Team interaction in healthcare settings: Leadership, rapport-building and clinical outcomes in ad hoc medical teams

1. Introduction

Communication plays a crucial role within healthcare settings, with the contemporary provision of patient care being often reliant on collaboration and joint decision-making performed by teams of healthcare professionals of different specialisms rather than autonomously functioning uniprofessional groups (Leathard, 1994; Thomas et al., 2014; Villagran and Baldwin, 2014). The reliance on successful interprofessional interaction tangibly links communication to clinical outcomes (Kuziemsky et al., 2009), making effective team communication central to patients' safety and the successful attainment of clinical goals. Conversely, poor communication among members of medical teams has been evidenced to routinely lead to instances of critical incidents and mistakes (US Joint Commission, 2014; Rider and Keefer, 2006; Slade et al., 2008). Individual clinical competence alone is thus often insufficient when ensuring patients' safety, with medical teams needing to effectively work collaboratively and establish rapport among one another to be able to draw upon the multiple types of medical expertise available in those teams and exercise what is termed as their 'collective competence' (Lingard et al., 2004). For those leading medical teams, this creates complex roles that require them to be able to not only effectively interact with individual members of ad hoc teams but also ensure that all interaction observed in that context aids the successful exchange of information and expertise.

In order to examine this interrelationship between leadership, rapport-building and clinical performance, the chapter presents data collected in the specific context of emergency medicine training as observed in a large teaching hospital in the UK. Seven video-recorded trauma simulations and seven video-recorded debrief sessions form part of the data. The video recordings are then also supplemented by field notes and training documentation collected as part of the ethnographic research carried out in the training, where trainee doctors prepare to carry out managerial tasks in their specialist roles.

In the chapter, the trainees' different leadership styles, as characterised by the means through which they delegate tasks and signal active listenership to other interlocutors, are identified and matched up to their relative success in the context of the clinical interaction. The relative success of their leadership performance, in turn, is established on the basis of the consideration of the overall

evaluation of the trainees' leadership skills by those taking part in the simulation and the effects that the candidates' leadership styles have on the joint completion of clinical tasks, particularly as evidenced by the overall speed with which the station is completed by the candidates. It is discussed, accordingly, whether the presence or absence of more elaborate rapport-building strategies, as exemplified by mitigation of requests and the use of markers of active listenership, in the discourse of trainee doctors correlates with a more positive evaluation of their leadership skills and whether this has a tangible effect on the team's performance and the joint achievement of clinical tasks as outlined in the clinical performance marking sheet. In our analysis, we concentre specifically on how other interlocutors' face needs and sociality rights, so the rights of other interlocutors to not be imposed upon but also have association with others (Spencer-Oatey, 2000), are attended to in interaction. We examine also the uptake of this management of rapport, examining the implications of its form for the goal-orientated aspect of communication observed in the medical sphere. We do not wish to make claims about the analysis providing an exhaustive overview of all of the features of rapport management observed in this context but instead focus on the features linked to the autonomy-imposition continuum in the communicative repertoires that the trainees draw upon. A close attention is paid specifically to the mitigation of requests and also the use of (in)directness – drawing upon a modified version of Blum-Kulka et al.'s (1989) CCSARP ('Cross-Cultural Study of Speech Act Realization Patterns') coding manual - and the concept of active listenership (Coates, 1986).

The aim of the chapter is to demonstrate the ability of linguistic research – and politeness research specifically – to have practical application in the healthcare setting. As asserted by Mullany (2009) and then Locher and Schnurr (2017), there is still a real need for healthcare communication research to be more 'applied', with a relatively limited number of politeness scholars and studies (Lambert, 1995, 1996; Spiers, 1998; Grainger, 2002, 2004; Jameson, 2003; Delbene, 2004; Woolhead et al., 2006; Backhaus, 2009; Brown and Crawford, 2009; Graham, 2009; Harrison and Barlow, 2009; Mullany, 2009; Zayts and Kang, 2009) addressing communicative issues pertaining to that sphere. There are even fewer studies exploring issues relating to politeness in interprofessional medical interaction (Arber, 2008; Graham, 2009), despite the coordination of interprofessional work being essentially a primarily linguistic – and more specifically a pragmatic - phenomenon.

