Contents

List of Figures and Tables ix

Foreword by Jeffrey Braithwaite x

Notes on the Contributors xii

1 Communicating Hospital Work 1
Rick Iedema

2 Institutional and Professional Orders of Ethics in the Discourse Practices of Research Recruitment in Oncology 18
Ellen Barton

3 The Communicative Functions of the Hospital Medical Chart 39
Pamela Hobbs

4 Governing the Operating Room List 67
Robin Riley and Elizabeth Manias

5 Dialogues for Negotiating Priorities in Unplanned Emergency Surgical Queues 90
Martin Lum and Anneke Fitzgerald

6 Personality Disorder in UK Mental Health Care: Language, Legitimation and the Psychodynamics of Organized Surveillance 109
B. J. Brown and Paul Crawford

7 Renegotiating Disjunctions in Interorganizationally Provided Care 138
Hannele Kerosuo

8 Anaesthetic Talk in Surgical Encounters 161
Catherine Pope, Maggie Mort, Dawn Goodwin and Andrew Smith

9 Corridor Conversations: Clinical Communication in Casual Spaces 182
Debbi Long, Rick Iedema and Bonsan Bonne Lee

10 The Role of Signs and Representations in the Organization of Medical Work: X-rays in Medical Problem Solving 201
Per Måseide

11 Why Do Doctors Not Engage with the System? 222
Christine Jorm, Jo Travaglia and Rick Iedema

12 Nursing through Time and Space: Some Challenges to the Construct of Community of Practice 244
Sally Candlin and Christopher N. Candlin

Index 268

1
Communicating Hospital Work

Rick Iedema

Introduction

The focus of this volume is on hospital communication and interaction. Our interest in what goes on in hospitals reflects a general rise in public scrutiny of the enactment and organization of hospital work (Davies and Harrison, 2003; Harrison, 1999). This increase in scrutiny is evident in a number of ways. Over the last decade and a half, we have seen a number of government-level inquiries into highly publicized failures affecting hospitals in the UK, the USA and Australia (Adrian, 2003; Douglas, 2002; Kennedy, 2001; Kohn *et al.*, 1999). Each of these inquiry reports contains the recommendation that the (re)organization of hospital care should be a priority concern for policy makers (UK Department of Health, 1997), health managers (Degeling *et al.*, 2004a) and practitioner clinicians (Berwick and Nolan, 1998). We also know from the public media (Meek, 2001), from policy announcements (UK Department of Health, 2000) and from academic research (McKee and Healey, 2002) that hospitals' organizational profiles and the contours of clinical work are changing rapidly. While many of these changes have been discussed in sociological and organizational theoretical terms (Dent, 1998; Flynn, 1999, 2004; Kitchener, 2000; albeit not to everyone's satisfaction: Davies, 2003), they have only in a very limited way been documented from microsociological, anthropological and discourse analytical perspectives (Iedema, 2003). It is for that reason that the research collected in this volume foregrounds discussions about what is happening in acute care and uses analyses of hospital discourse and interaction. By targeting hospital interactions, the research presented here captures the specifics of how clinicians address the organizational dimensions of care, and how these dimensions are negotiated alongside the patient diagnosis

and expert professionalization issues that are more commonly pursued in the literature.

This volume also appears at a time when much large-scale research is being done on how to change and improve health care in the face of social, organizational and technological complexities (Ferlie and Shortell, 2001; Grimshaw and Russell, 1993; Hoff *et al.*, 2004). Central here are concerns about 'barriers to reform', 'reasons for organizational inertia', 'lack of success of change strategies'. These concerns are most frequently addressed in terms of what in clinical terms is seen as 'gold standard' research: a quantification of large numbers of people's views on, and reactions to, reforms. These quantifications become the basis for causal–instrumental claims about 'what works' in influencing clinicians to work differently, more effectively and more efficaciously (Shojania and Grimshaw, 2005). Quantitative research is prevalent in health services research and hospital organizational research, but it runs the risk of obscuring what many of the reforms and proposed improvements mean for clinical professionals 'on the ground' (see Degeling *et al.*, 2004a, b); that is, how these reforms and improvements affect how clinicians enact, informate and communicate about their work. Given the changes that clinicians are facing and the pressures that are being brought to bear on them, describing not just opinions and espoused views but clinical conduct at the level of situated interaction (Greatbatch *et al.*, 2001) may enable policy makers as well as clinicians and clinician-managers to reflect on how professionals manage and organize the interactive details of contemporary health care. In sum, coming to terms with and centring reform debates around how hospital change is realized (or not) in situated interaction is an urgent task.

Perhaps most importantly, the emphasis on 'situated communication and clinical interaction' in this volume derives from the now widely shared acknowledgement that the quality of communications and interactions among clinicians is to a large extent a determiner of the outcomes of their work for patients. The efficacy of what clinicians do for patients – the ultimate protagonists in health care – depends of course in an important way on clinicians' expert-professional acumen. However, it is also increasingly clear that achieving good clinical outcomes for patients is contingent on interprofessional and professional–patient communications about the systematization and dynamic coordination of care processes (Pincock, 2004; Sutcliffe *et al.*, 2004) as well as a 'mindful' negotiation of professionals' mutual expectations and relationships over the substance of care (Weick and Sutcliffe, 2001). These issues are precisely the focus of this book.

Analysing hospital communication and clinical interaction: four aims

Having specified the general orientation of the book, let us now turn to the contribution it seeks to make to the literature. First, the book brings together recent research in the field of hospital communication and interaction done by discourse analysts, communication researchers, activity theorists and workplace studies researchers. In one sense, the book elaborates on work that has been done on clinician–patient communication (Ainsworth-Vaughn, 2003; Fisher and Dundas Todd, 1993; Maynard, 2003), intraprofessional relationships and clinical decision-making (Atkinson, 1995; Labov and Fanshel, 1977; Pettinari, 1988), medical professionalization (Atkinson, 1999; Erickson, 1999; Pomerantz *et al.*, 1995), and the documentational and administrative realities of in-hospital clinical work (Garfinkel, 1967; Rees, 1981), as well as the social dimensions of such clinical information (Cook-Gumperz and Messerman, 1999).

