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MULTIDISCIPLINARY TEAMWORK IN A UK REGIONAL SECURE MENTAL HEALTH UNIT
A MATTER FOR NEGOTIATION?

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Abstract

Multidisciplinary teamwork in health care is strongly advocated in policy documents and the professional literature, but evidence about its value is sparse. This paper argues that multidisciplinary rhetoric disguises the complexity of the relational processes involved. These processes are explored with reference to a qualitative study, conducted during 2002-4, of a UK medium secure forensic mental health care unit. Although some instructive examples of selective collaboration emerged from the present study, in general, non-medical professionals felt that their capacity to negotiate new ways of working was thwarted by medical dominance. Patients, the recipients of interventions from a range of professions, mostly bracketed them together as an all-powerful 'they'. Multidisciplinary working promoted only limited partnership in this organisational setting, and became primarily a process through which structural differences were reproduced. The paper draws on insights derived from symbolic interactionist theory to explore the achievement of, and failure to achieve, collaboration across professional boundaries. It will be argued, firstly, that organisational constraints on multidisciplinary collaboration together with actors' attempts to overcome then can be usefully analysed in terms of a dialectic between role-taking and role-making; and, secondly, that the impact of professional power differences can be understood through analysis of organisations as autopoietic systems.

INTRODUCTION

Multidisciplinary Working in Forensic Mental Health Services

The promotion of collaboration between professions in the UK and elsewhere reflects a partnership ideal embodied in policy reforms designed to improve the responsiveness of health and social service to patient needs (Leathard, 2003). However, the partnership vision is driven more by conviction than by compelling evidence that collaboration can generate service improvements (Barr, 2000). Similarly, the literature on the value of professional collaboration in health care tends to be prescriptive and journalistic rather than analytic and evidentially based (Cott, 1998; Glasby and Lester, 2004). The idea of multidisciplinary teamwork raises a number of conceptual problems. The familiarity of the word 'team' masks its vague and variable meanings (Dingwall, 1980). The meaning of 'multidisciplinary' is similarly ambiguous. It is one of several overlapping terms employed to describe collaboration between professions. Usage of such terms has been described as 'murky' (McCallin, 2001, p. 421). A focus on the 'disciplinary' implies that collaboration can be achieved through the sharing of distinctive knowledge bases. But the processes through which synthesis might be accomplished, for example through mutual accommodation, tend to be taken for granted.

The case for multidisciplinary collaboration appears particularly compelling in relation to forensic mental health services (Wix and Humphries, 2005). It is often assumed that mentally disordered offenders, whose problems are multifaceted, will benefit from the co-ordinated contribution of a wide range of professionals as they progress from secure care to rehabilitation in the community (McGuire, 2002). For instance, Jones and Plowman (2005, p. 145) recommend discussion of the cases of offenders with mental health problems via *'a congregation of diverse understandings and explanations of harmful behaviour and the assessment of risk'.* However, this optimistic view overlooks the potential for tensions to arise from differences in the interpretive frameworks which professionals bring to the task of collaboration, and downplays the impact of professional power differentials on the decision-making process (Onyett, 1997; Cott, 1997; Davies *et al.,* 2006). Processes of negotiation between members of different professions and their impact on patients remain little researched. In consequence, the effectiveness of multidisciplinary teams has not been demonstrated (Barker and Walker, 2000; Zarenstein and Reeves, 2000; McCallin, 2001; Glasby and Lester, 2004).

The present paper explores multidisciplinary teamwork from the perspective of participants in forensic mental health care, including service users as well as the professions involved in their care. It draws upon a qualitative study of one low/medium secure forensic mental health care unit, complementing a previous paper which explored variations in perspectives about the problems of service users (Davies *et al.,* 2006). The paper offers a means for exploring multidisciplinary relationships in forensic mental health and other human service contexts through locating research findings in a symbolic interactionist framework.

The construction of professional boundaries

In the past two decades, a number of policy initiatives have attempted to make UK healthcare more accountable, aiming to address the loss of public trust resulting from high profile health care scandals and to curb professional autonomy in favour of corporate governance (Allsop, 2002; Bradshaw and Bradshaw, 2004; O'Neil, 2004). The extent to which medicine and the other health professions are now entering a period of structural and cultural reform which challenges old hierarchies and protectionist practices, and renders professional boundaries more permeable, is open to debate.

Forensic mental health care offers a case study of multidisciplinary relationships played out in the context of historical change (Mason and Carton, 2002). The emergence of a newly framed clinical sub-domain in the 1970s is denoted by the use of the term 'forensic' as a prefix for professions such as psychiatrists, nurses, psychologists, occupational therapists and social workers caring for mentally disordered offenders. This development could have stimulated a rapprochement between professions. However, unclear delineation of the clinical domain, partly masked by the spurious precision of the term 'forensic' in this context, provides a problematic foundation for such collaboration (Whyte, 1997). The liminal status of mentally disordered offenders, caught between the mental health and penal systems, invokes competing professional perspectives about their diagnosis and treatment (Warner and Gabe, 2004; Nolan, 2005). Rather than serving as a bonding factor, the term 'forensic' may have compounded divisions associated with the contested concept of mental illness (King's Fund London Commission, 1997; McGuire, 2002).