While recognising the distinct nature of simulated interactions in comparison to real-life healthcare talk (for discussion, see Atkins, 2019), we wish to hypothesise that such simulated scenarios importantly provide a vital site for the formation of future professional practice and a means of determining what discursive practices are evaluated positively by experienced medical staff.

Therefore, they are worth investigating and analysing with the prospect of gaining a better understanding of the rapport building strategies observed in the context of ad hoc medical teams and informing professional practice and communication skills training in medical education as well.

2. Background

Communication observed in the healthcare sector has been an object of frequent linguistic study since the 1980s. Traditionally dominated by inquiry into doctor-patient interaction – particularly as observed in primary care (Mishler, 1984; West, 1984; Fisher, 1984; Borges, 1986; Silverman, 1987; von Raffler-Engel, 1989; Heritage and Sefi, 1992; Maynard, 1992; Cicourel, 1999; Sarangi and Roberts, 1999; Sarangi, 2004; Heritage and Maynard, 2006), the field slowly started to diversify. With its maturation, more attention started being paid to interactions between patients and members of allied medical professions as well as professional and interprofessional teams. This increased focus on the multiplicity of interlocutors and audiences pertaining to healthcare settings addressed the need for healthcare communication research to move beyond its primary patient-doctor focus (Iedema, 2005; Sarangi, 2006; Graham, 2009), recognising that healthcare communication necessarily involves 'a wide variety of interlocutors who occupy a whole range of different professional roles' (Mullany, 2009: 3-4). Interactions of patients and nurses (Crawford et al., 1998; Spiers, 1998; Grainger, 2002), physiotherapists (Ballinger et al., 1999), pharmacists (Pilnick, 1998; 1999) and occupational therapists (Mattingly, 1994) have been, accordingly, explored in more depth. More focus started also being placed on the investigation of how teams of different healthcare professionals interact with one another, importantly shedding light on the processes of multi-party delivery of care. The increased focus on the analysis of interactions which often did not involve patients at all also importantly demonstrated that, even in cases when the interaction only involved healthcare professionals, the quality of their interaction still had significant implications for clinical outcomes, patients' satisfaction (Brookes and Baker, 2017) and health.

2.1. Team interaction in healthcare settings

In recent years, healthcare settings have started becoming increasingly reliant on interprofessional work as a standard means of delivering patient care (Leathard, 1994; Thomas et al., 2014; Villagran and Baldwin, 2014), marking the departure from the traditionally predominant autonomous functioning of different healthcare specialisms to a more coordinated one (Leathard, 1994). In the context of the UK, and the UK National Health Service (NHS) specifically, this has been linked, among many, to the economic, political and social changes brought about during the 1980s (for discussion, see Thomas et al., 2014). During that time, pressure was placed on public services to

become more closely aligned to market-driven organisations, with there being calls for cost-effectiveness, patient choice, transparency, accountability and coherence, all in the face of tight controls over public spending and with healthcare contexts having to reconfigure the way in which they operate to adapt to this. This drive towards a more coordinated, multi-disciplinary patient care was accordingly one of the means of responding to the shrinkage in the resources available to healthcare services. Other drivers of this shift included concerns over information sharing, evidenced to lead to failures of due care, and the breadth of expertise available to healthcare professionals when responding to often complex medical concerns, many of which requiring attention of more than one specialism (for discussion, see Leathard, 1994).

While generally advocated, interprofessional team interaction can be also associated with its own set of limitations, not least those involving the complex and often-changing variables affecting it. As argued by Villagran and Baldwin (2014: 362), for example, 'all too often health organizations manifest fragmentation and turbulence that limit the capacity for optimal team functioning'. Hollenback et al. (2012) enumerate skill differentiation, authority differentiation, and temporal stability of ad hoc teams as significant factors affecting how they operate. Issues surrounding institutional hierarchies, varying disciplinary stances and ways of performing clinical tasks can, thus, all bear significant implications for the quality of exchanges that ad hoc teams have, having then implications for the clinical decision-making that those interactions inform. Physician-centredness and discursively-elaborated power asymmetries, in particular, can play a significant role in limiting interdisciplinary team's ability to provide coordinated patient care, with interprofessional collaboration being premised on 'power sharing and parity' where the medical profession often has the most to lose (Thomas et al., 2014: 16). Multiple studies demonstrate that, all too often, physician's satisfaction with team interaction is not met with similar levels of satisfaction from other members of the medical team that they lead (Nicotera and Clinkscales, 2010; O'Leary et al., 2010; Ng et al.,2017), suggesting that coordination in interprofessional collaboration is, in many cases, yet to be achieved.

