Human Relations
DOI: 10.1177/0018726707085947
Volume 61(1): 103–130

SAGE Publications
Los Angeles, London,
New Delhi, Singapore
http://hum.sagepub.com

The language of teamwork: Reproducing professional divisions in the operating theatre

Rachael Finn

ABSTRACT

Bringing together arguments from organizational studies and medical sociology, this study views teamwork as a discursive resource through which the social world is constituted in particular ways. Drawing upon an ethnographic case study of the operating theatre department, the nature and effects of these constitutive practices are examined. Significantly, this article argues that rather than unifying the professions, teamwork produces unintended divisive effects. Teamwork is used to promote unity, whilst at the same time pursuing divergent professional interests around the nature of collectivity. Employing distinct interpretive repertoires, professions construct different versions of team work and make competing legitimacy claims. These discursive practices both reflect and reproduce structural inequality between the professions. Ultimately, the privileged position of surgeons and anaesthetists over nurses and operating department practitioners is legitimated and maintained. This discursive action has far-reaching effects beyond the control of team members, with implications for policy-makers and organizational management. Exposing its performative and ideological nature, this analysis highlights teamwork discourse as co-constitutive with the structural context in which it occurs. The importance of critical reflection on the nature of teamwork as a concept is demonstrated.

KEYWORDS

communication ▪ discourse ▪ healthcare organizations ▪ professions ▪ teamwork

Introduction

There has been a resurgence of interest in team work as a system of work, reinforced through a vast literature promoting its potential benefits for organizations and employees (Mueller, 1994; Procter & Mueller, 2000). This reflects the way in which team work has become embedded and naturalized within our culture as something inherently good. This assumption is mirrored within the current healthcare context of the UK's National Health Service (NHS), whereby policy-makers, practitioners and academics have increasingly emphasized team work as the means through which efficient, safe and patient-centred outcomes can be accomplished, integrating care across institutionalized professional and organizational boundaries (DoH, 2000, 2002; GMC, 2006a, 2006b; Kennedy, 2001).

Drawing together arguments from organizational studies and medical sociology, these common sense assumptions are challenged within the context of the NHS. Rather than existing as an empirical reality, teamwork is socially constructed and a discursive resource through which particular interest-based versions of reality are constituted. Making the distinction between *team work* as material practice and *teamwork* as discourse[1] (Donnellon, 1996), the focus of study becomes the ideological uses and effects of *teamwork* within the distinct set of social structures characterizing the medical division of labour. Here, discourse is viewed as language, utilized in strategic and creative ways by social actors to pursue their interests in ways that appear plausible and legitimate (Potter & Wetherall, 1987). The approach is sociological (Watson, forthcoming) in that discourse is seen as analytically distinct from, but inextricably embedded within, aspects of the wider social structural context. Discursive action, and the social structures within which it takes place, are co-constitutive (Fairclough, 2005; Hardy et al., 2000).

Within the operating theatre context, teamwork is a discursive means through which professional members negotiate the contradiction between integration and specialization, furthering different versions of unity. Surgeons and anaesthetists use a technical-instrumental interpretative repertoire (Potter & Wetherall, 1987) to support existing work arrangements within managerialist organizational systems, legitimating their power and material privileges over other professions. In contrast, nurses and operating department practitioners (ODPs) utilize a relational repertoire, emphasizing the need for egalitarian working through achieving greater esteem from clinicians, but doing little to challenge social structures and the organizational systems that maintain them. In this way, discursive practices are both constituted by, and reproductive of, the structural inequality between

professions in which they are embedded. Ultimately, in reproducing the status quo, it is argued that teamwork has unintended divisive effects rather than serving as a means for unifying professional groups. Teamwork not only reproduces and maintains professional inequality, but also obscures the need for more fundamental changes in the work and social context that could do more to achieve the ends of both quality healthcare and an equitable workplace. Insofar as these discursive practices are functional for institutional interests, their far-reaching effects beyond the control of micro-level social actors are emphasized.

The article is structured as follows. First, I give an overview of the mounting critique of mainstream treatments of team work within organizational studies and medical sociology. This is the basis for a discussion of a sociologically informed approach to discourse as language in social interaction. The nature of the NHS operating theatre context will then be outlined, highlighting fundamental tensions faced in team work, and the structural inequalities characterizing the professional division of labour. The nature of teamwork as a discursive resource for negotiating these conflicts is outlined, discussing ways in which professionals constitute team work differently and make legitimacy claims in ways that further their interests. The unintended effects of these uses in legitimizing and reproducing professional boundaries and status quo of structural inequality within institutional arrangements are discussed. The practical implications for organizational management are emphasized.

Organizational studies of team work

Team work, as a system of work, has received increasing attention among practitioners and researchers over successive decades, viewed as innately good for both organizational productivity and employees (Mueller, 1994; Procter & Mueller, 2000). This has provoked a growth in more critical perspectives, challenging these assumptions around both the nature and effects of team work. This critique can be characterized by two fundamental, inter-related arguments. First, there is an emphasis on the socially constructed nature of team work, focusing on its normative dimension and pluralistic nature. Second, there is recognition that, rather than being characterized by consensus and unity, team work can be as much defined by conflict, difference and struggles between competing sets of interests brought together within the group work situation.

Within these critiques, there has been an increasing emphasis on moving beyond popular teamwork rhetoric to examine what actually

happens in the reality of team dynamics. Here, the functional role of language is highlighted as the fundamental building block of team activities determining outcomes, for example, impacting upon the incidence and management of error within safety-critical teams (Foushee & Helmreich, 1988; Weick, 1990). Donnellon (1996) argued that conversational practices reveal how, in practice, team work is difficult for members because of its fundamentally contradictory nature (Stohl & Cheney, 2001), requiring the oppositional elements of integration and specialization at one and the same time. Team dynamics are reflections of the ongoing management of this contradiction by team members. Donnellon (1996) argued that an interaction of individual preferences, power relations, professional socialization and wider contextual influences of management action, organizational culture and systems, mean that in reality, the balance swings in the favour of differentiation over integration. In this sense, team work reflects the nature of organizations generally, characterized by diverse and competing interests, tensions and contradictions from which collective action must proceed (Donnellon et al., 1986; Stohl & Cheney, 2001).

Within organizational studies, there has been a growing critique of team work within a broad discourse analytic perspective. Rather than differentiating between reality and rhetoric, and viewing language in terms of its functionality in relation to team activities, those working within a range of discursive approaches abandon this distinction. The fundamental role of rhetoric and language in the construction of reality is a key research concern in itself. Such approaches are influenced by the wider 'linguistic turn' within organizational studies (Alvesson & Karreman, 2000; Oswick et al., 1997; Watson, 2002, forthcoming). This moves beyond a focus on what happens within team dynamics, to examine team work and teamwork within the wider context of the employee–manager relationship, and the associated issues of power, control and contestation. The key argument is that teamwork can serve ideological purposes, in which language practices can play a central role in the mobilization, legitimation and reproduction of interests and social structures.

The term teamwork can serve particular rhetorical and persuasive functions, through which the desired cooperative spirit and need to be a 'teamplayer' are emphasized in the interests of management (Findlay et al., 2000; Ohno, 1988), often accompanying the introduction of some form of team work. We should therefore ask 'why use the t-word?' (Benders & van Hootegem, 2000: 54), focusing attention upon its opaque functions in particular social contexts. The emphasis is on the potential 'tyranny of teamwork' (Sinclair, 1992) as a discursively legitimated form of work,

serving as a socialization mechanism through which management attempt to control employees and align their motivations with organizational objectives (Ezzamel & Wilmott, 1998; Sewell, 1999). Examining self-managing teams within a US electrical company, Barker (1993, 1999) demonstrated how employees become complicit in their own control. Rather than increasing employee autonomy, team work actually increased managerial control through employees' self-disciplining, developing and internalizing a set of norms to govern the behaviour of themselves and others. Rather than providing liberation from the 'iron cage' of coercive, bureaucratic control, team work 'appeared to draw the iron cage tighter and to constrain the organization's members more powerfully' (Barker, 1993: 408) to the benefit of the organization.

