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Towards an Understanding of the Dynamic Socio-material Embodiment of Inter-professional Collaboration

Abstract

Many notions of inter-professional collaboration appear to aim for the ideal of trouble free co-operative communication between healthcare professionals. This paper challenges such an ideal as too far removed from the complex and contested relations of power that characterise the albeit skilful everyday social interactions which take place within healthcare practice, along with the associated pragmatic compromises made by disempowered practitioners. It is noted that these may be facilitated by modes of comforting myth and denial. To underline this point, psychiatric illness diagnosis is used as an illustrative example of how a historically powerful societal discourse can become thoroughly entrenched. The influence of a paradigmatically dominant discourse is shown to extend beyond the repetition of narrative within open dialogue and debate, to continue as tacitly reflected patterns within unconsciously habituated behaviour and durable artefacts that crystallise future affordances and limitations on action. However, the authors conclude by introducing optimistic theoretical speculation around the dynamic social mechanics of reflexive awareness and creativity, as these emerge within moments of significant dissonance between dialectically interacting layers of individually internalised and contextually embedded discourse, conversation and direct experience.

Keywords

Inter-professional collaboration, organisational change, social cognition, mental health, boundaries, new materialisms, power, social construction, reflexivity, habitus, discourse, human relations

Introduction

This paper begins by sketching out some of the underlying collaborative ideals found to frequent theoretical framing of inter-professional/inter-disciplinary collaboration. These are then challenged, by drawing upon empirical evidence, which indicates that the collaborative situation often implied is quite detached from the unavoidably controversial and frequently compromising intersubjective context of everyday social practice. It is suggested that the totality of such aspirations constitute an overly idealistic and so unrealistic view of collaboration. We would like to highlight that in our consideration of the empirical evidence we do not set out to offer the reader a treatise on inter-professional collaboration comprising a comparative account of evidence, which does or does not attest to its success. Indeed we are aware that there is a substantive evidence base in the field which testifies to the effectiveness of inter-professional collaboration in delivering healthcare (Lethard 2003; Reeves et al. 2008; Rossen, Bartlett and Herrick 2008). However, in addition to drawing upon competing or alternative empirical evidence, which we do in this paper, we recognise the benefits of critically engaging with evidence so as to offer a deconstructive reading of the popularly held discourses that support it. This approach has been comprehensively outlined and explicated in (Freshwater, Cahill and Essen 2013) and it is an approach that to a large extent underpins our analysis here.

An illustrative description of the multifactorial context and controversies surrounding psychiatry and its role in making 'mental illness' diagnoses is provided in support of our position. The contested nature of psychiatric diagnoses, the hegemonic power of psychiatry and the dynamics involved in its perpetuation are acknowledged and discussed. The subjugated role of nurses is then located within this paradigmatic regime, through recourse to how psychiatry is delivered and responded to, with the implications for inter-professional collaboration discussed accordingly. This then leads into an observation that professional

identity and its associated disciplinary territory is socially constructed during everyday social interactions, but with important acknowledgment that previous linguistic focussed understandings around what constitutes social construction have sometimes been lacking in their regard for the material basis of social power. A more recent materialist ontology that incorporates constructionism is consequently described.

We then move on to address deeper theoretical concerns, by attending to indications as to the general manner in which a materially variegated body of dominant discourse appears to be produced and reproduced, through its persistence as patterned social artefacts and routine behaviours. We conclude by giving speculative consideration to the kind of intersubjective socio-material conditions under which reflexivity emerges and in which practice can be creatively reconfigured. In our concluding remarks consideration is given to the process through which our conclusions have been drawn. As we advocate for the importance of critically engaging with and deconstructing evidence, we of course apply the same approach to our own thinking and evidence, acknowledging the degree of 'selection' in our sources and the degree of 'selection' in our analysis of them.

Inter-professional collaboration

D'Amour and colleagues (2005) carried out an extensive review of the various models, concepts and theories pertaining to 'interprofessional collaboration' that they found discussed within academic literature. A detailed over-arching description of successful collaboration can be usefully extrapolated from their thematic analysis as follows:

> A complex, dynamic and evolving process of skilful communicative interaction through which participants voluntarily breach their usual professional boundaries in order to accommodate multiple levels of collegiate sharing (of values, information, responsibility and action), to such a degree of interdependency as to render team members equitable in influencing team business and for mutual respect towards individual specialist knowledge, expertise and experience to exist.