Issues surrounding such lack of coordination are, in turn, evidenced to lead to poor communication and, at times, also critical incidents and mistakes (Gawande et al., 2003; Leonard et al., 2004; Lingard et al., 2004; Sutcliffe et al., 2004; Rider and Keefer, 2006; Slade et al, 2008; US Joint Commission, 2014). The case of Elaine Bromiley, a patient admitted to a hospital for a seemingly routine operation, provides one such example of poor team communication being associated with breakdowns in an ad hoc team functioning and effectiveness (Bromiley, 2008). Centering on failure of due care, the case highlighted the complexities of interdisciplinary team interaction, and

specifically communication across historically emergent and institutionally entrenched hierarchies in ad hoc teams. The investigation into Bromiley's death demonstrated for example that experienced nurses, despite having brought tracheotomy equipment into the operating theatre, felt unable to speak up when they thought a tracheotomy should have been performed on a patient. One of the key recommendations of the coroner's report in this case was, accordingly, fostering a more collaborative environment in ad hoc teams in order to allow all members of ad hoc teams to contribute to the delivery of patient care (Harmer, 2005). Similar recommendations were put forward in relation to the specific context of emergency medicine as well (Ng et al., 2017). In both cases, the role played by the establishment of rapport between different healthcare professionals in ad hoc teams was recognized, highlighting the fact that when all 'caregivers communicate effectively and have the opportunity to share their own pieces of the puzzle, the whole picture of patient care is enhanced; conversely, when there are pieces missing, patient care is compromised' (Graham, 2009: 14). This, in turn, highlights the close interrelationship between communicative and clinical practice and performance.

2.2. Training to lead and manage rapport

For those leading medical teams, it is recommended that, in order to avoid the aforementioned instances of breakdowns in team interaction or information-sharing, power asymmetries are to be discursively collapsed. Teamwork and effective team communication skills in turn are considered central to professional development of healthcare staff, with there being calls for their greater incorporation in the training of medical staff (US Joint Commission, 2014).

Despite the evident need for team communication training for practitioners, the delivery of it is still relatively scarce – the predominant focus being placed on the development of individual communication skills and competencies as opposed to those associated with working as a team (Kuziemsky et al., 2009). Moreover, the delivery and the design of such materials is constrained by the need to resolve a seemingly contradictory set of recommendations, with healthcare professionals – on one hand – needing to discursively collapse power asymmetries - which in British English may be often normatively associated with, among others, drawing upon more mitigated and also often less direct linguistic forms - and – on the other hand – being encouraged to rely upon direct linguistic forms to achieve clarity and efficiency (Apker et al., 2005; Orasanu and Fischer, 2008). There is consequently a lack of sufficient training and research which informs our understanding of what discursive strategies are and can be used in interdisciplinary contexts to foster shared decision-making and problem-solving, with rapport building in healthcare contexts – and interprofessional medical interaction specifically - remaining still under-researched.

