
# Delivering healthcare in multiprofessional teams: the negotiation of tasks

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**Purpose**

Multiprofessional team working is assumed to be difficult. This is often associated to professional identity and jurisdiction. Despite anticipated difficulties, few studies examine teams working in their main arena: team meetings. One important function of these multiprofessional team meetings is to determine future tasks and next steps for patients. This paper examines the negotiation between professionals of what these next steps should be.

**Methods**

Data was collected in 2018 and 2019, from three Community Learning Disability Teams in the UK, with a total length of 12 hours and 37 minutes. Conversation analysis (CA) was used to analyse 22 extracts, at points in the interactions when there were negotiations on the next steps the team should take for clients.

**Findings**

Negotiations were characterised by propositions and counter propositions. They occurred when a course of action was proposed that made a specific professional's role relevant, which were then countered by that professional. Countering was achieved by professionals separating themselves from the team, using first-person pronouns and making statements on their next steps. In both propositions and counters professionals orient to epistemics and deontics, important for how their turns-at-talk were receipted by other team members.

**Originality**

This paper shows that instead of problematic, professional identity was used as a conversational resource. Negotiations are key for multiprofessional teams to determine optimal next steps for patients, and who could and should do specific tasks. Professionals orient to knowledge of professional identity to propose tasks that others could do, and to counter these propositions.

Keywords: multidisciplinary teams, intellectual learning disabilities, teamwork, collaboration, conversation analysis

Multiprofessional teams are integral to the delivery of healthcare services. Often referred to as multidisciplinary or integrated teams (Journal of Interprofessional Care, n.d.), multiprofessional teams (MPT) in healthcare differ from other organisations as members have allegiances to their professional specialities (Firth-Cozens, 2001). Diverse specialities are needed for multiprofessional teams to meet the needs of their patient groups (e.g. in cancer care, Flessig et al., 2006; intellectual (learning) disabilities, Silver, 1986). In the UK, as well as secondary and community healthcare, there is a move to bring more MPT working to primary care (Chan et al., 2024). Integrating multiple professionals is not always straightforward though, as demonstrated by debates over the role of newer professions to primary care teams (Feinmann, 2024). This paper examines *how* healthcare delivery is done in these teams, with a focus on the negotiation of future tasks.

Multiprofessional teams must work together to complete tasks. There are a range of definitions for teamwork in healthcare (Rydenfalt et al., 2018), with 'cohersion, collaboration, communication, conflict resolution, coordination and leadership'(p.1) described as enablers to teamwork (Rydenfalt et al., 2017). For MPTs teamwork is anticipated to be hindered by their very nature. Heightened professional identity has been suggested as a negative factor for teamwork (Leach & Hall, 2011, Miller 2004). Different healthcare professions have developed distinct cultures, based on education and training, along with historical, social and gender issues (Hall, 2005). Professionals' cultures and identities are developed through societies (e.g. Academy of Medical Royal Colleges, 2020), and through professional regulation (e.g. Health & Care Professions Council, 2021). Regulation also links professional identity to 'scopes of practice'(Health & Care Professions Council, 2021).'Scopes of practice' may denote task boundaries between professionals. These boundaries have the potential to enhance collaboration and teamwork (Langley et al., 2019), if drawn on to enable collaboration (Quick & Feldman, 2014). However teams also

have to work through who in the team has the authority to do certain tasks and make decision, which is referred to in the literature as professional jurisdiction. Difficulties in MPT work have been attributed to breeches to jurisdiction (Kvarnstrom, 2008; Cain et al., 2019; Bradley et al., 2009; Hunter & Segrott, 2014). What is yet to be explored is how these boundaries and jurisdictions between professionals are evident in task negotiations.

Meetings are the main arena where professionals meet, patient cases are discussed, and tasks are then negotiated (Smart & Auburn, 2020). Team members must propose and agree future courses of action, as well as determine who will carry out the future course of action. This happens dynamically within the meeting interactions. Decisions will be led by professionals' knowledge of the individual patient and knowledge of the treatment options; but each professional's knowledge, of both the patient, the healthcare priorities, and the treatment options, will be different. At the same time, different professionals will have different authority and obligations over different types of work (e.g. a speech and language therapist would not often prescribe medication). These elements require negotiation within the meeting interactions. Observation of task allocation in MPT meetings has rarely been done, with most research based on retrospective accounts of team members' experience (e.g. Hunt et al., 2016; Jones, 2007; Lee et al., 2012). Examining discussions of task allocation could help understand where the reported difficulties arise and how these difficulties can be managed to achieve healthcare delivery.