Research on forensic mental health professionals' perceptions of collaborative relationships has generated evidence of their fragility. Whyte and Brooker (2001) concluded that staff working across different forensic mental health care settings can identify with both their professional and multidisciplinary teams, but find collaboration difficult to achieve in practice. Mason *et al.,* (2002) found that staff working in a small medium secure unit evoked rigid professional boundaries when reflecting on ethical dilemmas set by the researcher, even when asked to focus on multidisciplinary working. Forensic mental health nurses express support multidisciplinary teamwork but to experience their relative lack of status as an obstacle to participation (Robinson and Kettles, 1998; Coffey and Jenkins, 2002). These findings, similar to those obtained in other healthcare settings (e.g. Cott, 1997; Barker and Walker, 2000) suggest that professional allegiances and hierarchies relationships may impede collaborative working.

Symbolic interactionist perspectives on multidisciplinary relations

Research such as that summarised above focuses upon expressed professional attitudes to collaboration rather than exploring its workings in specific cases. As Cott (1998) has observed, little theoretical or empirical work has attempted to 'get inside' multidisciplinary healthcare work. This issue will be explored below from a symbolic interactionist framework which provides a particularly useful basis for analysing organisational life underpinned by the intersections of multiple systems of meanings.

Symbolic interactionism originated in the loosely associated ideas of a number of American social scientists working during the early to middle part of the twentieth century, including William James, Charles Cooley, John Dewey and the scholars

latterly most associated with the origins of this school of thought, George Herbert Mead and his disciple Herbert Blumer. A defining feature of this early work was a dialectical view of the relationship between the individual and society, such that self and society are constituted by, and cannot exist without, the other (Meltzer, Petras and Reynolds, 1975). Symbolic communication plays a central role in this dialectic relationship. Through a reflexive process, we 'take on the role of the other', aligning our behaviour accordingly (Blumer 1962). The order of society and its sub-sets constantly emerges from the bottom up through processes of negotiation which are influenced by selective interpretation and creativity, and are therefore in a state of constant flux. These ideas reflected the egalitarian ethos of American society, and faith in its potential for gradual progress, ideas which prevailed during the period in which symbolic interactionist theory was first developed (Shaskolsky 1970).

Mead's original formulation of symbolic interactionism, as faithfully recorded by his students and published in *Mind, Self and Society* (1934) postulated a dialectical relationship, between the 'I' and the 'me', the self and the generalised other. Children come to see themselves through the eyes of others, abstracting common but often implicit features of symbolically communicated perspectives such as culturally mediated notions about gender. At the same time, individuals actively interpret rather than passively absorb the views of themselves in the world which their culture offers them. In consequence, every individual internalises their culture differently. Moreover, the spontaneity of self can never be totally constrained by the internalised generalised other because the elusive 'I' becomes a 'me' as soon as reflected upon, generating another 'I' temporarily beyond reflexivity. This approach rejects the reification of both social structure and human nature, which symbolic interactionists consider to be abstractions derived from ontologically prior discursive acts (Perinbanayagam, 1991). Society can be located only in shared, internalised meanings which are actively interpreted by each of its members, as illustrated by the paradigmatic case of language structure, evolution, learning and usage.

The original characterisation of the relationship between the individual and society as dialectical has, to some extent at least, been lost sight of by contemporary qualitative health care researchers who have tended to emphasise role-making over role-taking. The rise of interpretivism can, in turn, be understood as a reaction to crude attempts to apply positivist models of science to human interactions in a field of enquiry dominated by medicine. This emphasis on socially situated individual acts of interpretation is reflected in Blumer's very widely cited three tenets of symbolic interactionism: firstly, that human beings act towards things on the basis of the meaning that the things have for them; secondly, that meanings are a product of social interaction in human society; and, thirdly, that these meanings are modified and handled through an interpretive process that is used by each individual (Blumer, 1969, pp. 2-6). Blumer accepted, as did Mead, that social contexts vary and that some leave less room for interpretation and negotiation. For example, he argued that social structural constraint involving 'fixed symbols' appertained more to isolated primitive than to modern societies in which *'streams of new situations arise and old systems become unstable'* (Blumer 1962, p. 190).

These quasi-structural influences on social discourse have become underemphasised in qualitative healthcare research. The reframing of symbolic interactionism as *'interpretive interactionism'* which *'attempts to make the meanings that circulate in the*

world of lived experience accessible' (Denzin, 2001, p.1) reflects the more recent emphasis on interpretation over structure. Since the last quarter of the previous century, interpretivism has dominated critical healthcare social science in opposition to the positivist methodologies espoused in health services research. Interpretivism has perhaps 'lost the peace' in that its hegemony makes it difficult to analyse entrenched organisational power structures, the key issue to be addressed in the present paper. Too many qualitative healthcare research papers which purport to explore the 'lived experience' of staff or service users translate operationally into descriptive listings of themes illustrated by qualitative data.

