the lack of permission to access hospital records is a recurring situation, ‘it happens all the time’ (health visitor extract 21). The proposed solution from the

co-ordinator is for the family to take part in a new system that is running alongside the hospital records where the family hold a summary record which they then give permission to the hospital staff to use (extract 22).

The second theme that emerges from this unit of analysis concerns the way that different professions accessed and used information that had been shared. The evidence of this in the data illustrates a range of opinions about the amount of information which was shared. The teacher (ASN) pre-school expressed doubts about the amount of information which was shared (extract 20) but the Headteacher welcomed the amount of information (extract 21). The early years worker recognised the importance of the professions involved sharing information about, 'what was going on in each child's life' (early years worker, extract 25) but she also referred to confidentiality within the meeting. The resource worker talked about sharing information but set it within the context of the data protection act (UK Government 1998), legislation which defines what professions can share from their records.

5.5 Power

The title for this unit of analysis sits within the *cultural knowledge* framework of ethnography of communication which I outlined in 5.2. Power is an aspect of the professional knowledge structure in this study, which along with the sharing of information discussed in 5.4 contributes to the *communicative competence* of the *speech community*. Saville-Troike (2003) suggests that power in studies of communication is more often illustrated through critical approaches to language

study such as critical discourse analysis rather than ethnography of communication where, ‘accounts are primarily descriptive’ (Saville-Troike 2003: 255). However in her introduction to ethnography of communication she noted that linguistic signs of power, such as the use of titles, voicing or the use of the passive voice illustrate culture-specific bases of power in ethnographic analyses.

In the data in this study power is expressed through the use of titles in the meetings to ‘encode status and prestige’ (Saville-Troike 2003: 255). It is not evident in the authority held by the co-ordinator and headteacher to allocate turns to talk but there is an indication of power ‘achieved through language’ (Saville-Troike 2003: 261) where access to knowledge provided some of the members of this group with the power to force action to arrange future support for the child and family. The balance and structure of power held by individuals in the meetings affected the ability of the team to work in partnership towards a common aim.

Saville-Troike (2003) refers to the use of titles as one of the most transparent linguistic signs of power and it is the way in which power is most evident in this study. Almost all of the participants, including the Mum and Dad, were referred to by their first names by everyone at all the meetings. This included all those present in the meetings and those who were referred to in discussion. The exception to this was the use of the title doctor along with the relevant surname for all medical doctors referred to in the discussions. The one medical professor who was referred to in discussions was also spoken about with a title and

surname. None of these professionals attended the meetings but the use of medical titles and their surnames was not connected to non-attendance as first names were used for other professionals who did not attend the meetings in person. The use of titles in this way was evident at the beginning of the first meeting when the co-ordinator was trying to put together the team around the child.

Co-ordinator	And the *physiotherapis*t is she still working?
Mum	No, she discharged him
Co-ordinator	Right, I'll take her out. Doctor *ENT*, will we keep her copied in .. .? Doctor *Metabolics* and Doctor [ ] is that your GP?
	Extract 27: meeting 1

In this extract the physiotherapist is referred to by her first name but as soon as the co-ordinator reaches the different doctors connected to the child she uses the title and surnames. In a meeting with a large number of participants where the group worked out together which professionals were working with the child through first names there was no reason given for using titles and surnames for the doctors working with the child and family. The co-ordinator did refer to a power difference between her role and that of doctors when she discussed the challenges she faced in promoting communication between the different professions working with a child.

Co-ordinator	[ ] for me within health I'm trying to get doctors to communicate too. And some of them think who is she and what does she think she's trying to do?
	Extract 28: co-ordinator interview

In this comment the co-ordinator identifies that there is a difference in power between her co-ordination role and that of the doctors which sometimes made it difficult for her to carry out her role.

In the meetings themselves it could be said that power sat with the chair of the meetings to allocate turns to talk, in a non-verbal expression of power (Saville-Troike 2003). However all three professionals who took that role: the co-ordinator, the headteacher and the principal teacher (ASN), were assiduous in their determination to ensure that all attendees were given space in the meetings to identify themselves and speak about the work they were doing, or planned to do with the child.

Headteacher	So if we can once again just go round the circle here because there's people here that you are maybe not so aware of, so can we start I'm (HT)
Headteacher	What I like to do at meetings is just to go round the circle and give everybody the opportunity to share things about { }
	Extract 29: meeting 2

Extract 29 illustrates the way in which all three chairs began the meetings, first with a series of introductions and then a structured 'opportunity to share things' (headteacher, extract 29). Each of the meetings were chaired in the same way with each participant accorded a 'turn' to talk, with no time limit put on their contribution. It was up to the individual contributor to answer questions about their work with the child during or after their statement. There was no evidence in the data of any of participants recognising any use of power by the chairs in the way in which the meetings were run. Indeed as expressed by the Headteacher above there was a tacit acceptance that the meetings were chaired in a way in which all participants 'had the opportunity to share things' (Headteacher Extract 29).

Meetings three and four include evidence of power achieved by the group through the sharing of information. The co-ordinator shared information in meeting 3 about a social work support team that was for children with additional support needs. This was not information known by any other members of the meeting. She identified the difficulties of accessing support in the future if the child's case was closed by the local children and families services and shared the information that a referral to the specialist team could be made then, while the child was still an open case with children and families services. The extract below shows the way in which this information was used in the meeting by the co-ordinator and the early years worker to convince the Mum that it was a good idea to refer the child for future support now. The information had not been shared by the children and families team who could make the referral so the information itself gave power to the two workers to go back to the support worker in the children and families team to request a referral to the specialist team.

Co-ordinator	Support to families, you've been discharged . . .
Co-ordinator	In *county* we actually have a social work team that's for children, not children with disabilities, but children with complex needs, additional needs. Did they discuss that with you at all?
Mum	Ehmm I actually can't remember
Co-ordinator	Okay, it's just for you for the future, if you were to need anything like community childcare, a bit of respite you could access that team. It's just that we wanted you to be aware that there is a team there.
	Gap while other issues are discussed
Early years worker	Could I just ask do you think there would be a need for the social work team that you were talking about, now that . . . do you think that would be and at what point do we decide?
	I think it would be, I am surprised I must admit that the team
	Right
	Did not think about referring *child* across to the *avenue* team or even discussing to be honest with you, and all I'd want to do today is to let you know that that team do exist. If in future you needed a help with { }
Early years worker	I'm just thinking that at times like this, the other day, last week { } I do think there could be times when, it's times like that *Mum* could do with a break
	Gap while other issues are discussed
Co-ordinator	I think we've got two routes, if we just refer you to social work now we'd need to go to the intake team, which is just general service. The other option is that I go back to *support worker* and say as a multi-agency team we've met today and we feel it would be useful for you for that referral to be made and maybe that would be the route to go?
	Gap while other issues are discussed
Early years worker	Having the referral doesn't mean you need to use it but they will be open to you
Mum	So it's more the family support, because social work have finished with us. There wouldn't be any harm to go ahead with it, because as you say, we don't need to use it. . . . just go ahead.
	Extract 30: Meeting 3

Extract 30 contains a series of comments from meeting 3, which follow the development of the discussion about the referral to a social work support team for children with complex additional support needs. This began with comments from the co-ordinator about the fact that the support to families team in

children's services were no longer supporting the family. The co-ordinator then shared information that she had about the specialist support team. The information she shared was not used immediately but the early years worker returned to this later in the meeting and asked about the referral system for that support. The discussion in the meeting about the support team led to the agreement to take action at that point when the child was still an open case with the children and families team. The meeting achieved power in this case through the sharing of information which supported the interprofessional team to ask for the referral to the specialist support team. The way that the meeting was empowered through shared information is an emerging theme and the success of that action can be seen in extract 31, as a representative of the team attended meeting 4.

Trainee social work disability support team	I'll have a word with Mum after the meeting, it's good to hear what's going on around the family just now and just see maybe if there's anything in the future that the disabilities team can offer. I know some of the things you're saying there about employment and that there is sometimes a facility for child minding and that so we may be able to support you with that. Coming down the line, respite is an option but needs to be planned quite far in advance but it is an option.
	Extract 31: Meeting 4

The comments from the trainee social worker in extract 31 illustrate the type of support the family can access in future because a referral has been made to the support team.

Ethnography of communication does not support a critical examination of the use of power in the data. The frameworks support the identification of the way in which power is expressed and used through language in this interprofessional context. The use of titles for one profession, the doctors, illustrates the way in

which the meeting recognised the power held by them in interprofessional practice. Conversely, the lack of use of titles for all the other participants in the meetings could be considered to indicate professional equality (Saville-Troike 2003). This indication of professional equality is supported by the action of the chairs of meetings who ran the meetings to enable the sharing and discussion of information. The difference in professional equality between the doctors and other participants is emphasised by the non-attendance of the doctors at the meetings and their participation in the meetings through written reports. The recognition of power held by doctors in comparison with the other members of the interprofessional group is an emerging theme in this unit of analysis.

