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Ethnography in Medical Emergencies

Research in the health care sector relies heavily on quantitative methods, mainly drawing on a positivist paradigm. When qualitative methods are employed, much of this qualitative work has focused on interviews (Reeves et al., 2013; see Roulston and Halpin, Chapter 40, this Handbook). Despite recent calls for diversifying research designs (e.g. Rapport et al., 2013), ethnographic designs (see Buscatto, Chapter 28, this Handbook) are still in the minority in qualitative health care research. This is a gap and opportunity for qualitative researchers to address. Within the existing scholarship, studies have looked into primary and secondary care but to a lesser extent in emergency contexts; when it comes to trauma, the gap is even greater. The few relevant studies have been conducted mainly in the USA and Australia and there is an almost complete void of sociolinguistic ethnographic studies in the UK, which is our own context.

We draw here on an ongoing project in a Major Trauma Centre (MTC) and discuss the strengths and affordances of interactional sociolinguistics (IS), an established approach that focuses on the analysis of situated real-life encounters. IS enables the researcher to connect situated encounters, micro-moments of interaction, to the broader organisational context. We discuss the implications for interpreting complex data and propose a spatiotemporal approach to field design and data analysis, taking into consideration the researcher's transition from an outsider to a legitimised participant. We close the chapter by making a case for participatory, collaborative designs for sociolinguistic ethnographic studies in health care in general and trauma settings in particular.

Trauma environments constitute high-pressure, time-sensitive settings and are significantly understudied. Qualitative ethnographic studies in trauma have focused on mapping the ecosystem of teams and Emergency Departments (EDs). They have shown the relevance of sociocultural and organisational factors (such as staff shortages and time pressure) that impact the work of clinical teams and the lived experience of patients. They have made a case for the potential of ethnographic studies to contribute to improving the quality of health services by identifying systemic issues that have an adverse effect on the provision of care.

As an example, Sarcevic and Burd (2008) conducted an ethnographic study in a US level 1 (highest) regional trauma centre, observing and videotaping 10 trauma resuscitations in order to identify the information distribution and needs of trauma teams. Similarly, Hightower (2010) conducted non-participant observation and in-depth interviews in a level 1 trauma centre and a much smaller satellite location and made connections between culture and the emergency physician habitus. Jacoby's (2015) ethnographic study also involved participant observation and embedded interviews to unpack the experiences of Black trauma patients in a Regional Resource Trauma Centre at the Hospital of the University of Pennsylvania. Jacoby's work is one of the most complete, capitalising on high levels of access; she was permitted to observe consented patients throughout trauma departments in the hospital including the Surgical Trauma Intensive Care Unit (SICU), the trauma surgical inpatient unit, and the outpatient trauma clinic. More recently, Purdy et al. (2020) conducted a three-month ethnographic study using narrative surveys, participant observation, and interviews in a large tertiary care hospital and MTC in Australia, aiming to define and improve relational aspects of trauma care. Turning the medical gaze on the importance of managing relationships and distinguishing between micro- and macro-coordination is well aligned with sociolinguistic ethnographic work as we will show later in the chapter (see e.g. discussion in relation to [Figure 48.1](#)). Purdy et al. (2020) called attention to the variability of the lived experience of medical professionals, also a topic where synergies between linguistic and medical research can be particularly fruitful.

None of the aforementioned studies focused on the analysis of interaction per se and they drew on mainstream methods for data collection and analysis. Nevertheless, they have shown that communication within the team is a core part of clinical performance and directly associated with clinical outcomes. Although this is not new for linguists, communication and teamwork are still viewed as separate from clinical

performance in many parts of health care and medical training. Despite evidence (Siassakos et al., 2010) showing that team-level clinical outcomes cannot be predicted on the skills, knowledge, and experience of individual team members and that team communication is a core part of doing clinical work, communication is not yet seen as practice. In previous work, we have shown the convergence between clinical analysis of medical performance and linguistic analysis of the management of interaction (Mesinioti et al., 2020). Linguistic work in emergency care has also shown that ineffective communication is a recognised contributor to patient harm in hospitals (Eggins and Slade, 2015) and has put forwards the need for the analysis of actual interaction. The few existing studies have identified that when information breakdown occurs, this may increase risk as, for example, in the case of handover or in information distribution across teams and departments in busy hospitals.

Further, Slade et al. (2015) carried out one of the most complete linguistic studies on communication between patients and clinicians in five EDs, illustrating the communicative complexity and intensity of work in the ED and identifying the features of successful and unsuccessful patient–clinician interactions. Their extensive data collection, based on a multimethod ethnographic design, includes observation of ED practices but also an audio recording of 82 patient trajectories through the ED from triage to disposition, review of patients' medical records, follow-up interviews with patients and staff, and interviews and focus groups with 150 ED staff members. Although not specifically focusing on trauma, their study provides a rich insight into the ways in which 'potential risk points' (2015: 81) can be identified through a detailed linguistic analysis of real-life data and ethnographic analysis of contextual factors affecting practice in EDs. Connecting linguistic analysis to the identification of high-risk moments, a concept that has visibility in medical research (Cosby and Croskerry, 2004), provides an angle that is suitable for sociolinguistic ethnography and can make a solid contribution to medical research more broadly.

The focus on studying real-life encounters is fundamental for sociolinguistic ethnographic work. Surveys have shown over the years what people think they do, and interviews identify what they say they do. The analysis of interaction provides us with a window into what they actually do in daily practice at work. As put by Drew and Heritage (1992: 3–4), interaction is institutional 'insofar as participants' institutional or professional identities are somehow relevant to the work activities in which they are engaged' (see also Kutter and Masson, Chapter 62, this Handbook). Evidently, the focus on micro-encounters also brings consequences for the necessary level of access and ensuing ethics and confidentiality matters. We discuss design matters further and illustrate the application through the case study we discuss here.

The rest of the chapter is organised into four parts. First, we discuss the relationship between qualitative health care designs, ethnography (see Buscatto, Chapter 28, this Handbook), and linguistics, and argue in favour of IS as a suitable theoretical framework for designing and conducting ethnography in emergency settings. We pay attention to issues around sampling and data collection. We then turn to the description of our context and illustrate the ways in which the designated team leaders claim control of the situation (or not) in the pre-briefing stage, focusing on role introduction and task allocation processes. We close the chapter by making a case for a spatiotemporal approach for capturing the researcher's position in the field and we close the chapter by making a case for a collaborative approach to sociolinguistic ethnographic designs.

Medical Ethnography and IS

Medical ethnography is a broad and diverse church. It is often narrowly seen as a qualitative research method; as in other branches of ethnography, the current thinking advocates a holistic approach (Angouri, 2018a) and sees ethnography as epistemology and methodology. This is well discussed in other chapters of the Handbook (see Buscatto, Chapter 28, and Hammersley, Chapter 4, this Handbook). Our interest here is on an approach that is relevant to qualitative health care researchers, namely IS, and the focus on the analysis of the interaction that adds to traditional approaches to ethnography. We discuss medical ethnography in particular and how researchers can go about designing medical emergency studies.