In another sense, the research presented here extends existing work by focusing on in-hospital communication against the background of the increasingly 'crowded clinical space' that is the contemporary hospital, the organizational challenges, clinical complexities and multiple roles that clinicians now have to confront and enact, and the rising levels of public scrutiny targeting what clinicians do and say to each other and to their patients. More specifically, the book acts as a forum for a number of international researchers who are engaged in studying the complex influences that are currently crowding into the clinical space: health policy and hospital reform, ethics guidelines, changing interprofessional positionings, shrinking resources, complex technologies, cross-organizational service agreements, and last but not least, the rising levels of communication work or 'immaterial labour' that characterizes face-to-face interactions among clinicians (Iedema *et al.*, 2006b).

A second contribution of this volume is that it provides a resource for researchers and students in the field of health research more broadly such that they can become acquainted with more detailed analysis of hospital–clinical interaction and communication than is currently available. While the sociology of health and illness has a problematic relationship with health organizational communication (Davies, 2003), applied linguistic and discourse research in health (Candlin and Candlin, 2003) and in hospitals in particular (Iedema, 2005) has at best been intermittent. Applied linguists and discourse researchers have therefore thus far been excluded not just from forums that address the

reform of hospital care but also from forums that determine the shape and focus of education about hospital communication. This is all the more unfortunate in light of the contribution that these researchers can make to the growing debate about the structuring of hospital services, and to informing the solutions that are currently being mobilized to deal with these complex issues (Degeling *et al.*, 2004b). As this volume demonstrates, the research methods and analyses presented here are able to throw special light on clinical conducts that are at the interstices between acute care expertise, clinical standards and evidence, hospital ethics, involvement of patients and consumers, and the organization, management and integration of cross-organizational services.

Important too in this regard is that the chapters in this volume are not exclusively the work of discourse analysts, but are also written or co-written by researchers from a range of different and complex backgrounds. Besides discourse analysts with a strong interest in health (Barton, Måseide, C. Candlin), a medical sociologist (Pope) and a medical anthropologist (Long), the book incorporates chapters by social scientists with backgrounds in nursing (Riley, Brown, Fitzgerald, S. Candlin), medicine (Jorm, Lum), allied health (Travaglia), pharmacy/nursing (Manias) and law (Hobbs). This variety of author backgrounds is further evidence of the relevance of discourse research for the exploration of health care and hospital organizational issues not just for the sake of advancing discourse theory, but for the sake of addressing and potentially resolving issues that confront health policy makers, health care practitioners and health managers.

A third contribution is that this volume enriches discourse analysis by testing its methods and approaches in a hitherto little explored site. With some exceptions (Wodak, 1996), discourse research has generally focused on sites that are populated with limited numbers of participants and stakeholders (such as general practitioners' consulting rooms). Replicating medicine's own preferred conception that positions medicine as the essence of hospital work (Colwell, 1995), such focus runs the risk of 'invisibilizing' the extent to which the doctor's work and the patient's treatment trajectory depend on exchanges with others (pathology laboratory scientists, allied health professionals, health administrators and managers, to name but some) in addition to the patient and immediate peers. The chapters brought together in this book bring these more complex facets of clinical work to the fore, showing how hospital work interweaves the contributions of many professionals. But in addressing these complexities, the chapters also come face to face with methodological assumptions that underpin discourse analytical

research. Prominent issues here are the shifting boundaries between text and context; between ethnography and language analysis, and between outside observer and inside change agent.

For example, each of the chapters shows that analysts have a lot of intimate sociological and anthropological knowledge of situated medical, nursing, allied health and managerial–administrative practice. This resonates with what Cicourel (1982) noted many years ago:

> Participants of discourse or readers of a text are always engaged in selective use of the information that they can attend to. Limited capacity processing constraints imposed by a complex setting and the participants' knowledge base can sharply reduce the participants' comprehension of what is taking place. The researcher faces similar problems. We normally examine single utterances or connected discourse that run for a few lines, giving careful attention to lexical items, pronominal usage and repetition, the repetition of clauses that give referential prominence to a person, object or event, WH-cleft constructions, IT-cleft constructions, relative clauses, rhetorical questions, and the like; yet we may avoid or be unaware of information that presupposes organizational constraints and complex social relationships that can be obtained only by ethnographic field research. (Cicourel, 1982, p. 53)

The centrality of ethnographic description in the research presented here has important implications for how discourse analysis goes about its business. Because many spheres of social life are becoming more complex, analysis of what goes on inevitably requires more explanation, contextualization and description. At the same time, the emphasis on ethnographic description helps to foreground actors' own concerns and interests, and may lead to a backgrounding of discourse analytical frameworks, technical categories and formal models. Rather than deploying conventional lenses such as hedging, control, power or politeness, this emerging research may instead choose to emphasize the specific problems and logics that are inscribed into sites and their practices. Immersed in ethnography, discourse research is not just a powerful sociological form of analysis, but also a form of enquiry that is of use to practitioners. Of relevance to the present book, this involves using discourse analysis to clarify the problems that clinicians have in coordinating complex services that straddle specialties (see the chapters by Riley and Manias, and by Lum and Fitzgerald); the struggles that result from policy makers seeking to reform hospital organizations and restructure workforce capabilities and rights (see the chapters by Brown and

Crawford, and by Jorm, Travaglia and Iedema), or the organizational–cultural and educational challenges that face health care workers in structuring and integrating their services in ways that benefit the patient (see the chapter by Sally and Chris Candlin).

A fourth contribution of this volume is that it contextualizes clinical–professional discourse with the growing centrality of information and communication in the workplace more generally. As several commentators have emphasized, contemporary workplaces are increasingly being reconfigured into becoming knowledge/information/communication networks (Castells, 1990) that demand not just more knowledge and information, but more *intelligent* and *affective* practices generally: 'today labour and society have to informationalize, become intelligent, become communicative, become affective' (Hardt and Negri, 2004, p. 109). The intelligent and affective dimensions of contemporary work are inherent in it not merely being 'done' but increasingly being 'talked' as well. This means employees have to be able to negotiate difference and dissent among one another, and 'organizationalize' their feelings, relations and selves (Iedema and Scheeres, 2003).