Power is not an aspect of Deweyan communication where the focus is on partnership and working together towards a common aim. While Dewey's concept of communication fits with the ideal of interprofessional practice as illustrated in GIRFEC it is a limitation of this analysis that power is not considered in relation to partnership and joint action. My analysis of power through ethnography of communication has emphasised for me that it is only those attending this series of meetings who had the opportunity to work together in partnership. The differentials in power highlighted through ethnography of communication in the use the use of titles was not a factor in the way in which the interprofessional group worked together in the meetings. In relation to Deweyan communication it highlighted the issue that because the doctors were not present they were unable to work in partnership in the interprofessional team. This impact of the identification of one aspect of power

differential in the study confirmed the importance to me of working with both theories in this analysis.

5.6 The medical letter

This title of the final unit of the analysis is a single continuous data extract from meeting 1 which encapsulates the issues identified in the units above: participants (5.1), meetings (5.2), roles and responsibilities (5.3) professional information (5.4) and power (5.5). This extract illustrates the way that information was shared and worked with in the meetings. It is an example of a series of individual *speech acts*, within an *event* established from the policy *situation* (Hymes 1974). The extract demonstrates the communicative competence of this speech community through the sharing of professional information. It shows the way in which the meeting worked in partnership towards an agreed aim of understanding the medical letter and highlights the parents' experience of receiving a letter neither they nor the group of professionals supporting their child understood.

Each meeting was structured the same way, with introductions followed by reports from each professional attending or contributing by letter. This structure had the effect of limiting the discussion between professionals during the meeting to short exchanges between two or three of them. This extract provided the longest example of a discussion between more than two participants from all the meetings. It illustrates a number of the issues identified above and

highlights differences in interprofessional working between those who attend the meetings and those who contribute by letter or report.

Health visitor	I don't have much more to report except the letter [ ]
Co-ordinator	Is this the letters you were raising with me *Mum*?
Mum	Yeah the difference in the letters to the [ ] I've got some more letters that I'll try and find for you
Co-ordinator	The one from *Professor of Genetics and Doctor of Genetics* ?
Health visitor	I don' t have the one from *Professor Genetics.* I've got one from *Doctor Metabolics*
Resource worker	Is that the one about the genetics?
Health visitor	Please don't ask me too much about the genetics.
Co-ordinator	I think for me there is one thing that becomes apparent from both of these letters, and *secretary* says that she'll do you a copy *heath visitor,* is that the [ ] you don't have this one? Are you happy with that?
Mum	Yeah
Health visitor	I don't have this one
Co-ordinator	[ ] is that we've got a bit of a, the one from *Professor Genetics,* she's describing . . . *Doctor Metabolics* is . . . What we need to do is we need to clarify that and my plan was to ask GP to help us with that, if that's okay to check which one's correct as obviously there's a bit of a difference there. [*intake of breath*] and for me what I'd be very keen to do is to ask *Professor Genetics*, gently if that could be written with a bit, a bit easier to understand.
Mum	It's just from the words really, she says
Co-ordinator	I defy anybody actually to
Mum	What is that? I just don't understand what it is
Co-ordinator	You've had an appointment with *Professor Genetics*
Mum	I think that we go back once a year to that one
Co-ordinator	Because my thought is as well that sometimes when they speak to you it's a lot clearer than what they actually put on the letter but I will
Mum	But they never mentioned that name at all
Health visitor	This is a medical letter
Dad	We've actually made arrangements for this blood test that they're wanting done
Mum & Dad (together)	That's the metabolic one
Health visitor	Did you get a copy of this actual letter then?
Mum	The genetic one, yeah I've got a copy
	Dad and health visitor speak together
Dad	This is
Health visitor	This is a medical letter from one doctor to another and normally we would do a letter to the parents which would

	be in simpler language
Dad	So maybe
Co-ordinator	So maybe there's been an omission there and you've got the wrong one. What we can do if you're happy is, if *health visitor* is . . . what we can do if you're happy is we can just take that forward and just check, is that okay
Mum	With the letters, it would be good if you got a copy of the letters, if a few on the list got a copy
Co-ordinator	That would be lovely thank you I'll take that forward
Dad	It's just that they are making big medical terms that we don't understand. Like the one that's on there we didn't understand it for the genetic thing that they . . . the person for
Mum	The metabolic thing, no we don't
Dad	And I actually looked at it online, and the terms online I read the first paragraph and I had to . . . because the actual interpretation online was not what I wanted to read which then puts more stress on myself and *Mum*
	Lots of voices speaking together
Co-ordinator	The internet is a fantastic thing but see if you get a word to go and look at
Dad	It just opens a whole
	Several different voices talking together
Co-ordinator	Why don't we as the team around the child write to *Professor Genetics* and *Doctor Metabolics* for information, we're not expecting them necessarily to come to the meetings but they know what's going on and that we're been discussing this here and they can see where we come from if you're happy with that
Mum & Dad	Yeah, yeah
Co-ordinator	Okay then well we'll do that and if it's okay with you, do you have a photocopier here, because I don't want to take away your only copy. . . If I could get a copy, we'll do that in a minute, okay?
	Extract 32: meeting 1

The first new lines of the exchange in extract 32 illustrate the difference noted in (5.5) about the way in which individuals were addressed or referred to in this series of meetings. The use of titles for the doctors and professor in this meeting highlight a tension between the way in which medical practitioners participated in the meetings, by report or letter, and the physical attendance by the other professions who were supporting the child. The letter itself emphasises the ownership of medical knowledge by doctors with specialist

knowledge, which the health visitor as the link health professional at the meeting had the responsibility to explain. The health visitor clearly saw that as outwith her own abilities, ‘Please don’t ask me about genetics’ (health visitor, extract 32). The co-ordinator, as the chair and the other health professional present at the meeting, tried to work with the letter to enable the mother to understand what the letter said. When the health visitor was shown the letter she identified it as, ‘a medical letter, from one doctor to another’ (health visitor, extract 32). Her next comment that there would normally be a different letter sent to parents, ‘which would be in simpler language’ (health visitor, extract 32) health visitor), emphasises the ownership of knowledge by the specialists and illustrates the way in which knowledge was shared with the parents. The co-ordinator took hold of the definition of the letter as one between doctors and suggested that the parents might have been sent the wrong letter, and looked to the health visitor for support in tackling that issue.

The mothers’ request that, ‘a few on the list got a copy’ (Mum, extract 32) shows the trust that had been established between the Mum and the co-ordinator in using the meetings as a way to develop understanding together. The child’s Dad was more concerned with the content of the letter and the use of terms in it that he did not understand. His description of the use of the Internet to look up these words provided an opportunity for the rest of the meeting to contribute to the discussion. It was only at this stage in the meeting that the wider group contributed to the discussion; the use of the Internet being something they all had experience of. The co-ordinator used this to make the

meeting work together and suggested that the team around the child wrote to the professor and doctor of genetics for information.

The medical letter shows the way in which the power of doctors was emphasised in the meetings through written contributions. The role of *professional knowledge* is the central aspect of this extract and the discussion demonstrates the way in which the meeting worked with the written submission in order to understand the contents. The focus on information and the power of the doctors are key aspects of the *communicative competence* of the group (Saville-Troike 2003). The extract demonstrates the variation in understanding between the participants about what the letter was, as well as a lack of understanding of the content. The discussion shows the way in which the *speech community* worked with the actual letter towards a shared understanding of what it was and how they should deal with it as a group. The medical letter demonstrates the group working together towards a common understanding in order to make something in common between them. It also illustrates the limits of what they could achieve as a group when working together towards a common aim. This raises the question of how much information or action the interprofessional meeting needed to hold in common to enable them to work together towards a common aim.

The focus in this study may be on communication between the professionals in the meetings but these meetings also included the parents as members and the medical letter illustrates the particular difficulties the parents faced when they received the letter. This was one of a series of letters, ‘ I’ve got some more that

I'll try and find' (Mum, extract 32) and it was difficult to understand because it was full of 'big medical terms' (Dad, extract 32). The child's father went on to describe the impact of the letter on him and the child's mother after he looked the medical terms up online, 'the actual interpretation online was not what I wanted to read which puts more stress on myself and *Mum*, (Dad, extract 32). The stress that the Dad refers to here highlights a communication issue between medical staff and the parents, and in the way the interprofessional meetings supported the parents. This highlighted a key aspect of communication in interprofessional practice, communication with the parents and the challenges faced by parents who receive letters and reports from all the services or agencies supporting their child (Band *et al*. 2002). The father talked of the stress placed on them both through trying to understand one letter. The professionals in this study worked together to connect the supports for the child but that did not involve understanding every aspect of that support. That was a role left to the parents.