The World Health Organisation authorises a simpler common-usage definition of inter-professional 'collaborative practice' as referring to situations in which 'multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care' (WHO 2010, 7). Yet the term 'interdisciplinary collaboration' is often similarly used to describe 'an interpersonal process characterized by healthcare professionals from multiple disciplines with shared objectives, decision-making, responsibility, and power working together to solve patient care problems' (Petri 2010, 80). The key difference between respective inter-professional and inter-disciplinary perspectives on collaborative practice appears to lay in whether greater emphasis is placed on the general care giving efforts of a mixed group of professionals or the application of specialist disciplinary knowledge within the context of care giving. However, to further complicate matters, D'Amour and colleagues found inconsistent and poorly defined uses of the words 'multidisciplinary', 'interdisciplinary' and 'transdisciplinary' in the literature. While a strict reading of the word 'discipline' implies compliance with a set of established rules for conduct, at the deliberate exclusion of other less compatible pursuits, these linguistic variations suggest a continuum along which differing disciplinary regimes may undergo varying degrees of convergence. It is questionable whether practice disciplines can ever really converge, or be transcended, except in the sense that professionals may admit to valuing or accepting a body of knowledge or way of knowing, in order to meet what is a

mutually agreed desirable outcome. Rather, a profession is perhaps most clearly defined by the boundary it manages in territorialising the operational skills, attributes and specialist knowledge that are constitutive of its own practice discipline (Hall 2011), alongside parallel social expectations which dictate that legitimate professionals ought to work together cooperatively as a virtuous characteristic of their status as professionals. While researching the antecedents for a reputedly successful collaboration within a healthcare team in the North of England, for example, Molyneaux (2001) asked team members which factors they felt contributed to them working so well together. Her participants readily pointed to various personal qualities such as the ability of team members to be supportive, co-operative and unselfishly egalitarian, while also emphasising the importance of good communication. It seems significant, though, that the consensual working model for which this team were being lauded had by their admission evolved out of the 'creativity' afforded to them by a lack of formal leadership status and similar occupational grading. Even this exceptional situation of formal status equality presents some unanswered questions to us about the precise nature of the social interactions that took place while the group was in the process of developing its working consensus. Freshwater et al. (2013) offer that many of the most useful insights from collaborative experience only become present-at-hand when reflecting upon everyday acts of intersubjective coping within situations of potential or actual collaborative failure. They suggest that managerial appeals for collaboration based on the assumed availability of collaborative social virtues may in fact ignore many instances in which professional power differences result in unacknowledged 'role violations'. In very simple terms, these occur when those with the least power to influence in any given practice situation (including patients) bend the emphasis and priorities of their official role to meet the paradigmatic agenda of those with the most power (Oborn and Dawson 2010). While such role violations are often passed off as necessary compromises, they may contribute to a form of superficially

harmonious collaborative failure that Freshwater and colleagues (2013) call ‘dysfunctional consonance’: ‘when patients and professionals alike are failed by the very systems they collaborate to uphold.’ Indeed, D’Amour and colleagues concluded their review by correspondingly recognising a need for deeper levels of social analysis when considering collaborative practice:

> The dynamic established between professionals is as important as the context of collaboration. Collaboration needs to be understood not only as a professional endeavour, but also as a human process (2005, 128).