Ethnography in medical settings, and beyond for that matter, is typically carried out through a combination of observations and interviews and the researcher's field notes. In Angouri (2018a), we discussed the variety of methods used by the researchers in sociolinguistically framed ethnographic research (on linguistic methodologies including ethnography, see also Litosseliti, 2018), and argued that ethnography does not

equate to one set of tools (Angouri, 2018a: 85). Ethnographic research can encompass a diverse set of methods, typically qualitative, ranging from interviews (see Roulston and Halpin, Chapter 40, this Handbook), narratives (see Rau and Coetzee, Chapter 42, this Handbook), and documents (see Jacobsson, Chapter 46, this Handbook), and can also include surveys and questionnaires. Observation is so deeply embedded in ethnography that is often seen as a *sine qua non*. Through observation, the researcher is attempting to capture and situate the phenomenon/a under study in their local context. We elaborate on the stages of accessing the field later on.

Linguists have argued that linguistic approaches and methods can add and expand theoretical and methodological approaches to ethnography and can contribute to the systematic analysis of patterns in the data. More broadly, the relationship between ethnography and linguistics – or ethnography, anthropology, and linguistics – is deep seated and well described. Language and culture are at the heart of the work of early and influential ethnographers (e.g. Hymes but also before Sapir/Whorf). At the same time, both linguistics and ethnography are broad and diverse areas of scholarly activity and have different orientations and foci. Rampton et al. (2004: 4), have captured the way in which the relationship between the two can be theoretically and methodologically mutually beneficial:

by linguistics “tying ethnography down”: pushing ethnography towards the analysis of clearly delimitable processes, increasing the amount of reported data that is open to falsification, looking to impregnate local description with analytical frameworks drawn from outside’. And ethnography ‘Opening linguistics up’: inviting reflexive sensitivity to the processes involved in the production of linguistic claims and to the potential importance of what gets left out.

This conceptual equilibrium has led to the development of new theoretical frameworks and approaches (notably linguistic ethnography, see Copland and Creese, 2015; Rampton, 2007) and also the foregrounding of established ones for enhancing traditional ethnography, and in our case, emergency ethnography. This is particularly the case for IS, which can provide a theoretical framework and also a methodology to enhance or expand data captured through datasets such as fieldnotes and interviews in health care research and more broadly.

IS has its origins in linguistic anthropology and ethnomethodology, particularly Gumperz's and Hymes' early work (see Hoey, Chapter 30, this Handbook). IS attempts to bring together the micro- (here-and-now interactions) and macro-level (large-scale social processes and the broader environment within which the interactants operate). IS is typically associated with the sociolinguistic end of the discipline and therefore focuses on interaction as the locus of the analysis and accepts that language is social and never context- or power-free. Depending on where/what/when/with whom we interact, we operate in a system of local expectations of behaviour that need to abide by wider social structures. At the same time, interactants can challenge structures and carry agency in either perpetuating or resisting the status quo.

The balance between structure and agency is fundamental in linguistic analysis; different methodological traditions address the relationship through either the sociocultural level or the situated moment. IS relies heavily on conversation analytic (CA) techniques in its microanalytic approach to interactions (for an introduction to CA see Drew and Heritage, 1992; see Hoey, Chapter 30, this Handbook). For CA and IS, the conversation floor is a central analytical locus. CA has shown that turn taking and turn design are direct manifestations of the social order and of power (a)symmetry. Through the analysis of the interactional flow and interactional trouble, moments where difficulty in making meaning are experienced by the speaker or recipient, features such as repetition, interruptions, hesitation, and mitigation are analysed and related to how speakers align or misalign. In hierarchical teamwork contexts, mis/alignment is significant for showing whether team leaders are reaffirmed or challenged, and tasks delayed, achieved, or failed (Angouri and Mondada, 2017). Interaction analysis pays attention to the ways in which participants respond to cues sequentially. The uptake, propositions, or actions that follow (or not) a turn are deeply embedded in the analysis of interactional patterns and interactional success or failure. CA work (e.g. Korsch and Negrete's (1972), classic study) already established from the 1970s the significance of health care institutions for the study of social action and the relationship between the interactional order and the social order.

Unlike CA, an IS analysis explicitly considers the wider sociocultural context impacting interactions and the

ways in which individuals enact and perform their roles. IS enables the researcher to connect 'doing' (micro-level) with the organisational (meso-level) and societal (macro-level) context. Further on this, a core concept in the IS tradition is conversational inference (Gumperz, 1982), referring to the situated or context-specific process of interpretation. Under an IS approach 'an act or utterance is read in a particular way by the interactants not on the basis of its linguistic form but on the potential meaning it carries in context' (Angouri, 2018a: 74). The concept of conversational inference allows us to consider in our analysis interactants' active predictions of what will come next in the light of ongoing talk and prior interactive experience (Tannen, 1992).

If ethnography gives us the conceptual principles of a project, IS provides the focus on language as practice and the tools to connect the micro-situated interaction with other pieces of information, captured through traditional tools such as fieldnotes and interviews, and a way to interpret them.

Angouri (2018a) has provided elsewhere a detailed discussion of the relationship between the micro-meso-macro levels of practice. [Figure 48.1](#) visualises the ways in which interactants operate at the interface of the institutional and sociocultural orders. It allows the analysts to connect language choices made in the immediate interactional space with implications for the broader institutional context (see the discussion of Excerpts 48.1 and 48.4). IS values the relationship with the professionals and sees them as collaborators in research designs, data analysis, and dissemination/actioning of findings (on collaborative designs see 'IS in the field' and the concluding remarks of this chapter).