A return to the dialectical origins of symbolic interactionism, advocated by one respected contemporary theorist (Perinbanayagam, 1991), can illuminate the operation of social power in organisational life. This position stands opposed to both the reification of social structure and psychological individualism.

> *It is evident that all discourse is constrained by roles and structures of roles - the elements of organizations. Conversely, roles and role relationships are constituted discursively. These are **simultaneous** processes that are dialectically related in which neither can be considered prior to the other … It is in this juncture between discursive interaction and dialectical relationships that the theory of "negotiated order" proposed by Anselm Strauss (1978) … comes into play.* (Perinbanayagam, 1991, p. 90, quoted author's emphasis)

Strauss *et al.* (1964) argued that professional boundaries were more fluid than organisational theories suggested. Critical of the functionalist concept of an organisation as a series of interlocking roles prescriptions, they defined *'**the organisation as an arena** in which ideologies are put into operation, clarified, modified and transformed'* (Strauss *et al.,* 1964 p14, quoted authors' emphasis).

Strauss *et al.* acknowledged that negotiations in the hospitals they studied were patterned by the differences in the ideologies of professions, and by *'structural features'* such as status and stability of teams (Strauss *et al.,* 1964, p374). However, they focus mostly on ongoing processes of negotiation between professional groups establishing and re-establishing divisions of labour. They emphasise the influence on negotiating positions of participants' diverse and actively constituted interpretations of how the broad, active aims of the hospital should be put into practice. At this juncture, the dialectical origins of symbolic interactionism, lost sight of when interpretivism won the methodological argument, as discussed above, can usefully be revisited.

Within a framework which refuses to reify society or accept an individualistic interpretation of human nature, the social structural end of the dialectic between the 'I' and the 'Me' can be analysed in terms of interactions between two types of process, role-taking and autopoiesis. The former is embedded in traditional symbolic interactionism. Turner, for example, explored the tension between 'role making' and 'role-taking'. He sought to shift *'the emphasis away from the simple process of enacting a prescribed role to devising a performance on the basis of an imputed other-role'* (Turner, 1962, p. 23), but accepted that regimentation and bureaucratic role prescriptions can constrain social interaction. Role-taking can be understood in terms of the constraining impact on individuals of a wider social consensus, not necessarily consciously articulated, about meanings. To illustrate with an example relevant to the

data analysis discussed below, Douglas (1990) depicted risk as a 'forensic device' which modern, science-based societies draw upon to negotiate the allocation of blame. Hence, the symbolic meaning of risk discourse is mediated by its cultural significance, itself contested and shifting.

A second process generating social order, that of autopoiesis, the emergence of structure from self-organised systems (Luhmann, 1993/2002) has been articulated more recently, perhaps in response to contemporary emphasis on the large-scale self-organisation of systems such as the internet and even the universe itself. However, some of the work of following generations of symbolic interactionists can readily be interpreted in terms of this framework, as illustrated by the following two examples. Goffman (1968) argued that specific structural features of 'total institutions' such as boarding schools, nunneries, asylums and prisons, namely the combination of hierarchical authority and playing out all roles to the same audience led to them becoming oppressive towards the selves of residents regardless of their official purpose. Abbott (1988) argued that dominant professions such as modern medicine become subject to processes of 'degradation' and 'regression'. Degradation involves retrenchment from functions considered of low status, and 'regression' a loss of awareness of the arbitrariness of the assumptions on which the professional world view is predicated, combined with a presumption of its universality.

Such autopoietic processes undermine the legitimising claims of the organisations or professions affected by them, creating tensions which can eventually bring about their decline and fall as social institutions. The present paper will explore the interplay of role-making, role taking and autopoiesis in one particularly fraught social arena, that of multidisciplinary work aimed at balancing safety and autonomy in the risk management of patients/offenders by forensic mental health services.

METHODOLOGY

The study methodology (see Heyman *et al.*, 2004) will be outlined only briefly for the purposes of the present paper which offers a theoretical exploration of multidisciplinary interactions. The Unit which provided the setting for the present study is located in a deprived, inner-city area of London. It caters for about 100 patients, around 90% male, and has a large proportion of participants, particularly patients and junior nursing staff, belonging to diverse ethnic minorities. Fieldwork was undertaken between 2000 and 2003 in two phases. In the first phase, 44 staff interviews were conducted in order to explore their views about the Unit, and to guide directions of enquiry for a second phase focusing on patient perspectives. The second phase included, where possible, two interviews with each of 10 patients, completed about a year apart, an interview with a staff member involved in their care, and observation of case conferences. Ten patients were interviewed, and a staff perspective obtained for nine patients. Five patients were re-interviewed, four were discharged, and one died during the study period. Because of organisational problems, only two case conferences were observed, limiting the extent to which conclusions could be drawn. However, the data analysis draws primarily on data obtained from the interviews and a multidisciplinary workshop at which the findings were discussed with Unit staff.