These developments are particularly evident in health care (Iedema *et al.*, 2005) where we are witnessing a particularly strong rise in communication work or 'immaterial labour' (Hardt and Negri, 2004): clinicians are becoming more and more involved not just in 'informationalizing' their work, but also in determining how to act on that information through mutual or self-directed management (Iedema *et al.*, 2006b). In addition to clinicians having to informate their work in increasingly far-reaching ways, the changes in health care organizations confront clinicians with having to renegotiate the bases of their relationships (as recounted in Riley and Manias's chapter); they have to revisit their understandings of what other professionals do (as Kerosuo's and Maseide's chapters show), and they have to carefully balance competing interests and wants (as is evident in Barton's chapter).

Together, communication, the informationalization of care and the devolved management among clinicians serve to create new sites of clinical identification and struggle. They displace old ways of doing and saying and make possible, and *require*, new ones (Rose, 1999). Spending increasing amounts of time on immaterial labour, clinicians are having to invent new rules, genres, rituals and structures with which to govern and 'contain' this immaterial labour (Deetz, 1994). Central here is that clinicians have no choice but to rethink their professional–occupational relationships, their power balances and their self-identities. The hospital policy and health care reform literatures address these

matters only tangentially, lacking ways in which to talk about identity, identity change and the performance of identity of clinical employees. It is here in particular that the present volume makes an important contribution.

The contemporary hospital

The hospital is one among the most complex kinds of social organization produced by humankind. This complexity is evident at a number of levels. First, it is inherent in the work that hospitals do, which includes helping mothers to give birth to babies, providing palliative care for people who are dying, with a wealth of medical and surgical interventions in between. These services are provided by a large variety of professionals: doctors who belong to a wide range of specialties, nurses and their various specializations, allied health professionals, clinical and lay managers, medical technologists and pathology laboratory scientists, each of whom is expected to organize their work relationships with each of the others in dynamic and flexible ways in situations where people's lives may be at stake. Second, hospitals are complex environments because the many services just referred to rely on many different mechanical, informational and pharmaceutical technologies. These technologies, moreover, are undergoing constant change, to the point that a clinician who leaves work for a few months will generally need some training upon re-entry. Finally, hospitals' complexity derives from the historical ways in which the clinical professions have negotiated their relationship with the state. Besides a wide variety of clinical certification controls, this relationship encompasses complex funding models, cost hierarchies and resource allocation decision-making. Moreover, these mostly historical arrangements are now coming under challenge from changes in clinical treatment focus, workforce pressures and accountability requirements, with the twenty-first century witnessing growing concerns about how to fund and achieve appropriate levels of clinical quality, safety and service integration.

With people getting older and contracting chronic and co-occurring diseases, and with medicine raising its technological capability with which to take on these diseases, the need to manage this complexity is now acute. Historically, and in most Western nations, the management of hospital processes was built on an uneasy relationship between clinicians and lay administrators. The global economic downturn in the 1970s coupled with rising hospital expenditures motivated governments to target hospitals with more stringent approaches to rationalizing

hospital work and to managerialize the clinical work. Policy makers set in train hospital reform processes that encouraged clinicians to assume managerial responsibilities and they began to issue and monitor the deployment of formalized guidelines, procedures and regulations as a means to further closing the gap between clinical practice and policy reform.

While these developments began to be debated in literatures informing medicine, nursing and allied health, as well as in medical sociology and anthropology, they largely left discourse analysis and health communication research untouched. This is all the more surprising given the rising importance of communication and information in the contemporary hospital, and the growing emphasis on these matters in clinical–professional forms of education. Thus, there is a clinical communication research literature that inspects clinicians' interactive processes with patients with the purpose of formulating doctor–patient communication competencies (Hulsman *et al.*, 2005), and a health information management literature that studies options for the storage and handling of clinical information (Hovenga and Lloyd, 2002). The complexities of the communication–information interface have been researched in sociotechnical terms (Berg *et al.*, 2000; Berg and Timmermans, 2000), but less often in interactive terms (Aarts and Peel, 1999; Greatbatch *et al.*, 2001). Research into the interactive dimensions of hospital communication and information practices remains overshadowed by studies that transform the details of situated clinical interaction into a discourse of formal categories, numerical values and causal relationships with the aim of deducing certainty about the effects of particular kinds of behaviour (Lingard *et al.*, 2004).

Complementing this existing body of literature, the present volume addresses the challenges of organizing the contemporary hospital at the level of how hospital employees communicate and interact with one another. In doing so, the book adds to attention thus far accorded by scholars working in discourse analysis to public institutions such as the media and education, and to specific spheres of institutional life such as the courtroom and the GP consultation. At the same time, the book seeks to initiate dialogue with other literatures that have pondered over the challenge of hospital organization and communication for quite some time now, but without the benefit of being able to critically analyse the details of situation interaction or of medical and policy documentation bearing on hospital interaction. To this end, this book presents a range of chapters by scholars from around the world to provide insight into the discourses and practices of the hospital.

An overview of the chapters in this volume

The book's main aim is to illuminate how hospital clinicians coordinate and organize their everyday work. Accordingly, the chapters in the book focus on situated interactions among clinicians, on the ways in which clinicians document their work, and on the discourses that bear on how clinicians do their work. These issues are presented by drawing on empirical data of situated practice, clinical documentation and interview transcripts. These data are analysed to map the tensions that arise from the shifting relationships between clinicians' professional and institutional practices and discourses (Sarangi and Roberts, 1999).

In their own way, the studies collected here illustrate how hospital-based clinical discourse is a 'crowded space'. Rather than just being comprised of expert–clinical talk with peers and patients, this discourse encompasses kinds of talk and writing that reveal and acknowledge the interests and 'the presence' of many other stakeholders, such as policy makers, researchers, professional colleagues, whole patient populations, as well as the public generally. The present studies illustrate the tensions that affect how clinical work is currently done by panning out to take these crowded spaces into account. For example, Hannele Kerosuo's chapter discusses an intervention that showed how complex care can be organized across organizational and service boundaries without information getting lost and patients thereby being put at risk. The challenge taken on here is to institutionalize cross-boundary communications involving GPs, specialists and community carers, and to support these communications with a care management plan that all the parties give their approval to.