We can begin to meet this challenge by firstly acknowledging that professionals already routinely experience relational proximity and interdependence, prior to any explicit notions of collaborative practice ever being imposed, through everyday social interactions as diverse as negotiating who washes cups in the staff kitchen through to intimate social relationships outside of official working hours. While conventionally informal, these interactions all provide potential opportunities for reinforcing professional boundaries and power relations. We might add that professional identity is itself often closely aligned with an individual’s overall sense of self, to the point of their professional role being felt as ‘who they are’ to a certain extent. Any threat to a professional boundary is likely to be experienced as personally threatening by those who have most invested in it. An overly technocratic and unaffected approach to managing mixed professional situations arguably risks disregarding various potential manifestations of individual and collective coping that fall outside the rational concerns of policy implementation. Cameron (2011) goes so far as to suggest that it would be naïve of healthcare managers to believe that professionals have the ability, willingness and capacity to move easily beyond their respective professional boundaries without facing

significant challenges. Her own research findings indicated that professionals working within the UK National Health Service regularly engaged in 'boundary disputes' when increased collaborative demands appeared alongside a policy agenda that was perceived to undermine their established professional boundaries. She proposes that the very existence of 'fragmented fields of knowledge' (2011, 57) presents a fundamental source of resistance to service reforms; concluding that the 'reforms aspired to in policy need to be underpinned by structural change and informed by an appreciation of subjective accounts of boundaries if they are to succeed' (2011, 58). The obvious implication to be drawn from Cameron's observations is that territorial resistance might explain many instances of everyday collaborative failure. While predicated on porous professional boundaries, collaboration (whether inter-professional or interdisciplinary) occurs against a backdrop of enduring protectionism.

Finn and colleagues (2010) drew further attention to the interface between these competing priorities by demonstrating that collaborative discourse is prone to appropriation as a convenient 'linguistic resource' within existing professional power struggles. The dominant professions in their study displayed a tendency for regarding 'teamwork' as an activity that contributed to lower status colleagues knowing better what was expected of them. While other professionals of intermediate status, in this case nurses, considered it a means by which they could better influence day-to-day practice decisions. The authors consequently suggest that the reified discourse of teamwork 'reproduces and maintains various forms of occupational inequality, as well as obscuring the need for more fundamental change in the work and social context, both from the perspective of those who wish to reform healthcare and those who would wish to see a more equitable workplace' (Finn et al 2010, 1149). A more explicit account of these observations might be to say that the strategic disciplinary

wielding of collaborative discourse by some doctors assists them in maintaining their dominance of some nurses, through the compromises it is often able to elicit. The paradigmatic hegemony of psychiatry is an illustratively useful if extreme example of where nurses are expected to collaborate as supposed equals within a fundamentally unequal professional context.

Psychiatric hegemony as a contested collaborative context

There is a wealth of historical evidence to show that the field of mental health has been constantly beset with 'contested jurisdictions' (Scull 2011) and 'contested professional rationales' (Pilgrim and Carey 2010). Central to these appears perennial controversy surrounding how society, and in particular psychiatry, goes about labelling certain aspects of human distress, experience or behaviour as representative of a 'mental illness' – an even wider 'field of psychiatric contention' (Crossley 2006a, 552). A noted opponent of psychiatric labelling was himself a psychiatrist, Thomas Szasz, who in the late 1960s articulated his belief that psychiatry's practices deviate from the norms found in conventional medicine because its diagnostic categories are socially evaluative ones. Like others before him Glackin (2011) has attempted to challenge Szasz's account, in his case by demonstrating that the whole of diagnostic medicine is socially evaluative. In doing so he makes some valid and significant points about the ways in which all disability is socially defined relative to both the abilities and skills that society decides are important and the prevailing statistical norms for their performance; his core proposition being that:

> All judgements of medical or psychiatric 'dysfunction' reflect our collective willingness or reluctance to tolerate and / or accommodate the medical or psychiatric conditions in question (Glackin 2011, 455).

One of the chief controversies surrounding psychiatry has been its inability to formulate a testable biological account or consistent set of behavioural symptoms for many claimed psychiatric conditions (Anckarsäter 2010, Bracken et al 2012). Nevertheless, Glackin's analysis helps us to confirm that even if a clearly reductive biological basis for mental illness diagnosis is lacking the views of psychiatrists and others in society may cohere around a common-sense understanding of which witnessed behaviours and reported perceptions constitute psychological 'dysfunction', meaning that a mental illness diagnosis is essentially always linked to normative judgement. Strand (2011), in turn, provides a useful socio-historical account for how the third edition of US psychiatry's Diagnostic and Statistical Manual (DSM-III) became the world's primary guiding text for psychiatric classification. He reminds us that it was psychoanalysis which provided the initial aetiological credentials that would enable psychiatry to garner its acceptance as a legitimate modern medical profession. DSM-III only assisted psychiatry with gaining enough of a foothold to eventually usurp psychoanalysis from its dominant position because of the parallel convergence of various social factors in its favour, rather than through any particularly convincing scientific validation for its inherent biological reductionism. Continued belief in the social desirability of artefacts such the DSM-III (and subsequently DSM-IV) among powerful economic stakeholders such as health insurance and pharmaceutical industries has contributed to psychiatrists maintaining their now long-standing privileged position of being able to make life-changing judgments about a person, based on their biomedical codification of what have often been no more than societal mores (Glackin 2011).