Lightly structured phase one staff interviews explored staff views about the Unit, their role within it, and factors facilitating and impeding the delivery of high quality care. In phase two interviews, patients were asked about their moves towards, and sometimes away from, rehabilitation, their feelings about their care, and how they viewed their future. The research design followed the principles of grounded theory (Strauss and Corbin, 1990), with data collection and analysis intertwined around the exploration of emergent themes. Interviews are quoted verbatim. Respondents are identified through pseudonyms, and information which might identify individuals has been removed. The NHS Local Research Ethics Committee approved the research.

DATA ANALYSIS

Perspectives on multidisciplinary relationships are discussed below in relation to the following emergent themes: the impact of medical power; tension and collaboration between disciplines; the dynamics of marginality, blame and retreat; the achievement of multiprofessional collaboration through diplomatic work; and the peripheral position of patients. Overall, staff portrayed multidisciplinary collaboration as a problematic and fragile process. Patients tended to lump staff together as an ubiquitous other possessing attributes which were mostly viewed negatively.

Medical dominance: A context for conflict between professions

Medical authority is embodied in the ultimate legal accountability of consultants for treatment. In addition, Unit doctors mostly took the view that patients' primary need was for pharmaceutical interventions, over which they had jurisdiction. This position legitimated their strategic primacy. The following account illustrates the way in which the presumption of primacy could shape the medical view of multidisciplinary collaboration.

Personally, I think medication is really important. Rehab is the next step once medication has kicked in … once he is a bit better, and has a bit more insight, and is not so badly psychotic. I think psychology is very useful … I think occupational therapy is very important for lots of people to build cooking skills or health care, trips to the community, psychology, and then occupational therapy, and social work of course. They will get accommodation and benefits and [deal with] *lots of other social sort of problems … It is a combination.* (Neelam, senior house officer)

Although the above analysis advocates a combined approach, the contribution of nursing is not mentioned, and bio-medical expertise is given primacy. Doctors tended to see themselves as open to other perspectives, but often in a context where their own prevailed. One well-established psychiatrist attributed the effective operation of her teams to her clear and inclusive style, saying she required each profession '*to provide written reports which they stand over and argue'*. However, observation of ward rounds, including her own, showed that they were, in practice, dominated by medical considerations. The other professions frequently mentioned medical dominance as a block to collaboration, as illustrated below.

I believe that they [senior doctors] *are used to getting their own way here … And I believe the previous legacy here always pandered to the consultants … I find the medics medicate, and that's it. I don't see enough of the other therapies here.'* (Norman, senior nurse manager)

Similarly, the psychologist quoted below depicted an ongoing struggle between psychologists and doctors, fuelled by the latter's arrogant use of power.

I think it's always been too medically centred, you know. The medical profession, they are the ones that make the decisions. If you are lucky, they'll ask your opinion. I mean, obviously, there are variations across consultants, but, you know, there is a constant battle. And it's not just consultants. I mean the registrars and the senior house officers will come in and make decisions that are, you think, 'Hold on. You've known someone for six minutes. We have been working with them for a year. We might have a different idea'. (Pamela, senior psychologist)

This respondent complained that doctors outranked any other professional, regardless of their age, seniority within their own profession, expertise, clinical experience or familiarity with a particular patient. Nurses expressed similar indignation that doctors could impose their opinion even when they hardly knew the patient.

They've taken him [patient] *off the old anti-psychotic, and put him on the new one which isn't having any effect at the moment. And then, to calm him down, they've put him on 60mg of diazepam, which is a huge amount. It's just massive, and he's still frustrated because he's feeling drowsy all the time. … And nursing staff have gone to the consultant and had it changed twice, but the junior doctors are coming in and changing it back.* (Francesca, ward manager)

The perception that one entire professional caste totally outranked another, nurses in the above example as all ward managers are nurses, fuelled conflict between

professions. It engendered a climate inimical to genuine collaboration despite wide acceptance of the ideal of collective working.

> *We pay lip service to inter-team collaboration, but there's also a lot of hostility over it all, particularly between the nurse and the medical staff … There's very little collaboration, … almost nil collaboration between nursing and psychology. And we, we're just working on relationships between occupational therapy and nursing staff, but that's at very early stages at the moment ... Psychologists tend to be out on their own. They give no feedback whatsoever, and very little input towards the clinical teams, particularly the clinical team meetings.* (Martin, ward manager)

This diagnosis of tokenistic commitment to collaboration across the Unit illustrates a widely shared view that co-operation between certain professions only occurred to a very limited extent. Nurses, including the ward manager quoted above, saw psychologists, who complained about their invisibility to doctors, as themselves marginalising other professions. Psychologists thereby appeared to replicate the power dynamics between medical staff and themselves.