The medical letter evidences the emerging themes I have identified in this chapter. I noted in the first unit of the data analysis (5.1) that the bounding feature of the *speech community* was 'working with the child' and that the community was soft-shelled. The discussion in this extracts shows that 'working with the child' included doctors who saw the child regularly, but infrequently. 'I think we go back once a year to that one' (Mum, extract 32). It also illustrates the flexibility of the community shell in that the professor of genetics and the doctor who was a metabolic specialist were included in the community through their written letters to the parents at the start of the

discussion but by the end of the discussion were placed outside the *speech community*, 'Why don't we as a team around the child write to *Professor Genetics* and *Doctor Metabolics* for information' (co-ordinator extract 32). The discussion demonstrates the way that the participants worked together to define and redefine the role of the *speech community*.

The role of power is particularly evident in the medical letter extract as it demonstrates an undiscussed power held by doctors which influenced the work of the meetings. There is spoken recognition of that power in the way in which the co-ordinator proposes to deal with the letter:

> [*intake of breath*] and for me what I'd be very keen to do is to ask *Professor Genetics*, gently, if that could be written with a bit, a bit easier to understand (co-ordinator extract 32).

The time given in the meeting to work together to understand and agree further action on the letter demonstrates the level of importance placed on a medical letter by the interprofessional group. The way in which the meeting agreed to act and write requesting further information shows the way that *speech community* itself could hold and use power through sharing information, albeit information they did not understand, and agree joint action from that.

The letters themselves illustrate the permissions needed to share information, in this situation for the health visitor to receive a copy of the letter she doesn't have. The discussion about the content of the letter highlights the areas of professional responsibility; here it was the professional role of the health visitor to represent all health services in the meeting. It raises issues of professional

competence, in that the health visitor did not feel competent to explain the letter from the professor of genetics to the meeting. She stated clearly at the start of the discussion, ‘Please don’t ask me too much about genetics’ (health visitor extract 32). The theme of the transmission of professional information, what was shared and why is evident in the confusion of the discussion when the health visitor points out that the letter, ‘is a medical letter, from one doctor to another’. This prompts the co-ordinator to suggest that there had been a mistake and that perhaps the parents had received the wrong letter.

The discussion of the letters in this meeting shows the participants working together to reach a common understanding of the information in the letter. The variation in understanding between the participants is evident from those who spoke and also from the fact that the majority of the discussion was held between the parents who had received the letters and the two health professionals in the meeting, the co-ordinator and the health visitor. The resource worker appears to have heard about one of the letters and asks, ‘Is that the one about genetics?’ but makes no further contribution to the discussion. The letter shows the way that the participants worked together to agree what the letter was and then how to deal with it. The agreement to write to the professor and doctor demonstrates the strength of the *speech community* and the solution they reached together. The extract illustrates the complexity and detail of the discussions around one area of professional information in this series of meetings.

6 Interpretation of the data

In this chapter I will consider the themes which emerged from the data analysis (5) and interpret them in relation to the theoretical frameworks of the study. The interpretation will inform a discussion of the outcomes of the research in the form of 'fuzzy generalisations' (Bassey 1999) that will take the findings of the research into the practice discourse of interprofessional communication. I have grouped the themes into four sections, each relating to a specific part of the theoretical framework of my study. The first three of these focus on aspects of ethnography of communication, namely *speech community* (6.1), professional working practices (6.2) and power (6.3). The fourth section addresses the area of Dewey's conception of communication in which partners are working towards an agreed aim and making something in common (6.4). This interpretation of the data themes in relation to the theoretical frameworks will support the identification of the 'fuzzy generalisations' (6.5) from this study. At the end of the chapter I will consider these generalisations in relation to the research questions which provided a focus for my research. These questions are:

(6.6) What are the dynamics of communication in an interprofessional planning meeting?

(6.7) In what ways is the communication process affected by the professional knowledge of the participants in an interprofessional planning meeting?

(6.8) Do professional languages have a particular role in the communication process in interprofessional planning meetings?

I began the interpretation of the data by linking the themes from the data to the theoretical frameworks I used in the analysis of the data. I found that the themes related to the three areas of ethnography of communication and one

aspect of Dewey's definition of communication. This interpretation groups the themes as follows:

Speech community:

- The definition of the bounding feature of the *speech community* as, 'working with the child' (5.1)
- That the speech community was soft-shelled and participants could join or leave the community at any time (5.1)
- That the participants worked together to define the role of the *speech community* (5.2)

Professional working practices:

- Professional competence related to the professional roles held with the child (5.3)
- Professional responsibility (5.3)
- Permission to share professional information (5.4)
- The transmission of professional information, what was shared and why (5.4)
- Variation in understanding between participants (5.3)

Power:

- Recognition of the power of held by doctors in comparison with other members of the interprofessional group (5.5)

- The power to make a service referral from the interprofessional meeting that was developed by the group through the power of shared information (5.5)

Making something in common:

- In working together towards a common understanding of each *event* the meetings were in Deweyan terms making something in common (5.2)
- The meetings were used to define and redefine the issues they were working with in order to make something in common between them (5.3)

6.1 Speech community

The definition of *speech community* in ethnography of communication is that of 'a community sharing rules of conduct and interpretation of speech' (Hymes 1972: 54). Saville-Troike (2003) developed this definition to include the fact that the participants in a *speech community* are likely to vary in time or in relation to particular situations. Also that the definition of a *speech community* will depend on the context and shared understanding, and that speech communities may be considered as part of a group of nested communities which interact with each other. Three of the themes from the data support the interpretation of the participants in this series of meetings as a *speech community*. The first and most important of these is that there was a bounding feature to the community. To be a member of this community the professionals had to be 'working with the child'. This bounding feature provides the first rule of conduct for the community, i.e. to be a member of the community you must be working with the

child. Secondly, the community could be defined as ‘soft-shelled’ in that the membership varied. The nature of this shell was demonstrated in the way in which the doctors were in and then outwith the shell in the medical letter (extract 32 p.138-9). The flexibility of the shell of this community was also evident in the way in which the student social worker from the disabilities support team joined meeting 4 (extract 31 p.135). A related aspect of speech communities that could be seen in the data, but did not emerge as a theme was that of nested communities. Nested communities are evident in the data when comments are made about the relationships between participants and other speech communities. For example in extract 16 (p.115) when the teacher (ASN) pre-school listed the other types of early years workers she encountered in schools and networked with. Those comments are an example of way in which workers in interprofessional practice connect with other professions in relation to different pieces of work they are doing. The teacher (ASN) pre-school worked with a number of children in different pre-school settings. In each setting she was part of a different interprofessional team, depending on the range of professions supporting each child. If the idea of speech communities is followed through into practice, this teacher would be part of a different speech community for each child she worked with. As the teacher worked in a specific geographic area it was likely that some of her work was with the same individuals, but each grouping of professionals would be a different speech community. Each of the workers in these interprofessional groups would also be part of a speech community in their own professional area. Nested speech community is a term which is used in ethnography of communication to identify the relationship between each of these communities and acknowledge the

importance of recognising each speech community. It is the speech community that provides the framework for each person's speech and interactions in that community.

> For individuals who are members of multiple speech communities, which one or ones they orient themselves to at any given moment – which set of social and communicative rules they use – is reflected not only in which segment of their linguistic knowledge they select, but which interaction skills they utilize, and which aspects of their cultural knowledge they activate (Saville-Troike 2003: 21).

In this study the idea of nested speech communities encapsulates one of the key aspects of interprofessional practice, that each professional in an interprofessional group is also a member of at least one other professional speech community, that of their own profession. They are also through their practice, likely to be a member of different interprofessional teams. In this way they become a member of a different 'nested' speech communities all connected through the work of each practitioner.

The final theme from the data which supports the definition of the members of the meetings as a speech community is that they worked together to define what the community was. There were a number of examples in the data of this theme. The headteacher summarised it in her remarks at the end of meeting 4 (extract 11 p.108) as everyone coming together and working together to ensure that the support systems for the child were running smoothly. Or, as the principal teacher (ASN) pre-school expressed it, 'to make sure that *child* gets everything he's entitled to and in a place that he's comfortable and happy' (extract 7 p.106). The identification of the professionals present in these

meetings as a speech community should be considered in relation to the data in extracts 2 and 3 (p.97-8) which indicated that the meetings were the first opportunity that this group of professionals had to form a speech community. The work that the group did to agree a membership rule for the community and who met that membership rule is also a demonstration of Deweyan communication. The group worked together, in partnership, toward a common aim: of understanding who should be part of the group and why. What they 'made together', in Deweyan terms the outcome of the communication, was the speech community itself.