2.3. Research into politeness phenomena in medical interaction

Politeness research that has been carried out in relation to talk observed in medical settings draws upon different theoretical and analytical frameworks devised by politeness theorists. Among these, studies influenced by Brown and Levinson's (1987) now seminal work (Lambert, 1995, 1996; Spiers, 1998; Grainger, 2002; Backhaus, 2009; Brown and Crawford, 2009), the theory of politeness premised on the idea that 'a wilful fluent speaker of a natural language, further endowed with two special properties – rationality and face' that will typically act in such a manner as to not threaten one's or other people's face. With the latter being defined as 'the public self-image that every member wants to claim for himself [or herself]' (Brown and Levinson, 1987: 58-61) and associated with the way the term is commonly used metaphorically, for example, in the phrase 'to lose face', for Brown and Levinson (1987: 60), politeness is concerned with conflict avoidance. This is in line with the argument that 'it will in general be to the mutual interest of two MPs [model persons] to maintain each other's face', something critiqued by some scholars (Schmidt, 1980; Kasper, 1990: 194) on the premise of viewing communication as something 'fundamentally dangerous and antagonistic'. The argument that politeness is linked to conflict avoidance at least to a certain extent is not without any merit nevertheless, particularly given that impoliteness is an option that could be taken at any point during an exchange (Mills, 2011) and also with face being affective and associated with its own set of sensitivities. In Brown and Levinson's model of politeness (1987), this general orientation towards cooperation in interaction is realised through attending to one's or other interlocutor's face. This can take the form of linguistically displaying either greater emphasis on expression of familiarity, in line with people's desire to 'be appreciated and approved of', or the drive towards an expression of deference, recognising other people's 'basic claim to territories, personal preserves, rights to non-distraction' (Brown and Levinson, 1987: 61). In the study of politeness observed in the context of healthcare, this attendance to face has been also noted. Politeness practices associated with the orientation towards either deference or familiarity has been observed, for example, in the contexts of nurse-patient (Crawford et al., 1998; Spiers, 1998; Grainger, 2002; Backhaus, 2009) and interprofessional interactions (Lambert, 1995, 1996; Jameson, 2003, 2009) as well as mediated healthcare talk (Adolphs, Atkins and Harvey, 2007; Brown and Crawford, 2009; Harrison and Barlow, 2009). Healthcare professionals interacting in those settings in turn are evidenced to be responsive to the situational factors affecting the orientation that they take. In the studies of Spiers (1998), Grainger (2002) and Brown and Crawford (2009), for example, the practitioners can, on one hand, show deference when communicating bad news to another interlocutor but also use humour, fostering familiarity, when engaging in problematic or embarrassing talk.

Another framework often used to study politeness in medical settings is Locher and Watts's (2005) relational work. The concept itself is defined as 'the work people invest in negotiating their relationships in interaction' (Locher and Watts, 2008: 78), with relational work being developed as an alternative model of politeness to the one presented by Brown and Levinson (1987). Building on Brown and Levinson's (1987) work, the model accounts for what is argued to be 'the entire continuum [of] polite and appropriate and impolite and inappropriate behavior' that can be observed in talk (Locher and Watts, 2005: 11). In healthcare communication research, Zayts and Kang (2009) and Zayts and Schnurr (2013) draw upon the work of Locher and Watts (2005), evidencing how relational work is discursively negotiated by interlocutors involved in a given exchange. By examining interactions observed in the specific context of genetic counselling in Hong Kong, the authors argue, similarly to other studies of investigating politeness in healthcare talk that were discussed earlier, that politeness practices are context-dependant to a great extent, being quintessentially pragmatic phenomena.

The politeness research that has been observed in the context of healthcare communication so far has already generated important insights into the person-orientated aspect of communication observed in healthcare settings. There is nevertheless much need for further research, with alternative approaches to and models of politeness – such as the discursive approach to politeness (for discussion, see Linguistic Politeness Research Group, 2011) or rapport management (Spencer Oatey, 2000) – offering fruitful new perspectives on the issue, with one of the chapters in this volume drawing upon both (see Chapter x). In this chapter, we will draw upon a modified version of Spencer-Oatey's (2000) framework (discussed in detail in the Analytical Framework section), investigating specific aspects of rapport management, namely the mitigation of requests and active listenership, and considering both verbal and non-verbal realisation of politeness phenomena. In doing so, the chapter aims to illustrate the potential of politeness research to test theories of best practice and also examine the extent to which the performance and evaluation of specific communicative practices is context-bound.

3. Data and methods

The data presented in the chapter is collected in the context of medical training carried out in a large teaching hospital in the UK. The training forms part of the preparation of trainee doctors for their summative exam for specialism in emergency medicine in the UK and Republic of Ireland – the Fellowship of the Royal College of Emergency Medicine (FRCEM) final exam. The trainee doctors prepare specifically for the Objective Structured Clinical Examination (OSCE) element of the exam, OSCE involving a completion of strictly-timed stations 'where a standardized clinical task is

performed under the observation of one or two examiners who score the performance on a structured marking sheet' (Newble, 2004: 200). Preparatory exercises, such as the simulated trauma case examined in this chapter, are common practice in the run up to the FRCEM exam. They also provide trainee doctors with a crucial opportunity to practice the performance of leadership tasks, providing an insight into the development of the trainees' linguistic repertoires.

The data set presented in the chapter consists of seven video recordings of such trauma simulations as well as seven debrief sessions which occur directly after them. The trauma case presented in the recorded simulations involves an unidentified patient being admitted to an ED by a paramedic after being found next to a crashed car. In the simulation, each trainee doctor is expected to perform leadership tasks in order to: i) examine the patient; ii) identify the type of trauma suffered by them – in the case of the specific scenario, internal bleeding; and then iii) dispatch them to the appropriate department of the hospital – in the scenario, the operating theatre.