The potential identified above for developing collaboration between occupational therapists and nurses may reflect their coterminous position at the lower end of the professional hierarchy. However, the research suggested that those in low status positions find it difficult to affiliate whilst also struggling to maintain and gain recognition for their own position. As discussed below, feelings of marginality and powerlessness experienced in the multidisciplinary team as a whole, particularly by nurses, led them to retreat from rapprochement with other professions. The strongest examples we were given of productive working between professions came from those in higher status positions discussing collaboration with each other.

Tension and collaboration between middle-ranking disciplines

Like doctors, psychologists, social workers and occupational therapists defined multidisciplinary teamwork in distinctive terms consistent with their professional values and expertise. Whereas doctors often presumed the universality of their approach, these other professions tended to emphasise the value of multiple perspectives. Psychologists considered patient *'insight'* to be a key issue affecting their ability to progress. This concept underpinned psychologists' claim to provide a special therapeutic relationship with patients which opened up access to otherwise concealed information, for example about traumatic memories.

> *I think its remarkable, the kind of information that we as psychologists or therapists pick up, or are able to explore, that isn't that easy to explore in other situations or disciplines. The strength of having different people on a team is that each one has unique contributions which together complement one another and give a much fuller picture.* (Pamela, senior psychologist)

Psychologists tended to regard themselves as open to other complementary professional standpoints. But they were perceived, particularly by nurses, as prone to withhold information and to operate exclusively, in contrast to social workers.

> *The social workers play a lot more into the team, into the nurse management, because we liaise with the social workers a lot - hostels, community provision, accessing the patient's family to use as a resource … If patients have children, we need the social workers to support what we are doing with the family. So we actually use them as a resource to a greater degree than we would use the psychologists … The psychology input needs a lot of improvement to work cohesively in the team.* (Laura, ward manager)

This account emphasises the complementary roles of nurses and social workers in rehabilitating patients, and views the stance of psychologists as a barrier to good liaison. Similarly, Bella, a health care assistant, saw psychologists and nurses as *'sister groups'* whose potential for kinship could not be realised because of the psychologists' reluctance to share information.

> *I see psychologists will come in, take the patients and go without reporting that to the nurses, so the nurses don't know what is happening with their patients really. And I think, if the psychologists would communicate more, like, you know, generally what their plans are and what they are doing, that would help things … I just hear from the nurses. They are upset.* (Bella, health care assistant)

The role of social worker required wide internal and external networking, encouraging them to be inclusive in their working practices. From this stance, the process of debate could be viewed as beneficial for patients, rather than as a source of conflict.

> *For me, you can't beat a stable multidisciplinary team … professionals from various backgrounds, nursing, education, therapy, psychology, all coming from different viewpoints. And if there's honesty and respect there, there's the ability to challenge … The patient will benefit from having that openness.* (Patrick, social worker)

Patrick's idealistic analysis values *'challenge'*, i.e. negotiation based on the communication of distinctive perspectives. Unlike respondents from other professions, he did not express concern about the damaging impact of differential power on the communication process. However, social workers were rarely cited as pulling rank on other professionals and were seen to be more open to joint working than doctors and psychologists.

Occupational therapists believed that their practical approach could complement the more specialist expertise of other professions.

> *A whole variety of different kinds of practitioners are involved in this … [care planning]. It's not really a professional thing, although certain skills that you have in, in, in your work, you know. Psychologists have generally got more knowledge about working with cognitive … processes, … anger management, the social training … whereas we've got more, typically we've got more kind of practical ways …we bring different skills to be gained, if you like … And we're talking about core areas of skills that our clients have got problems with … communication skills or … health management difficulties or learning … how to*

take their medication by themselves. They don't want to have to, to be dispensed every day by nurses. (Luke, occupational therapist)

This account stakes out a distinctive occupational therapy contribution which might usefully synthesise with those of other professions. However, denotation of occupational therapy skills as *'practical'* implies that the profession may be held in lower esteem than others such as psychology which, by implication, is seen as grounded in a theoretical discipline.

Although occupational therapists were strongly committed to multidisciplinary working, they felt ignored by doctors, and questioned the extent of collaboration between other professions.

> *The ward rounds and the meetings, they are multidisciplinary care plans, you know. People do, everybody puts into them. But when it comes down to actually joint treatments and running joint groups, and, you know, working with people together, it's, it's less obvious really … One of the big things I've noticed has been, it's either a nurse or a doctor who goes to assess people. There's very little kind of both going together or, you know, joint sessions that way.* (Oliver, occupational therapist)

This analysis suggests that the capacity of any one profession to collaborate with others may be limited by the degree of third party co-operation between other occupational groups.