6.2 Professional working practices

Five of the themes identified in the data relate to areas of professional working practices in particular professional knowledge and the transmission of professional information. The first two of the themes address competence and responsibility. The issue of competence relates to the roles that each profession held with the child and the expectation expressed by individuals that they were either competent or not to carry out specific aspects of the work with the child. The resource worker was direct about the fact that it was not part of her role, i.e. she was not competent to be the key worker for the child (extract 13 p.114). She also commented that she did not feel that it was part of her professional responsibility to take on the role of key worker, 'it wouldn't take priority because of {my} child protection work' (resource worker, extract 13 p.114). The theme of professional responsibility is more evident in the data than that of competence. This is because there were a number of areas where the

work of one profession was apparently the same or similar to another. The student social worker commented about her work in relation to the work of the early years worker, ‘so we’re kind of doing opposite things that complement each other’ (student social worker, extract 15 p.115). Similarly, the teacher (ASN) pre-school was concerned about the difference in professional responsibility between herself and the other early years workers she encountered in schools (extract 16 p.115).

Two of the themes were about permission to share professional information. The question of what was shared and with whom ran throughout the series of meetings and involved everyone at the meetings, the professional workers and parents. It was the parents who were first asked for permission to share information with the professionals at the first meeting, which they questioned because they thought that all health professions had access to medical records which provided collated information about their child. The issue of permission and access to records was a particular issue across the different areas of the health service in this study. Other professions expressed more concern about the amount of information that all the professionals working with the child heard in the meetings and commented on national legislation in relation to that. This theme demonstrates a considerable range of understanding in the meetings about the information that could be shared, who gave permission for access to information held by different services and the amount of information individual professions needed to support or develop their work with the child.

The final theme in the area of professional working practices concerns the variation in understanding that was visible at various points in the series of meetings. It was illustrated in the discussion about the medical letter and in the way in which the meetings debated the role of the key worker. The on-going discussion about the role of the key worker and who should hold it may have been particularly evident in the data because it was a new role being introduced in this geographic area through the health-based team around the child. The child in this study was the first where the team around the child continued their support systems as the child moved into school and the first time the interprofessional team working with the child and his family had been asked to identify a key worker in this way. The professionals in this study were also aware that the GIRFEC policy included identifying a 'named person' for each child, although that had not been introduced in this local authority area at the time of this study. The variation in understanding about role of a key worker may reflect the range of knowledge and understanding about this aspect of changing practice in the area of my study.

6.3 Power

Data analysis through ethnography of communication identified the ways in which power was evident in the language of the meeting, through the use of titles and the access to knowledge which supported a referral request from the interprofessional group. This and the related themes from the data identify the presence of power in the interactions between the professionals in the meetings but not the role of power in these interactions. Fairclough (2001) in his work on

language and power discussed the role of power '*behind* the discourse' (Fairclough 2001: 51, emphasis original). In particular how the discourse used was shaped by power and how people were then shaped by the discourse. Mayer (2008) in an investigation of the way in which discourses dominate institutions and how institutions promoted those particular discourses, found 'that these institutions seek to legitimize their interests and existence through discourse which they seek to transform or recontextualise social practices' (Mayer 2008:2). The series of meetings in this study were held in one institution, a school, but they brought together a range of professionals from different institutions. The meetings were not an established structure so the role of power in the meetings was developed as the meetings were conducted. The structure of the meetings reflect the meeting processes of health and education in the locality of the study but the interprofessional nature of the data collected in one location from professionals who represented different institutions does not support an analysis in relation to the institutional discourse. The relationships between the participants in the meetings do reflect the power dimension in existing professional relationships as the co-ordinator noted in her comment about doctors, 'And some of them think who is she and what does she think she's trying to do?' (extract 28 p.131). It is important then to reflect on Fairclough's question, if the language used in the meetings was shaped by power and if the professionals in the meetings were themselves influenced or 'shaped' in Fairclough's words (2001: 51) by that language.

The first theme in the data linked to power is the use of title of doctor or professor from medical doctors throughout the discussions. The use of titles is

noted by Saville-Troike (2003: 255) as ‘one of the most transparent linguistic signs of power’, which demonstrates, ‘reference to individuals with whom one is in an asymmetrical social relation along an inferior-superior dimension’ (Saville-Troike 2003: 256). In other words, the use of titles for medical doctors in this study shows that all the other members of the speech community considered doctors to be superior to them and to hold more power. It also demonstrates differentials in power between professions within the health service. As noted above this was commented on directly by the co-ordinator in the difficulties she had in working with a range of consultants (extract 28 p.131) and by the health visitor in relation to the professional knowledge she was expected to share (extract 32 p.138-9). The medical letter section (extract 32 p.138-9), at the conclusion of chapter 5 illustrates the impact of that power on the way in which the professionals in the meetings worked together. The indication of power through the use of titles combined with the medical letter suggests that parts of the meetings were shaped by the power that sat with the medical practitioners. This was a power that was exercised in the meetings through written reports or letters but was acknowledged by other members of the interprofessional team through the use of titles and the way in which they approached the medical letter as a group. In this study it is likely that the involvement of a number of medical doctors with the child in this study could have indirectly influenced the discussions in the interprofessional team. In a critical discourse analysis (Fairclough 2001) this would be seen as reflecting the power relationships that are accepted as convention between doctors and other professions and identify the influence of that on the language of the interprofessional group. It is

however only an indication from a study which focused on the ways in which the professionals were working together to communicate.

The strength of the group working together is an indication of the power of the interprofessional group particularly where the professionals worked together between meetings 3 and 4 to act on information shared in meeting 3 and access another support team for the child. This was the most overt use of power in this study, whereby some members of the community worked towards a common aim to have the child referred directly to a particular social work support service. In Deweyan terms they worked in partnership, towards an agreed aim and created something from their joint actions, in this case attendance at meeting 4 from a representative of the disabilities support team.

Deweyan communication succeeds where there is 'participatory democracy and equality between partners' which Balloch and Taylor (2001a: 2) suggest as a starting point for partnership working. They note in their analysis of a number of projects and policy initiatives in this area that, 'partnership has largely left existing power relationships intact' (Balloch and Taylor 2001a: 8), which is also indicated in this study. The role of power in interprofessional practice is identified in recent literature as an issue to be addressed in partnership working (Allan 2012, Humes 2012). This echoes the conclusion reached by Balloch and Taylor (2001c: 284) that, ' if a partnership does not address issues of power it will remain symbolic rather than real'. The close connections between Balloch and Taylor's definition of partnership working and Dewey's concept of communication highlight the importance of power in interprofessional practice. It

is an aspect of practice that is not fully revealed in the structure of my data analysis through ethnography of communication and suggests that the use of Dewey's concept of communication could support the analysis of power in partnership working.

6.4 Making something in common

The data in the study illustrates one aspect of Dewey's concept of communication: participants working together towards an agreed aim making something in common between them and shared by the partnership. Two of the themes from the data illustrate the way in which the participants worked together. Firstly the way in which the community worked together to define the role of the *speech community* and to agree that to be a member of the community each professional should be working with the child. The way that the community worked together to agree a common understanding of each event was particularly evident in the medical letter (extract 32 p.138-9). Secondly, the work they undertook together to define and redefine issues in order to make something common between them could be seen in the way in which the meetings worked with issues such as the role and appointment of a key worker until there was a common understanding between them about the role.

6.5 Fuzzy generalisations

Bassey (1999) suggests that educational case studies can produce general statements with built-in uncertainty, which he called, 'fuzzy generalisations'.

The uncertainty is to allow each generalisation to illustrate, ‘something has happened in one place and that it may also happen elsewhere’ (Bassey 1999: 52). In interpreting the data from this study it is important to consider which of the themes from the data can provide such generalisations which will contribute to our understanding of professional practice in interprofessional planning meetings. My interpretation of the themes from the research suggests that this case study provides the following fuzzy generalisations:

- The way in which the participants in this series of meetings worked together to define and redefine the aims for their work can be seen in Deweyan terms as how they made something in common between them.

- That the identification of a bounding feature, the nature of the shell and a common aim for an interprofessional group can enable that group to be considered as a *speech community*.

- That recognition of professional competence and responsibility were considered when agreeing support for the child.

- There was uncertainty in the group about the permissions needed to access and use information within and between professions.

- There were concerns about the amount of information that was discussed in the planning meetings with recognition that the sharing of information improved the support for the child.

- That doctors were accorded more power by participants in the meetings than any other profession.

- The meetings and the sharing of information gave power to the group to act in what they saw as the best interests of the child.