In her chapter, Ellen Barton considers how doctors enrol patients in clinical trials without exacerbating the conflict of interest that they already embody in being both doctors that are charged with caring for patients and researchers wanting to experiment on patients. Barton's chapter offers a sensitive description of enrolment discussions, and addresses the ethical constraints that doctors are now answerable to. She carefully delineates the risks of principlism, or the notion that we can impose sweeping normative principles on people's actions without taking account of the specifics of situated practice.

In her chapter, Pamela Hobbs homes in on how various clinicians communicate about the progress of women's pregnancies and deliveries through the obstetrics medical chart. She traces the progress of a pregnant woman from admission to delivery of her baby through a careful reading of how the different clinical professionals write in

her chart. Hobbs thereby illustrates how the paper chart is a dynamic device through which clinicians together negotiate and home in on uncertainties and significant developments. Hobbs contextualizes her discussion of this practice with the impending computerization of the medical chart, and offers a view of the issues that an electronic chart confronts in respecting the existing dynamics that link clinical progress and notation.

Robin Riley and Elizabeth Manias's chapter looks at how nurses and surgeons negotiate over the order of patients going into surgery and how they 'manage' their frequently diverging professional priorities and interests in doing so. Riley and Manias reveal 'the list' (the theatre list on which the order of patients going into surgery is documented) as a space of interprofessional contestation and gendered struggle. The nurses are described as being caught in a contradictory position: being responsible for managing the 'domestic' logistics of the operating theatre, they are in a position of relative power that nevertheless turns on their familiarity with, and ability to manoeuvre around, surgeons' personalities and expectations. Riley and Manias conclude the nurses embody a curious 'governmentality': their intimate knowledge of individuals does not automatically translate into power over those individuals, but becomes the basis for their considerable emotional labour to maintain nursing–medicine relationships.

In a companion chapter, Lum and Fitzgerald investigate clinicians' views about how surgery lists are drawn up and changed. Adding to Riley and Manias's perspective from nursing, Lum and Fitzgerald's chapter shines a light on the tensions internal to medicine. In eliciting views on the logic that underpins the surgery list, the authors explore the possibility of referring priority decisions to a shared system of criteria. They find that the grey area that bridges non-urgent cases and highly urgent cases remains permeated with claims and contestations over the perceived importance of some kinds of medical work compared to others. The conclusion that the authors draw from their analysis is that the challenge of uniting clinicians around a common set of criteria with which to manage the surgery list remains.

Looking out towards the impact of health policy on health care work, Brian Brown and Paul Crawford discuss the implications of contemporary UK mental health policies for how health care workers approach their work and their patients. They reveal how UK mental health documentation and related policy and professional guidelines promote a clinical definition of personality disorder as hinging on an unduly 'open-ended self', which contrasts with the reflexive, self-governing and

'ordered' person preferred in contemporary political regimes. At the same time, the mental health care worker's role is increasingly defined and characterized in terms of organizational and occupational flexibility. The contradiction between these two tendencies, they argue, leads to new kinds of uncertainties and contradictions for the individuals who populate the interface between mental health care work and mental disability.

Hannele Kerosuo, drawing on her recent doctoral research, describes clinicians' and patients' involvement in an experiment which she and her colleagues Yrjö and Ritva Engeström devised to enhance the continuity of care across organizational boundaries. This important work devised face-to-face meetings among clinical and community participants in the care process, as well as documentary devices with which to facilitate these interactions and render the information produced there portable. Kerosuo's chapter presents a unique example of how applied social scientific research can extend the communicative and linguistic repertoires of (health) organizational actors.

For their part, Catherine Pope, Maggie Mort, Dawn Goodwin and Andrew Smith describe how anaesthetists coordinate among themselves the application of anaesthetic drugs to their patients while at the same time monitoring the drugs' effect on patients. The seemingly casual talk that anaesthetists engage in with patients is shown to be integral not just to monitoring patient's anaesthetic progress but also to communicating that progress to other members of the anaesthetic team. Safe practice here, far from being a proceduralized and formalized process, is a delicate unfolding of embodied sensitivities and communications that involves the whole anaesthetic team.

Debbi Long, Rick Iedema and Bonne Lee report in their chapter on the complexity of clinicians' corridor interactions, and how these are important for the coordination of their patients' care. The authors show how the talk in one hospital corridor in a spinal pressure sore clinic is different from the talk that takes place in the consulting room, the meeting room and the ward round. Taking place away from the patient and away from formalized organizational spaces, they show that corridor talk is highly dynamic by being oriented towards significant facets in patients' progress and towards specific details of the unfolding care. The space within which the talk occurs makes it possible for clinicians to move dynamically from one to the other without formalized agenda, enabling them to act on what they see as requiring urgent attention or resolution.

Per Måseide investigates the use of X-rays and how radiologists' 'ways of seeing' are heavily interdependent on their 'ways of talking'. Måseide analyses in detail how seeing is dynamically produced from talking, suggesting that the visual object (the X-ray) does not contain 'objective' information in and for itself, but becomes seeable as a result of clinicians' comments, their pointing and questioning, and their intent to draw conclusions from this practice for how to treat their patients.

In their chapter, Christine Jorm, Jo Travaglia and Rick Iedema investigate the construction of personal agency on the part of medical specialists with regard to their relationship with 'the system'. The system represents the organizational context within which these doctors do their medical work, and includes the hospital, the health bureaucracy and the health political stratum. The chapter argues that doctors speak about themselves in ways that construct different kinds of agency, thereby revealing different attitudes towards 'the system'. On one end of the spectrum, doctors see themselves as being able to act, but only in defiance of a system that 'gets in the way'. On the other end, doctors speak about the system in more personalizing terms, using 'we' to suggest they see themselves as integral to 'the system'. These constructions, the authors argue, have crucial implications for how and the extent to which doctors engage with the patient safety agenda, by aligning themselves (or not) with organization-wide initiatives to ensure patients are not harmed while in their clinical care.