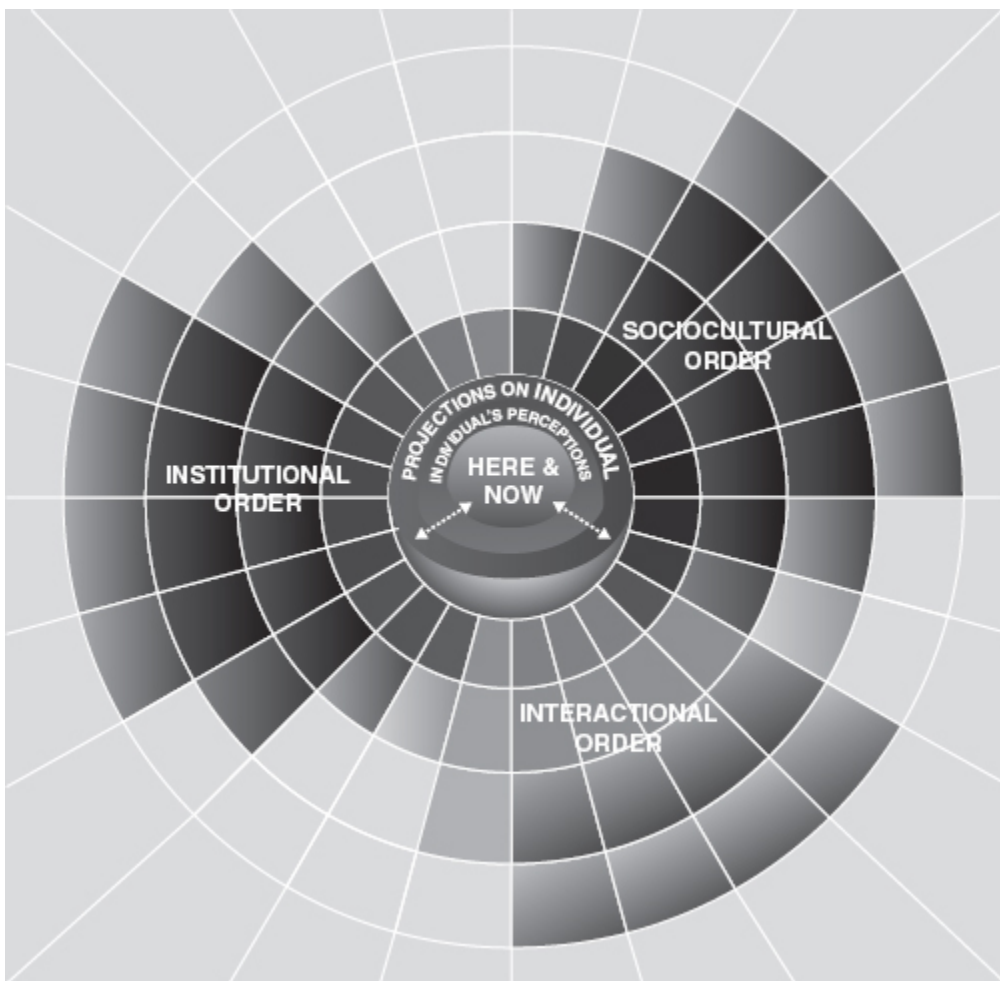


Figure 48.1 'A model for contextual interpretations' (Angouri, 2018a: 188)

A combination of methods gives access to both the micro- and macro-context and provides a holistic reading of ethnographic data. This process is enacted, primarily, in and through the researcher. IS is well aligned with developments in ethnographic thinking and current debates on reflexivity and subjectivity (Alvesson

and Sköldbberg, 2009; Lichterman, 2017; see Alvesson et al., Chapter 2, and Staller and Chen, Chapter 5, this Handbook) are also relevant. Although the role of the researcher is widely discussed and issues associated with writing ethnography (Van Maanen, 1983) are known, the challenge between connecting selected instances that caught the eye of the researcher and the broader environment is still open to further theoretical and methodological discussion. Interaction analysis, concerned with the identification of stable and recurrent practices, can contribute to moving beyond the overreliance of selected instances to identifying patterns in the data (hence avoiding the methodological anathema of cherry-picking).

To this end, an IS approach is particularly well placed for providing us with a holistic study of fast-paced, complex settings such as trauma care. IS's core contribution lies in the inferencing capacity that provides the researcher with the tools to identify, record, and subsequently interpret patterns of 'contextualisation cues'; these have been originally defined as 'any verbal sign which, when processed with symbolic grammatical and lexical signs, serves to construct the contextual ground for situated interpretation and thereby affects how constituent messages are understood' (Gumperz, 2001: 221–222). As with traditional ethnography, 'interpretability' increases the longer we stay in the field, and we progressively get access to the dynamics of professionals' relationships (i.e. access to staff members' small talk, including gossip). IS provides the theoretical and methodological framework to capture, organise, revisit, and re/interpret the data connecting what is marked (seen/perceived as different) to unmarked events and micro-moments to social order. In and through IS, the researcher identifies, records, and subsequently interprets patterns of contextualisation cues. How and where interaction can be captured by the researcher is a core issue for research designs exploring professional settings in general and medical contexts in particular.

The approach we are advocating is based on the principles of participatory design; according to which, the researchers jointly decide with the participants which events and how much and how best to capture and record them. Workplace sociolinguists have written on the significance of giving agency to the participants and involving them in the research on equal footing at all stages from the design to the analysis. Research questions, and the overall design, emerge and/or change in the process of working in partnership on a topic. This, evidently, means that the researcher is not the sole controller of the process. Uncomfortable though it may seem according to traditional research ideals, creating an open and equal space generates more robust results for research in sensitive contexts.

It is also a pragmatic position as the researcher, and particularly the qualitative researcher, needs the participants for navigating local meanings, deeply embedded in the institutional order (see later on for the participant's paradox). Research in professional settings has shown that by adopting or adapting a 'hands-off' approach to the actual data collection (Angouri, 2018b; Holmes and Stubbe, 2015; Stubbe, 2001) and giving control to the participants, researchers gain clearer insights into professional ecosystems. The benefits of the quality of the dataset outweigh any limitations that come with a 'bottom up' design (for a discussion see Angouri, 2018a). Datasets may include a smaller or more diverse sample, but typically it is better framed for the purposes of a jointly agreed project. This feeds in the interpretability of IS data as we show through the example we discuss here.

IS has been adopted widely in the study of team leadership (Holmes et al., 2011) but there is little research on medical teams. Leadership has been associated with clinical outcomes for quite some time now (West et al., 2003) and medical associations (e.g. Royal College of Nursing, 2011) have indicated its critical role for patient safety and quality of care. It is, therefore, a fruitful area for future ethnographic studies. We draw on one study here to illustrate how IS is applied in one case of sociolinguistic research and to pave the way for more studies to take place in hospital settings.

We discuss an ongoing project on teamwork and leadership in a designated MTC, one of the busiest MTCs and EDs in the UK. The study emerged through the ongoing collaboration of investigators and is an example of what can be achieved through co-designed projects. Our work focuses on leadership and role allocation in the multidisciplinary trauma team context and specifically in how team leaders do leadership in trauma pre-briefings.

Ethnography in a Major Trauma Centre

The locus of our study is the resuscitation area, commonly mentioned as ‘resus’, a key area in ED, dealing with the most seriously ill (medical) or injured (trauma) patients. It contains the equipment and staff required for dealing with immediately life-threatening illnesses and injuries. The rest of the ED includes majors, taking care of seriously ill or injured patients who are not in immediate danger of life, and minors, where patients with not immediately life-threatening conditions are treated, and the paediatric ED. The resus we investigate is six bedded, including one paediatric, two adult trauma, and three adult medical resus bays (see [Figure 48.2](#)); note, however, that the adult bays are often used interchangeably depending on demand. Our focus is on adult trauma patients highlighted in [Figure 48.2](#).