Subjugation of nurses within the psychiatric regime

We can start to locate the paradigmatically subjugated position of nurses, relative to this socially sanctioned psychiatric dominance, by examining the ways in which patients are routinely diagnosed and treated. For instance, Dillon (2011) has written about what it was like to first reveal her own disturbing childhood experiences of sexual abuse to an inpatient psychiatrist, only to be told without further investigation that her recollections were a delusional aspect of her supposed illness. Her encounter is a good example of where the hegemony of biomedical psychiatry, enshrined within the DSM, can lead to a situation in which the quite individual experiences (and needs) of a patient are frequently ignored. What most psychiatrists would still describe as the symptoms of 'schizophrenia', such as hearing voices, Dillon has gone on to identify as belonging to a set of both unconscious and conscious 'survival techniques' originating in the trauma of her abuse (Dillon 2011, 142). Research evidence has begun to suggest that a proportion of hallucinations may indeed be dissociative manifestations of past trauma (Longden et al 2012, Varese et al 2012). However, traditional psychiatry has seldom been interested in the actual content of hallucinations and instead treats their presence as a wholly undesirable event requiring quasi-compulsory or coercive pharmacological suppression. This approach persists in most mental health systems around the world, despite valid scepticism around whether the effects produced by many psychiatric medications are of a desirable enough strength beyond placebo effect to make their expensive and often physically deleterious use actually worthwhile (Kirsch 2011, Goldacre 2012, Hutton et al 2012).

Significantly, for the day-to-day collaborative experiences of nurses, Dillon's quickly learnt strategy as an inpatient was to co-operate with the dominant priorities of psychiatry and lie about the content of her thoughts, so as to expedite her release from hospital. In doing so she was effectively colluding with those nurses charged with both observing her behaviour and administering her treatment on behalf of psychiatrists, by helping them to believe that this activity had been in some way successful. By doing so she unwittingly contributed to a practice milieu that is arguably characterised by high degrees of dysfunctional consonance (Freshwater et al 2013). It has been convincingly suggested, for example, that continued belief in the appropriateness and effectiveness of psychiatric treatment by mainstream nurses provides a convenient 'mediatory myth' (Scheid-Cook 1988) that enables ideological inconsistencies between the espoused humanistic values of nursing and the coercive elements of psychiatric treatment to be ignored (Moncrief 2010). While it would be unfair to suggest that nurses and others (including some critical psychiatrists) have not contributed to humanistic adjustments in mental health practice, these have tended to occur within an only partially diversified mainstream system in which psychiatrists have continued to retain their professional dominance. The most recent humanistic reforms within the UK mental health system, for example, have centred on integrating services geared towards helping patients to establish, reclaim, or otherwise 'recover' a personally meaningful life with other people in society. But as Stickley and Wright (2011a, 2011b) note in their two-part review of all UK academic and grey recovery literature from between 2006 and 2009, traditional psychiatry's continued hegemony means that:

> There remain tensions between the coercive nature of mental health law and the humanistic philosophy enshrined within the recovery paradigm. This is further complicated by the clash between the biomedical philosophy that has historically

> dominated psychiatry and the emerging philosophy of the recovery paradigm (2011a, 254)

Meanwhile, the pharmaceutical industry now spends twice as much on marketing its products as it does on research to prove their efficacy (Goldacre 2012) and a further strong wave of medicalization has been evident throughout the on-going development of DSM-V (Vanheule 2012).