Finally, Sally and Chris Candlin reflect on the changes that nursing has undergone over the last three decades. They use the concept of community of practice (CoP) to highlight the complexity of these changes, and in doing so take the opportunity to raise questions about the term 'CoP'. They argue that, given the growing multiplicity of roles inherent in contemporary nursing, the notion of CoP may come up against difficulties. This is because, while in the past nursing was relatively homogeneous in its roles, responsibilities and practices, nursing now encompasses a wide variety of intersecting specializations, such as the nurse practitioner, the community nurse, emergency nursing, intensive care unit nursing, and so forth. The authors also comment on the tensions that have developed between the rising importance of spiritual and emotional labour on the part of nurses to engage with their increasingly older and sicker patients on the one hand, and nurses' growing involvement in technical specializations such as nuclear and neurological medicine on the other, putting considerable pressure on the social and interpersonal dimensions of nursing.

Conclusion

As Davies *et al.* (2000) point out, much health care reform policy is framed within mechanistic and 'Taylorist' approaches to intervening in hospital culture.[1] Prominent in these approaches are 'human factors engineering' (Gosbee and Anderson, 2003) and other techniques such as 'root cause analysis' (Bagian *et al.*, 2002) adopted into health care from the commercial sector (Iedema *et al.*, 2006b). In contrast to these rather mechanistic approaches to understanding and intervening in clinicians' communications and situated interactions, discourse research depicts the formal, non-formal[2] and affective dimensions of communication and interaction (Iedema *et al.*, 2006a). This detail provides not just a better sense of how much goes on between people in their everyday exchanges, but also of the complexity of what they do and say.

Perhaps more importantly, discourse research calls attention to how people's communications and interactions are not just motivated by the 'objective circumstances' they are part of and want to express in language, but also by the personal investments they make into how they speak, who they speak with and what they speak about. Put in these terms, discourse research holds the mirror up to the discursive practices that constitute personal and professional identity as well as – in this case – the complex facets of hospital work. The point is that discourse research seeks not merely to understand and explain how things work. It also engenders reflexivity about how things work that enables actors to reassess the efficacy, appropriateness and convenience (for others) of what they do and say. Reading through the chapters presented in this book, we are alerted to facets of everyday clinical and hospital work that we – even those deeply familiar with hospital practice – previously might not have noticed. Having now been alerted to them, we may be able to engage with them in our own contexts and find ways of revisiting the practices and assumptions that sustain them.

The research presented in this book shows that it is possible to address the imperatives of policy reform and hospital reorganization without lapsing into mechanistic conceptions of how people act and think (Dale, 1997; Davies *et al.*, 2000). It also shows that it is possible to keep the complexity of situated work in focus, while at the same time engaging with the general contours of hospital work. In that sense, the research collected in this volume goes beyond the Taylorist principle popular in health and hospital reform policy and management. In that sense, it adds an important new dimension to the health debates currently

occupying most industrialized nations, by acknowledging and engaging with the complexities that hospital staff confront.

Notes

1 F. W. Taylor (1856–1917) was a US engineer who restructured organizations into conveyor belt factories, rendering their production process more efficient but also more mechanistic and depersonalizing.
2 Non-formal here refers to a modality of interaction that is neither informal and personalized, nor formal and proceduralized, but that affords negotiation of organization managerial issues in a dynamic, ad hoc or *heterogeneous* way.

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Index

Aarts, J. 8
activity systems 144–5, 202–4, 219–20
activity theory *see* cultural historical activity theory
Adler, G. 117
Adler, P.S. 144
Adrian, A. 1
adverse events 222
agency 12, 116, 222, 228–9, 231, 235–6, 246
Ainsworth-Vaughn, N. 3
Albrecht, T. 20
Allen, B. 69
Allen, D. 81, 85
altruistic caring 264
Amalberti, R. 222
anaesthetics 11, 161–81
anaesthetic team 161–81
anaesthetists 11, 71, 75, 78, 90, 92, 94, 95, 100–1, 161–81, 227
  intermediary role of 102–4
Anderson, T. 13
Anderson, W. 183
Annas, G. 35 n. 2
Anspach, R. R. 39, 40
Antonovsky, A. 183
Appleby, L. 116, 118
Aranda, S. K. 262
Arney, W. 22
Arnold, E. 83
Ashmos, D. 90
Atkinson, P. 3, 39, 40, 41, 42, 43, 50, 52, 54, 60, 61, 62, 201, 207
autonomy 22–3, 33, 35, 78, 82, 85, 124, 130, 225, 229, 238–9, 250, 253, 255, 258
  see also patient autonomy

background knowledge 43–4, 55
Bagian, J. P. 13, 223
Baker, G. R. 222
barriers to enrolment in clinical trials 20–1
Barton, D. 248, 255
Barton, E. 24, 35
Beauchamp, T. 23, 31, 36 n. 3
Beck, U. 109, 125, 126, 130, 131
Beck-Gernsheim, E. 109
Berg, M. 8, 68, 71, 201
Bergen, B. 22
Berkow, R. 57
Berwick, D. 1, 222, 239
Biderman, A. 183
bioethics 22–3, 31ff.
  principlism 31
  conflict w/ medical ethics 33–5
Blackshaw, L. 118
Bliton, M. J. 183
Boggs, K. 83
Bogner, M. S. 94
borderline personality disorder 109–37
boundary work 165
Bowers, L. 122
Brennan, T. A. 222, 223, 224, 238
Breu, K. 182
Brown, B. 68
Brown, R. 20
Buchanan, D. 100
Buie, D. 117
Burke, K. 215
Burr, V. 111