Others have argued that managerial control through team work and teamwork is a more contested process without guaranteed success (Mueller, 1994). Managerial discourses of teamwork have been examined as a potential form of control through securing employee commitment, or a site of employee resistance within the context of the automotive industry (Knights & McCabe, 2000; McCabe, 2000). The conclusion is that 'while the discourse of teamwork is seductive . . . [it] is open to interpretation and manipulation, and may be re-constituted and re-represented so as to secure ends other than those intended by management' (McCabe, 2000: 203). In support of this view of teamwork as contested, Coupland et al. (2005) argue that the introduction of team work in a steel factory, rather than enhancing collectivity and consensus between managers and workers, increased 'us-and-them' attitudes, with loyalties becoming more fragmented and individualistic.

Team work in medical sociology

Studies of team work within the public sector, and healthcare context specifically, have been neglected within organizational studies, with its emphasis on private sector, manager–employee relations. Team work however, as encapsulating the classical sociological concern with the division of labour, has been a popular focus of study in medical sociology (Allen & Pilnick, 2005). The emphasis on the value of team work in healthcare by successive governments over recent decades has been noted (Allen, 2000a; Dingwall, 1980). The current NHS context is no exception, where the assumption is that team work is inherently good for organizations, employees and patients. Team work has been promoted as a key element of policy aspirations for a modernized NHS, as the means to efficient, safe (Kennedy, 2001; Mayor,

2002; NPSA, 2003) and patient-centred care (DoH, 2000, 2002; GMC, 2006a, 2006b) through improved integration and breaking down professional boundaries and hierarchies.

The common assumption is that team work in healthcare is characterized by consensus, cooperation and interdependency, as a function of complementary professional roles (Blau, 1972). However, healthcare teams face much the same challenges as others, encompassing the fundamental contradiction of the need for both integration and specialization of professional groups (Donnellon, 1996). Healthcare is characterized by an increasingly fragmented, specialized, professional division of labour. Each profession has a distinct role and socialized membership, with a historically developed and institutionalized set of hierarchical relations between them. This provides for fundamentally different professional interests. As a consequence, the tendency is towards conflict and contestation, to the detriment of professional integration (Allen, 2000a; Dingwall, 1980; Dingwall & MacIntosh, 1978; Webb & Hobdell, 1980). However, mutual interdependency makes collaboration essential to achieving outcomes, so that ultimately this tension must be negotiated in interaction so that collective action is not undermined.

These processes of negotiation within teams are contested and ideological, in which professional boundaries are central (Gieryn, 1983). The emphasis is on the set of social relations brought together in team work, and the integral issues of power, conflict and resistance, as roles and status are negotiated (Allen, 2000b, 2001; Harvey, 1995; Stein, 1967; Wicks, 1998). Professional boundaries, based upon socialization and historical institutionalized relationships of unequal power and reward, result in different 'ecologies' or discourses of the patient (Anspach, 1987; Chambliss, 1996; Fox, 1992; Svensson, 1996) and views on the nature of team work along occupational lines, that must be negotiated through the course of work (Cott, 1998; Griffiths, 1997). The form that team work takes in any given context can be understood as the outcome of these micro-political struggles. While the collaborative ideology of teamwork is a potential form of social control to promote cooperation and prevent conflict among disparate professionals (Opie, 1997), its inherent ambiguity as a 'loose rubric' for action opens up space for the negotiation of working arrangements in the context of established authority relationships and discourses of the patient (Griffiths, 1997).

While valuable in emphasizing the context of professional relations in which team work is constructed and contested, these studies focus on team work as a negotiated outcome, rather than the significance of teamwork language itself as the arena through which these negotiations take place.

Viewing teamwork as a linguistic resource, Dingwall (1980) considered its usages among primary care health professions. While rhetorically asserting cooperation between occupational groups, each profession could use teamwork as a resource in very different ways to address their own particular occupational dilemmas, arising from an increasingly fragmented division of labour and the difficulties of coordinating work, faced with occupational demarcation and power. Thus, general practitioners employed a version to support their superior status based on rhetoric of increased efficiency through cooperation, antipathetic to the egalitarian models furthered by health visitors and social workers. In this sense, deploying teamwork could be a way of providing the linkage and cohesion needed between occupational groups, but in particular, interest-based ways.

This article draws together these critical arguments within organizational studies and medical sociology to examine the uses and effects of teamwork as a discursive resource within the context of the NHS operating theatre department, thus addressing concerns that the fields have become increasingly disconnected in recent years (Allen & Pilnick, 2005; Davies, 2003). Such a challenge to common sense assumptions in a climate of renewed emphasis on team work is vital, as 'words are performative precisely because their deployment is unexamined, taken for granted and assumed to do nothing' (Learmonth, 2005: 633).

The notion of discourse

In contrast to the increasing tendency towards study of discourse as orders of meaning and practice (Alvesson & Karreman, 2000), this article views discourse as language in social interaction (Potter & Wetherall, 1987). Rather than a means of representing social reality, language is a form of performative social action (Austin, 1962; Wittgenstein, 1953) through which reality is actively constructed (Berger & Luckman, 1967), bringing 'objects into being' by making the ambiguous material world meaningful (Hardy et al., 2000: 1231). Social actors are creative and strategic in their use of language as a resource, trying to invoke particular versions of the world that suit their interests in particular contexts, in ways that appear plausible, legitimate and factual. One resource through which this takes place is the 'interpretative repertoire', thought of as 'a lexicon or register of terms and metaphors drawn upon to characterize and evaluate actions and events' (Potter & Wetherall, 1987: 138). This process is not neutral but ideological, though language use appears naturalized in such a way as to make these functions opaque (Learmonth, 2005). Discursive action attempts to silence

other alternative constructions, implies particular courses of action and 'promotes particular attitudes and discourages others' (Oswick et al., 1997: 6). Organizations thus are characterized by processes of contestation, as actors engage in discursive activity to pursue competing interests. Viewing discourse as language in social interaction, this article examines the linguistic practices through which actors construct, further and legitimate particular versions of team work to pursue their interests, and the local or institutional ends these practices might serve (Hardy et al., 2000; Potter & Wetherall, 1987).

The approach taken here is sociological, viewing language use as embedded within, but analytically distinct from, the wider context in which it occurs (Watson, forthcoming). Discursive practices lie at the nexus between structure and agency in a co-constitutive relationship with the social structures that frame it (Fairclough, 2005). This relationship means local-level discursive activity can have 'complex, far reaching effects that are beyond the control of single individuals' (Hardy et al., 2000: 1232). A pre-structured social world both provides a set of opportunities and constraints on discursive action, shaping the capacity to reproduce, modify or transform that world. Discursive choices therefore represent agency within certain limitations of the social structures in which they are rooted, shaping what can be said, how, by whom and when. With the need to have resonance with others, one aspect of this constraint is the resources that are culturally available to draw upon as an accumulation of other micro-level struggles over time (Watson, forthcoming), and the ability to speak legitimately within them with 'voice' (Hardy et al., 2000; Potter & Wetherall, 1987).