These generalisations suggest that the ways in which this interprofessional team worked together enabled Deweyan communication in the team. This is an important finding in relation to interprofessional practice and also reflects the aims of current policy (Scottish Executive 2006). The identification of Deweyan communication was supported by the analytical frameworks of ethnography of communication and adds to our understanding of the way in which communication in an interprofessional team is developed. Aspects of ethnography of communication also indicated the important role that individual professional competence and responsibility played in the agreement of support for the child. The generalisations identified an issue for practitioners in relation to the professional information they shared and a question about the permissions needed in law to do so. This issue is likely to be addressed in planned legislation to support GIRFEC and interprofessional practice (Redford 2012). The identification in the generalisations of the power held by the medical professions has important implications for the membership of interprofessional teams. The generalisation which identified the different way in which doctors contributed to the team and impact of their written medical reports on the way the interprofessional group worked together has implications for the way in which interprofessional teams communicate. The finding that working together

and sharing information empowered the interprofessional team to act in what they saw as the best interests of the child provides evidence of the important role that interprofessional communication can take in planning support for children and young people.

6.6 What are the dynamics and complexities of communication in an interprofessional planning meeting?

The generalisations from this case study illustrate a number of key aspects of the dynamics and complexities of communication in interprofessional planning meetings. In particular they add to our understanding of the work of the meeting that supports and enables communication, the key dynamic of working together. The complexities of communication in an interprofessional planning meeting are demonstrated in my findings through the ways in which professional information is accessed, shared and worked with in the meetings.

The identification of the role of a bounding feature and the way in which that was used in this study to enclose and enable participants to work together is in direct contrast to discussion in the literature of boundaries framing individual professions and limiting working together in a similar context. In this case study the bounding feature of working with the child focused the discussion in the meetings through the needs of the child. In previous studies the work in interprofessional meetings was often focused on either the separate pieces of work each agency did with the child or young person (Webb and Vulliamy 2001) or the connections between the agencies (Anning *et al*. 2010). My study also

illustrates the role of power as a dynamic in communication through the way in which the analysis demonstrated that existing power relationships were reinforced in new contexts. This finding was perhaps to be expected in interprofessional practice (Forbes 2006a, 2009) but it is not an issue that has been addressed widely in the literature in relation to interprofessional communication.

The group in this study was established to work together to support a child. My research of this process illustrates the way in which they were communicating through working together towards an agreed aim and making something in common between them. The role of this as a key dynamic in interprofessional communication echoes the early work of Øvertveit (1997) who emphasised the collective responsibility of interprofessional teams. The idea of working towards an agreed aim can also be seen in the proposal of a 'common goal' (Sloan 2006) and the 'clarity of purpose' recommended by Atkinson in 2007. The data in this case study provides new evidence to support our understanding of the way in which working towards a common aim enables communication in interprofessional meetings.

The dynamic of working together was reflected in the establishment of the group as a *speech community*. As the findings demonstrate this community had a bounding feature or rule that you had to be working with the child to be part of the *speech community* but that the community was flexible and professionals could join or leave when they met / did not meet the rule for participation. The idea of a community, with a rule for participation, working together towards a

common aim to facilitate communication in an interprofessional meeting is not discussed in the literature. This finding from the case study provides new evidence to support the understanding of the way in which communication is enabled in interprofessional meetings. This was demonstrated in the study by the way the co-ordinator and headteacher worked to include in the meetings all professionals who were working with the child. As the co-ordinator asked of several professionals in the first meeting, ‘ But will she be on the list?’ (co-ordinator, extract 1 p.97) and was illustrated in meeting 4 when the trainee social worker from the disability support team joined the group for the first time.

The issues of ‘boundedness and context’ in collaborative working practices was proposed by Eason and colleagues in 2000. The use of boundedness in their analysis related to the external boundaries imposed on interprofessional work through timescales or agreed actions. They noted that child protection work was one of the most bounded forms of collaborative practice because each profession had very specific tasks to undertake as part of the collaborative practice. It was that practice, of child protection meetings, that the headteacher in this study chose to contrast with her work in the series of meetings in this study. The meetings in this study are representative of the practices introduced through GIRFEC and related legislation and are not ‘bounded’ by outcome and timescales as proposed by Eason and colleagues (2000) but are bounded in this case by the fact that the participants are working with the child at the centre of the study. This is a reversal of the previous consideration of boundaries in the literature on interprofessional practice: as the boundary here includes participants in a group together, with rules for participation instead of defining

individual roles and responsibilities. However, it is important to note that the doctors in this study did not appear to be ‘bound’ to agreed outcomes as the other participants and their actions could be interpreted as still working to the boundaries of outcome and timescale, as defined by Eason and colleagues in 2000.

The issues of boundaries was also addressed by Nixon and colleagues in 2001 where they considered the role of institutional and professional boundaries and the impact that had on work between professionals and communities. Their analysis considered restrictions placed by different types of boundary on interprofessional practice, this can be contrasted with the role of the bounding factor in this study which was a key dynamic in supporting the work of the interprofessional community. The tensions and restrictions on interprofessional practice discussed by Nixon and colleagues (2001) can be related to the professional boundaries evident in my study in relation to the work of medical specialists and the way in which their written contributions to the planning meetings affected communication within the meetings. The written medical reports were read out in each of the meetings but were not discussed, apart from the medical letter (extract 32 p.138-9), which had been posted to the parents who took it to the meeting for discussion. The reports were contributions to the planning meetings, each of which were introduced by the chair and read out loud to the meeting. All other contributions to the meetings were oral, and involved questions from other participants and discussion across the meeting as they were given. In that way the participants in the meeting interacted with each other as information was shared between them. There was

no interaction with the written reports apart from the medical letter. It was apparent in the discussion of the medical letter that part of the role of the health visitor was to represent other medical professions in the meetings and to talk to their reports or letters. It seems that this role had not been fully developed in this case study as the health visitor did not have a copy of the letter the meeting discussed, although she had a copy of one from a different specialist. This highlights a tension between the expected role of the health visitor in this series of interprofessional meetings and the existing professional boundaries in the health service.

The discussion of the medical letter and the way in which medical reports were included in the meetings illustrates that the interprofessional team saw these contributions as different to the other parts of the meetings and gave them a particular status in comparison with other oral reports. As I noted in 5.5 this can be considered to reflect the professional role held by doctors and the relationships between them and other professions. Fairclough (2001: 32) makes the point in relation to social roles that ‘it is only through being occupied that these positions continue to be part of the social structure’. In this new interprofessional meeting structure, the recognition of the power held by the doctors is likely to have reinforced the existing place of their professional power. This in turn confirmed the boundaries between their practice and that of the interprofessional group. The case study illustrates the strength of the differential power bases in interprofessional meetings and the way in which established professional power structures were recognised and reinforced within a new interprofessional situation.

The power accorded to doctors in this study interrupted the way that the group worked together. It is possible that the strength and influence of this power as a dynamic in the meetings was reinforced by their non-attendance at the meetings and their use of written reports or letters. The use of the written word is likely to have reinforced the existing power that sat within their professional role.

> The power accorded writing over speech may be due in part to its permanence and accessibility to confirmation by others, but there is also a common acceptance of some intrinsic power in the written word (Saville-Troike 2003: 260).

The power of the doctors as a dynamic in the meetings interrupted the work of the group but did not limit or distort the communicative process. The doctors were members of the group but because they did not attend in person they were not part of the way the group worked together to discuss and agree action. This emphasised the difference between those who attended the meetings and who were working directly with the child and family, and the medical professionals who saw the child as a patient according to a medical diagnosis and reported accordingly.

The way in which the meetings and the sharing of information gave power to the group to act in what they saw as the best interests of the child illustrates a second aspect of the dynamics of power in the meetings. This was seen in meetings 3 and 4 where shared information about the disability support team and support from the meeting, gave the interprofessional team the power of knowledge to go back to the child and family social work team, who were no

longer working with the child and family, and ask for a referral to the disability support team. The exercise of power through their joint action could be seen as, 'A dynamic co-constructed product of interaction' (Saville-Troike 2003: 263), in that they worked with the power that sat in the role-relationships that existed in the speech community.

The dynamics of communication identified above inform the flow and structure of interprofessional meetings. The complexity of those meetings can be seen in the generalisations which address professional competence and responsibility and the issues around the sharing of professional information or knowledge. The findings from this study illustrate new layers of complexities in interprofessional practice which influence communication in planning meetings. This was particularly evident in the ways in which professional competence and responsibility were worked with until understood and jointly agreed in relation to the role of key worker. The level of uncertainty about the amount of information shared in the meetings, combined with the recognition that sharing information improved support for the child illustrates the complexities in communication that also sit at the centre of interprofessional practice.

6.7 In what ways is the communication process in interprofessional planning meetings affected by the professional knowledge of the participants?