What these observations help us to appreciate, in returning to the primary focus of this paper, is that a contestable but only very occasionally redistributed set of enduring power relations can develop between professionals and their patients and among different types of professional. The associated tensions (and modes of denial) are bound to be lived out during the emotionally complex and situated day-to-day social interactions of those most affected. Professional discourse actually represents the accumulated historical legacy of many such social interactions, including those that maintain traditional social class and gender based divisions of labour and power (Hall 2011). Over the course of modern history various expressions of distinct professional identity (and associated practice territory) have emerged, been instituted, sustained, criticised, fought over, further developed and occasionally dispensed. We might usefully describe this over-arching process as the social construction of bounded professional identities in dialectic perpetuity, but in doing so recognise that identification with the genre of social constructionism requires further qualification.

Social constructionism and the material reality of everyday life

When social constructionism came into vogue, during the 1990s, it was usefully described in an introductory text as encapsulating a set of ‘family resemblances’ found to occur across the work of various authors, rather than as constituting a theory in itself (Burr 1995). Social scientists had become increasingly interested in identifying the historically and culturally specific social processes that generate taken for granted knowledge and its correlate social actions – the so called ‘social construction of reality’ (Berger and Luckmann 1966). However, a predilection among this wave of theorists for over-emphasising the study of language appeared to lead to them disregarding the otherwise embodied and materially stratified nature of personal and social power (Cromby and Nightingale 1997). Danziger (1997) responded by distinguishing between two key variants in the way that different theorists attended to power in society:

> In the lighter versions, there is little or no reference to the problems of power, and if they are alluded to, they are treated as effects of discourse. Problems of power, if recognised at all, are embedded in essentially discursive relationships, whereas in ‘dark’ constructionism discourse is embedded in relations of power (Danziger 1997, 410)

Burkitt (1999) built upon Danziger’s characterisation by adding his own emphasis concerning the perpetuation of discourse, while attempting to resolve these light and dark perspectives. In doing so he acknowledged that although social practices such as dialogue are able to change society the tone and strength of such changes are subject to diverse structural power relations that permeate embodied, prosthetic and otherwise materially stratified social reality. His curtailment of language thereby placed it alongside other human artefacts:

> … I do not think that symbols alone can characterise what is unique about the patterns of human relations, actions and knowledge: instead, it is the creation and development of artefacts that mark out what is distinctive about human life, and such artefacts include language, tools and other instruments and inventions (Burkitt 1999, 79).

More recently, the contextually disembodied and epistemologically relative treatment of discourse has been held off through a particular casting of Critical Discourse Analysis (CDA) outlined by Fairclough, in his approach to organisational studies (2001, 2005). His commitment to a philosophical position of critical realism is combined with deconstructive techniques from discourse analysis, so that his CDA is prefaced by:

> …a dialectical-relational social ontology which sees objects, entities, persons, discourses, organisations and so on as socially produced 'permanences' which arise out of processes and relations…and which constitute a pre-structured reality with which we are confronted, and sets of affordances and limitations on processes (2005, 923).

This distinctly socio-material outlook (see also Fairclough et al 2004) shares many family resemblances with another set of emerging post-Cartesian approaches to social sciences investigation which have come to be labelled 'new materialisms' (Coole and Frost 2010). This term unifies the work of an otherwise unconnected group of academics working across diverse fields of study who have mutually recognised 'the way concepts and experience,

meaning and matter, emerge historically and reciprocally as embodied actors immerse themselves in and engage with/within material and social environments'; and as such 'reopens the real to social scientific inquiry, but without renouncing the critical reflexivity that constructivism insists upon' (Coole 2013, 455).

The remainder of this paper is premised on the above materialist oeuvre. As such it consists of some fairly speculative exploratory analysis which will attempt to eschew the light headedness involved in over-emphasising linguistic communication and ignoring the heavy material body through which it is enacted. Enduring power is thus treated as being entrenched within the gradient layers of material investment in its dominant discourses, such that thoroughgoing forms of discourse are not only found to be recurrent within the repeated narratives of speech and song, making them tangibly accessible to dialogue, but continue as correspondingly reflected patterns in habituated human behaviour and resistive artefacts that readily afford certain future actions and limit others. The words running through a stick of seaside rock provide a crude literal example and barely adequate metaphor for the deep material complexity of discursive life.