Thus, the focus here is not only teamwork discourse, but also the wider organizational and structural context in which it is embedded. This includes the discursive context of available resources, and in this sense the approach to discourse can be characterized as 'middle range' (Alvesson & Karreman, 2000). While attention focuses on the details of micro-constitution practices, wider connections are made, highlighting the complex and far-reaching effects of teamwork discourse at the institutional level. This enables consideration of how wider systems are reproduced, contested and transformed, and demonstrates 'the power of language to reproduce and transform power relations by considering what is put at risk in actual interactions' (Coupland, 2005: 363).

Method

The research was a single case study (Eisenhardt, 1989; Yin, 1994), conducted within an operating theatre department within an NHS university

hospital in the Midlands, UK, between 1999 and 2003. An ethnographic approach was adopted to gain holistic insights into the complexities of the socio-cultural context of work (Atkinson & Hammersley, 1998), allowing the examination of teamwork as a discursive practice in social interaction in the course of everyday work. Data collection techniques involved observation of everyday work as a participant observer, in situ informal interviews as conversations (Mischler, 1996) arising during the course of observation, the collection of documents (organizational bulletins, minutes of meetings), and attendance at meetings and one non-clinical skills training event within the department.

Observation was carried out over a period of five months, providing a total of 250 hours of observation, carried out across the different physical areas of the department, including operating theatres, anaesthetic rooms, training and meeting rooms, corridors, coffee room and changing room. A representative sample of six theatres was selected across a range of surgical specialities (general, orthopaedic, spinal, vascular, ear nose and throat, neurosurgery). Focusing on core theatre staff of surgeons, anaesthetists, nurses and ODPs, a sample of 24 key informants (one member of each core profession per theatre) was selected with whom to conduct informal interviews. Some 48 interviews (two per participant) were conducted across the course of the study. Observational data involved all theatre members, providing a total sample of 60 participants (some members working in more than one sampled theatre).

Data recording relied upon the collection of detailed field notes, using shorthand note taking techniques for efficient, accurate recording. This decision was taken in recognizing the fundamental importance of building rapport and gaining acceptance as an unnoticed participant in the setting as key to ethnography, and the practical difficulties of gaining consent for, and deciphering recordings, given the large numbers of theatre participants. Given the central focus on language practices, all instances of teamwork talk observed were recorded verbatim as they occurred. Overall the study as a whole recorded 400 pages of observational field notes, with a total of 80 instances of teamwork talk (an instance being a comment or conversation between actors in which teamwork was used as a referent).

Data collection and analysis was carried out iteratively (Glaser & Strauss, 1967), with recorded data frequently revisited to identify emerging analytic themes and compile ongoing theoretical notes. The analytic process was driven by the principles of discourse analysis (Potter & Wetherall, 1987), viewing language as social action. Instances of teamwork talk were examined for their content and structure, examining reiterating patterns and themes in the sets of concepts being invoked around the term, as the basis for identifying interpretative repertoires and their uses. This draws upon principles of

constant comparative method (Glaser & Strauss, 1967) such that similarities and differences in accounts and circumstances of their production could be identified (Silverman, 1993).

Case study: The NHS operating theatre department

Reflecting wider international trends, the UK NHS operating theatre department has seen an increased emphasis on the significance of team work within current policy aspirations towards safer, patient-centred care (Mayor, 2002; NPSA, 2003), manifest in a growth in training and education initiatives aimed at enhancing team work skills and culture for improved outcomes (Bleakley et al., 2006; Edmondson, 2003; Helmreich & Davies, 1996). Here, the emphasis is upon 'teamwork that crosses old professional boundaries to deliver seamless care' (NHS Careers)[2] and the value of all professions' contributions, the essence of which is captured in the following statement:

> Teamwork is of crucial importance . . . collaboration between professionals is at the core of what we mean by teamwork . . . teamwork as a means of serving the patient implies a multi-professional team and a sharing of responsibility . . . teamwork is the collective collaborative effort of all those concerned with the care of the patient.
>
> (Kennedy, 2001, chapter 22: 2)[3]

This emphasis on improved integration makes sense as operating theatre teams face the difficulties emanating from the contradiction discussed earlier between specialization and integration of inter-dependent professional groups (Dingwall, 1980; Dingwall & MacIntosh, 1978; Donnellon, 1996). Core professional groups of surgeons, anaesthetists, nurses and operating department practitioners (ODPs) have their own distinct roles and perspectives in relation to the patient within a fragmented division of labour, but are mutually interdependent and so must effectively coordinate their activities and overcome these tensions so that outcomes are achieved and collective action is not threatened (Fox, 1992). ODPs and nurses have the responsibility of preparing the anaesthetic room and assisting anaesthetists in the induction of the patient. Theatre nurses, headed by a charge nurse, have the role of ensuring the operating theatre is prepared for surgery prior to the arrival of the surgeon and patient, and perform a variety of roles during the course of operations. Scrub nurses work alongside the surgeon at the operating table to provide the necessary equipment as and when it is

needed, while 'runners' carry out tasks to ensure the smooth running of the procedure, such as fetching necessary equipment, liaising with wards and gathering necessary patient information. Anaesthetists and surgeons have overall responsibility for care of the patient, their work activities being closely interdependent such that close communication and coordination are essential. The composition and size of teams vary according to workload, the procedure, available staff and skill allocation within the department as a whole.

A number of issues in the operating theatre provide grounds for divergent professional interests, making the negotiation of the integration-specialization contradiction challenging. Different professional perspectives towards the patient are coupled with deeply ingrained professional identities, socialized through education and training, holding a stronger affinity than the team as a whole (Blane, 1991). The wider organizational systems of New Public Management (NPM) and notions of managerialism (DoH, 1997, 2000), within which all personnel work, exacerbate this challenge to teams. The efficiency imperative, emphasizing the maximum use of limited staff resources and a reliance on agency personnel, works to undermine collectivity through a reliance on transient teams. Differential accountability and reward systems ultimately can work to encourage professional 'silos' and 'tribalism' (Bate, 2000; Finn & Waring, 2006; Timmons & Tanner, 2004).

The social structure of the operating theatre is a fundamental basis for professional divisions. Managerialist imperatives carry potential negative implications for all healthcare personnel, for example, through greater accountability, challenges to autonomy, and increased workload, as a consequence of the drive for increased patient throughput in the quest to meet targets. However, the social structure of fundamental inequalities of power and material reward between professions mean that some fare better than others within these organizational systems and logic. Doctors have maintained their historically developed position of social and material advantage over other healthcare professions within hierarchical social relations (Blane, 1991; Nancarrow & Borthwick, 2005). Thus, while clinicians may feel increasing pressure within managerialism, they at least enjoy power and material privileges within the division of labour as an antidote. Nurses, and other allied health professions, in contrast, continue in relative disadvantage, while simultaneously being the target of various cost-cutting exercises, which in itself can pose a challenge to both managers and government insofar as they must still harness the discretionary efforts of the nursing workforce (Bolton, 2004).

This social structure provides for professions' divergent positional interests (Deetz, 1992) in maintaining or challenging this status quo. While

surgeons and anaesthetists have an interest in reproducing and legitimating their privileged position, nurses and ODPs may seek to challenge this. However, these struggles take place within existing social structures, meaning that ultimately some have more power from which to proceed. It is easier to maintain the status quo from a position of advantage than it is to challenge it from a subordinate one. In this article, teamwork discourse is examined as one micro-level strategy through which these professional struggles take place.