In each trauma simulation, the trainee manages a team of two healthcare professionals (Figure 1), a junior doctor and a nurse. Other healthcare professionals involved in the simulation include: a radiographer, a paramedic and a surgical consultant. With the exception of the role of a paramedic, all of the healthcare professionals' roles are acted out by experienced medical staff. The successful completion of the station is, thus, reliant also on the successful management of the trainee doctor's medical team, requiring from the trainee leading the team to request specific tasks to be performed by its members in a bid to achieve specific medical goals and complete the station within the allotted time.

Figure 1: The main participants of a simulation (l-r): consultant observing the simulation; paramedic (actor); trainee doctor; patient (actor); nurse (healthcare professional) and F2 doctor (healthcare professional).

Once the 14-minute simulation is completed, actors and healthcare professionals involved in the simulation are asked to assess how well the trainee managed the team overall. Apart from providing their comments, they are also asked to score the candidate's leadership performance on the scale of 1 to 5, 5 representing the best score. The scores given to trainee doctors by other participants of the simulation are then used in the analysis and to group the participants into high and good performers, and identify trainees whose leadership performance was assessed less favourably by members of their medical team. Out of the 7 simulations presented in this chapter, only one has received many recommendations for improvement and is evaluated less positively than simulations of other trainees, with one of its participants stating 'I didn't really know what to be doing most of the time'. The other trainee doctors are assessed either well or very well, with 3 trainee doctors being grouped into the 'high performers' category and 3 trainees being assessed well. All of the 'high performing' trainee doctors complete the station ahead of the allotted time, performing all of the key clinical tasks outlined in the marking sheet, whereas this can be observed only in one case in the 'good performers' group. The trainee whose leadership is assessed less favourably is observed to complete only some of the clinical tasks specified in the simulation marking sheet. Table 1 below outlines each station completion time.

Table 1: Station completion times

	Candidate	Station completion time	All of the key clinical tasks performed (Yes/No)
High performers	Candidate A	13:50	Yes
	Candidate B	12:03	Yes
	Candidate C	10:58	Yes
Good performers	Candidate D	12:36	Yes
	Candidate E	14:00	No
	Candidate F	14:00	No
Candidate assessed less favourably	Candidate G	14:00	No

4. Analytical framework

In the chapter, the evaluation of trainees' leadership performance and also the time it takes them to complete the station are matched up to the specific communicative means they use when managing their team. This is to assess which communicative strategies are evaluated more positively and are associated with greater efficiency. The analysis itself is divided into two parts: quantitative – where each feature under scrutiny is coded and quantified to look for patterns, and qualitative – where the patterns observed in the data are explored in detail through discourse analytical means. Sections 4.1 and 4.2 therefore will introduce the two key features under scrutiny, that is requests for action and active listenership, outlining the means through which they were coded and how the specific coding schemes were selected and operationalised in the quantitative analysis. Section 4.3, on the other hand, will discuss the framework employed in the qualitative analysis.

4.1. Delegating tasks

The delegation of tasks is one of the key foci of the analysis due to its interpretation as a prototypical aspect of the performance of leadership (Mullany, 2007; Holmes, 2009; Schnurr, 2009; Baxter, 2010), with leadership being argued to be not only discursively performed (Fairhurst, 2007) but also taking a multiplicity of forms (for discussion, see Fairclough, 1989 and Dwyer, 1993). The

different formulations of requests for action in turn suggest that, as argued by Holmes and Stubbe (2003: 40), '[u]nderlying every interaction […] is the delicate balance between the pressure to get job done well and efficiently on the one hand and *affective* considerations of collegiality and concerns for other people's feelings, i.e. politeness, on the other hand'. Such balancing of more relational and transactional elements of interaction is something that that has been noted by linguists some time ago (McCarthy, 1991; Coupland, 2000; Holmes, 2000), with the transactional aspect of such interaction encompassing 'getting business done in the world' (McCarthy, 1991: 136) and with the relational aspect having 'as its primary functions the lubrication of the social wheels' (McCarthy 1991: 136) in line with the recognition that language can be used to 'promote, maintain, or threaten harmonious social relations' (Spencer-Oatey 2008:4).