The findings in this case study must be considered in relation to professional information, rather than professional knowledge, because of the structure of the

study and the agreement not to collect professional data about work with the child. The data in the study concerns general practice information rather than knowledge about individual professional practice with the child and family. This is a limitation of the study which will be further discussed in chapter seven. The focus in the study on the communication processes evidences two areas in which the professional information held by participants affected the communicative process. The issue of permission to share information and access to it was part of the discussions in each of the meetings. This finding suggests that the uncertainty caused by this affected the way in which professional information was used in the meetings. Although I found concern that too much information was shared in the meetings, there was also recognition that this improved the support for the child because participants felt that they had a greater understanding of the range of support the child received. This in turn supported the work they did together. This suggests that information sharing enhanced the processes of communication and this finding contributes to our understanding of the role of a shared knowledge base in interprofessional practice.

The research question about professional knowledge was developed from the acknowledgement in the literature that a lack of shared knowledge was one of the, 'more complex communication demands of interprofessional practice' (Freeth 2001: 44). This statement from Freeth implies that sharing professional knowledge is a recognised part of interprofessional communication. However, as I noted above (6.6) there is actually little in the existing literature about professional knowledge and interprofessional communication. Anning and

colleagues (2010) discussed the issue of specialist and general knowledge in interprofessional practice and Atkinson (2007) noted the development of new knowledge through interprofessional practice. This follows the work of Eason and colleagues who specifically identified the development of what they called a 'shared knowledge base' in 2000 and it is to this area of professional practice that the findings from this study contribute new understandings to the way in which professional knowledge affects the communication process in interprofessional teams.

The heart of the communication process in this study is the way in which the participants in the meetings worked together to define and redefine the aims for their work. This process was affected by the knowledge held by each participant as they worked towards an agreed outcome. The findings demonstrate that the participants in this study recognised that sharing information led to improved support for the child. The information shared can be seen as contributing to what Eason and colleagues defined as a 'shared knowledge base'. This shared information supported the work the community did together in what Dewey defined as a meaning-making process. The information shared contributed to the agreements reached in the meetings: as to who should be a member of the speech community, what it meant to be a key worker and who should hold the post and how to work with the medical letter. It was not that the meaning-making process was affected by the professional knowledge of the participants it was that the participants shared information they held to work together towards an agreed aim. There was one example in the data of the use of individual professional knowledge, where the co-ordinator shared her

knowledge of a social work support team in meeting 3, and the meeting then used that information to agree to act together in what they saw as the best interests of the child.

The findings from this case study here identify that permission to access or share professional information remains an issue in interprofessional planning meetings. They also contribute to our understanding of the ways in which professional information is used as part of a shared knowledge base to work together and enhance the meaning-making processes in interprofessional planning meetings.

6.8 Do professional languages have a particular role in the communication processes in interprofessional planning meetings?

The generalisations from this case study show that professional languages do not have a particular role in interprofessional planning meetings. The findings suggest that the dynamics of the communication process in the meetings supported the development of a shared knowledge base which should be considered in relation to the role of professional languages and the related 'mode of thought' discussed by Pietroni (1992:14). The finding that doctors were the most powerful participants in this study raises questions in relation to the difficulty that the parents and professional staff had with the medical terms used in the medical letter (extract 32 p.138-9). This was the only overt language issue in this case study and it illustrates a difference in language use between

the doctors and the other professions in this interprofessional setting. Sills (2007: 93) asked how important the understanding of 'discipline languages' was in interprofessional education. The findings in this case study suggest that it is not that interprofessional education is needed to support interdisciplinary understanding but that one discipline, the most powerful, is not working in synergy with the others to enable interdisciplinary understanding.

This research question about the role of professional languages was included in this case study in response to a continuous reference in the literature that differences in professional languages limited interprofessional communication (Webb and Vulliamy 2001, Band 2002 and Petitt 2003) and more recently interprofessional practice (Hingley-Jones and Allain 2008 and Anning 2010). I noted in the literature review above (2.5) that professional languages were first addressed in academic literature in a paper by Pietroni (1992) in which he identified 11 types of professional languages used in health and social care. That paper was written at a time when interprofessional practice was developing in health and welfare and did not include education. Pietroni used the languages he identified to analyse the complexity of interprofessional communication. His paper has often been cited to reinforce the idea of different professional languages but his conclusion in that paper was not about professional languages but, 'the mode of thought made possible by different languages' (Pietroni 1992: 14). The finding from this study that the interprofessional team worked together to make something in common supports the interpretation that in this study there is no evidence of difficulties with professional languages between those attending the meetings. The areas of

professional information that the meetings worked with to make something in common included professional competence and responsibility, which links to Pietroni's focus on modes of thought, as the participants worked together to understand the 'mode of practice' of each profession.

Professional languages continue to be viewed as a 'stumbling block' (Anning *et al*, 2010: 85) in interprofessional communication but the writers in that study also acknowledged that professionals have the ability to share their knowledge and skills, as the findings in this study demonstrate. The focus on professional language in the literature has moved to the way in which it is used to show, 'strong demarcations of professional identity and orientation' (Harris and Allen 2011: 415). This is demonstrated in the findings of this case study where the doctors are the most powerful participants in the meetings. The way in which power was emphasised through the use of medical language was seen in the medical letter (extract 32 p.138-9). The finding that the meetings and sharing information gave power to the group to act in the best interests of the child demonstrate a difference between the way in which the other professions were working together towards a common aim and the actions of the doctors, who were not present in the meetings. This finding illustrates that medical languages continue to be a' stumbling block' (Anning *et al*. 2012: 85) towards communication in interprofessional planning meetings.

7 Implications for practice

The implications for practice are both the starting point and the conclusion for research undertaken within a professional doctorate programme. My practice experience prompted the focus of this case study, which in turn has provided a number of insights into the dynamics and complexities of communication in a series of interprofessional planning meetings. In this chapter I will consider the limitations of my study (7.1) before moving on to discuss the implications of the findings for practice (7.2). I will then discuss the implications of this study in relation to the developing policy situation in interprofessional practice in Scotland (7.3) and the interprofessional expectations of teachers (7.4). The chapter ends with a discussion of areas for future research (7.5).

7.1 The limitations of this study

As research undertaken as the final part of the study for a professional doctorate this research was carried out with specific expectations: it is small, directly linked to practice and established from a theoretical basis. The size of the study limits the strength of the recommendations that I can make from the findings but also provides a richness of data about the dynamics and complexities of communicative practice in interprofessional planning meetings. The size of the study is a limitation in relation to the generalisation of findings from the study, but the choice of methodology, an educational case study as advocated by Bassey (1999) supports the development of 'fuzzy generalisations' from the study. This provides a construct to take the findings of

my study into professional discourse with a built-in recognition about the level of generalisation that I can make from the case study. The changing policy context when I collected the data is in one way a limitation on the study, but the findings from the research illustrate the way in which one interprofessional team worked within the changing policy situation in their locality.

The choice of ethnography of communication as the theoretical framework for the study was at times challenging to me as the researcher as I struggled to find the best fit for those frameworks with my data. While it was challenging to work with, the application of the theory does not limit the outcomes of this study, and in fact the use of the theory provides one of the key findings of the study. The limitation in relation to ethnography of communication is in the application of it to this type of case study. The theory itself was developed as a framework for the study of individual *communicative competence* and the relationship between language functions and social functions (Figueroa 1994). The focus of my research was on the use of language in communication as part of professional functions. As far as I am aware this was a new application of the theory and any studies available for comparison related to social situations and larger data sets. My change of use of the theory has limited the effectiveness of my use of it in this study. Two aspects of the theory: the *speech community* (Hymes 1974) and the *cultural knowledge* framework (Saville-Troike 2003) were most relevant to the structure of my research and could be developed further in relation to the analysis of interprofessional communication. The analysis of data in relation to the concept of *speech community* suggested that a wider study in this area, which incorporated the data from each of the professions represented in the

study, would evidence the structure of nested speech communities and the way that communication worked within and between them. The framework of professional, rather than cultural, knowledge highlighted a blurred understanding by participants of professional knowledge and professional information. The challenges of applying ethnography of communication to this study illustrate the incompleteness of the work and the underlying questions about *communicative competence*, of each individual within their own professional knowledge base, that still remain to be answered.

The combination of ethnography of communication with Dewey's concept of communication provided me with a way to analyse the nature of communication in interprofessional practice and to identify the dynamics and complexities of how communication worked for this group of professionals. There is a limit to the study from the focus of Deweyan communication on working together to create something in common. However, the focus in analysis on Deweyan communication also illustrated areas where such communication was not possible.

I must also recognise that my choice of Deweyan communication for the study came from my practice background and experience in working with colleagues from other professions to agree and carry out interprofessional actions. So my personal focus on participative action framed and limited the focus of this research by emphasising the partnership aspect of interprofessional working.