Conversation analysis (CA) is well suited to analyse discussions about task allocation, with a focus on displays of knowledge and power over future actions (or tasks). Prior CA work has built our understanding of knowledge displays (Mondada, 2013, Lindström & Weatherall, 2015, Maynard & Heritage, 2005) and displays of power over future actions (Stevanovic & Perakyla, 2012, Kawashima, 2017). Research in non-clinical and/or clearly hierarchical workplaces has demonstrated how during interactions team members can make displays of

knowledge and authority over what should happen next (e.g. Lindstrom & Weatherall, 2015, Wahlin-Jacobsen & Abilgaard, 2019). This previous work can be applied to help understand task allocation in healthcare MPTs where hierarchies are ambiguous. Thus, building on prior conversation analytic research, we address the question of how tasks are allocated in multidisciplinary healthcare teams, through displays of knowledge and power over future actions in interaction, to accomplish patient care.

## Method

This study was part of the first author's doctoral thesis, which focused on collaboration in Intellectual Learning Disability (I(L)D) MPTs (Tremblett, 2021). Here the focus is on the audio-recordings of MPT meetings, collected from three community based I(L)D teams in South-West England.

### Participants

All three teams work in the community with adults with I(L)D, but each team would share an office to complete administrative tasks and hold team meetings. They were labelled as multidisciplinary teams by their organisations. The size of the team varied from six to 30 people. Team members included nurses, clinical psychologists, occupational therapists and speech and language therapists as team members. More details on the teams and their organisation are available in Tremblett (2021).

### Data

Data were collected in 2018 and 2019, and provided 12 hours and 37 minutes for analysis, where over 140 clients were discussed. The aim was to video record the meeting to include body gestures in analysis, but no teams consented. Audio-recordings were made with two Dictaphones (to capture all talk in a large space) and some recordings were collected by the teams, whilst some were collected by the researcher who was present in the meeting. When

present, the researcher took observational notes for context, but not to be analysed. The meetings were mostly to discuss new referrals to the team. Other meetings included a supervision meeting for a training programme, and a discussion of a complex client. Meetings were subsequently transcribed and all identifying details obscured in recordings, or given pseudonyms in transcription.

## Ethics

The research was designed in line with the British Psychological Society Code of Ethics and Conduct (2009, 2018), and [university ethics information] authorised the research project. Consent was gained from every team member to record meetings. Careful consideration was given to the recording of patient information, as the patient was not present to provide consent. Patient and public involvement advice from those with love experience of I(L)D advised that along with being impractical, seeking consent from patients would be too burdensome. Permission from the NHS Caldicott Guardian was given to access this type of data without patient consent.

## Analysis

A conversation analytic approach was taken. Conversation analysis (CA) is a fine-grained systematic approach that inductively aims to understand naturally occurring interactions. CA seeks to understanding the sequential organisation of talk and pays attention to details, such as words, grammar, and intonation, that shape intersubjectivity (Leydon & Barnes, 2020).The first author initially repeatedly listened to the meeting recordings for any moment of resistance and disagreement between team members around a proposed future course of action and/or task allocation. 22 extracts were identified. Talk was extracted at the point in the meeting that a proposal or task allocation had been made and ended when talk moved on to a different topic. These extracts were transcribed in detail using Jeffersonian conventions (Hepburn & Bolden, 2017) to note detail such as intonation changes and pause length. Each

extract was then analysed line-by-line, examining what each person said, how it was said, and how it was responded to by other team members. The aim was to understand what people accomplished by what they said, and how mutual understanding was reached (or not) between team members.

A CA approach is guided by previous findings in CA and this analysis drew on the concept of epistemic and deontic authority. Stevanovic (2013) describes epistemic authority as 'knowing what is true' and deontic authority as 'determining what "ought-to-be"'(p.19). Both are claimed in conversation. Epistemic authority is displayed through knowledge claims made and asserted in conversation (Heritage, 2013). These claims can vary on a gradient that display high epistemic authority (K+, more knowledgeable) or low epistemic authority (K-, less knowledgeable). Deontic authority can be displayed when asking others to do things and determining the right to do your own thing (Stevanovic, 2018). Claims to deontic authority can also vary on a gradient, from high deontic authority (D+, more power of determination, e.g. 'Shut up'), to low deontic authority (D-, less power of determination, e.g. 'I'm sorry, I can't hear the weather report') (Stevanovic, 2018). The extracts were categorised iteratively based on the deontic and epistemic claims made during the negotiation of tasks.