Teamwork as a discursive resource in the operating theatre

References to the value of team work were evident among all professions in the operating theatre department. However, it was also recognized that there was some ambiguity and difference of opinion as to what exactly this meant in practice:

> No one agrees exactly what constitutes good team work. There are no gold standards.
>
> (Consultant anaesthetist 2)

Thus, while on the one hand there may appear to be agreement on the basis of a shared emphasis on team work, at the same time there were fundamental differences between members as to its nature. Teamwork discourse can be viewed as promoting both collectivity and difference at one and the same time. In this sense, it is a resource through which the contradiction between integration and specialization can be negotiated. As a referent, teamwork has two important characteristics that together make it functional in this sense.

First, as discussed earlier, teamwork has important rhetorical associations of unity, with inherently positive associations. This implicit moral evaluation, or 'accent' has been identified an important quality of linguistic referents that gives them performative power (Hardy et al., 2000; Learmonth, 2005). The speaker is given legitimacy insofar as they are promoting something positive and beneficial, enabling actors to constitute versions of the world that appear plausible and legitimate (Potter & Wetherall, 1987). This can disguise other, potentially more subversive work being carried out by the speaker. Second, teamwork is inherently ambiguous. The ambiguity of language has been recognized as particularly useful in enabling collective action in work situations characterized by divergent interests between actors (Donnellon et al., 1986). Ambiguity can be employed as a strategic resource, to create an appearance of sufficient consensus between social actors as the basis for collective action in the face of holding very different sets of interests

and goals. As Eisenberg (1984) puts it, 'strategic ambiguity is essential to organizing because it allows for multiple interpretations to exist among people who contend that they are attending to the same message . . . it can also serve to hold strained relations together and reduce unnecessary conflict' (p. 231). In this sense, teamwork is flexible enough to allow the pursuit of unity and difference at one and the same time, glossing over the differences among social actors, reducing the likelihood of these becoming the source of conflict and people held accountable for pursuing them.

Teamwork can create a sense of shared goals and collectivity in that all operating theatre personnel endorse it as valuable and important. However, its ambiguity can provide sufficient space for the pursuit of different interest-based versions of that unity, while limiting the potential for jeopardizing the basis for collective action. Discursive space is opened up through which professions can constitute a variety of possibilities in ways that remain opaque. It is to a discussion of the nature and effects of these constitutive practices that I now turn.

The interpretative repertoires of teamwork

While widespread use of teamwork among operating theatre staff might initially be taken as indicative of consensus, this disguises the pursuit of divergent professional interests as to what this actually entails. Professions draw upon different interpretative repertoires, or registers of terms to characterize and evaluate the world (Potter & Wetherall, 1987), invoking particular concepts in attempting to bring different notions of team work into being (Hardy et al., 2000), and to encourage certain actions and attitudes through implying what it is to be a good team worker.

Surgeons and anaesthetists both draw upon a 'technical-instrumental' repertoire to constitute team work, centring around emphasizing efficiency of the work process as an end in itself, and the skills and attitudes of individuals necessary for coordination to achieve this. This interpretative repertoire, underpinned by rationalist views of team work as an objective and controllable work process, draws on terms such as 'coordination', 'communication', 'things running smoothly', 'shared understanding' and 'awareness':

> With team work, you just need a bit of awareness into the need to tell everyone exactly what you are doing . . . it becomes problematic when in difficult situations people decide they are going to sort things out for themselves and don't tell anyone. This shouldn't happen.
>
> (Consultant anaesthetist 1)

> I think teams are absolutely crucial. Knowing the people you are working with in a team is crucial for things to run smoothly. It can really wind you up and slow things down when you're not.
>
> (Consultant anaesthetist 2)

In these accounts, shared understanding achieved through effective communication becomes the responsibility of team members, with the ultimate aim of an efficient work process. Within this repertoire, there is still flexibility to constitute different types of team work dependent on the context and procedure involved, for example, with complex operations being about 'coordination of activity and knowledge of the work of others' and high turnover lists as about 'keeping the list moving efficiently'. The important point is that within the technical-instrumental repertoire, all types of team work are underpinned by the rational efficiency imperative.

A further significant aspect of this constitution of team work among clinicians is the set of social relations furthered as the means to achieving these ends:

> Team work is really important. There's too many inefficiencies in theatres. Different people work in different ways. The benefit of team working is that people get to know how you like things done.
>
> (Consultant surgeon 1)

> Team work is always better when you've got an ODP you know because they know exactly what you want without you having to ask. They're one step ahead. The problem with agency ODPs is you spend half your time explaining what you want and how you do things.
>
> (Consultant anaesthetist 4)

As these remarks show, hierarchical social relations are inherent within team work for surgeons and anaesthetists. Efficiency relies on nurses and ODPs acting in accordance with the superior power of clinicians, as technical experts, to define the nature of the work process. It becomes the responsibility of staff as good team workers to ensure they 'know how you like things done'.

This 'technical-instrumental' interpretative repertoire was in stark contrast to discursive activities of nurses and ODPs. They draw upon a very different 'relational' repertoire of resources to constitute team work:

> There have been a lot of culture changes. They work more as a team now. We don't tolerate any rudeness from the surgeons or anaesthetists and by the same rule we afford them the same courtesy.
>
> (Senior ODP 1)

Within this repertoire, the relational aspects of work are emphasized through terms such as 'courtesy', 'respect', 'appreciation' and so on. Team work involves egalitarian working with surgeons and anaesthetists in terms of the distribution of esteem. With this emphasis on the emotional, 'non-rational' aspects of work, being a good team worker is not so much about skills, but about a normative morality and a sense of respect for one's fellow workers on the part of clinicians. Importantly, team work lies at the heart of the work experience for nurses and ODPs and their sense of satisfaction:

> I like working in theatres, but I hated it on the wards. A consultant would never speak to you on the wards. Team work was bad on the wards. There's much better relations and you can have a laugh in theatres.
>
> (Theatre nurse 6)

For this theatre nurse, operating theatre work is more enjoyable and gives greater satisfaction than working on wards because of better team work, defined in human relational terms.

These interpretative repertoires need to be understood within their social context of production, reflecting divergent professional interests as a product of their material position within the social structure. Surgeons and anaesthetists occupy a privileged position of power and material reward over nurses and ODPs within the division of labour, leading to different interests in maintaining and legitimating, or challenging the status quo respectively. Attempting to shape the nature of team work and the ways in which people act through interpretive repertoires demonstrates the pursuit of these interests in hierarchical working on the part of surgeons and anaesthetists, and egalitarian relations among nurses and ODPs. Significantly, this discursive activity is enabled and constrained by the same social structural conditions it seeks to address, such that high-status clinicians have greater power to further their material interests than subordinate members. In this sense, teamwork is co-constitutive with inequalities of power within the division of labour.

The technical-instrumental repertoire of surgeons and anaesthetists is a means by which their material interests are legitimated, both reflecting and reproducing their position of power within the social structure. Significant is the wider organizational context of New Public Management (DoH, 1997, 2000) in which work is situated. This managerialism is 'a kind of system logic, a set of routine practices, and an ideology . . . it entails a set of routine practices, real structures of rewards, and a code of representation' (Deetz, 1992: 222). This dominant logic and systems emphasize the rationality of efficiency and effectiveness, to be achieved through control and coordination

of the work process via hierarchy based on technical expertise. Clearly, surgeons and anaesthetists draw upon the resources made available by managerialism to constitute team work. The point is that it is within this system that clinicians have gained and maintained their privileged position within the social structure of healthcare professions as technical experts; as such its reproduction serves as a means through which those privileges can be legitimated and reproduced. Surgeons and anaesthetists are able to occupy a privileged subject position and speak with voice within managerial resources to mobilize their interests and attempt to silence alternative constructions that might threaten them.