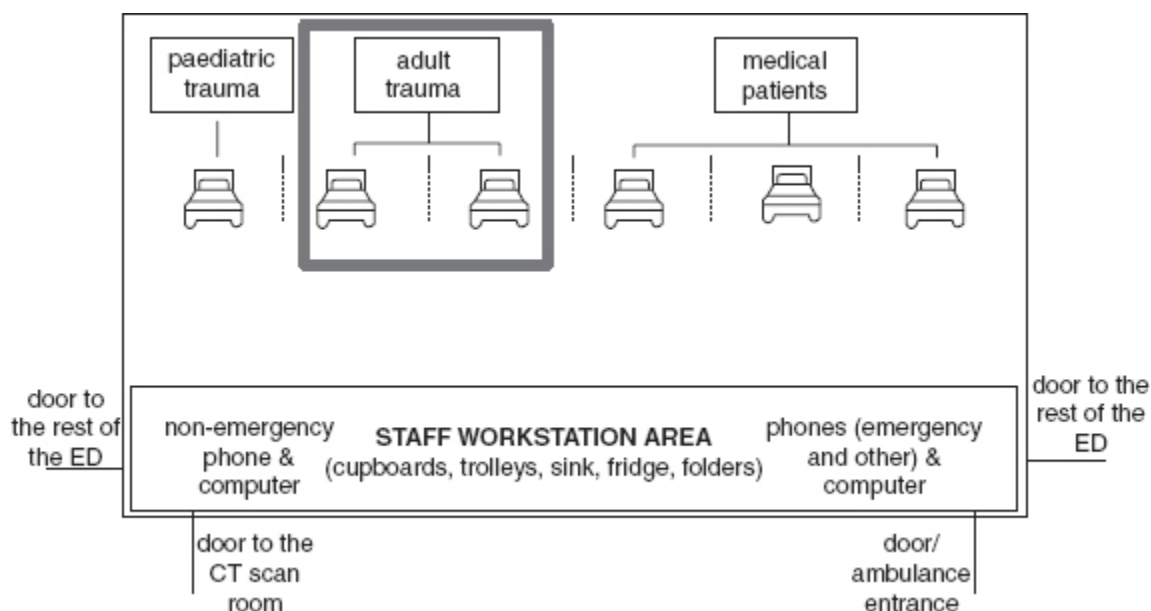


Figure 48.2 The resuscitation area layout

Trauma teams are particularly complex due to their multidisciplinary and ad hoc formation. They are drawn from the specialties of intensive care, emergency medicine, trauma and orthopaedics, surgery, nursing, and support staff, each of whom contributes simultaneously to the assessment and management of the trauma patient, coordinated by a team leader (Georgiou and Lockey, 2010). In contrast to other medical contexts, where teams are stable, there is variation, both nationally and internationally, in trauma team composition (Tiel Groenestege-Kreb et al., 2014) dependent on the trauma severity and the involved risk, the time allowed prior to the patient arrival, and the staff members' availability at a particular moment. The ad hoc formation of the teams, with staff members external to the core trauma team joining in, combined with the rotation of staff members in different departments, can pose significant challenges to effective team performance – and consequently patient safety – and require investigation.

In our setting, trauma cases are usually handled by an ED consultant (leading/coordinating the team – often taking notes, too), a middle-grade doctor (undertaking the primary survey), a resus practitioner (resus practitioners are not doctors but have a core role in receiving major trauma patients, assisting with the initial assessment and airway management, transferring the patient to the resus bay, taking patient's temperature, removing patient's clothes, etc.), and one or two ED nurses (assisting with any required procedures); these are also joined by an airway competent doctor – often an anaesthetist – (responsible for assessment and management of airway and ventilation), and another doctor (responsible for the intravenous access). Depending on the local situation, however, the team can grow considerably, with various specialists (e.g. orthopaedic surgeons, cardiothoracic surgeons, neurosurgeons) joining the team. The size of the teams ranges from five to 14 staff members.

The coordination of large medical teams is directly relevant to clinical performance. A core element in the process is the allocation of roles; the significance of roles in professional practice is well evidenced and will not be discussed here. Already in the 1970s, useful debate occupied scholars (e.g. Giddens, 1979; Goffman, 1959) on the stability and fluidity of roles and associated practices as points of articulation between individual

and social norms.

In our study, we look into the team briefing event, which medical literature (e.g. Steinemann et al., 2016) has identified as a critical and still a qualitatively understudied stage of trauma care. As with any research, prior literature is a core part of identifying where to put the magnifying glass on. With interactional research, prior literature and feedback from the professionals themselves is even more important for the researcher in order to identify the events to target and collect interactions from (see later on collaborative designs). For hospital, and particularly emergency ethnography, workload negotiation, shared understanding of roles, and associated tasks determine the quality of team intervention and, due to their complexity, are particularly good candidates for sociolinguistic ethnographic research. They are also of interest to the relevant medical research, which is important for the applicability of research and its impact potential. As those tasks are enacted linguistically, IS provides a suitable toolkit for looking at their interactional accomplishment.

In the rest of the chapter, we show how IS captures interactional patterns and the process by which we approach our data for drawing inferences.

Allocating Roles and Responsibilities in Trauma Briefings

We draw below on two examples to illustrate the pre-briefing patterns we identified in the data and the variability between team leaders. We pay attention to floor management as a central focus of IS research. We discuss the ways in which the designated team leaders claim control of the situation (or not), focusing particularly on role introduction and task allocation processes.

The analysis of our data has shown a continuum between more to less structured briefings in trauma emergencies. Excerpts 48.1 and 48.4 illustrate the impact of more structured and unstructured pre-briefings on the overall interactional flow. They are drawn from trauma cases of similar urgency, severity, and risk involved. The two teams also had a similar amount of time to prepare. The arguments we put forwards are not concerning these two examples as isolated cases; IS data always represent a systematic occurrence of features that are associated with local meanings.

Excerpt 48.1

Context: Six staff members have gathered around the trauma bay following the switchboard's alert for a trauma call to ED with an estimated time of arrival (ETA) of 10 minutes. Multiple parallel conversations are ongoing. We join when the floor is claimed by the team leader.

Members shown in the excerpt:1 Leon: ED consultant; Kim: Intensive Care Unit (ICU) registrar; Lisa: ED registrar; Mona: medical student; Rob: registrar of unknown specialty; Jack: orthopaedic registrar.