## Results

The following analysis shows the impact different claims of deontic authority, and the use of epistemic claims, during task negotiations between team members. The first section focuses on how team members resisted task propositions by claiming ownership over the right to determine future tasks. The second section focuses on how team members allocated tasks to other members of the team by telling people what to do. A table is provided in Appendix 1 to describe the teams and professionals in the extracts.

Resistance to proposed tasks

Professionals need to be able to resist other team members' propositions and reach an agreed consensus on what tasks need to be done, and by whom. 'Resistance displays' can be observed in interaction, and can be passive (e.g. silence, hesitation, (Heritage & Sefi, 1992)) or explicit (e.g. refusals, rejections, counters, (Huma et al.,, 2023)).

Professionals made claims of deontic and epistemic authority when resisting propositions. Countering a proposition with an alternative course of action was the main way of resisting and was done in ways that displayed different deontic authority. Minimal accounting for the alternative course of action demonstrated high deontic authority and tended to be accepted by the team. The more knowledge claims and accounting displayed lowered the speaker's deontic authority and provided an opportunity for resistance from other team members (reflecting findings by Stevanovic & Perakyla, 2012).

Here three illustrative extracts are shown as exemplars of how resistance to proposed tasks was achieved with different deontic authority claims. First, we provide an example of when resistance to the proposal is accepted by the team, leading to extracts where establishing who will do what takes more turns in interaction. There is a preference for early acceptance, to allow the conversation to continue, which is important in MPT meetings when there are many clients to discuss and limited time available.

Extract 1 below demonstrates resistance to a proposition from a community nurse there is no need for further work with the family. The occupational therapist counters this proposition with a clear display of deontic authority about what should happen next with the client.

Extract 1: PB- TC- E19

(CN3: Community nurse; OTh: Occupational Therapist; Psy: Psychologist)

```
01  CN3:    Yeah: [I ↑went through the]
02  ???:          [ (missed)          ]
03  CN3:    communication profile with mum a:nd .hh (name)
04  ???:    [(mmm)]
05  CN3:    [and  ] everybody's happy with it↑
06  OTh:    Okay↓ Thank you so much I'll I'll I'll still
07          want to do some sort of: f::eedback with the
08          team I think but >thank you for doing that<
09  Psy:    Don't the safeguard the social care need to
10          come up with a plan:
```

We join the extract after the community nurse (CN) has given the team an update on the clients housing situation as they have been subject to an eviction notice. In response to the occupational therapist (OT) evaluating the family's decision not to tell the client ('its indefinite at the moment isn't it', not shown), the CN agrees then moves to provide feedback on a communication profile (see line 01 and 03). The CN completes their display of client knowledge with a statement pointing to a conclusive 'upshot' of doing the profile, that 'everybody is happy' (line 05; Heritage, 2012). The CN's statement suggests no further tasks are needed, underscored with an extreme case formulation (Pomerantz, 1986) that 'everybody' is okay. Although the statement itself on line 05 is structured as an assertion, the upward intonation at the end of the turn brings an element of questioning, adding an element of uncertainty to the proposition that no further action is needed. This lowering of authority may reflect that communication profiles are not their area of expertise. The OT's then counters this assertion and displays higher deontic authority over future actions. First, they immediately respond with 'okay' to acknowledge the CN's assessment. They then move to thank the CN which claims ownership over this decision, whilst managing the sensitivity of disagreeing (cf. line 08 'thank you for doing that'). Next, the OT separates themselves from the rest of the team by using the first-person pronoun 'I'll', rather than 'we'. Finally, the OT proposes that the next task for this client is something for their role to

do (providing feedback, lines 06+07). This proposal is declarative ('I'll still want to do some feedback with the team') and does not require approval by other team members so displays high deontic authority (Stevanovic, 2018). The OT's resistance is accepted as there is no explicit opposition received in the conversation – instead the conversation moves back to discussing the clients housing situation (line 09).

In sum, despite the CN making clear claims to firsthand knowledge of the client to support a proposed course of (no further) action, this is countered by the OT's high deontic claim over what they will do next, which is accepted.

In extract 2 we show again how these steps can be used to resist propositions. In this extract an occupational therapist (OT) is proposing that a client needs some standardised mental health assessments, but the consultant psychiatrist (CP) resists this suggestion.