Managerialist logic can be articulated by anyone, but it does not carry the same implications for all groups, as it positions them differently (Deetz, 1992). Nurses and ODPs occupy a relative subordinate structural position within existing organizational arrangements. While they have a positional interest in challenging the status quo for greater equality with clinicians, their subordinate position also constrains their power to discursively mobilize those interests. They are unable to occupy a privileged subject position within managerialist discursive resources, and do not have the power to create their own resources from which to legitimately challenge their inequality with voice. The policy aspirations of government emphasizing collective responsibility and the need to break down hierarchies has opened up discursive space for legitimate claims for egalitarian working for nurses and ODPs. However, these aspirations are ambiguous as to what this actually means in practice, and are very much up for negotiation at the local level. While this ambiguity might be useful for government in limiting their accountability for aligning with any one profession (Donnellon et al., 1986; Eisenberg, 1984), insofar as it does not directly invoke the need for structural change, nurses and ODPs are not given space to legitimately challenge social structures with voice.

Thus, while the relational interpretative repertoire of teamwork used by nurses and ODPs reflects their interests as subordinates in egalitarian working relationships with clinicians, these appeals to egalitarianism are only in terms of esteem, equal recognition and the emotional dimensions of work, rather than more fundamental redistribution of material reward and power at the level of social structures. Their repertoires seek to redistribute esteem within existing organizational systems, but do not challenge those systems as the means from which from which their material inequality emanates. Constrained by their structural position, nurses and ODPs fail to mount any challenge to the organizational and structural arrangements within which their disadvantage is perpetuated. The result is that the two interpretative repertoires can co-exist without any real threat to the status quo. While surgeons and anaesthetists are able to reproduce the status quo from a

position of power, the actions of nurses and ODPs as subordinates fail to mount any real challenge or put it at risk.

Teamwork then has unintended divisive effects, not only in the reproduction of professional boundaries but more fundamentally as an ideological means for reproducing structural inequality between the professions. Co-constitutive with the wider organizational and structural context, these discursive practices however also have more far-reaching implications at the level of institutional interests, highlighting the ways in which micro-level discursive practice can have effects beyond the control of individuals within the social structure (Hardy et al., 2000). The discursive actions of nurses and ODPs serve functions for both the organization and government. Both managers and government are faced with the ongoing dilemma of how to ensure the continued discretionary effort of nurses and allied health professions in the face of a number of potential threats, such as the increased work, limited financial reward, job insecurity and increased accountability under the systems of managerialism (Bolton, 2004), with constant reassertion of power on the part of clinicians. The ambiguity of policy aspirations opens up space for negotiating more egalitarian working, but does not present any challenge to the status quo from which nurses and ODPs can speak with voice. At the same time, the importance of shared responsibility and shared effort are emphasized. In settling for the relational reward of increased esteem exemplified within teamwork, this represents a cheap and effective solution to ensure continued effort and commitment without the need for more costly radical change, which would also carry the threat of resistance and conflict from privileged clinicians. Managers, government and clinicians all stand to win from what can be considered 'distorted communication' (Deetz, 1992) on the part of nurses and ODPs, who are ultimately complicit in their own subordination.

The effects of clinicians' discursive practices are however not entirely beneficial to their position either. While they have a positional interest in maintaining managerial rationality as the system that maintains and legitimizes their privileges, this too carries costs. Clinicians have other interests that may be undermined by the perpetuation of the managerialist logic, such as the protection of clinical autonomy in the face of managerial accountability systems and maintaining control over the work process. While managerial systems provide clinicians with advantages over other professionals, they can carry costs in terms of control over work and their relationship with managers within the social structure. What this shows is the power of managerialism as a logic and organizational system to reproduce itself and the social structures embedded within it (Deetz, 1992), in this case through constitution of team work by a privileged group at the micro-level.

Doing attributional work: Making legitimacy claims through teamwork

One use of these technical-instrumental and relational interpretative repertoires is in the evaluation of team members, making attributions for problems arising during team work. Teamwork is a resource through which members assert their legitimacy, undermining the competence and motivations of others along professional lines. It is not only important that these practices further particular versions of team work as shown above. Crucially, using particular teamwork repertoires suggests particular individualized explanations, and by implication, certain courses of action as solutions to difficulties, with the effect that alternatives are silenced and some conflicts are legitimized over others. While these practices represent divisive work in reproducing boundaries between professions at the local level, they also have more far-reaching consequences at the level of organizational and structural arrangements. In constituting failings as due to individual team members, alternative constructions on the basis of more fundamental ways of organizing and social structures are silenced. As will be discussed, these activities serve important ideological functions in maintaining the institutional logic of managerialism and status quo of structural inequality.

Surgeons and anaesthetists draw upon the technical-instrumental repertoire of teamwork and the efficiency imperative to constitute problems encountered during the course of team work. This is utilized as a discursive resource for evaluating and asserting legitimacy over each other on these grounds:

> You should have come and watched this morning's list, it was [consultant surgeon's] list, it was a complete joke, there were so many cock-ups! There's just a complete lack of responsibility for anything, they say it's not our fault! They only see things from their point of view, they're not team workers at all! They just don't do it! Surgeons aren't prepared to communicate at all.
>
> (Consultant anaesthetist 4)

> Oh come on, this is ridiculous [turns to me]. You see, this is the thing with team work, there's so many inefficiencies. Some anaesthetists are much slower than others.
>
> (Consultant surgeon 1)

This anaesthetist uses the technical-instrumental repertoire of teamwork to undermine the skills and motivations of surgeons by asserting that they 'are

not team workers at all' and are not prepared to be either. This of course stands in contrast to the anaesthetist speaker, who in making these claims is seeking to assert superiority as a team worker. In a similar way, the surgeon undermines the competence of the anaesthetist on the grounds of inefficiency, as he waits for the anaesthetic induction to be completed and patient brought into theatre. What both accounts do is to constitute individual professional members as the source of difficulty.

It is not just tensions between surgeons and anaesthetists that are mobilized in these terms, as both also use this repertoire to undermine the legitimacy of nurses and ODPs as team workers on the basis of their perceived inefficiency, for example in relation to not having adequately prepared the anaesthetic room or operating theatre, or for working too slowly. Within these accounts are the assumptions about hierarchy outlined earlier, where nurses and ODPs have the role of ensuring things are done in line with the preferences of clinicians. Failure to do this is constituted as poor team work:

> I'll be frank with you. This is the worst place I have ever worked in terms of inefficiencies. It's so difficult to engender team work because they don't know your biases and idiosyncracies. I know how I like things set up, how I like the room, but people don't bother to find the information out. It's a failure of management and the individuals to do the preparation. I've tried for three years to get 8 o'clock starts, but people bend it surreptitiously and put it back to 8.30. There's a lot of coffee drunk between 8 and 9 I can tell you! I mean what time do the nurses get in, around 7.30? And what actually gets done?
>
> (Consultant surgeon 4)

In this example, difficulties encountered are constituted as a lack of team work motivation on the part of both theatre nurses (and management), in that they 'don't bother' to find out and act upon the surgeon's preferences, or use time efficiently, wasting time drinking coffee. In contrast, the surgeon is of course legitimated by his efforts to improve team work in terms of enhancing efficiency.