1.	Leon	OK you all (1.0) can we (.) possibly step in and just
2.		pre-brief (.) e:hm we're missing ITU [but
3.	?	[yeah
4.	Leon	they told me we've got an (indec) here so: ((sighs))
5.		(1.0) hopefully wards coming in (.) (do) introductions
6.		(.)(saying the obs) (.) and the:n (.) we chat about what
7.		we plan to do (.) does that make sense↑ [yeah↑
8.	Kim	[yeah=
9.	Lisa	=mhm
10.		((several lines omitted))
11.	Leon	so (.) my name is Leon Jones (.) I'm the trauma team
12.		leader (1.0) ((he looks at Lisa and makes a gesture to
13.		pass her the floor))
14.	Lisa	my name is Lisa: (.) I'm the: ED registrar (1.0)
15.	Leon	you're doing [the primary survey
16.	Lisa	[and I'll be doing the primary survey
17.	Mona	I'm Mona (.) a student in the ward (1.0)
18.	Rob	ehm (indec) reg
19.	Kim	Ki:m (.) ITU=
20.	Leon	=IT -IV access [Kim↑ (.) you're good
21.		with that↑
22.	Kim	yes
23.	Jack	Jack (.) ortho reg (2.0)
24.	Leon	Jack (.) if you (.) if you're happy to hang around and
25.		help over↑=
26.	Jack	=of course↑

In lines 1–2, Leon, the ED consultant and team leader performs a speech act of opening the pre-briefing, by verbally asking his colleagues to step in to the pre-brief and performing a relevant gesture. Such explicit speech acts are indexing the opening of a briefing event and are marked in our data. Leon succeeds here in gaining interactional control as manifested in the team's uptake; all staff members gather around him immediately and stop the parallel conversations. In lines 5–7, Leon quickly sets a short-term plan, a process previously identified as contributing to effective medical leadership in emergencies (see, for instance, Hershkovich et al., 2016).

Moving forwards, Leon introduces himself in lines 11–12, mentioning both his full name and his role (I'm the trauma team leader). Health care professionals' introduction within their team has been identified as a contributing factor for improving patient care, with the introduction of self and role being recommended in the World Health Organization's safety curriculum on 'being an effective team player'. Leon opens the floor to Lisa, in lines 12–13, by looking at her and making a relevant gesture. The uptake shows that the team interprets the cues accordingly; Lisa is the only one taking the floor and introduces herself (line 14). Following Lisa's institutional role (ED registrar), Leon establishes their situated role in the encounter, the task she will be performing (the IV access). This move, to identify and allocate roles at this stage is one of the structural characteristics of successful pre-briefings in our data. More broadly, looking into differentiating characteristics of events, that are locally significant at the micro-level, is a common goal for ethnographers in general; for IS, the identification of the sequential architecture of those events is a core stage for exploring 'what is going on' in a setting, accessing local evaluations of what is effective/ineffective practice, and ultimately connecting situated encounters to the organisational landscape.

After Lisa, Mona, Rob, Kim, and Jack take turns and state their role and task. A number of other linguistic features are also significant here, one of which being pronouns. Pronouns are widely explored in linguistic literature and are associated with group membership. They are also an accessible feature for those coming

new to linguistic ethnographic work. Leon uses the collective personal pronoun *we* throughout the excerpt, establishing a shared team identity (lines 1, 2, 4, 6, and 7). To this shared team identity also contributes the fact that Leon confirms with staff members that they are happy with his role allocation (lines 20–21 and 24–25). Given the power asymmetries in such a hierarchical context, it might be the case that staff members would not openly disagree with the team leader, even when asked; nevertheless, fieldnotes and ad hoc interviews with staff members also point to the same direction – that Leon ‘has control of the situation’ and ‘everyone knows what they’re doing’ (see Excerpts 48.2 and 48.3 below); we return to the usefulness of bringing datasets together later on.

There is no interactional trouble manifested in the excerpt above (see, for instance, lack of interruptions, overlaps, long pauses, and mitigation markers), which often occurs in ad hoc team formations. The team leader’s speech act of opening the pre-briefing, in combination with his clear role introduction and task allocation, seem to be effective mechanisms of claiming control here (cf. Excerpt 48.4) and maintaining smooth interaction flow.

Apart from the study of linguistic features, such as the use of pronouns, and the use of floor controlling markers (OK, line 1; so, line 11), IS designs also include the analysis of interviews and fieldnotes from the same perspective. These are analysed and coded for content (what is said/observed) but also for the overall architecture of the accounts (how/when something is said) provided by the participants to the studies. These accounts feed into and complement the analysis of the core encounters.

As an illustration, we provide two short excerpts here in relation to Excerpt 48.1, which illustrate how post-event conversations (ad hoc interviews) can shed light on the analysis of the encounter. Excerpts 48.2 and 48.3 are in line with our interactional analysis; the successful control of the floor by the team leader, which we showed above, ‘filters through’ to the team who identify him as being in control of the situation.

Team's Perceptions of the Leader's Performance in Follow-Up Conversations Excerpt 48.2

Leon is one of the calmest and this filters through – he shows he has control of the situation. With other consultants it can get extremely chaotic.

(ICU registrar)

Excerpt 48.3

Leon is really good – this is why it was so quick, because everyone knew what they were doing. When this isn't the case it's flapping out, this is when the communication doesn't work.

(resus practitioner)

We next turn to an example that illustrates a different type of opening encounter; this is manifested in short role allocation without protected floor time.

Excerpt 48.4

Context: Five staff members gather around the trauma bay and greet each other. Laura, an ED registrar, who will be leading the team together with Mike, the ED consultant, claims the floor and abruptly starts allocating roles. We join the excerpt from the moment the team leader takes the floor.

Members shown in the excerpt: Laura: ED registrar; Asa: resus practitioner; Mike: ED consultant.

1.	Laura	hello↑ ah: Asa does airway (.) you're taking [bloods
2.	Asa	[I am Asa↑
3.	Laura	we're doing the primary survey
4.	Mike	yes she's Asa=
5.	Laura	=because obviously I want to [(indec)
6.	?	[(you're taking
7.		over) from Asa
8.	Laura	oh OK [cool
9.	Asa	[I am Asa↑
10.	Laura	oh ((they all laugh)) I've literally done that twice
11.		today (.) ((paramedics arrive))

Mora: anaesthetic registrar; Jarett: registrar of unknown speciality

Compared with the previous case, Laura performs here a much shorter and less structured pre-briefing, skipping the marked step of asking everyone to introduce themselves. Even though the two teams operated under the same time window, there is no introduction and all the role allocation taken place is in lines 1–4. If we compare this to the pre-briefing in Excerpt 48.1, we also note the lack of confirming with the rest of the team that they are comfortable with their tasks. Laura shares here the role of the team leader with Mike; this is something we do not find regularly in our data and this lack of a designated leader might be one of the reasons causing problems in controlling the floor and encounter.