In order to establish how trainee doctors attend to such concerns in the process of direction-giving in the simulations that are analysed, the requests for action produced by the trainees are coded using a modified version of the CCSARP ('Cross-Cultural Study of Speech Act Realization Patterns') coding manual (Blum-Kulka et al., 1989). The coding scheme provides an outline of the different types of components of requests and the forms that they take (see Tables 2 and 3). Head acts, which are listed in Table 2, for example, can realise a request in their own right. They can also be expressed with varying degrees of directness, with certain forms – also indirect, as it is the case here - being highly conventionalised (e.g. 'Can you…?') and associated with requesting something from another interlocutor (Blum-Kulka and Olshtain, 1984). While not always being more polite (for discussion, see Mills and Grainger, 2016), the more indirect forms can demonstrate the speaker's orientation towards the mitigation of imposition of a certain request that they make (Fraser, 1990). The (in)directness of a speech act, in turn, is linked to the explicitness with which its illocutionary force is expressed, with Searle (1975: 60) linking this closely to linguistic form (locution) and defining indirect speech acts as "cases in which one illocutionary act is performed indirectly by way of performing another".

Table 3, in turn, outlines the external and internal modification that can be made to a request in order to strengthen or mitigate its force. The internal modification can include, for example, lexical mitigation in the form of hedges (e.g. 'perhaps') or politeness markers (e.g. 'please') that can further mitigate the strength of a request. External modification, finally, encompasses utterances that accompany the main requesting unit, the head act, and can include, for example, explanations as to why the request is made. Such instances of external modification can also act as means of mitigating or strengthening the force of a request.

Table 2: Types of head acts, defined as parts of speech acts which can realise them independently (based on Blum-Kulka et al., 1989)

	Strategy	Example
Direct	Mood derivable	*Get me an F2.*
	Obligation statement	*We need to get someone to come down and put a drain in.*
	Want statement	*Just want to get a chest x-ray.*
Indirect	Suggestory formulae	*Let's make sure we've got the chest drain trolley.*
	Query preparatory	*Can we put the trauma call in?*
	Hint	*You did give me a GAS but I don't think I actually did [see it].*

Table 3: Internal and external modification of head acts (based on Blum-Kulka et al., 1989)

Internal modification	Lexical	
	a) Hedging	*Could you **perhaps** help?*
	b) Understaters	*Linda, can you **just** let radiology know that we'll need an x-ray?*
	c) Subjectivisers	*John, can you get IV access **for me**?*
	d) Downtoners	*We should **probably** put in a drain on the right-hand side.*
	e) Politeness markers	*Can we get a handover then, **please**?*
	f) Collective pronouns	***We** need to activate major haemorrhage protocol.*
	g) Time intensifiers	*Okay, so we need to transfuse him **straight away**.*
External modification	Preparator	***Have we got a trauma team here?** Can we put a trauma call out?*
	Grounders	*So, **if they haven't arrived then**… yes, let's get him down so we can do a DPL.*
	Disarmers	*I'm sorry… **you're busy** but can we get some fluids ready as well?*

	Promises of reward	*If we can get the chest drain in then **that would be fantastic**.*
	Imposition downgraders	*I think we should probably put a binder on his pelvis guys **when we get a chance**.*
	Appealer	*Set him up in here before we start. **Is that alright?***

In the study, the different types of requesting and modification strategies are identified in the data and then quantified. On the basis of such quantification, it is explored whether there is any correlations between how trainee doctors delegate tasks to their teams and how their leadership skills are assessed by those whom those tasks were delegated to. The description of the linguistic profiles of trainee doctors that is enabled through such analysis is then used to help shed light on the types of leadership practices which are afforded a prototypical status in the simulated setting presented here. In addition to exploring how specific components of the candidates' linguistic repertoires are associated with the enactment of leadership, the chapter also sheds light on the relative success or failure of these strategies on the goal-orientated aspects of communication in this trauma scenario, in which tasks are to be jointly achieved.

4.2. Active listenership

The enactment of leadership, and the management of rapport observed as part of it, does not only involve speaking nevertheless, but can also be associated with listening, often also visibly demonstrated by the use of markers of active listenership by interlocutors. Defined as a 'way of indicating the listener's positive attention to the speaker' (Coates, 1986: 99), active listenership necessarily involves signalling attention to what is being said and, consequently, preoccupation with establishing or maintaining rapport (Knight, 2011).