Nurses and ODPs certainly made counter-claims to such attacks on their legitimacy as team workers, but importantly these proceeded from the relational interpretative repertoire outlined earlier. Thus, while in attributing difficulties encountered during work to surgeons' and anaesthetists' lack of team working, this was in terms of their concern for egalitarian working relationships and the lack of courtesy, respect and appreciation shown to nurses and ODPs by clinicians:

> Team working is bad here. Morale is low. It's just the arrogant, obnoxious attitude of many people and the contempt with which they treat their colleagues. Many of the anaesthetists work with you all day and you are running around for them and the next day they won't even acknowledge you.
>
> (Anaesthetic nurse 1)

> The problem is I'm doing someone a favour, and yet I'm the one who has to sort out someone else's cock-ups! Where's the team work in that? It's not my fault, but I get all the rubbish, she [consultant anaesthetist] comes out smelling of roses!
>
> (ODP 4)

In the first example, the anaesthetic nurse does work to undermine the legitimacy of anaesthetists according to the relational repertoire of teamwork, constituting them as the cause of low morale among nurses due to their attitudes. In the second account, an ODP is expressing his frustration at being held responsible by a consultant anaesthetist for dealing with a breakdown in coordination and mix up over the order of patients between the porter and anaesthetist. The ODP reasserts his own legitimacy through undermining the anaesthetist as a team worker on the grounds of not taking responsibility for her own mistakes.

The divisive effects of teamwork in reproducing professional boundaries are evident within these local-level attributions. This mirrors discussion within the wider literature of the construction of accounts as legitimation devices, such as the telling of 'atrocity stories' as a means of doing occupational demarcation between healthcare occupations (Allen, 2001; Dingwall, 1977; Timmons & Tanner, 2004) and the practice of 'attributional egotism' (Brown, 1997) whereby successes and failures are constituted as a product of oneself and others respectively. In being used as a means of dividing rather than uniting healthcare professions, teamwork serves as resource for demarcating between 'us' and 'them' in organizational life (Coupland et al., 2005).

The effects of these attributional discursive practices embedded within social structures are however more fundamental and far-reaching, serving important ideological functions with institutional and structural implications. This is accomplished not only because certain versions of team work are being furthered with the effects discussed above, but importantly because of the explanations of problems invoked and their solutions as a consequence. Constructing the nature of problems and solutions in particular ways silences alternative versions of events and courses of action, and in so

doing, furthers particular sets of positional interests over others. In effect, these accounts indicate what conflicts can be legitimately mobilized by whom in this context and which are silenced.

Constituting problems through the technical-instrumental repertoire of teamwork, surgeons and anaesthetists are locating both the source and solution to difficulties as situational, and lying within the domain of the technical skills and attitudes of individual professional members. By implication, managerial systems and roles that might assist these are legitimated. While drawing on a relational repertoire emphasizing motivations and morality, the accounts of nurses and ODPs are also focused upon the individual professional member as the source and solution to problems. Significantly, both practices create individualized constructions, such that wider organizational and social structural factors are not constituted as significant. The complex, dynamic operating theatre department makes team work inherently difficult (Edmondson, 2003) and problems encountered are likely to be the result not only of individuals but the organizational systems and social structures in which they work, such as through managerial efficiency imperatives undermining team stability and offering differential reward systems, for example (Finn & Waring, 2006; Timmons & Tanner, 2004). Individualized attributions, however, suggest that solutions to team work difficulties should be sought within existing organizational and social arrangements, rather than looking to those arrangements as problematic. While individual attributions for team work difficulties dominated, there were very occasional references to organizational issues as problematic:

> There's time pressures and we're under resourced and under staffed. That does nothing to enhance team spirit and team formation because it means we're all having to move around all the time!
>
> (Anaesthetic nurse 2)

This account invokes the lack of time, equipment and staff resources as undermining team spirit and formation. However, what is significant is that even these explanations, rather than promoting any fundamental structural change, invoke the distribution of resources as the source of and solution to problems within existing organizational and social systems. The nature of these systems is not constituted as problematic and remains unquestioned, such that the status quo is not put at risk.

Ultimately, these practices enable the status quo and basis of structural inequality between professions to remain unquestioned, in which subordinate members are complicit. This again reflects the way in which discursive action is enabled and constrained by the existing organizational and structural

context, in which subordinate members have limited discursive space through which to mobilize conflict and challenge the root causes of their disadvantage.

In this sense, the discursive practice of teamwork is functional for both organization and government insofar as they are not called into question. Conflicts that might question fundamental ways of organizing are not mobilized. However, the implications can be negative in two senses. First, these individualistic attributions run counter to a wider policy emphasis within the NHS on systems thinking and the need for an open, low blame culture as the basis for effective team work and safe outcomes (Kennedy, 2001; Leape, 1997; NPSA, 2003). Attributions of blame evident in the operating theatre can undermine the sense of collectivity, openness and thus the ability to learn, share knowledge and achieve safe, effective team work. Second, in focusing efforts on improving individual skills and attitudes within existing systems, attention is detracted away from other possible solutions to professional integration at more fundamental levels of organizational systems and social structures. Such solutions might involve the redistribution of material reward for team-based incentives for example, efforts to counter the negative effects of efficiency drives on team formation and stability, and more fundamental challenges to power inequalities for enhanced communication and engagement. In silencing these alternative explanations and courses of action, individualized attributions undermine the potential to bring about fundamental changes in team work. Insofar as outcomes are potentially compromised, this is something that not only implicates medical professionals, but management, organizational systems of the NHS, and government as key agents. Most importantly, patients stand to lose the most.

Discussion

This analysis serves as an antidote to the mainstream assumptions that team work, as an empirical reality, is inherently good, revealing its opaque ideological functions as a discursive resource within the context of professional relations in the operating theatre. The value of such critical reflection on teamwork is highlighted whereby these opaque ideological and performative processes are exposed (Learmonth, 2005), rather than inadvertently contributed to through researchers' uses in common sense, empiricist ways (Watson, 2002). The growing critique within organizational studies and medical sociology is supported, where team work is characterized by contestation and conflict within power relations of the division of labour. The approach to discourse addresses recent calls for a focus on language in social

interaction (Alvesson & Karreman, 2000) and for sociological discourse analysis that understands discursive activity as analytically distinct, yet firmly embedded within wider social structures (Watson, forthcoming), serving as an antidote to the dominance of post-modernist approaches. In this way, the analysis has highlighted teamwork discourse as at the nexus between structure and agency (Fairclough, 2005), in a co-constitutive relationship with the organizational and social structures in which it is embedded.

The value of the rhetorical and ambiguous qualities of teamwork as a referent have been highlighted, providing a resource through which collective action can be sustained in the face of divergent professional interests (Donnellon et al., 1986; Eisenberg, 1984). As a resource for negotiating the ongoing contradiction between specialization and integration, the effects are however unintended in that it serves as a means of dividing rather than uniting the professions. This provides support for the argument that team integration is often compromised as a product of the social and organizational contexts in which they work (Donnellon, 1996). Drawing upon different interpretative repertoires (Potter & Wetherall, 1987) to mobilize technical-instrumental and relational interests, and utilizing these in attributional work, the boundaries between professions are reproduced. At this local level, this supports the literature on the significance of professional boundaries as an on-going accomplishment in healthcare contexts (Allen, 2000b, 2001; Cott, 1998; Griffiths, 1997; Harvey, 1995; Nancarrow & Borthwick, 2005; Opie, 1997; Stein, 1967; Svensson, 1996; Timmons & Tanner, 2004; Wicks, 1998).

The divisive effects of teamwork, however, are more fundamental, as co-constitutive with social structures of inequality and clinician power within the division of labour. In the sense that teamwork reproduces rather than transforms wider organizational systems and social structures from which professional divisions emanate, it can be viewed as an 'imaginary for change' (Fairclough, 2005), and supports the argument of Dingwall (1980) that 'talking about teamwork is largely a means of making certain sorts of occupational claim rather than as a way of concerting action' (p. 133). However, the contribution of this article has been in extending the analysis beyond consideration of the set of social relations within the professional division of labour in two related ways.