Caesarean section 72, 74–5, 96–8, 103
Candlin, C. N. 3, 249, 255
Candlin, S. 3, 249, 252, 254, 261, 262, 263
canonical order of information 47, 54
Caplan, A. 35 n. 2
Carabine, J. 111
case conferences 183, 185
case management 39, 182
Castells, M. 6
category system 93
Chafe, W. 24

change laboratory 142–3, 146–7, 152, 153–7
Charmaz, K. 227
Childress, J. 23, 31, 36 n. 3
Christiansen, C. 39, 60
Churchill, K. 92
Chur-Hansen, A. 183
Cicourel, A. 5, 40
civil inattention 178–9
Clarke, J. 128, 129
Classen, D. C. 223
Cleary, M. 118
Cleckley, H. 121
clinical information 3, 8, 154, 183, 187
clinical role 261
clinical trials 9, 18–38
clinician-manager 2, 103
Coeling, H. 83
Coiera, E. 62
Collins, R. 165
Colwell, C. 4
communication competency 247
communication practices 67, 244, 247
communities of practice 12, 211, 244–67
complex adaptive systems 138
complexity 7, 11, 12, 13, 14, 69, 86, 138, 191, 235, 239
conflict resolution 187, 193, 197
consensus building 264
contested positions 259
continuity of care 11, 157, 258
contradictory 27, 55, 197
conversation 43, 74, 80, 83, 119, 163, 170, 175, 178, 182–200, 219, 253
conversational analysis 164, 177, 179
conversational etiquette 177
Cook-Gumperz, J. 3, 39, 61, 207
Corder, S. 246, 248
Cornbleet, M. A. 223
corridor consultations 182–200
Cowan, J. A. J. 222
Crawford, P. 68, 252, 262
Cresswell, J. 227
Crichton, J. 114, 115
critical discourse analysis 111
Crowe, M. 118, 119
cultural–historical activity theory 142, 143, 144, 154
culture 13, 110, 125, 129, 182, 201, 226, 248
  Western 113
Cunningham, F. G. 45, 47–8, 55, 57, 61

Dale, K. 13
Darjee, R. 114, 115
D’Armour, D. 103
Davidson, S. K. 183
Davies, C. 1, 3
Davies, H. T. O. 1, 13
Davis, P. 222
Dean, M. 69, 86
deconstruction 69, 118, 225, 239
Deetz, S. 6
Degeling, P. 1, 2, 4, 100, 224
Delacour, S. 118
DelVecchio Good, M. J. 33
Dent, M. 1
depression 123, 124, 194, 197
diachronic perspective 244, 256
diagnostics 140, 188
Diamond, I. 120
dietitian 185, 187 (Table 9.1), 195
Dingwall, R. 178
disclosure 121, 130, 250
discourse analysis 4–5, 8, 19, 24, 35, 39, 40, 111, 139, 143–4, 164, 179, 223
discursive choices 255
discursive expertise 263
discursive practice 13, 67, 70–1, 76, 79, 82, 84–5, 144, 244, 247, 254
disruption 149, 151, 197
dissatisfaction 192
distributed cognition 202, 203–5
doctor–doctor communication 183
doctor–patient communication 161–81, 182
documentation 3, 8, 9, 10, 39–66, 118, 128, 152, 183, 206, 224
domain-related competence 245
Doolan, L. 92
Douglas, N. 1, 222

Downey, G. L. 182, 188
Drew, P. 19
Drewery, W. 117
Dundas Todd, A. 3
Duranti, A. 214

Easton, R. E. 42, 50
Eckert, P. 246
education 4, 6, 8, 40, 42, 62, 184, 244, 245, 249, 251, 256
Edwards, D. 111
Edwards, N. 238
elective surgery 91, 92, 93
emergency 12, 43, 72, 81, 83, 90–108, 140, 227, 260
emergency surgery 75–7, 90–108
emotion 26, 31, 86, 91, 98, 105
end of life 183
Engeström, Y. 139, 142, 143, 144, 145, 156–7, 158, 202
equipment 70, 73, 77–9, 82, 84–5, 163, 187, 188, 192, 202, 204, 216, 257
Erickson, F. 3, 39, 41, 43, 50, 54
Erikson, E. 116
Escalante, V. 145
Espago, R. 36 n. 3
ethicists 183
ethics in interaction 35
ethnography 5, 139, 143
see also video ethnography
evidence-based care 119
evidence-based practice 260
expertise 4, 33, 34, 61–2, 104, 125, 126, 157, 162–3, 197, 201, 204, 246, 263–4
Eysenbach, G. 222

Fairclough, N. L. 111, 120, 247
Fallon, P. 124
Fallowfield, L. 20
Fanshel, D. 3
Fauci, A. S. 57
Fenwick, J. 253
Ferlie, E. B. 2
Ferrera, P. C. 92
Fisher, A. 74–5, 82
Fisher, S. 3
Fitzgerald, J. A. 90, 95, 102
Fleming, I. 20
Flewett, T. 125
Flick, U. 227
Flynn, R. 1
Fonagy, P. 117
Foot, K. A. 144
Forster, D. 92
Foucault, M. 67, 69, 77, 82, 83, 109, 119, 130
Fox, N. 164
Fox, R. 23
Fraser, K. 118
Freidson, E. 91, 94, 97, 207, 225

Gaba, D. M. 94, 101
Gabel, R. A. 91, 92, 102
Gallagher, H. 35 n. 2
Gallop, R. 118
Gamarnikow, E. 85
Garfinkel, H. 3, 202, 206
Gee, J. 253
general practitioners (GPs) 143, 145, 185
Gergen, K. L. 117
Giddens, A. 109–10, 125, 126
Gilligan, C. 83
Giltrow, J. 44
Gladwell, M. 31
goal-oriented interaction 254
Goffman, E. 170, 178, 179, 202, 215
Goldstein, A. 23
Gollop, R. 223
Goode, L. D. 223
Goodman, J. 22
Goodwin, C. 202, 207–8
Gordon, C. 69
Gosbee, J. 13
Gotay, C. 20
governmentality 10, 69, 83, 87, 110, 129
Graham, R. 238, 239
Grainger, K. 263
Gramsci, A. 112
Gray, A. 201
Greatbatch, D. 2, 8
Greener, I. 127
Greenhalg, T. 138, 157
Grimshaw, J. M. 2
Grodin, M. 35 n. 2