Very early in the episode, the lack of introductions causes interactional trouble, evident in the multiple interruptions and overlaps in lines 2–9, delaying the team. Laura goes straight to allocating the airway role to Asa without knowing who this person is; Asa, who stands right next to her, attempts to introduce herself overlapping with Laura twice (lines 2 and 9); the emphatic speech and the rising intonation in both her turns indicate possible surprise or annoyance. This is of particular importance if we also take into account the strict professional hierarchy (the meso-level in our approach). The interactional trouble already caused early in the pre-briefing is evident throughout the episode:

12.	Laura	are you: taki:ng↑-
13.	Mike	-I will I just e:h (indec)
14.	Laura	and you:: a::re
15.	Mora	(happy) doing the IV
16.	Laura	Asa is-
17.	Mora	-no <u>he</u> is [(indec)
18.	Laura	[you are (.) OK (.) I don't know your
19.		name I'm sorry
20.	Jarett	I'm Jarett
21.	Laura	Barett
22.	Jarett	Jarett
23.	Laura	Jarett (.) Jarett is gonna:-
24.	Mike	-e::h (indec)

In lines 12–24, with the team working for some time now, Laura attempts to summarise what everyone is doing, but, contrary to the team leader in Excerpt 48.1, she has difficulties in controlling the floor; her turns include mitigation and hesitation. Linguistically this is often indexed through markers such as pauses, stretching sounds, and lexical fillers (Rieger, 2003); see, for instance, Laura's elongated vowels in turns 12 and 14 and short pauses in line 18 and the way she is frequently interrupted by other team members (lines 13, 17, and 24). Hesitation in high-risk environments is often read as indexing low confidence and our data provide linguistic evidence to this claim. Laura appears interactionally less confident in controlling the floor

than Leon in managing the situation. As a result, she faces difficulties in controlling the interactional floor – this filters through the team as evident in the team's uptake.

In lines 18–23, quite late in the episode, the lack of introduction at the beginning causes further delays and disrupts the overall structure of the summarising process, as Laura turns to a staff member but realises that she does not know who he is and goes back to asking him his name. The elongated vowel in line 23 also indicates uncertainty about the task Jarett is going to perform and results, again, in her interruption by the ED consultant.

Overall, the analysis of our data shows that in cases in which the pre-briefing stage is incomplete or absent, this is associated with interactional trouble in different stages of the event. Interactional trouble in its turn can be translated locally for its impact on the team's overall performance. As we show here, uncertainty over roles/tasks is common in our data. This creates a domino of information recycling and/or risk of information loss. The risk associated with information loss is well documented in the literature (e.g. Pithier et al., 2005); IS allows to identify the exact locus, impact, and effect and provides the ethnographer with a systematic way to observe, note, and interpret how teams 'do' and ways in which research can provide opportunities for intervention. Going back to [Figure 48.1](#), IS provides the conduit for a contextual interpretation of interaction, which, in this case, enables us to connect floor management to role/task achievement and team leadership in the MTC. If and when professionals are involved in the research process, interventions can also be designed to improve current practice.

To sum up, through these two cases, we aimed to give the reader a tangible example of how IS can be applied in sociolinguistic emergency ethnographic studies and to provide those coming new to the field with a feel of the data and foci of IS research. Further on this, beyond the analysis of linguistic features, the contextual reading of interactional data depends, between others, on the length of stay in the field and the ways in which the researcher works with the participants. In the case of medical ethnography, and in all complex systems of activity, a collaborative, co-created design is the best if not the only way to be able to capture what is locally significant. We discuss this further in turning to the spatiotemporal analysis we are advocating for the data and for the researcher's position in the field.

Is in the Field: Matters of Design in Sociolinguistic Ethnography Revisited

Building relationships with participants is necessary for accessing and understanding 'what is going on' in the field. This is even more relevant for studies that draw on sensitive data and recordings of actual interaction. One of the core challenges in the design and carrying out of sociolinguistic work is, unsurprisingly, around ethical clearance. Collaborative, participatory research designs provide a strong foundation for negotiating access and jointly navigating the complex process of ethics for health care research. There is a good body of literature on how to establish first contacts for ethnographic study (e.g. Blommaert and Jie, 2010). Cultivating strong relationships based on trust is the golden rule for any ethnographic project; the significance of strong relationships is heightened as the sensitivity of the medical setting increases and the research takes a language-first approach, zooming on micro-interactions.

Further, as with mainstream ethnography, the more time and social capital we acquire, the more the quality of the insight increases with the researcher moving progressively away from an 'outsider' position.

The out-in/sider binary has received significant criticism for being a simplification of a complex relationship. The relationship between the researcher and participants can be better understood as a continuum, rather than being 'in' or being 'out' these positions are liminal and not linear. How much one can 'see' varies depending on the nuances of each setting, the degree of access and the time allowed for familiarisation. Pope (2005) argues that, when conducting ethnographic research in medical settings, research roles are not fixed; rather, they 'move along a continuum from observer to participant' (2005: 1181). In the same line, Sarangi (2002: 122) notes that as discourse researchers in health care settings 'we remain, for the most part, peripheral but legitimate participants, eager to rely on our subjects' insights'. This move from the periphery to the centre of action is negotiated in situ between the researcher and the participants in the local ecosystem of the ED. Although this in itself is not new, a participatory IS approach enables us to capture the process of having access to more layers of meaning, originally well hidden and protected from the outsider.

We argue that researcher participation is negotiated linguistically and spatially in the field. The negotiation relies on the researcher successfully interacting with the participants and, to some extent, convincing the participants of their trustworthiness. This is a boundary negotiation activity, and it is, as we illustrate below, embedded in the material space where organisational practice is enacted. When in the field, the researcher goes through a gatekeeping process that leaves a linguistic and spatially negotiated footprint.

We therefore propose that a spatiotemporal analysis is beneficial to interactional data (see also Mesinioti et al., 2020) and can capture holistically the nuances of carrying out medical ethnography and particularly in trauma centres. It also provides an analytical framework for hospital-based sociolinguistic ethnographic projects; in short, sociolinguistic hospital ethnographic designs need to consider ways to access interactions but also access spaces where the action is taking place.

Let's see our case study as an illustration. At the early stages of the fieldwork, staff members agreed to be audio recorded and that was our only source of data. As our relationship developed and the researcher progressively shifts from an outsider to a legitimised presence, team members started sharing information for interpreting what was captured in the recordings; for instance, after handling the trauma cases, they would often make evaluation claims for themselves and their colleagues in follow-up conversations. This gives richer access to the team dynamics and increases inferencing capacity. While in the field, the researcher is initially positioned as a complete outsider; this is marked in the spatial layout of the field. In our case, this is depicted in the zones of activity that were being made visible and available to the researcher over the period of the first two months ([Figure 48.3](#)).