First, it has highlighted the crucial significance of the wider institutional context in these processes, providing a set of opportunities and constraints for discursive action. While subordinates have limited discursive space provided by policy aspirations, managerialism is central to the power of clinicians to reproduce their privileged position. The logic and systems of managerialism (Deetz, 1992) become a means through which the fundamental

inequalities between professions are perpetuated, providing particular opportunities and constraints for discursive action to professions by positioning them in different ways, with implications for team work. This analysis supports arguments about the capacity of managerialism to reproduce itself as 'a way of doing and being that conflicts with and suppresses other modes of thinking' (Deetz, 1992: 222), in this case through the micro-discursive activities of healthcare workers in their constitution of team work. The mobilization of alternative positional interests among all professions and conflicts on these grounds is suppressed. In this way, team work becomes another aspect of organizational life colonized by managerial imperatives.

Second, and related, the way in which micro-level discursive action can have far-reaching and unintended consequences is highlighted (Hardy et al., 2000). Serving institutional functions at the levels of organization and government interests, teamwork produces effects that are not entirely to the benefit of professional members. The legitimation of managerialist systems and managers as agents through teamwork carries costs for all healthcare professions including surgeons and anaesthetists, but most for disadvantaged nurses and ODPs who, constrained in their power to mobilize their positional interests and threaten the status quo, are complicit in their own on-going subordination. While statements of policy aspirations emphasizing the breaking down of professional hierarchies, joint effort and shared responsibility opens up space for the negotiation of egalitarian working, its ambiguity does not present a challenge to social structures from which nurses and ODPs could speak from legitimately with voice. This is politically functional, as a means of sustaining the input of nurses and ODPs, and achieving efficient, safe outcomes without the need for increased material reward or radical systemic change.

The organizational and political implications, however, are not entirely positive, as there are real costs in terms of the capacity to bring about improvements to team work. Discursive constructions are one way of constituting the nature of problems and solutions. When these constructions become successful in driving particular courses of action for improving team work, alternatives with the potential to do more to achieve the ends of quality healthcare and an equitable workplace are not given attention. This can be seen currently within the NHS, whereby technical-instrumental approaches to team work have become prioritized, reified in strategies focusing on improving the skills and attitudes of individuals (Bleakley et al., 2006; Edmondson, 2003; Helmreich & Davies, 1996). While this can bring about improvements in outcomes, these benefits could arguably be greater through examination of more fundamental ways of organizing and social structural relationships to bring about greater integration, making the shift

from multiprofessional to interprofessional working (Bleakley et al., 2006). Given that the primary objective underpinning any efforts to enhance team work is to improve the quality of outcomes, it is patients who have the most to lose and gain.

Acknowledgements

Many thanks to Professor Graeme Currie for his helpful feedback and support, and to the three anonymous reviewers and editor for their constructive comments. The ESRC UK doctoral funding for the research is gratefully acknowledged.

Notes

1 'Team work' and 'teamwork' are utilized throughout the article to denote reference to practice and discourse respectively. Note that Donnellon (1996) uses 'teamwork' to refer to rhetoric as opposed to discourse specifically.
2 Here, 'teamwork' (as opposed to 'team work') has been utilized as it appears within original quotes from sources, and therefore in these instances does not reflect reference to discourse.
3 Ditto note 2.

References

Allen, D. The continuing tension between teamwork and specialization in acute care. Discussion paper, seminar 3, Bristol Royal Infirmary Inquiry, 2000a. Available online at: [http://www.bristol-inquiry.org.uk/seminars/brisph2_seminar3points.htm].

Allen, D. Doing occupational demarcation – the boundary work of nurse managers in a district general hospital. *Journal of Contemporary Ethnography*, 2000b, *29*(3), 326–56.

Allen, D. Narrating nurse jurisdiction: 'Atrocity stories' and 'boundary work'. *Symbolic Interaction*, 2001, *24*(1), 75–103.

Allen, D. & Pilnick, A. Making connections: Healthcare as a case study in the social organization of work. *Sociology of Health and Illness*, 2005, *27*(6), 683–700.

Alvesson, M. & Karreman, D. Varieties of discourse: On the study of organizations through discourse analysis. *Human Relations*, 2000, *53*, 1124–49.

Anspach, R.R. Prognostic conflict in life and death decisions: The organization as an ecology of knowledge. *Journal of Health and Social Behaviour*, 1987, *28*, 379–98.

Atkinson, P. & Hammersley, M. Ethnography and participant observation. In N. Denzin & Y. Lincoln (Eds), *Strategies of qualitative inquiry.* London: Sage, 1998, pp. 110–36.

Austin, J.L. *How to do things with words*. Oxford: Clarendon Press, 1962.

Barker, J.R. Tightening the iron cage: Concertive control in self-managing teams. *Administrative Science Quarterly*, 1993, *38*, 408–37.

Barker, J.R. The discipline of teamwork: Participation and concertive control. Thousand Oaks, CA: Sage, 1999.

Bate, P. Changing the culture of a hospital: From hierarchy to networked community. *Public Administration*, 2000, *78*(3), 485–512.

Benders, J. & van Hootegem, G. How the Japanese got teams. In S. Procter & F. Mueller (Eds), *Teamworking*. London: Macmillan, 2000, pp. 43–59.
Berger, P.L. & Luckman, T. *The social construction of reality*. London: Penguin, 1967.
Blane, D. Health professions. In G. Scambler (Ed.), *Sociology as applied to medicine*. London: Balliere-Tindall, 1991, pp. 221–35.
Blau, P. *The dynamics of bureaucracy*. Chicago, IL: University of Chicago Press, 1972.
Bleakley, A., Boyden, J., Hobbs, A., Walsh, L. & Allard, J. Improving teamwork climate in operating theatres: The shift from multiprofessionalism to interprofessionalism. *Journal of Interprofessional Care*, 2006, *20*(5), 461–70.
Bolton, S. A simple matter of control? NHS hospital nurses and new management. *Journal of Management Studies*, 2004, *41*(2), 317–33.
Brown, A.D. Narcissism, identity and legitimacy. *The Academy of Management Review*, 1997, *22*(3), 643–86.
Chambliss, D. *Beyond caring: Hospitals, nurses and the social organization of ethics*. Chicago, IL: University of Chicago Press, 1996.
Cott, C. Structure and meaning in multi-disciplinary teamwork. *Sociology of Health and Illness*, 1998, *20*(6), 848–73.
Coupland, C. Corporate social responsibility as argument on the web. *Journal of Business Ethics*, 2005, *62*, 355–66.
Coupland, C., Blyton, P. & Bacon, N. A longitudinal study of the influence of shop floor work teams on expressions of 'us' and 'them'. *Human Relations*, 2005, *58*(8), 1055–79.
Davies, C. Some of our concepts are missing: Reflections on the absence of a sociology of organizations in Sociology of Health and Illness. *Sociology of Health and Illness*, 2003, *25*, 172–90.
Deetz, S. *Democracy in an age of corporate colonization*. Albany: State of New York Press, 1992.
Department of Health. *The New NHS: Modern, dependable*. London: HMSO, 1997.
Department of Health. *The NHS plan*. London: HMSO, 2000.
Department of Health. *Shifting the balance of power: The next steps*. London: HMSO, 2002.
Dingwall, R. 'Atrocity stories' and professional relations. *Sociology of Work and Occupations*, 1977, *4*, 371–96.
Dingwall, R. Problems of teamwork in primary care. In A. Lonsdale, A. Webb & T. Briggs (Eds), *Teamwork in the personal social services and health care*. London: Croom Helm, 1980, pp. 111–37.
Dingwall, R. & MacIntosh, J. (Eds.). *Readings in the sociology of nursing*. Edinburgh: Churchill Livingstone, 1978.
Donnellon, A. *Team talk: The power of language in team dynamics*. Boston, MA: HBS Press, 1996.
Donnellon, A., Gray, B. & Bougon, M.B. Communication, meaning and organized action. *Administrative Science Quarterly*, 1986, *3*(1), 43–55.
Edmondson, A. Speaking up in the operating room: How team leaders promote learning in inter-disciplinary action teams. *Journal of Management Studies*, 2003, *40*(6), 1419–52.
Eisenberg, E. Ambiguity as strategy in organizational communication. *Communication Monographs*, 1984, *51*, 227–42.
Eisenhardt, K.M. Building theories from case study research. *Academy of Management Review*, 1989, *14*, 532–50.
Ezzamel, M. & Wilmott, H. Accounting for teamwork: A critical study of group-based systems of organizational control. *Administrative Science Quarterly*, 1998, *43*(2), 358–97.
Fairclough, N. Discourse analysis in organization studies: The case for critical realism. *Organization Studies*, 2005, *26*(6), 915–39.