Social interactions and the generation of official artefacts

Burkitt reminds us that 'the reality of everyday life – the sum total of all our relations – is built on the ground, in daily activities and transactions. This happens in our working relations but also in friendship, comradeship, love, the need to communicate and play' (2004, 212). Everyday social interactions are, of course, also often fraught with enmity, rivalry, mistrust, hidden motives and competitiveness. Burkitt goes on to further describe everyday life as

being replete with unofficial and official discourses interacting in mutually sustaining ways. At its most robust, when understood as formality, official discourse has elsewhere been found to 'index interactional closure' (Iedema 1999) through its 'crystallisation' (Burkitt 2004) into durable artefacts such as the DSM-III. Iedema, by way of a particularly concrete example, traced the stakeholder consultation processes associated with planning a hospital through from thoughts expressed as informal talk; their decontextualized reconstitution at different levels of representative writing activity; their further depersonalised assimilation into a formal and very technical planning narrative; and final culmination within the actual patterns of a built structure. In doing so he found a largely irreversible process over which only the privileged tend to have ultimate critical control and veto.

The major product of at least one such planning process, a US psychiatric emergency department, was the subject for a separate study into the material circumstances of collaborative failure during mental health practice (Cohen et al 2006). A concept from cognitive psychology – distributed cognition (Hutchins 1995) – was used as the theoretical basis for examining the complex range of information transaction processes that occur across a discrete practice environment. As such, cognitive activity was regarded as being at once rooted in individual human brains, socially extended (Gallager 2013) and embedded (Huebner 2013) in the layout of rooms, whiteboards and patient notes etc. The researchers were thus able to identify numerous ways in which everyday use of seemingly mundane objects produced 'latent flaws' in the flow of professional encounters and so contributed to instances of collaborative failure. Such findings provide a useful pointer to the extant interplay between practicing agents, information and available material structures of practice, in that these all provide cognitive 'scaffolding' (Krueger 2011) for collaborative practice to either succeed or fail. We might add that this interplay is very often characterised by routine

behaviours that unfold in a largely unconscious concert with the official artefacts that prior powered negotiations have produced both to encourage and to accommodate them.

Habituated professional behaviour and freedom

While unofficial discourse is able to crystallise into the seemingly static and relatively permanent embodiment of an official discourse, moulded by the influence of social power, there is another more malleable semi-permanent entrenchment which seems to occur as a consequence of official influencing. This is when the habituated human embodiment of official discourse imbues it with the dynamism necessary to perpetuate its reproduction as a practice culture, constituted through ubiquitously repeated practical responses across actors. Bourdieu has used the word 'habitus' for elaborately referring to:

> …systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principals which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them (1990, 53).

Habitus appears next to what he has called 'doxa', a 'near-synonym' for social discourse (Amossy 2002, 376) that denotes the largely unarticulated and taken-for-granted ontological positioning with which a particular 'field' of social activity is pervaded. Social discourse is thus expressed and perpetuated uncritically via the shared routine behaviour (the habitus) of actors in that field and can be thought of as knowledge which is at once below the surface and

yet continues to support that surface. For example, even before members of a profession go about carefully arranging the education and socialisation of prospective new members into their habitus they usually follow a selection process that appeals to a predefined set of bedrock values and attitudes (O'Conner 2007). This assists them in perpetuating a dominant 'cognitive map' (Hall 2007), enforcing 'symbolic boundaries' (Cameron 2011) and otherwise grounding loyalty in a discrete sense of purpose and morality (O'Conner 2007).