Extract 2: PB-TA-E12

(OTh: occupational therapist, Cha: Chair/manager, CPs: Consultant psychiatrist; mini PASAD: assessment for psychiatric disorder in people with LD; PD: personality disorder; MDRAS: Montgomery-asberg depression rating scale)

```
01  OTh:    >↑What ↑are ↑the ↑assess↓ments on the mental
02           health pa- pathway as part of the initi:al
03  CN3:    (.) S:o kinda [things like ]
04  OTh:                  [°assessment°]
05  Cha:    mini PASAD [or  ]
06  OTh:               [yeah]
07  Cha:    Glasgow anxiety scale or the
08          [Glasgow depression              scale]
09  OTh:    [Sounds like it would be really helpf-]
10           (.)
11  Cha:    [It might be worth]
12  OTh:    [Doing those      ] as an initial.
13  CPs:    I think I'll go and see her actually and go
14          from th:ere (.) And the problem with all the:
15          (.) with all the the the: um (tck) things like
16          MDRAS and everything else is that it's a very
17          blunt to:ol °er particularly° if you've got
18          somebody who potentially has got things like
19          borderline PD thrown [in]
20  OTh:                         [mm]
21  CPs:    for good measure
22  OTh:    Yeah
23  CPs:    They're really <not that helpful> I'd ra:ther go
24          and see her clinically and ↑then go from ↑there=
25  CN3:    = I think she's had a lot of changes in her (.)
26          review
```

From lines 01 to 12 the OT and chair (Cha) are discussing the different tools that could be used to assess the client, developing a case that a mental health assessment is a relevant task that the team must undertake. At line 13, the CP begins to claim deontic authority in this domain of mental health to counter the proposition. They respond to the OT and Chair, and separate themselves from the rest of the team using first person pronouns ('I'll' line 13), before suggesting a role relevant future task ('go and see her actually' line 13). The statement is declarative, which may display a high deontic claim. However, there is no immediate affiliation to this initial deontic claim, as no other team member begins to speak at the first pause in line 14. This could be due to the CP beginning their turn by stating 'I think' on line 13 (Stevanovic, 2018), lowering their display of deontic authority by adding some uncertainty for this different course of action. The CP then provides their professional knowledge about why the assessments are not adequate displaying high epistemic authority

(lines 14-18). After an agreement token ('yeah') by the OT on line 22, the CP concludes that the proposed course of action is 'not that helpful' (line 23), and moves to make a higher deontic claim (lines 23 and 24, 'I'd rather go and see her clinically and go from there'). This declarative statement is designed so it does not require approval from other team members (Stevanovic, 2018). The high claim over future action is accepted by the team, with the community nurse moving the conversation on. Extract 2 demonstrates that high deontic claims over what future tasks a professional does are accepted by the team.

Extract 3 is an example of resistance to a proposed future action that displays weaker deontic authority. The presence of hesitancy and accounting designs the speaker as having a weaker claim to resist the proposal.

Prior to the extract, this team is discussing a group therapy programme they deliver, and a clinical psychologist (CP) proposes having another team meeting to go through the training manual. A community nurse (CN) attempts to resist this proposal, as they only work with the team when delivering the programme.

Extract 3: PB-TB-E18

(CLD: community learning disability nurse, CPy: Clinical Psychologist, CP2: clinical psychologist)

```
01  CPy:    Would >that feel okay with< ↑you guys↑ to:
02  CLD:    Well ↑I'm the the thing is
03  CPy:    <I don't want to use [up the time we have  ]
04  CLD:                         [You've      you've   ]
05          I feel as if I'm more, I'm more happy to be le:d
06  CP2:    [mmhmm             ]
07  CLD:    [because it's it's] I'm only: I'm suppose
08          to be helping you so the group can run
09  ???:    yeah
10  CLD:    >Else it won't be able to< ↑run
11  CPy:    Su[re ]
12  CLD:     >[so I] don't take< ow:nership of it I come an-
13          My view ↑of it I'm guided by you about what needs
14          to be done I don't understand the whole concept
15          >though because I've not done the< t↑raining and
16          it's: not going ↑to happen for: me .hh so But for
17          you guys as the fa[cilitator]
18  Cpy:                      [yeah yeah]
19  CLD:    I'm ↑co facilitating
```