Findlay, P., McKinlay, A., Marks, A. & Thompson, P. 'Flexible when it suits them': The use and abuse of teamwork skills. In S. Procter & F. Mueller (Eds), *Teamworking*. Basingstoke: Macmillan Press, 2000, pp. 222–43.
Finn, R. & Waring, J.J. Organizational barriers to architectural knowledge and teamwork in operating theatres. *Public Money and Management*, 2006, *26*(2), 117–24.
Foushee, H. & Helmreich, R. Group interaction and flight crew performance. In E. Weiner & J. Nagel (Eds), *Human factors in aviation*. San Diego, CA: Academic Press, 1988, pp. 189–227.
Fox, N. *The social meaning of surgery*. Buckingham: Open University Press, 1992.
General Medical Council. *Management for doctors*. London: GMC, 2006a.
General Medical Council. *Good medical practice*. London: GMC, 2006b.
Gieryn, T.F. Boundary-work and the demarcation of science from non-science: Strains and interests in professional ideologies of scientists. *American Sociological Review*, 1983, *48*, 781–95.
Glaser, B.G. & Strauss, A.L. *The discovery of grounded theory*. Chicago, IL: Aldine, 1967.
Griffiths, L. Accomplishing team: Teamwork and categorization in two community mental health teams. *The Sociological Review*, 1997, *45*, 59–78.
Hardy, C., Palmer, I. & Phillips, N. Discourse as a strategic resource. *Human Relations*, 2000, *53*(9), 1227–48.
Harvey, J. Upskilling and the intensification of work: The extended role in intensive care, nursing and midwifery. *The Sociological Review*, 1995, *43*(4), 765–81.
Helmreich, R.L. & Davies, J.M. Human factors in the operating room: Interpersonal determinants of safety, efficiency and morale. In A.R. Aitkenhead (Ed.), *Quality assurance and risk management in anaesthesia. Clinical anaesthesiology: International practice and research* 10 (2). London: Ballieres, 1996, pp. 277–98.
Kennedy, I. *Final report*: *Learning from Bristol: The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary*. CM 5207. London: Stationery Office, 2001.
Knights, D. & McCabe, D. Bewitched, bothered and bewildered: The meaning and experience of teamworking for employees in an automobile company. *Human Relations*, 2000, *53*(11), 1481–516.
Leape, L.L. A systems analysis approach to medical error. *Journal of Evaluation in Clinical Practice*, 1997, *3*(3), 213–22.
Learmonth, M. Doing things with words: The case of 'management' and 'administration'. *Public Administration*, 2005, *83*(3), 617–37.
Mayor, S. Poor teamwork is killing patients. *British Medical Journal*, 2002, *325*, 1129.
McCabe, D. The team dream: The meaning and experience of teamworking for employees in an automobile manufacturing company. In S. Procter & F. Mueller (Eds), *Teamworking*. London: Macmillan, 2000, pp. 203–21.
Mischler, E.G. *Research interviewing: Context and narrative*. Cambridge, MA: Harvard University Press, 1996.
Mueller, F. Teams between hierarchy and commitment: Change strategies and the 'internal environment'. *Journal of Management Studies*, 1994, *31*(3), 383–404.
Nancarrow, S.A. & Borthwick, A.M. Dynamic professional boundaries in the healthcare workforce. *Sociology of Health and Illness*, 2005, *27*(7), 817–919.
National Patient Safety Agency. *Seven steps to patient safety: A guide to NHS staff*. London: NPSA, 2003.
NHS Careers. Available online at: [www.nhscareers.nhs.uk], accessed November 2006.
Ohno, T. *Toyota production system: Beyond large scale production*. Cambridge: Productivity Press, 1988.
Opie, A. Thinking teams, thinking clients: Issues of discourse and representation in the work of health care teams. *Sociology of Health and Illness*, 1997, *19*(1), 259–80.

Oswick, C., Keenoy, T. & Grant, D. Managerial discourses: Words speak louder than actions? *Journal of Applied Management Studies*, 1997, *6*(1), 5–12.
Potter, J. & Wetherall, M. *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage, 1987.
Procter, S. & Mueller, F. (Eds). *Teamworking*. London: Macmillan, 2000.
Sewell, G. The discipline of teams: The control of team based industrial work through electronic and peer surveillance. *Administrative Science Quarterly*, 1999, *43*, 397–428.
Silverman, D. *Interpreting qualitative data: Methods for analysing talk, text and interaction*. London: Sage, 1993.
Sinclair, A. The tyranny of the team ideology. *Organization Studies*, 1992, *13*(4), 611–26.
Stein, L. The doctor-nurse game. *Archives of General Psychiatry*, 1967, *16*, 699–703.
Stohl, C. & Cheney, G. Participatory processes/paradoxical processes: Communication and the dilemmas of organizational democracy. *Management Communication Quarterly*, 2001, *14*(3), 349–407.
Svensson, R. The interplay between doctors and nurses – a negotiated order perspective. *Sociology of Health and Illness*, 1996, *18*, 379–98.
Timmons, S. & Tanner, J. A disputed occupational boundary: Operating theatre nurses and Operating Department Practitioners. *Sociology of Health and Illness*, 2004, *26*(5), 645–66.
Watson, T. Professions and professionalism: Jumping off the bandwagon better to study it. *International Studies of Management and Organization*, 2002, *32*(2), 93–105.
Watson, T. Business discourse, narratives and the sociological imagination. In F. Bargiela-Chiappini (Ed.), *Handbook of business discourse*. Edinburgh: Edinburgh University Press, forthcoming 2008.
Webb, A. & Hobdell, M. Coordination and teamwork in the health and personal social services. In S. Lonsdale, S. Webb & T.L. Briggs (Eds), *Teamwork in the personal social services and health care*. London: Croom Helm, 1980, pp. 97–110.
Weick, K.E. The vulnerable system: An analysis of the Tenerife air disaster. *Journal of Management*, 1990, *16*(3), 571–93.
Wicks, D. *Nurses and doctors at work: Rethinking professional boundaries*. Philadelphia, PA: Open University Press, 1998.
Wittgenstein, L. *Philosophical investigations*. Oxford: Blackwell, 1953.
Yin, R. *Case study research: Design and methods*. Beverly Hills, CA: Sage, 1994.

Rachael Finn, PhD, is Research Fellow at the Institute for Science and Society, University of Nottingham. Her current interests focus upon the issue of inter-professional working, including teamwork, culture, knowledge, power and safety in changing institutional environments, with particular reference to the healthcare context. Her work utilizes ethnographic and discourse analytic methodologies.
[E-mail: rachael.finn@nottingham.ac.uk]