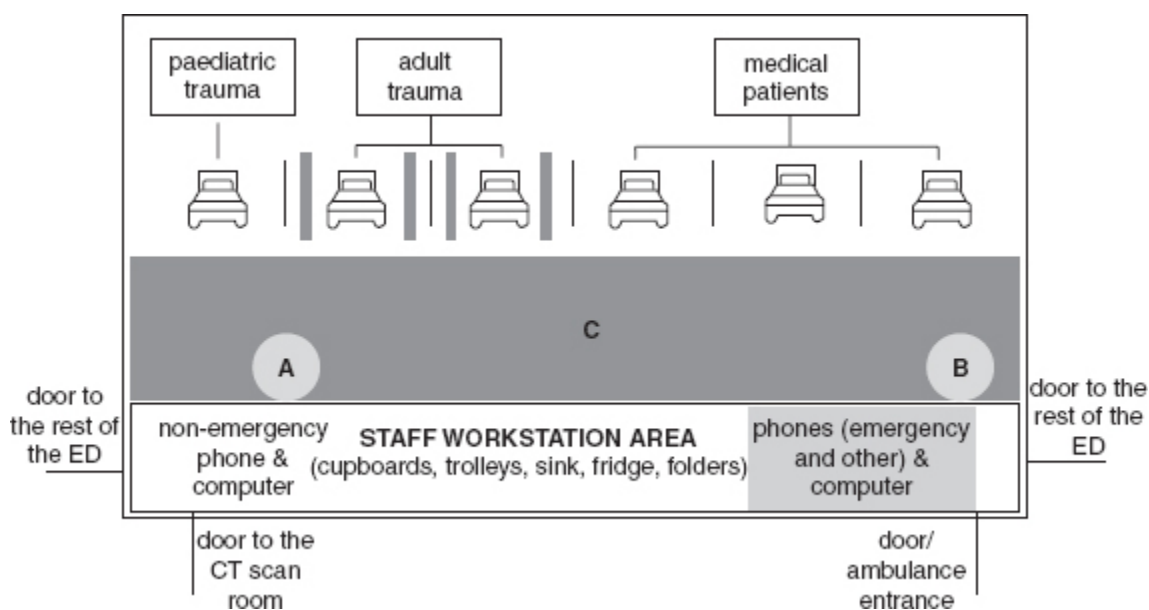


Figure 48.3 The researcher's legitimisation in the material space of the resus

A revised version of the summary figure ([Figure 48.2](#)) shows where the researcher was positioned while in the different zones marked on the graph.

Initially, the researcher was explicitly assigned zone A to stand, where, as she was told, she would not bother any of the staff members and she was not in the middle of any equipment; zone A was also close to the trauma bays that were our focus. As shown in [Figure 48.3](#), zone A is a peripheral material zone on the left side of the room.

The researcher, who at first is blind to the organisational practice, accepts the material zone offered to them and appreciates not feeling particularly exposed in this new setting. In our case, the starting position was next to the door, usually not crowded, and indeed close to the trauma bays. What the researcher did not know back then is that those bays could be left empty all day, as staff members try to keep them free for major traumas; practically, it meant that the researcher was positioned away from the action.

Having spent some time in the resus, observing participants' professional routines, we identified the light grey zone shown in [Figure 48.3](#) as one core area in the resus. This zone is the part of the workstation that includes the only emergency phone in the room and one of the two non-emergency phones.

The light grey zone also contains a computer which, although not the only computer in the room, is the computer most widely used; this is the computer used by the nurse in charge and the other ED staff members in order to check medical data. Staff members, when not performing tasks on the patients, stand close to the emergency phone and the computer; when they started inviting/allowing the researcher in zone B, we realised that the light grey zone was a key material zone of backstage communication, offering some privacy to staff members. The material shift from zone A to zone B signalled a transition to the researcher's status and provided access to staff members' informal conversations, jokes, and personal remarks.

After consolidating a presence at this, now privileged space, the researcher reaches a point where they can move freely in the material space of the field. In our case, this is the whole room (dark grey area – zone C), using both peripheral and central zones within the room. Staff member questions are oriented towards helping the researcher, for example, asking about the progress of the project and actively engaging with offering readings and suggestions. Angouri (2018a) argues that the researcher's transitioning from the position of the outsider to that of an insider is 'an ongoing process whereby the researcher engages and understands the activities of a research site up to a point' (2018a: 87).

We argue that this ongoing process is also embodied as illustrated in the transition from zone A to zones B and C. At that point, legitimisation as a participant by staff members is also manifested through the use of another artefact, the curtains around each resus bay; these curtains are regularly used for giving patients and staff privacy, and at the same time, mark epistemic territories; not everyone is allowed in and those deciding who is in/out are in a position of power. At late stages of the fieldwork, the researcher was allowed in that space as one of the team (see grey areas at the sides of the trauma bays in [Figure 48.3](#)). Note that this does not mean that the researcher loses their visibility as external to the core team; this would never be a risk for a social scientist in a medical setting anyway and being a participant does not indicate being involved in the team's core business.

The material shift from behind the curtains to 'inside' the resus bay was an indicator of being included and having the team's acceptance and trust. Accessing spaces protected from the outsider is documented in ethnographic research. In order to capture significant interactions through multiple datasets, linguistic ethnographic designs need to factor in and have awareness of the zones that open to the researcher. This process requires time, which often is challenging given the constraints of research projects.

In our case, the transition through the three analytical stages lasted approximately two months. [Figure 48.4](#) provides a simplified summary of the process and enables us to zoom in on core stages. Sociolinguists who focus on the study of the workplace (Angouri, 2018a; Angouri et al., 2017; Holmes and Stubbe, 2015) have written extensively on the importance and commitment in forming strong relationships with participants that need to be governed by collaboration and mutual respect. The strong relationship between the investigators is undoubtedly an asset in the project we are using as a case here. An established relationship not only increases the researcher's level of access in the field and understanding of the local context; according to Angouri (2018a: 102), 'the workplace analyst needs their participants for interpreting their data'. As the researcher forms relationships with the local communities, they also form relationships that will enable them to translate the new environment and its discourse and ways of doing.

mid-March			<i>legitimised participant</i> researcher seen as part of the group increased levels of access
late February		<i>legitimised presence</i> establishing social and interpersonal relationships participants as co-creators & co-agents	NO ACCESS
end of January	<i>outsider</i> participants' perceptions of being evaluated	NO ACCESS	NO ACCESS
mid-January	participants' curiosity about the newcomer researcher	NO ACCESS	NO ACCESS
	zone A	zone B	zone C

SPACE

Figure 48.4 Core stages of the researcher's legitimisation process

The analysis of our data shows that the researcher moves from > outsider to > legitimised presence > to legitimised participant. The first two stages are characterised by no or shallow participation in the life of the field. Shallow participation involves limited agency over deciding where the 'centres' of action are, understanding 'what is going on' and limited opportunities to speak or socially interact with the participants. We consider a staged representation to be useful for capturing the spatiotemporal negotiation of the researcher relationship with the participants; and for exploring the dynamics of engaging with the field. Creating a spatiotemporal axis is also important for capturing and tracking the multiple readings that become possible as more spaces open up to the researcher. Note that some of the patterns we discussed earlier (Excerpts 48.1 and 48.4) were made visible to the researcher when access to zone C was granted.