Marginality, blame and retreat at the bottom of the hierarchy of professions

The nursing workforce stood out from the other professions in terms of its greater size, its more elaborate internal hierarchy, and the absence of a specific therapeutic rationale. One ward manager described nursing as '*a generalised sort of discipline'*. Ward-based nurses were charged with managing patient care, safety and security on a daily basis. They typically claimed professional distinctiveness through acquiring detailed knowledge of individual patients. In the context of this general claim, ward managers tended to emphasise the important operational role of nurses in facilitating and maintaining the information flows surrounding multidisciplinary care. However, nurses at all levels expressed strong views about their marginal place in multidisciplinary teams, and wanted greater recognition for the potential nursing contribution.

> *There is room for other disciplines to sort of derole themselves, like being in control of meetings, to chair meetings, some of the time … We have agreed that disciplines take it in turns to chair the meetings now, where it should be social workers for four weeks, then nursing for four weeks, then doctors for four weeks.* (Jasmine, nurse and ward manager).

This analysis suggests that for professionals to work together, the more powerful must share control. The nurse manager regarded her ward consultant as exceptional and welcomed her attitude of '*pre-valuing the nurses input'*, and being '*willing to listen'.* However, the consultant's experiment on integrating the nursing perspective into

multidisciplinary team working ultimately foundered. Less senior nurses were not convinced about the possibilities for power sharing.

> *The view from the nurses is that the MDT tends to view the nurses as being the ones who provide the predominance of care, twenty-four hours, taking into account that, as has already been mentioned, they have primary responsibility for security and risk management. But the experience of the nurses, in our group anyway, is when the nurses attend the MDT that predominance of responsibility seems to go to the bottom, in terms of importance and discussion … We also felt that, when things went wrong generally, that it would be the nursing staff that would generally be criticised.* (Craig, staff nurse, multidisciplinary workshop)

This quotation captures the incongruity which nurses identified between, on the one hand, the reliance placed on them to provide front line care, safety and security, and on the other, being relegated to *'the bottom'* in multidisciplinary team meetings. Feelings of marginality were associated with a '*blame culture'* which made initiatives designed to include nurses in multidisciplinary decision-making less likely to succeed. According to the consultant whose experiment on role sharing appeared to be inclusive, nurses failed to innovate because they were too *'forensic',* i.e. too focussed on security. But when security was breached, nurses were blamed, a double bind noted by a sympathetic occupational therapist.

> *Talking about sort of blame thing, there is something I noticed in the low secure ward … It was sort of set up to be more multidisciplinary. But, since then, there has been a rain* [cluster] *of incidents. And, because of the blame culture, the discipline* [nursing] *is increasingly retreating into themselves. You know, the nurses start being particularly blamed and … it's extremely difficult for them to sort of maintain their prominence and significance in the multidisciplinary team … There is a fear of actually engaging in the multidisciplinary process because that is a potential for further blame.* (Toby, occupational therapist, multidisciplinary workshop)

Thus, the dynamics of the blame could stimulate retreat behind professional lines. In consequence, opportunities for those occupying relatively lowly occupational positions to become actively engaged in decision-making about patients became more limited. Some very junior nurses decentred from the struggle between professions, viewing multidisciplinary care from a patient perspective.

> *We talked for one hour without the patient, and the patient was called in for ten minutes. He was just asked questions like, 'How do you feel now? Are you happy with where you are?' I just think they should be there from the beginning, talk about everything.* (Samantha, student nurse)

This view corresponded to that of many patients who bracketed the professional disciplines together into an entity, as discussed below.

Offsetting barriers to multidisciplinary collaboration: The use of diplomacy

Only one account of achieving genuine collaboration in a particular case was obtained. Although exceptional, this account clearly illustrates one respondent's perceptions of the work required to overcome barriers to professions working together, and thereby documents successful role-making.

> *So what Haris* [social worker]*, Sean* [community psychiatric nurse] *and I have done is, in terms of thinking about Daniel being discharged, we, I'm determined to do a joint risk assessment … In a way it is an indirect piece of work … You actually needed to put in some kind of behind the scenes time in order to be able to meet and compare notes about that,* [the risk]*, and to gather information.* (Timothy, psychologist)

The intractability of the difficulties associated with this case may have stimulated exceptional efforts to cross disciplinary barriers. Daniel's discharge prospects were complicated by his status as an illegal immigrant. His offending history made him unsuitable for unsupervised release into the system which dealt with illegal immigrants, and outside agencies were pressing for him to be kept in the Unit. The consultant, following his medical disciplinary framework, prioritised assessment of Daniel's mental state as the most important consideration. The psychologist and social worker questioned this illness-focused analysis. The psychologist's depiction of himself as 'determined' conveys a sense that he was striving against structural forces impeding multidisciplinary collaboration. He felt that these organisational restraints could only be overcome through diplomatic effort, conducted 'behind the scenes', and, significantly, excluding the consultant. Haris, the social worker, considered multidisciplinary working in this, and another similar case in which he liaised with the psychologist, to be creative and productive. However, effective informal working with some colleagues could exclude others, however inadvertently.