7.2 The implications of the findings for practice

Bassey (1999) suggests that the development of what he called 'fuzzy generalisations' would be the outcome of a theory–seeking or theory–testing case study. The findings in this case study are the outcome of theory-testing and suggest new applications of theory to research in this area of professional practice. The findings from this case study should be considered in light of the limitations discussed above and against the following definition:

> The fuzzy generalizations arise from studies of singularities and typically claims that it is possible, or likely, or unlikely that what was found in the singularity will be found in similar situations elsewhere: it is a qualitative measure (Bassey 1999: 12)

In this section I will work with each of the findings from the research and consider the implications for interprofessional practice. The findings themselves are presented as a series of bullet points throughout this section.

- The way in which the participants in this series of meetings worked together to define and redefine the aims for their work can be seen in Deweyan terms as how they made something in common between them.

This finding provides evidence of an important dimension of communication in this setting. It illustrates the creative and productive aspects of interprofessional communication. The use of Dewey's conceptual definition of communication in the study has enabled us to see the participative action of the group as they created new meanings together. It demonstrates the process of communicative action in detail as the group worked together to create together a shared

understanding of who should be a member of the group, what the aim of the group was and to struggle with the definition and responsibilities of the role of key worker. The implications of this finding for practice suggest that the communication of different perspectives and expectations (Easen et al. 2000, Anning et al. 2010) is not the core issue for communication in interprofessional practice. The issue for interprofessional practice is to ensure that the context of an interprofessional team will provide the opportunities to work together towards an agreed aim and communicate with each other. This finding suggests that the work of CAIPE (Barr 2007) and the identification of communication as a skill to be learnt could be relevant to practice if that skill was how to work together towards an agreed aim. In practical terms this would involve the teaching of the interaction skills of verbal and non-verbal communication (Thompson 2009). This is an area of practice development in the initial training for several health and welfare professions (Barr 2007) in relation to communication with clients and supervising colleagues. It is an area that could be recommended for both initial qualifications and professional development programmes with a focus on the development of interpersonal skills to use with colleagues in other agencies. This is particularly in relevant to the current policy situation in Scotland through the implementation of GIRFEC.

Communication skills between organisations are a recognised issue in business, particular in international development in cross-cultural business communication. In those situations the development of communication skills are seen as, ‘necessary to achieve personal, group, and organizational goals’ (Ayoko *et al*. 2004: 169). The communication skills referred to in that context

are the interpersonal skills recommended by Thompson (2009), to actively listen and respond in an appropriate way to develop understanding. Thompson has published a series of self-help guides that are currently used in both initial and professional development programmes in social work. He identifies verbal communication as area for 'continuous professional development' and adds that, 'Verbal communication is a very skilled activity, and high quality practice takes a long time to develop' (Thompson 2009: 111). It is these areas of skills development that would support practitioners across health, welfare and education to communicate in a Deweyan sense and work in partnership towards a common aim.

- That the identification of a bounding feature, the nature of the shell and a common aim for an interprofessional group can enable that group to be considered as a *speech community*.

This finding arises from the theory-testing aspect of the study and illustrates the use of the construct of *speech community* in the analysis of the data. Each of the elements of ethnography of communication in this finding has a relevance to practice. The identification of this group as a *speech community*, from data collected across a series of 4 meetings, suggests to me as the researcher that other interprofessional groups working in a similar timescale, i.e. meeting regularly but not frequently to discuss a specific issue could be regarded in the same way. This finding has an important impact on practice where research has previously demonstrated the need for groups of professionals to have time and resources to develop work together (Atkinson 2007). It illustrates the fact that

focused pieces of interprofessional work can support the development of a *speech community* from the group of workers who are part of that work. This is in direct contrast to the time and resources often committed to the development of interprofessional teams (Atkinson 2002, Brown and White 2006).

The identification of the group in this study as a *speech community* came from their own agreement of a bounding feature for the group, that members were 'working with the child'. It is important to note that in interprofessional groups established through education systems this is often the reason for the establishment of a group, where everyone who is 'working with the child' is invited to take part in planning meetings. The development of the *speech community* in this study adds to our understanding of the impact of that on interprofessional communication. The role of the rule 'working with the child' was demonstrated in the case study by the attendance at the first two meetings of a number of promoted staff whose service was working with the child, but who were not doing so as individuals. They were not 'working with the child' and so did not become members of the *speech community* and did not attend meetings three and four. The bounding feature of 'working with the child' facilitated communication in the meetings because each professional working with the child focused the information they shared through the child and what he had achieved and not through what their service or agency had provided. This meant that the questions and discussions as the meeting worked together to ensure continued relevant support for the child were focused on the connections between those actions and the way in which that worked best for

the child. This approach supported the way in which the participants worked together and communicated.

The soft-shell of the speech community implies a flexibility of practice and the ability of the group to expand or contract as was needed to meet the needs of the child and family. This contradicts suggestions in the literature that current professional training produces practitioners who are 'inflexible' (Harris and Allen 2011). Indeed the soft shell could be seen as indicating a 'deterritorialisation' of practice, as advocated by Allan (2006b) for initial professional education programmes for social work, health and education. This would provide less focus on the individual profession and a wider recognition of the working together in practice.

- That recognition of professional competence and responsibility were considered when agreeing support for the child.

This finding should be considered in light of the evidence in the literature of interprofessional practice (Atkinson 2002, Pettit 2003, Hingley-Jones and Allain 2008) that a focus on professional roles and responsibilities limited interprofessional communication. The recognition of the competence and responsibility of individual professions in this study demonstrates a situation in which the identity and skills of individual professional roles supports communication in an interprofessional setting. This has implications for both initial professional training and interprofessional training (Glennie 2005, Charles and Howarth 2009). It supports my own practice experience in interprofessional teams that working together towards agreed outcomes is easiest when the

individuals representing each profession are confident of their own competence and aware of their professional responsibility in relation to the focus of the interprofessional work. The finding indicates the importance of professional development opportunities to enable practitioners to keep up to date with developments in policy and practice, which in turn will provide them with the confidence to contribute from their professional role in interprofessional practice.

- There was uncertainty in the group about the permissions needed to access and use information within and between professions.

This finding reflects issues which were often identified as communication in the literature (Robinson and Cottrell 2005, Murphy and Stewart 2006), but actually relate to the movement of information from one profession to another. It must be acknowledged here that in the changing policy situation in which the research was conducted not all participants were certain of the current policy rules with regard to sharing professional information. This links to the above point about competence and responsibility and indicates a need for each agency or organisation to provide appropriate professional development for their staff to ensure that they know current practice policy in relation to sharing information.

- There were concerns about the amount of information that was discussed in the planning meetings with recognition that the sharing of information improved the support for the child.

This finding reflects the dilemma that sits at the heart of interprofessional practice and is discussed in the literature from the early analyses of Webb and Vulliamy (2001) to more recent analyses of the development of children's services (Forbes and Watson 2012). The implications for practice are linked to the previous finding about uncertainty, and identify a need for individuals to be more confident about the information that could be shared as part of interprofessional practice. The finding is also linked to the question I raised in my analysis of the medical letter (extract 32 p.138-9) about the amount of information the interprofessional group needed to hold in common in order to work together. The medical letter itself highlighted a difference in the way information was shared in written reports by the doctors 'working with' the child in this study and presented orally by the rest of the professional group, who struggled with uncertainty about what they could share. This is an issue that sits in national policy and legislation but is enacted through local policy and professional procedures, and therefore identifies an area of practice that should be addressed in on-going professional education programmes. Such programmes will support individuals to know what information should be shared and in what way but will they are not likely to address the major differences in information sharing, in the enactment of interprofessional practice between medical and other professions in this study. The contrast between the written reports contributed by doctors to the meetings and the oral reports presented in person by the other professionals highlights the underlying tension of the power differential between the doctors and all other professions. It has major implications for the development of interprofessional practice and raises issues discussed by Forbes (2009) in relation to the application of power and

knowledge in work relationships. In that study Forbes used social capital mapping to highlight, 'How *power* and *professional knowledge* operate at each point of the intersection' (emphasis original, Forbes 2009: 128). The conclusion in that paper highlighted the way in which some ' *types of knowledge*' (emphasis original, Forbes 2009: 128) were privileged and differences in power relations at different points in the mapping. My research, from a different theoretical framework highlights similar issues in relation to medical information which was given a different place in the meetings and the power of the medical profession in relation to that.

- The doctors were accorded more power by participants in the meeting than any other profession.