Through the shift from the periphery to the centre of action, the researcher moves closer to the emic understanding of the phenomena under study. In sociolinguistic ethnographic research, this also opens a space for collaboration between the researcher and the core gatekeepers. Collaboration is central for the researcher to be able to read complex teamwork in a trauma setting. Being semi-dependent on the participants for translating the data, challenges the widely accepted ideal of unobtrusiveness – or 'fly on the wall' principle – and we briefly address this matter next.

The 'fly on the wall' is a well-intentioned metaphor but quite limited for a medical ethnography in general and sociolinguistic ethnography in particular. Although the 'fly on the wall' has been associated with the study of symbolic figures in anthropology and ethnography such as Malinowski's work in the Trobriand Islands (e.g. the well-worth-reading *Argonauts of the Western Pacific* [1922]), the concept of studying communities conceived as 'homogenous' and 'different' to the researcher is outdated. Applied to the modern organisation and particularly the medical context, a fly on the wall will most certainly fail to go far and instead of meeting Geertz's 'thick' description ideal (Geertz, 1973), it will remain unavoidably thin. In line with this, Sarangi (2019) recently argued that it results in the researcher's 'inability to interpret the observed phenomenon in a manner which is aligned with the participants' perspective' (2019: 113).

The effect the observer has on the people and situations observed was (and often still is) perceived as a drawback. Labov (1972) was the first who introduced the well-known observer's paradox, referring to the impact of the researcher on the behaviour of the observed, and in Labov's case, the change in linguistic performance in the researcher's presence. The obstacles such an approach imposes on our understanding of

the context already caught researchers' attention in the 1980s (see, for instance, O'Hanlon and Wilk, 1987). In the health care context, Wind (2008) problematised the concept of participant observation, arguing that it is based on an assumption that the ethnographer will become one of 'them'; in Wind's words, 'the character of fieldwork in highly specialised health care systems does not fit well with this assumption' (2008: 79).

As an extension of the observer's paradox but with a focus specifically on 'naturally occurring' data settings, Sarangi (2007) introduced the participant's paradox, which refers to 'the activity of participants observing the observer against a set of expectations' (2007: 578). Sarangi also identified an analyst's paradox, referring to the process of 'obtaining participants' insights to inform our interpretive practice, especially in light of tacit and layered embeddings of professional conduct' (2007: 579). Angouri (2018a: 87) also raises the importance of 'collaborative research [among researcher and participant] instead of the researcher attempting to be able to fully interpret "what is going on"'.

Approaching sociolinguistic ethnography as a collaborative activity is in line with the position of linguists who have championed ethnography as theory and praxis for the study of language use (e.g. Hall, 2009; Rampton, 2006). In this context, ethnographic observation is a situated activity and a process that changes over time as the relationship between the researcher and the participants evolves. We close our chapter by suggesting that collaborative designs lead to better quality but also, from experience, are the only way for social scientists to reach complex medical contexts.

Conclusion

We made a case for taking an IS approach and we also proposed a spatiotemporal analysis to fieldwork, research participation, and data inferencing. In line with a growing body of literature on the spatial and material dimensions of institutional spaces (e.g. Dale and Burrell, 2008), a spatiotemporal approach can provide ethnographic research with analytical tools to capture the dynamics of 'access' and 'fitting in' in the field. It also provides a reading of the data that enables the researcher to unlock different layers of meaning that are made available over time and through the analysis of significant encounters. The ethnographer is always conscious about entering unfamiliar territory. They negotiate their zones of activity as their engagement and access increase. This is a fruitful avenue for further theoretical and methodological advancement.

We also made a case for a collaborative approach to research designs. We argue that creating spaces where researchers and participants, in our case medical professionals, can co-design agendas leads to a better understanding of the context, findings that can be implemented for the benefit of the organisation, and a theorisation that builds on the lived experience of the participants instead of being based on top-down ideals imposed by the researcher.

Collaborative research designs are also useful in making medical researchers aware of the benefits of sociolinguistic, and more broadly social science, ethnographic research. The need for creating a collaborative space with the participants becomes quickly visible to the ethnographer who becomes the new face in a complex and sensitive environment. In the current, COVID-19 context, physical presence in the field takes a whole new dynamic. A hands-off approach to the data collection that empowers the participants to be in charge of the data collection becomes a necessity with significant implications for ethnographers. Relationships of trust between research teams will become more significant and collaborative research offers a theoretically robust way forwards for carrying out quality fieldwork in medical research.

To conclude, although ethnographic research is still peripheral in mainstream health care, an increasing number of voices critique an overreliance on well-tried methods and call for new approaches, particularly for the understanding of complex dynamics and multi-factorial questions, such as the ones we discuss here. Ethnography is well suited to meet these agendas and provide fresh ways of looking at complex phenomena. Leadership in emergency settings and particularly trauma has not, yet, been studied enough in sociolinguistic ethnography and qualitative health care more broadly. We hope our study will help others who design hospital-based ethnographic work in high-risk emergency contexts.

There is, however, a long way to go to address established ideologies and preferences of journals and

editorial boards that influence the field. A good illustration is the BMJ response to criticisms of a lack of qualitative research, arguing that the BMJ has chosen to focus 'on quantitative research that reports outcomes that are important to patients, doctors, and policy makers' (Loder et al., 2016). The assumption that only quantitative research can have an impact on patients, doctors, and policy makers is anything but new and brings us back to well-known debates in research methodology. The long-lived and still thriving simplistic dichotomy of qualitative versus quantitative research is to date the dominant discourse of influential boards and academic outlets and is perpetuated in professional praxis. Consider ethics application forms that are primarily applicable to quantitative methods and include questions such as 'how many hours of [interviews/observations]?' 'exact sample size of [interviewees/observed]' 'duration of [data collection stages]', and so on. Already from the outset, sociolinguistic research and qualitative enquiry more broadly are recontextualised for the purposes of forms that are not fit for purpose.

We hope collective action will challenge this hegemonic ideology. We align with those who argue that reliance or priming of any one epistemological-methodological tradition fails to capture the necessity of multimethod research for giving voice to patients, doctors, and policy makers whose experience we collectively aspire to improve. In order to mark a change, multimethod research is needed, particularly for making medical emergencies safer for patients. Our work aspires to contribute to this agenda and paves the way for others to follow (see the Chapters in Part V, this Handbook).

Transcription Conventions

- [Point of overlap onset.
- (.) Pause shorter than one second.
- (X.0) Pause about X seconds.
- ↑ Rising intonation.
- Interruption.
- (.) Rising intonation.
- : Sound stretching.
- (()) Researchers' notes.
- = Continuous utterance with no break or pause and/or latch.
- word Stress or emphasis.

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- ethnography
- hospitals
- health
- trauma
- interviews
- teams
- health care
- participant observation

<http://dx.doi.org/10.4135/9781529770278.n49>