Gruendemann, B. 68
Gustafson, D. H. 223

Hacking, I. 204
Hadley, R. 92
Hagen, T. 93
Haigh, R. 124
Hak, T. 252
Hall, C. 226
Hall, J. 20
Hall, O. 90
hallway consultations *see* corridor consultations
hallway medicine 183
Ham, C. 223, 239
Hammersley, M. 111
handovers 119, 182
Hanley, J. 183
Hannan, T. J. 62
Happell, B. 68
Hardt, M. 6
Hare, R. D. 121
Harre, R. 226, 228
Harrison, S. 1, 201
Hart, S. D. 121
Healey, J. 1
health care delivery 124, 263
health care system 139, 151, 155, 224–6, 263
health outcomes 253, 255
health-seeking behaviour 184
Heard, S. R. 182, 183, 184, 185
Heartfield, M. 118
Heath, C. 62
Hemmingway, C. 182
Herdman, E. A. 255
Heritage, J. 19
Heslop, L. 260
Hicks, O. 184
Hill, O. 123
Hindmarsh, J. 161, 164, 177, 179
Hinshelwood, R. D. 128
Hobbs, P. 39, 40, 42, 43, 47, 50, 51, 54, 61, 63
Hoff, T. 2
Hogarth, R. 31
holistic nursing care 262
Holmes, J. 247, 265
Holt, T. 138, 157
Horsfall, J. 118, 126
Hosking, D. M. 113
hospital-based training 250
hospital chart 39–66
Hovenga, E. 8
Howarth, D. 70
Hulsman, R. 8
Hunter, K. M. 39, 40, 42, 47, 62
Hutchins, E. 202
hybrid discourse 261
hyperscoliosis 188

identity 7, 13, 41, 68, 69, 116–17, 124, 130, 186, 217, 225, 228, 239, 246–7
Iedema, R. 1, 3, 6, 13, 50, 139, 143, 144, 182, 185, 186, 189, 191, 196, 197–8, 223, 253–4
immaterial labour 3, 6, 191
infection control 194, 197
infectious diseases 185
institutional order 19
intensive care 196, 253, 255, 258–9
interactional order 10, 24ff.
interdiscursivity 260–1
interorganizational care 138–60
interpersonal dynamics 100
IRB review 23
irony 192, 197
Irvine Doran, D. M. 223

Jakobson, R. 215
James, D. C. 46
James, N. 86, 161
Jecker, N. 36 n. 3
Jenkins, V. 20
Johnson, N. 183
Johnstone, B. 24
joint enterprise 248
joint problematization 19
Jorm, C. 223

Kahneman, D. 98
Kam, P. 223
Kassier, J. 238
Katz, J. 23
Kendell, R. E. 115
Kennedy, I. 1
Kerosuo, H. 142, 143, 157

Kerr, D. 238
Killbridge, P. M. 223
King, D. 94
Kitchener, M. 1
Kizer, K. W. 223
Kjekshus, L. E. 93
Klopper, H. 118, 126
Knorr Cetina, K. 201
Koch, J. L. A. 115
Kohn, L. T. 1, 224
Kopp, V. 161
Krawitz, R. 113, 120, 126, 131
Kress, G. 83
Kristiansen, I. S. 93
Kunreuther, H. 31

Labov, W. 3, 21
Lancashire, W. 184
Langley, G. C. 118, 126
Larson, J. R., Jr 39, 60
Lave, J. 244, 256
Lawson, M. 124
Leape, L. L. 222, 239
Lemonick, M. 23
Lennox, D. R. 92
Lerner, B. 20
Levinson, S. C. 219
Lewin, S. 198
Lewis, G. 116, 118
Lian, O. S. 93
Liaschenko, J. 74, 82
Lieb, K. 113
liminal space 185
  liminality 191, 193, 197
Linehan, M. M. 123
Lingaard Laursen M. 92
Lingard, L. 8, 39, 42, 50, 161
Lloyd, S. 8
Locock, L. 223
logistic knowledge 84
Long, N. 139, 145
Luff, P. 62
Lupton, D. 68

Mackenzie, C. F. 94, 101
Main, T. F. 122, 125
Makoni, S. 263
Manias, E. 67, 70, 82, 94, 97, 100
marginal 189
Markman, M. 20
Martin, D. 92
Martinussen, P. 93
Måseide, P. 206
Matchar, D. B. 94
Maudsley, H. 114
Mayer, T. A. 94
Maynard, D. W. 3
McConnell-Ginet, S. 246
McDermott, G. 124
McDonald, C. 255
McGee, P. 68
McIntyre, M. 255
McKee, M. 1
McKenzie, W. 117
McLoughlin, V. 223
McNeilis, K. 20
medical abbreviations 39–66
medical dominance 255
medical education 184
medical errors 222, 239
medical ethics 33–4
  conflict w/ bioethics 33–5
medical records 182
medical research 21–2
medico-legal 183
Melosh, B. 68, 85
mental health 109–37
Messerman, L. 3, 39, 61, 207
meta-clinical 191
meta-space 189
methods 24–5
Meyerhoff, M. 246, 247, 248–9, 265
Middleton, D. 144
Midttun, L. 93
Miers, M. 84, 85
Miettinen, R. 145
Miller, P. 69, 128
Millon, T. 113
Mishler, E. G. 204
Mohr, W. K. 118
Mol, A. 204
Morley, I. E. 113
Morrall, P. 124
motivational relevancies 249
Mühlhäusler, P. 226, 228

multicultural and pluralistic society 263
multidisciplinary health care teams 185, 186
Murphy, G. F. 50
Murray, T. 178
mutuality 246
  of engagement 246
  of goal 248

narratives of experience 245
negotiation 264
  of meaning 260
Negri, A. 6
Nehls, N. 118
Newnes, C. 127
new work order 253
Nolan, P. 252, 262
Nolan, T. W. 1
non-ascribable information 188
non-linear process 197
Norman, I. 68
Norton, G. P. 222
nurse practitioners 185
nursing 244–67
nursing governance 67
nursing practice 244–67
nursing research 261