Viewing multidisciplinary care from the periphery: the views of patients

The hierarchical distinctions which concerned the professions held far less significance for patients who viewed them from a greater social distance. Even compliant patients, who might have been expected to relate more closely to professionals, tended to locate them in a single uniform category.

> *Ward rounds are for thinking about my care every week, what progress I am doing. So like, for example, I request my unescorted leave to increase from three hours to more. So I put my request this week, and the ward round is going on now at the moment. If they want to see me they will call me.* (Azhar, patient)

The quotation uncritically depicts a process in which the patient occupies a peripheral space, waiting to be summoned if required. For patients who rebelled against the Unit regime, *'they'* became a rejected other possessing negative attributes such as unhelpfulness and unfairness. Their portrayals of service shortcomings emphasised features common to all professional groups, including limitations arising from caring as paid employment and staff turnover as well as the power differential between themselves and staff.

If they don't discuss your case in a ward round, there's nothing you can do about it. I don't feel they're doing anything to help me … They don't let me see my notes. These things belong to me … Apart from moving me from ward to ward, they have not done anything for me. (Daniel, patient)

Similarly, Greta, one of the few women patients, portrayed a gulf between patient and staff in her cynical dismissal of them, saying, *'They don't give two shits. They're just doing a job'.* Her global dismissal of staff, based on a shared attribute of all the professions, illustrates the impact of social attributes which cut across professional identity into the care relationship.

Patients were more likely to identify general limitations to their multidisciplinary care than were staff who were preoccupied with their specific disciplinary identities and the complexities of relationships between professions.

CONCLUSION

The conclusion will discuss the findings presented above with reference to the analysis of organisational power from a symbolic interactionist perspective. A disjuncture between the abstract generalisations of symbolic interactionism and the concrete details of qualitative empirical studies must be noted. The present paper provides no more than a single organisational case study within one healthcare context, making generalisation doubly problematic. Its substantive findings can only be developed into a wider formal theory of multidisciplinary collaboration at a speculative, hypothesis-generating level. Qualitative research exploring multiple perspectives on relationships between professions can, however, penetrate the 'black box' of outcomes. Such research can be used to generate and even test middle range theories if findings are mapped against other studies undertaken in different organisational settings, in this case with respect to answering the question of why the outcomes of multidisciplinary collaboration are so often disappointing.

Doctors, the highest status profession working at the forensic mental health unit discussed in the present paper, gave the most optimistic accounts of the accomplishment of multiprofessional collaboration However, the interview data indicated that this optimism was predicated on the presumed primacy of the medical model. This qualitative finding suggests the hypothesis that the highest status group in a differentiated social system may be most open to others because collaboration provides a means of extending their hegemony. Neelam, the doctor quoted at the beginning of the data analysis section, represented relationships between the professions in a way which can be visualised in terms of a set of concentric circles surrounding a medical core. In contrast, other professions asserted the distinctiveness of their own disciplinary contribution, summarised below.

Non-medical staff respondents most commonly depicted relationships between the professions in terms of boundary clashes, communication failures, stereotyping by one profession of another, exclusion of patients from effective engagement in their treatment, uninformed decision-making, disrespect and the existence of a collectively reproduced blame culture. It has recently been observed that *'despite the many inquiries and directives, and the adoption of therapeutic language, forensic units still appear to find it difficult to embrace progressive* [multidisciplinary] *practices'* (Nolan, 2005, p13). Similar conclusions have been drawn in other healthcare arenas. Far from

promoting collaboration, multidisciplinary interaction appears, paradoxically, to re-invoke professional boundaries (Cott, 1998; Brown *et al.,* 2000; Coffey and Jenkins, 2002; Hugman, 2003).

Studies of multidisciplinary teamwork in mental health care settings have uncovered tensions associated with differences in philosophies of care (Onyett, 1997; Whyte and Booker, 2001; Mason *et al.,* 2002). Such findings do not rule out the possibility that communication can bridge differences between the interpretive frameworks associated with professional disciplines. However, the research discussed in this paper supports the view that versions of interactionism which emphasise interpretation and role-making underestimate the impact of power inequalities upon the capacity of professional groups to communicate across occupational boundaries (Morgan *et al.,* 1985; Cott, 1998).

With respect to role-taking, the data suggest that each profession defined itself in terms of a broad service mission such as curing illness (medicine), generating insight (psychology), providing post-discharge resources (social work), improving daily living skills (occupational therapy) and holistic personal care (nursing). Such service missions provide broad, abstract interpretive frameworks for actively negotiated role-making, required to fill in concrete performative details which, in turn, dialectically redefine wider organisational and cultural role definitions through bottom-up processes (Cicourel, 1973). Staff other than doctors did identify examples of productive joint working between potential professional kin. Although rare, these exceptions are theoretically significant because those who described them mentioned specific strategies designed to overcome the established social structure such as 'deroling' and use of preparatory diplomacy. They provide glimpses of potentially transformative role-making in action. It was argued in the Introduction that the dialectical origins of symbolic interactionism have been lost sight of, in healthcare research at least, due to the rise of interpretivism. An approach which explores the dialectical relationship between role-taking and role-making in the context of autopoiesis provides one way of returning consideration of social power to the centre of symbolic interactionist analysis of organisational life.