We join the extract after the CP has proposed that the MPT have more meetings, and checks if 'that feel[s] okay' (line 01) with the team. The question is designed for agreement, with a candidate response that it 'feel[s] okay' built into the question (Hayano, 2012; Pomerantz, 1988). The CN then takes the floor to respond (line 02). They start their turn with a 'well' which forecasts that they will not be affiliating (aka agreeing) in their response to the question (Pomerantz & Heritage, 2013). The CN then builds their counter to the proposition that they attend more meetings, separating themselves from the rest of the team by using a first-person pronoun ( 'I'm' line 02). However, they display some hesitancy through disfluency (repetition of 'the') and another statement that forecasts the upcoming dispreferred response ('the thing is', line 02). The forecasted disagreement is quickly responded to by the CP on line 03. The CP appears to try and repair the CN's disagreement, potentially suggesting a new meeting is needed so that time is not 'taken up' (line 03) during other meetings. However we cannot confirm this as the CP is cut off by the CN with overlapping talk and stating they are 'more

happy to be led' (line 05) rather than attend further meetings. Although they continue to talk, the CP only acknowledges what is being said(Stivers, 2013; 'mmm' line 06, 'yeah' line 09, 'sure' line 11). In response to a lack of acceptance by the CP, the CN moves to account for their counter proposition (lines 12 and 16), that orient to, and display knowledge over their job role. The CN uses first-person declarative statements about what they can do (repeated use of 'I'; they are there to be 'guided' line 13; they 'don't take ownership' line 12), clearly displaying knowledge of their own role (Heritage, 2012). They also draw on their knowledge over the other professionals' role ('you guys as facilitator' line 17), which boundaries tasks between team members. The shift from making counter propositions of what they will do in the future, to displaying epistemic claims about what they currently do in their role is comparable to Extract 2. However, unlike Extract 2, Extract 3 does not finish on an explicit deontic claim. Instead, the CN re-iterates their role in the team ('I'm co-facilitating', line 19) which may implicitly boundary what they might do in the future. A clear counter proposition the CN could have made would be 'I won't attend any further meetings'. The extract only shows part of the discussion, and the CN continues to explain why it is not their job to attend more meetings for another 50 seconds, before the conversation moves on.

The analysis of these three extracts has demonstrated how professionals can counter and resist proposed tasks by displaying claims of knowledge and authority over their role. Claims to determine a future course of action tended to be accepted when displays of high deontic authority (D+) were made. Features of high deontic authority are evident in Extract 1, and 2. Clear and direct declarative statements are accepted by the team. However, if the deontic claims are presented with weak deontic authority (D-) there is less acceptance, partially seen in Extract 2, and clearly seen in Extract 3. A D- claim is not accepted by the team, and the speakers move to claim higher epistemic authority about their professional role rather than make deontic claims.

Allocating tasks to another professional

In the previous section we have examined how professionals can resist proposals for future tasks. Here we focus on how professionals propose that other team members' complete tasks and how they manage potential resistance to these propositions.

Two techniques were identified when allocating tasks to another professional. First, team members display knowledge about the other professional's domain to build a case that they should do a piece of work. Second, they make a proposition for what the other professional should do from a D- (low deontic authority) position. These propositions tend to be neutral and non-personal in their construction. The two techniques help team members manage a delicate situation of telling another team member what to do, particularly when they have already resisted a proposed course of action. Extract 4 is an example of an Occupational Therapist (OT) saying 'no', and a Clinical Psychologist (CP) using the two techniques to propose what the OT1 should do.

Extract 4: Allocating tasks: PB-TA-E1

(SLT: speech and language therapist, Cha: Chair, NPr: nurse practitioner, CPy: clinical psychologist, OT1/2: occupational therapist)

```
01  CPY:    So is there any OT [involvement at the moment
02  OT2:                       [another core group meeting
03  OT1:    ↓No
04  CPy:    Right
05  OT1:    He's supposed to be having community enablers
06          (.) going in as well
07  SLT:    O↑h
08  NPr:    Yeah: it's taken a long time: I think <and mum
09          is also strugg↑ling to get hold of (name)
10  Cha:    Okay=
11  NPr:    =she was saying (.) so
12  OT1:    But ↑these are social care issues
13  ???:    Yeah
14  OT1:    So you know I'm not- I don't think that as a
15          te:am we need to rush in to deal with the
16          situation that's to do with primarily right now
17  ???:    mmm
18  OT1:    social care needs
19  CPy:    But in terms of his ↑functional skills like
20          mu:m I was ↑thinking↓ about like her not
21          appreciating why he might need the
22  NA1:    mm
23  Cpy:    visual sequencing=
24  Cha:    =yeah
25  NPr:    you know
26  OT1:    (name)'s involved though in terms of like the
27          visual sequencing stuff
28  CPy:    yeah but in terms of ta:sk sequencing and things
29          to ha- have an understanding of how he:
30          approaches tasks how he is best going to learn
31          new tasks I ↑think that might be a ↑role
32  Cha:    ye:ah
33  SLT:    ye↑ah↓ does↑ when↑ did↑ you ↑ask mum about
34          autism where do they un- do they what do they
35          understand about it and do they think he's got it
```