However, habitus is not exclusive to the bounded fields of professional practice. It emerges from concentrated and persistent activity across the heterogeneous fields in which social discourses become forged, deformed and potentially reformed in plural dialectic relation with other similarly embedded patterns of persistence, each demonstrating greater or lesser powers of resilience according to the mass of their embodiment. For example, Crossley and Crossley detect a reformist mental health patient 'voice' which is itself a distinct 'social movement' and so 'structured by historically specific habits or habitus' that are 'sediments of prior struggles from which they have emerged' (2001, 1489). What might be regarded as the individually personalised embodied landscape of interacting discourses generates individual behaviours that are both contextually tied and in some instances inconsistent across situations. Habitual immersion in dominant social discourses also makes humans prone to being bound in outmoded 'internalised structures' that allow us to 'think we are free without being conscious of our own determinations' (Hilgers 2009, 745). Bourdieu (1990) himself suggests that consciousness of personal habitus can only really be experienced as a feel for whatever task is at hand. However, Crossley (2006b) significantly expands the reach of consciousness through examining examples of where personal reflexivity appears to emerge as a natural component of the dissonance generated during dialectic interplay between competing internalised discourses, conversation and practical experience (i.e. living life). As

such he is able to salvage conscious and adaptive human agency from an area of social theorising that can otherwise seem superficially deterministic. In doing so he reanimates the possibility of social change occurring as a deliberatively creative act, through what Hilgers separately referred to as a second less illusory mode of freedom, which is the 'fruit of analytical thought about ourselves through the exposition of structures that a reflexive distance makes possible' (2009, 745). This mode of freedom is readily recognisable as integral to experiences of contingent self-determination:

> Jazz is an activity marked by paradox: musicians must balance structure and freedom, autonomy and interdependence, surrender and control. They grapple with the constrictions of previous patterns and structures: they strive to listen and respond to what is happening; at the same time they try to break out from these patterns to do something new with all the risks that both paths entail (Barrett 1998, 619).

Intersubjective dissonance and creative innovation

In further considering the everyday social conditions likely to support creative innovation we can turn again to Burkitt (2004). He makes a useful distinction between 'game' and 'play' like activity, associating these with official and unofficial forms of discourse respectively. On his account, a game has strategic direction and necessitates people having to habituate specific skills in order that they may effectively and invariantly move through a game according to its established rules. Whereas play is depicted as being more directionally open, experimental and creative, requiring intrinsic 'human capacities', such as 'empathy,

understanding, and fellow feeling' (Burkitt 2004, 217). While these human capacities may in themselves be rooted in the prior embodiment of superordinate rules for sociality, this does not detract from the underlying relevance of Burkitt's interpretation. However, where he reemphasises that mutually supporting interactional relationships exist between official and unofficial discourses, adding that game and play respectively characterise these interactions, we should perhaps be very mindful of other more destructive or combative modes of relating and apparently meta-semiotic acts of playing with the game itself (see Finn et al 2010). By applying Crossley's (2006b) learning to these phenomena we can begin to proffer that, aside from other uncontentious and playful opportunities for creativity, these discordant interactions (collaborative failure, essentially) may serve to catalyse critical reflexivity among those who are involved in them, and so become a potential precursor to problematizing an official game and subjecting it to creative innovation.

The theory of Personal Construct Psychology (PCP) helps us take this line of thinking a stage further (Kelly 1955). It holds that deep creative innovation occurs as part of a cyclical movement between loose and tight modes of construing:

> Loose constructions are those notions of the world that vary in their meanings, whereas tight constructions are those which offer definite statements of structure and in which meaning can be clearly specified (Epting et al 2003, 242).

According to PCP, paradigmatic personal creativity begins with a disruption to tight sedimentary layers of individually entrenched personal constructs, forcing a person to

experience a conscious break in their habituated assumptions and involuntarily enter a looser state of personal uncertainty (Kelly 1955). This cycle then continues with a period of experimentation, successful movement through which culminates in them settling into a new layering of revised personal constructs. We can enhance this cyclical appreciation by recalling that it is virtually impossible to definitively disentangle the so called individual from the socio-material situation of their relational being. Whereas PCP assist us in identifying that individuals may occasionally enact very tight personal construing, we can go on to infer that aspects of that construing are likely to have become habituated through their active compliance with an established set of game rules, while simultaneously reinforced through routine use of any associated social artefacts (to the point of them sometimes being dependent upon these). Conversely, where a person enacts loose personal construing in response to a situation of uncertainty, crisis, or loss, their potential experimental alliance with others who have been similarly affected may lead to successful collective challenges to the dominant status quo and a revised consensus on appropriate use of available resources.