However, this dialectical process has to be located in relation to the self-organisation of professional groups in conditions of unequal power. Such power differences can be conceptualised initially as a feature of role-taking. They exist in culturally and organisationally shared perceptions of the status of groups who have come to recognise themselves, and be recognised by others, as possessing a collective identity. Their dynamic impact sets in train autopoietic processes which impact on the role-making/role-taking dialectic. The professions working at our research site recognised a hierarchy of professions, with medicine in a superordinate position, followed at some distance by psychology, then social work and occupational therapy, and finally nursing. This ordinal structure gave rise to contradictions with the internal structuring of professions, since it placed doctors above members of the other professions, however senior or experienced.

The general stance of medicine can be well-described in terms of Abbot's (1988) concepts of 'regression' and 'degradation', mentioned in the Introduction. Regression refers to a tendency to retreat inside a world generated by the shared defining presuppositions of a dominant professional group. In consequence, members of a

profession come to regard founding presuppositions, for example the primacy of mental illness among the problems of the client group in question, as universal truths, losing awareness of their assumptive epistemological status. Degradation refers to the hiving off by a superordinate profession of aspects of its role which it considers too low in status, for instance, in the forensic setting, involvement with security issues. Regression and degradation are fuelled by the collective self-interest of a dominant profession, according to Abbott. But they contain the seeds of self-destruction for such a profession which cannot reflect critically on or renew its founding assumptions, or interpretively take the role of the other professions, and which loses control of the vital functions which it relinquishes.

The other professions defined their position in the world of the forensic mental health unit in relation to the medical superpower, asserting the distinctiveness of their professional mission in terms of a core interpretive category such as insight (psychology) or holism (nursing), as noted above. This distinction between the claims to universalism and complementarity made by the top and other groups respectively may have wider autopoietic significance, and be replicated elsewhere, as may certain attributes of the stances exhibited by other disciplines. Psychologists, the second ranking group, complained about the arbitrary exercise of power and disciplinary limitations of medicine as much as others. But they were also seen by other professions as mainly non-collaborative. Such disjunctions may reflect the dynamics of second-ranking status more generally. Like the second son of the ruler in a Shakespearean tragedy, psychologists were close to but blocked from supreme organisational power. They responded to this uncomfortable position by challenging the universality of the established order whilst distancing themselves from lower status groups.

Among the next two status groups, social workers appeared more oriented towards multidisciplinary collaboration than occupational therapists, perhaps because interfacing with others was fundamental to their role. The diffuseness of their claimed special contribution, based on holism, made nursing somewhat invisible, unmentioned when members of the other professions discussed disciplinary contributions. Again, the existence of this holistic position may reveal a general process of professional self-organisation. The delivery of services by specialists may require an organisational 'glue', provided by a profession which specialises in generalism. Despite its strategic centrality, such professions will tend to be marginalised against those which have accrued status through the validation of their claims to specific expertise. The combination of front-line nursing disenchantment and disengagement and the development of a blame culture made the frequent occurrence of security lapses which occur in this and other forensic mental health units more or less inevitable.

Ironically, at the other end of the status hierarchy, patients mostly put staff into a single category, albeit a negative one. Their depictions of the professions as a homogeneous, all powerful 'they', reflected their feelings of powerlessness. As found elsewhere, patients appeared to be on the receiving end of multidisciplinary decisions (Barker and Walker, 2000; Happell *et al.*, 2004) delivered in a culture dominated by *'a discourse of treatment and care, control and compliance, and professional expertise'* (Warne and Stark, 2004, p 660). This finding suggests another hypothesis of wider significance for organisational life, that role distinctions are blurred by social distance. This difference in viewpoint can generates gaps in perspective between staff who are

preoccupied with their professional identities *vis a vis* other professions and service users who do not grasp such distinctions, and who are more concerned with the yawning power gap between themselves and any staff member.

In conclusion, a symbolic interactionist framework provides a useful tool for understanding the operation of social power in discursive interactions. This framework makes a dialectical view of the relationship between role-taking and role-making analytically central (Perinbanayagam, 1991). Emphasis on the two-way mutually constitutive but also tense relationship between the individual and organisational social structure takes analysis beyond a single focus on individual lived experience. This dialectical approach can be complemented by drawing upon the concept of autopoiesis. Professions organise themselves in terms of distinctive guiding principles. But the bodies of thought built on these foundations do not contain external references guiding relationships with other disciplinary universes of meaning. Collaboration between professions therefore requires highly innovative and fragile role-making, as illustrated by respondent discussions of 'deroling' and diplomacy.   Multidisciplinary teamwork is unlikely to become organisationally embedded unless structural inequalities between professions, and between professions and patients, are addressed.

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