Prior to this extract the team have been discussing the need for assessments to be completed for a client before the Clinical Psychologist can lead a case meeting with the client and their family. A different Occupational Therapist has just stated that they thought that OT was due to

attend a different meeting about this client, but OT denies this. We join the extract when the CP asks if there is any occupational therapy involvement (line 01). This works to request clarity from OT, whilst suggesting a role for occupational therapy with the use of the marker 'any' (line 01). From lines 03 to 18, the OT1 builds up to a claim that there are no tasks for an occupational therapist to do with the client. On line 05 the OT draws on knowledge of what should be happening for the client, then on line 12 clearly states that the problems the client has should be addressed by social care. On lines 14 to 16, the OT starts to resist the proposition, initially separating themselves from the team, however they go on to repair their turn – changing 'I'm not', to 'I don't think as a team'. They then counter with an alternative proposition, that the team should 'not rush in' (line 15). Instead of displaying claims over what they personally should do, they are claiming authority over what the team should be doing. This claim is not accepted by the team. Rather, the CP begins to counter with a proposition for why the OT should work with the client.

The CP begins their proposal using knowledge about the OT's professional domain. The CP resists the OT's suggestion that it should be social care, starting their response with 'but' (line 19) which is marked with emphasis, projecting the alternative proposition to come. The CP then mentions two technical aspects of the client's care that relate to the OT's profession - 'functional skills' (line 19) and 'visual sequencing' (line 23). The CP does this in a delicate manner – stating 'I was thinking' (line 19-20). The chair agrees with this suggestion, latching on to the end of the CP's turn at line 24. The OT resists the proposition, by stating another person is involved with the client's visual skills. The CP persists, again drawing on knowledge of the OT's profession (Heritage, 2012), this time with regards to task sequencing (lines 28 to 31). After the CP has displayed knowledge of the OT's professional domain, they make a proposal for what the OT should do. Their response 'I think that might be a role' is delicate and contains two items that constructs the CP as being uncertain, weakening their deontic

authority - 'I think' and 'might be' (Stevanovic, 2018). The proposal neither directly names the OT, nor does it name their role, which keeps the proposal relatively neutral, although it is still clear from the way the turn is constructed that the CP is suggesting that 'it might be a role' for the OT specifically. A high deontic claim would be reflected by a statement such as 'That is a role (for you)'. The rest of the team display agreement with the CP (lines 28 to 31), and both the chair and the speech and language therapist (SLT) agreeing with 'yeah' (line 32 and 33). The SLT then moved the conversation to a different area (line 33-35).

The two techniques used to allocate tasks to another professional (using knowledge about another professional's domain, along with a D- proposal for what the other professional should do), can also be seen in Extract 5. Here the Clinical Psychologist (CP) displays knowledge about a client to propose that a speech and language therapist should do an assessment. They list information that makes an autism assessment something that is relevant for the speech and language therapist (SLT) to do. In this extract, the CP begins with a proposition, then lists the information, before allocating the proposal to the SLT.

Extract 5: Task allocation: PB-TA-E4

(CPy: Clinical psychologist, SLT: Speech and language therapist; NA1: Unknown; ADOS: autism diagnostic observation schedule)