Finally, there appears to be synergy between a key principle of PCP and Burkitt's depiction of official and unofficial discourses operating in dynamic interdependence. PCP suggests that neither completely tight or loose states are desirable as fixed states for living life, with it being more functionally befitting that a person is able to move back and forth between these states in appropriate response to their changing life circumstances. So, whereas it may be natural for a group of professionals to respond to a dysfunctional practice culture by breaking out of its tight constraints and exploring looser territory, it is only when the creative results of such an exploration undergo enough stabilisation for the sustained constitution of a revised discourse, followed by uncritical rule following, that a transmissible habitus and further material crystallisation of official practice appear.

Summation

Analysis of the academic literature that informs inter-professional collaboration in healthcare (D'amour et al 2005) suggests that a degree of unwarranted idealism underpins what are an otherwise diverse range of concepts and models. Empirical research reveals that when this idealism informs healthcare management aims, managers may make unrealistic assumptions about professional behaviour (or to be more precise the formal and informal behaviour of professionals as people). The still largely fragmented silos of professional knowledge production (Cameron 2011) are just one identified source for the reified paradigmatic tensions that are expressed within day-to-day battles over healthcare practice territory, along with abiding resistance to the shared values and porous boundaries supposedly needed for otherwise disciplined professions to collaborate. Two key sceptical concepts - role violation and dysfunctional consonance (Freshwater et al 2013) – were used in this paper to propose that there may be scenarios where inter-professional practice gives the outside impression of collaborative success while tacitly empowering one group to continue its paradigmatic dominance over others. Psychiatric diagnosis, as the basis for many tasks of observation and treatment carried out by nurses working in mental health settings, was recognised a contentious example that illustrates how a seemingly paradigmatic level of disciplinary dominance, derived from the fairly arbitrary social genealogy of professional status, can present a strong formal resistance to realising the egalitarian values of collaboration often promoted in the language of inter-professional practice.

Professional status was thus found to be socially constructed, but with a theoretical caveat that constructionist thinking is often in need of careful dissociation from former linguistic

excesses in social theorising and weighing down with the vital body of its enactment. The resulting material life cycle of embodied discourse speculatively presented in the later part of this paper was derived through recourse to both empirical findings and a liberal degree of abductive reasoning. At this juncture we would like to offer a deconstructive reading of our own method of analysis, incorporating as it does abductive reasoning. As indicated in the introduction section, we never intended to present a balanced 'for and against' account of the evidence relating to inter-professional collaboration. First, accounts of evidence attesting to the effectiveness of interprofessional collaboration have already been well rehearsed (Lethard, 2003; Reeves et al., 2008). Second, we wished to engage in a method of analysis which went beyond the synthesis of positive and negative evidence to direct a critical lens on the construction of the evidence itself, including its supporting discourses. Therefore in our consideration of empirical evidence, our focus has been on a method of deconstructive reading which is about harnessing critically reflexive responses to the evidence, rather than a concern with simply representing the amount of supporting and non-supporting literature surrounding inter-professional collaboration. So our approach is presentational and discursive rather than representative. Directing the critical lens even further inwards, to the process of deconstructive reading itself, discloses the selectivity that (necessarily) underpins every critical stance we adopt; from the selection of sources, to the selection of theoretical perspectives we draw on in formulating our responses and the discourses that we ourselves use to promulgate the practice of deconstruction.

Given that selectivity is an inescapable condition of analysis, we nevertheless, feel we have offered a potentially useful hyper-reflective backdrop for beginning to anticipate the range of dynamic human relations that are likely to occur at different stages of movement between structurally loose and tight modes of practice, unofficial and official expressions of discourse, habitus and reflexive freedom. We propose that this embryonic model could serve as a

heuristic device to assist in delineating dynamic human relations during collaborative encounters. We would recommend, therefore, that it is opened up to empirical testing, along the lines we have discussed and within a range of inter-professional contexts, to enable further refinement and deconstruction of the model. Beginning to anticipate the full range of dynamic human relations likely to occur opens up possibilities for not only how we theoretically frame inter-professional collaboration but also how we might be able to reconfigure inter-professional practice so as to creatively negotiate through conflict.

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