The implication of this finding for interprofessional practice is considerable. It identifies an imbalance in the interprofessional team in this study between the medical profession and all the other professions working with this child. It highlights a difference in the interpretation of 'working with' which this group agreed as a definition for their joint work. For the majority of professionals in this study, 'working with' meant exactly that. They had an identified period of work or a specific task to do to support the child to the next stage of his education. The doctors referred, and deferred, to in the interprofessional meetings had a varying involvement with the child: from long-term support from the GP to analytical referrals to specialist staff. None of the doctors were 'working with' the child in the same way as the rest of this interprofessional community yet the rules of this *speech community* included them as members. This finding is a

challenge for interprofessional communication because some of the community were not present when common aims and actions were agreed. The interprofessional community in this study worked together to 'include' the doctors as part of the community working with the child but this finding indicates that the doctors were seen by the team as separate and more powerful, included but not on a par with the rest of the community. As I discussed above this finding indicates that the doctors were working to boundaries of outcomes, timescales and procedures of their profession (Eason *et al*. 2000). This is in direct contrast to the boundary established for this community of 'working together'. It demonstrates a chasm between the interprofessional practices of doctors and the other professions in this community, an issue that was evident in the work of this community in the deference given to contributions of doctors to the meetings. The power given by the community and held by the doctors in this case study served to reinforce the differences in the way in which they enacted interprofessional working practices. This finding does not relate to the dynamics of communication in interprofessional practice but to the conceptions of interprofessional practice and a key difference that is particularly relevant for interprofessional teams working with children with profound and complex support needs, many of whom have on-going long-term support from specialist medical staff. This is an issue for policy-makers who have included medical practitioners in the GIRFEC framework without acknowledging the conception of interprofessional practice held by doctors. It is a challenge for the other professions in interprofessional groups who 'come up against' medical systems when they are trying to work together in partnership.

- The meetings and the sharing of information gave power to the group to act in what they saw as the best interests of the child.

This finding illustrates what Deweyan communication can do to support and enable interprofessional practice. The meetings, the discussions, the sharing of information and agreement of aims and pieces of work with the child in this study gave the interprofessional group power to work together for the child. In some ways it echoes the finding in the literature that communication is a key aspect of interprofessional practice (Murphy and Stewart 2006, Sloan 2006) but in this study should be viewed through communication as defined by Dewey. Importantly for practice it adds to our understanding of what communication actually is and the ways in which communication can strengthen the work of an interprofessional group and develop their support for the child or family they are working with. This finding suggests that interprofessional practice could improve if individual professions had a better understanding of the processes of communication and their role in developing it in practice.

In the introduction to this study I hoped that the research would provide a better-theorised understanding of the complexities of such communication processes and lead to improvements in communication itself. The findings from my study confirm that the use of the conceptual definition of communication from Dewey as an *object-theory* (Biesta *et al*. 2011: 235, emphasis original) and ethnography of communication as a sense-making theory have provided a better theorised understanding of the dynamics and complexities of communication in this setting. In particular the findings illustrate the way in

which the group worked together to make something in common, the issues which enabled or disabled this process and the extent of commonality that was needed for them to work actively together. The group met because they or their service was connected with the support for one child. The process of agreeing who was a member of the group through the definition of 'working with the child' provided a core structure of membership who were then able to reach agreements in common on particular areas of support. The process of making something in common was supported by the establishment of the group and the understandings they reached together of the focus of the meetings. In a similar way the debate within the group about the role of a key worker led to a common understanding and agreement about who was most appropriate to hold that role. The timing of that agreement, when the worker identified had finished her work with the child, was not in itself a limiting factor to the agreement. It illustrates an interesting dynamic of the communicative process that the work they did together to reach that agreement provided an on-going focus for the work of the group and enabled further understandings to be reached together. In this case study the debate in the group about the role of the key worker was a strong enabling process as it developed shared understanding about that role across the membership. In a similar way the work the group did together to understand and respond to the medical letter (extract 32 p.138-9) was also an enabling part of the communicative process. The common agreements reached in the group were directly concerned with support for the child and the focus of the discussion in the meetings. The differences in the level of information and understanding across the group enabled the work they had to do together to reach commonality. The agreements they made together were all focused on

the support the child was receiving. They required agreement in the meetings and action for some individual members in relation to direct work with the child. The level of commonality needed to reach agreement was directly related to the work with that child and the agreed role of individual professions, as is recommended in the GIRFEC process. It is important to note the practical focus of these meetings, which did not include developing knowledge about the role, values or knowledge base of other professions, supported the process of making things in common. The very areas, such as the role of the meetings and of individual professions (Vulliamy and Webb 2003a b, Pettit 2003), which might have been considered as limiting communication in these meetings provided opportunities for the group to work together and agree a common understanding.

7.3 The implications for practice in the current policy setting

My study demonstrates that there is much more to communication in interprofessional planning meetings than the giving and receiving of information (McQuail 1984) and I would now like to consider the implication of my findings in relation to the to the current policy situation in Scotland.

The practitioners in this study were working within the national context of GIRFEC and legislative framework for additional support needs in Scotland. At a local level they were working within education and children's services developments and separate, but parallel, health developments. This is part of a rolling process of development in Scotland that was described to the Education

and lifelong learning committee of the Scottish Parliament in in the following way:

> If we introduce new children's legislation in 2014, as is planned, we need to take some of the anomalies out of the ASL act and take the best out of the Children (Scotland) Act 1995 and get to a solution in which we have a single assessment and a single plan for a child (Butcher 15.05.12, Col 1077as cited by Redford 2012: p.85)

The current Scottish Government is planning to introduce a new piece of legislation which will amend the additional support for learning legislation (Scottish Executive 2002, Scottish Government 2009), develop the Children (Scotland) Act from 1995 and build on the experience of GIRFEC, some aspects of which will move from recommended practice to legislation. The complexity of these on-going interconnected developments was acknowledged in the evaluation report of the pathfinder project which supported the introduction of GIRFEC in the Highland council area:

> *Getting it right for every child* is about radical transformational change. That is, change that requires not only a major shift in systems and working practices but also a shift in the basic assumptions that inform the way people think about their work (Scottish Government 2009: 131).

The findings from this case study illustrate part of that changing policy context and provide key indicators of the impact of the changes introduced through GIRFEC in a non-pathfinder area.

My research highlights the need for information policies which are understood by all staff. The development of individual practitioner understanding of the local policies about the sharing of professional information would support

communication in interprofessional practice. The study also indicates that the recognition of professional competence and responsibility is part of the process of interprofessional communication. It contributes to the group working together to agree a common aim which supports the communication process in an interprofessional group. This suggests that policy needs to recognise and support professional as well as interprofessional roles and responsibilities to provide practitioners with a framework to support interprofessional practice. The difference in the conceptualisation of interprofessional practice between doctors and the other professions in this study highlights an issue that is not addressed in current policy. It is an issue for the medical profession in relation to their role in interprofessional planning meetings and it is an issue for the other professions in the way they include or not, medical practitioners in their interprofessional practice.

An important message for policy-makers from this study is that communication in interprofessional practice is not an issue of websites, leaflets and booklets (Scottish Government 2009) but the opportunity for professions to work together in partnership towards an agreed aim.

7.4 Interprofessional expectations of teachers

The prompt for this research came from my own practice background in education and the study was carried out in a school, through the education service of a local authority. So it is relevant to return to that single professional focus and consider the implications of the research for teachers. It is interesting

to note that the outcomes for teachers as partners in interprofessional planning are the same outcomes as those of all professions represented in this study of interprofessional planning meetings. There is a need for all professionals to have the opportunity to work directly with each other in partnership towards an agreed outcome. It is not so much as Allan (2006) proposed that there is a need for 'deterritorialisation' of professional training towards a stronger interprofessional focus, but a need for individuals to have confidence and awareness of their own professional knowledge and skills. It is the development of an appropriate sense of their professional self (Boreham 2007) and confidence in their own professional knowledge and skills that will support them as participants in interprofessional practice and enable them to communicate to meet the needs of the children and young people.

7.5 Areas for future research

Forbes and Watson(2012) in the conclusion to their recent collection of papers on *The Transformation of Children's Services* suggest that that there is a need to understand, 'the forms of practitioner relational networks and flows of knowledge' in what they call trans-sectoral integration (Watson and Forbes 2012: 188). They also argued of the need for:

> an analytic is needed to critically locate the operation of power and knowledge in work relations and to identify where inter/professional relations break down in policy-practice incoherence and disconnects (Watson and Forbes 2012: 188).

My case study supports their identification of these issues in relation to power and knowledge in interprofessional practice but equitably further investigation into interprofessional communication through a Deweyan perspective could identify the areas where interprofessional communication supports coherence and connection in practice. In particular further study of the construct of *speech communities* in interprofessional communication would provide data to improve our understanding of the impact for practice of the successful interactions between professions. This could develop our understanding of the way in which communication occurs in the *speech community* in interprofessional meetings and the relationship between that and the *speech communities* of the different professions represented. An investigation such as that would develop our understanding of communication in this area of interprofessional practice and the way in which professional information is shared and worked with in partnership.

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