| | | |
|---|---|---|
| 01 | CPY: | She has- ↑Well we ↑said un↑us:ually we |
| 02 | | thought it would be helpful for her to have |
| 03 | | an autism assessment because she's °got° lots |
| 04 | | of classic features but has never had any |
| 05 | | assessments missed kinda missed seems to have |
| 06 | | missed out on all that stuff so um: She seems |
| 07 | | to e- she's she's e- very hypersensitive very |
| 08 | | hyper acoustic sensitive so w- will °at° times |
| 09 | | wear ear defenders seeks out kinda stuff to |
| 10 | | try and make sense of stuff that might be |
| 11 | | distressing for her .hh has fixed routi:nes |
| 12 | | doesn't like change won't go on holiday |
| 13 | | she went on holiday had to come back in two |
| 14 | | days cus it just threw her °she has° routines |
| 15 | | like if it's bedtime and she already got her |
| 16 | | pyjamas on she'll have to go in her bedroom |
| 17 | | and pretend to take> like go physically as if |
| 18 | | she is tak- undressing and putting her pyjamas |
| 19 | | back on keep the routine the same .hh dad has |
| 20 | | to do things a certain wa:y |
| 21 | NA1: | mm |
| 22 | CPy: | um And we we just feel like it might be |
| 23 | | helpful y'know [in terms of (missed)] |
| 24 | SLT: | [So how would you ] propose |
| 25 | | we do that |
| 26 | Cpy: | Pardon |
| 27 | SLT: | How would you see us doing that |
| 28 | CPy: | Well we thought as a starter you could do your |
| 29 | | (.) >all your< all your training |
| 30 | | [won't go to waste] |
| 31 | SLT: | [heh heh ] |
| 32 | CPy: | cus you could do your |
| 33 | SLT: | Well I'll have to find someone to lend us an |
| 34 | | ADOS first |
| 35 | CPy: | [right] |
| 36 | SLT: | [but ]I could a- I could ask my contacts |
| 37 | CPy: | Yep that would be perfect |
| 38 | SLT: | in other other organisations |
| 39 | CPy: | That would be per↑fect um |

Just before the start of Extract 5, the CP is summarising a previous meeting about the client. The meeting outcome was that speech and language therapy should be involved. We join the extract when the CP is proposing the SLTs future action, from a low deontic status 'we thought it would be helpful' (lines 01 & 02). The proposal is again neutral and does not directly name the clinician who they are proposing should be involved. Instead, the CP makes the SLT doing

an assessment relevant by displaying knowledge of the client. The CP provides an extended explanation of the client to support relevant diagnosis features, e.g. 'hyper acoustic sensitive' (lines 07 and 08) is supported by wearing 'ear defenders' (lines 08 and 09); 'fixed routine' (line 11) is supported by 'won't go on holiday' (line 12). This displays knowledge that the client is diagnostically relevant to an assessment. When listing these features there are no obvious places where it would be appropriate for another team member to respond, and the design of the talk builds such a lengthy case it would be hard for anyone to disagree. The CP's completes their turn with another proposal, again from a low deontic status 'we just feel like it might be helpful' (line 22). The CP proposes this future action not as their own idea, but the team's idea. Feeling something might be helpful provides some uncertainty to the suggestion (cf. Stevanovic, 2018). The SLT respondsby asking how the CP thinks the SLT should do this (line 27) – they do not argue with the reason why an autism assessment is relevant, they counter the proposal that they should do it. To manage the SLT's resistance, the CP constructs the SLT as separate to the team (we vs. you, line 28), however they never get as far as explicitly stating what they should do. Instead, they draw on knowledge of the SLT's professional training ('all your training won't go to waste' lines 29 and 30). The SLT's receipts this suggestion with some laughter, which potentially manages the disagreement (line 31, Jefferson, 1984; Arminen & Halonen, 2007; Potter & Hepburn, 2010). The CP's orientation to the SLT's professional training is not resisted and leads to action: the SLT states they will try find an ADOS (Autism Diagnostic Observation Schedule, line 34 & 36).

The analysis of these two extracts has demonstrated how team members approached telling other professionals what to do. Telling another professional what to do is treated with sensitivity – propositions are made from a D- position shortly after or before the speaker's explanation (which has built a K+ position, Heritage, 2012 ) of why the other profession is relevant to a client's care. The propositions are not explicitly accepted – but neither are they

resisted. The talk moves forward. In terms of deontic gradient (Stevanovic, 2017), professionals do not explicitly direct another professional what to do - e.g. 'you have to complete an assessment', either a general statement is made e.g. 'we thought it would be helpful … to have an autism assessment' (lines 01-02, Extract 5) or in other extracts not shown, what could become an explicit direction is never completed.