occupational therapists 185
Okamura, H. 183
O'Malley, P. 119
operating room nursing 68
operating room/theatre 90
operating room/theatre list 67, 92
orders of discourse 247
orthopaedic surgeon 185
outpatients 185, 187

palliative care 183
Paris, J. 113
Parker, I. 111, 118
passive voice 43
patient autonomy 31, 250, 255
patient safety 222
Pearce, C. 184–5
Pecker, M. S. 40
Peel, V. 8
peer support worker 185
Peleg, A. 182, 183
persuasion 25ff., 32–3
Pesonen, N. 140
Pettinari, C. 3, 39, 61–2
photo-voice 70
physiotherapist 185
Pilley, J. J. 260
Pilnick, A. 161, 164, 177, 179
Pincock, S. 2
plastic surgeon 185
Plsek, P. E. 138, 157, 224
Pollak, S. 83
Pomerantz, A. M. 3
Porter, R. 21
Porter, S. 118
post-bureaucratic 189, 191
Potter, J. 111
power 100, 250
power relations 69
pressure ulcers 185
Prichard, J. C. 114
primary care 252
Prince, E. F. 43
problem solving 201–21
professional–client relationship 245
professional deskilling 255
professional growth 253
professional hierarchies 196
professionalism 251
  independent professionalism 260
professional role
  shifts in 258
professional space 248, 250
progress notes 41
Pullen, D. 183
Pylkkänen, K. 141

quality of care 196
Quinby, L. 120

Radcliffe, N. 127
radiology 201–21
Ray, I. 114
Reason, J. 222
Redelmeier, D. A. 98
Redfern, M. 222
Rees, C. 3, 39, 42, 43, 44, 46, 47, 52, 63
Reeves, S. 198

reflexive self 109–37
Reid, A. M. 183
Renholm, M. 141
repertoires of experience 245
research recruitment 18
  decision-making in 22–3, 30, 31–3, 33
  deferral of 30
  recruitment vs consent 34–5
  subtopics 26: eligibility 25–6; medical 26–7; direct benefits of 29
  uptake of 30–1
research regulation 22
  Belmont Report 22
  45 CFR 46 22
residents' notes 50
Resnick, M. 202
resource allocation 99, 264
respiratory care 188
Reverby, S. 22
Riley, R. 67, 70, 82, 94, 97, 100
rituals (*including* ritualized) 196
Roberts, C. 9, 19, 24, 36 n. 5, 50, 247–8
Rodríguez, C. 139, 154
Roper, N. 262
Rose, N. 6, 69, 82, 83, 109, 112, 128, 130
Rosewater, L. B. 120
Roter, D. 20
Rothman, D. 19, 21, 22, 23
Ruckdeschel, J. 20
Runciman, W. B. 224
Russell, I. T. 2
Russo, F. 18

Saaren-Seppälä, T. 142
Samsa, G. P. 94
Sandelowski, M. 68
Sarangi, S. 9, 19, 24, 35, 36 n. 5, 50, 247–8, 249
sarcasm 192
Sauls, D. J. 46
Schattner, P. L. 183
Schatzki, T. R. 204
scheduling 90
Scheeres, H. 6, 139, 143, 253–4
Schiffrin, D. 24
Schneider, C. 23, 32–3
Schneider, K. 115
Scollon, R. 246, 247, 264
Sears, W. G. 260
self-determination 250
Shadbolt, N. E. 183
Shafer, A. 161
shared repertoire 245
Shekelle, P. G. 223
Shojania, K. G. 2, 223
Shortell, S. 2
Siegler, E. L. 40
Sigurosson, H. 68
Silk, K. R. 120
Silverman, D. 21, 225, 237
Simpson, A. 124
Sinclair, C. M. 222
Singer, P. 92
skill exchange 187
sleep apnoea 188
Smail, D. 114, 130
Smallwood, R. 223
Smith, R. 238
Snyder, W. 246
social capital 98
social worker 185
Spigelman, A. D. 183
spinal cord injury 185
spirituality 252
Starr, P. 21, 23
Stein, L. 79
Street, A. F. 262
Stubbe, M. 247
Suchman, L. 202
Sutcliffe, K. M. 2
Svensson, R. 81
Swan, J. 183
Swan, N. 222
Swartz, M. 113
Sweet, S. 68
Swenson, C. R. 128
Szirom, T. 100

Tadros, V. 114
talk
  affective 187
  clinical 187
  descriptive 165–6, 173
  emergence 171–7, 178

evocative 169–70
functional 166–9, 172–6
induction, broken 165–71, 178
organizational 187
reflexive 187
technological 187
Tannen, D. 83
Taylor, C. 226
Taylor, F. W. 14
Taylor, I. 238
Taylor, S. 252
team meetings 165,185
teamwork 177, 252
therapeutic communication 253
time management 187
time trajectory 263
Timmermans, S. 8, 201
topic 24–5
topic selection 260
Traynor, M. 111, 118
triage tool 95
tribe/tribal 100
Turner, V. 185
Tusting, K. 248, 255
Tversky, A. 98

unplanned surgery 67–89, 90–108

van Bueren, E. M. 223
van Dijk, T. A. 111
Verheul, R. 123
video (*including* video ethnography) 139, 186

Wadhwa, L. 92
Waitzkin, H. 118
Wald, H. 223
ward rounds 182
Warner, S. 117, 120
Waters, K. A. 50
Watson, C. 113, 120, 131
Watts, I. 185
Weed, L. L. 50, 61
Weick, K. 2
Weinholtz, D. 49
Wenger, E. 244, 246, 248, 256
Westen, D. 116
Wetherell, M. 111
wheelchair 188
White, S. 226
Wicks, D. 85
Wiener, C. 223
Wigens, L. 259
Wilcox, J. 83
Wilkins, T. 117, 120
Wilkinson-Ryan, T. 116
Wilson, B. 100
Wilson, R. 222, 224, 238
Wilson, T. 138, 157
Wirth-Cauchon, J. 113
Wodak, R. 4, 50, 139, 143, 144
Wonderlich, S. A. 120
Wong, W. H. 119
work flow planning 187

X-rays 201–21