## Discussion

In this paper we have described how MPT members resist proposals for future work-related tasks by displaying authority over what they, as a professional, will (or will not) do in the future. Clear claims that counter a proposition are accepted; more hesitant claims require extended accounted from professionals to explain why they are countering a proposition based on what their professional role is. We have also described how MPT members persuade reticent team members to complete a task – by drawing on knowledge of their colleague's role, whilst displaying low authority over what the other professional should do. We have drawn on the concept of deontic authority, to understand how different displays of authority over future actions have different results- with low authority displays over what others should do, when accompanied by high authority displays of what the others can do, accepted by MPT members. High authority displays over what you as a professional will do are accepted by the team when countering and resisting a proposition by other team members. In this way team members navigate the sensitivities involved with disagreeing with propositions or telling other members what to do.

The analysis demonstrates how the negotiation of tasks, and disagreements over who should do what, are resolved by MPT members. In contrast to professional jurisdiction and identity being things that lead to difficulties in MPT working, this paper has shown how orienting to professional identity and jurisdiction can be a method to negotiate task allocation. The benefit of examining how 'identity' and 'jurisdiction' are oriented to is that we can identify how, rather

than being fixed 'things', professional identity and jurisdiction are flexible resources that healthcare professionals can use during negotiations. These resources are a helpful part of the professionals' collaboration practices that allow healthcare MPT members to work out who is going to do what.

Healthcare professionals would often talk about themselves as individual professionals, rather than part of a team, when resisting proposed tasks or being told what to do. This may relate to both professional jurisdiction and accountability. The distinction between team versus individual tasks (cf. Salas et al., 2008) is important as professionals only have jurisdiction over their own tasks, as team tasks require consensus. In terms of accountability, different professionals will be regulated, and more responsible, for different tasks and their outcomes. In our data we demonstrated that claiming authority over tasks as individual professionals is achieved flexibly in interactions, rather than being pre-assumed. Therefore, a support worker who might traditionally be seen to have a low level of power could make a high-status deontic claim in a meeting, which if accepted in interaction, means that the traditional hierarchical structures do not hold the same levels of importance as might be assumed (cf. Liberati et al., 2016, Robinson & Cottrell, 2005).

This paper is the first, to our knowledge, to examine and analyse the talk between healthcare MPT members in multiparty meetings, using conversation analysis, to show how task allocation is done to achieve service delivery. The research was part of the authors PhD thesis and they were an outsider to this healthcare setting. Further depth could be added through co-researchers that are also members of I(L)D community teams. The teams consented for audio recording, but not video-recording, meaning that we could not capture other team members' invovlment in the interaction, or other non-verbal elements (Kendrick, et al., 2023). This research was also completed pre-pandemic, so it may be more likely that meetings are held online, and this could shift the dynamics of how propositions are resisted and countered (e.g.

there may be the possibility to use chat functions). The focus of this research was to explore when disagreements about tasks occur, and how these are resolved. Future researchers may want to examine more straightforward agreements to task allocation decisions as a point of comparison.

Understanding of how task propositions are negotiated, through the use of displaying knowledge or authority over what should happen, could feed into reflective practice for I(L)D community MPTs (e.g. using Reflexive Interventionist CA; O'Reilly et al., 2020). Future work could look to see how this understanding of task negotiation can feed into training on collaborative working. Although the work here focuses on I(L)D services, many services in healthcare rely on integrated care delivered by teams of multiple professionals, many of which will need to negotiate tasks successfully daily.

## Conclusion.

Service delivery in healthcare relies on multiprofessional working, that is often determined to be difficult a-priori. Close examination demonstrates that, although task allocation may be felt as difficult, healthcare professionals draw on conversational strategies to complete negotiations and get agreement on what needs to happen.

## Disclosure statement

The author reports there are no competing interests to declare.

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Supplementary material_ Appendix 1

Teams and staff included in extracts

| | |
|---|---|
| **Team A** (Extract 2,4,5) | 20 members during observations from multiple professions |
| Cpy | Clinical Psychologist |
| SLT | Speech and Language Therapist |
| Cha | Chair; Clinical Team Leader with a nursing background |
| NPra | Nurse Practitioner; specialist nurses that can prescribe medication |
| OT1/OT2 | Occupational therapists |
| Cps | Consultant psychiatrist |
| **Team B** (Extract 3) | Six members during observations – only nurses and psychologist in the team |
| CLD | Community learning disability nurse; a specialist learning disability nurse that visits patients at home |
| CPy | Clinical Psychologist |
| CP2 | Clinical Psychologist |
| **Team C** (Extract 1) | 30 members during observations from multiple professions |
| CN3 | Community Nurse; a nurse that visits patients at home |
| Oth | Occupational Therapist |
| Psy | Psychologist |