In the analysed data, two forms of active listenership are identified – verbal and non-verbal, with those being further translated into verbal backchannels, gestures, gaze, body movement and head nods (Knight and Adolphs, 2008). With the exception of gestures, which – in the case of the data presented in this chapter - are produced more frequently by trainee doctors when giving instructions to their team, the different markers of active listenership (for overview, see Table 4) are identified and quantified in fragments of interaction where trainee doctors respond to other interlocutors' extended stretches of talk, usually observed in the context of handovers. Different forms of trainees' employment of active listenership is coded and then compared, showing discrepancies in how many markers of active listenership are evoked per one second of other

interlocutor's talk, or how frequently and for how long the trainee doctor orientates their body to the other interlocutor or makes eye contact with them. The annotation of markers of active listenership was carried out in ELAN. Similarly to the analysis of the use of requests for action, the examination of the presence of active listenership markers acts as a means of establishing how much orientation there is to rapport-building in each leadership performance and what consequences this has not only for its evaluation of leadership but also the efficiency of the performance of clinical tasks. As argued by Sarangi (2016: 3), '[a] team discussion, or even a dyadic interaction, will not be productive if no one adopts an active listener role, signalled through backchanneling cues, minimal responses or simply mutual gaze and posture orientations', highlighting its important role in ad hoc medical team talk.

Table 4: Types of markers of active listenership observed in the data (adapted version of Knight and Adolphs' (2008) coding scheme)

Marker of active listenership	Sub-type
1. Backchannel	Verbal (e.g. *mhm, yeah*)
	Non-verbal (headnod)
2. Eye gaze	
3. Body orientation	

4.3. Rapport management

In the qualitative analysis of the data presented in the chapter, apart from discussing the aforementioned linguistic forms of requests for action and markers of active listenership, their use is also analysed in conjunction with the examination of the broader management of rapport performed by each trainee doctor. 'Rapport' itself is defined by Spencer-Oatey and Franklin (2009: 102) as 'people's subjective perceptions of (dis)harmony, smoothness-turbulence and warmth-antagonism in interpersonal relations' while 'rapport management' is defined as 'the ways in which this (dis)harmony is (mis)managed'. In Spencer-Oatey's (2000, 2007: 644) politeness-theoretical model, the concept of face, defined as 'associated with positively evaluated attributes that claimant wants others to acknowledge [...] and with negatively evaluated attributes that the claimant wants others NOT to ascribe to him/her', is central to the proposed model and also becomes dichotomised. Quality face, which is one of the two conceptualisations of face provided by Spencer-Oatey (2000: 14), is proposed to be 'concerned with the value that we effectively claim for ourselves in terms of [...] personal qualities'. Identity face, on the other hand, is primarily 'concerned with the value that

we effectively claim for ourselves in terms of social and group roles' (Spencer-Oatey, 2000: 14). The model importantly departs from the primarily individualist face associated with, for example, Brown and Levinson's (1987) model, exploring aspects of face linked to individual, relational as well as social identities that a participant may evoke discursively in any interaction. Drawing on concepts adopted from social psychology, Spencer-Oatey (2009) acknowledges thus the importance of incorporating social perspectives in theorising the management of human relations. This becomes very useful when considering contexts such as the one analysed in the chapter, where not only individual but a relational and social identities – as well as group membership – can become become relevant at any point in interaction among groups of people working across a range of professions and also different levels within the institutional hierarchy. While recognizing the value of the incorporation of the social perspective in the analysis of rapport management nevertheless, the distinction between quality and identity face will be abandoned in the chapter. This is due to the fact that, as acknowledged by Spencer-Oatey (2009: 641), 'in many circumstances [a particular self-aspect] may be just one feature of a person's individual identity, yet in other situations it may be the feature that construes his/her collective identity'. It is difficult therefore to draw parallels between how specific self-aspects relate to enactment of personal (individual) and social (relational and collective) identities and, accordingly, corresponding aspects of face, so respectively quality and identity one. Instead, the non-dichotomised concept of face will be used here, drawing upon a conceptualisation of the notion provided by Goffman (1967: 5), with the concept of face being defined as 'the positive social value a person effectively claims for himself [or herself]' and providing a catalyst for the management of rapport.

Another concept that is linked to face and that will be operationalised in the chapter is the notion of sociality rights (Spencer-Oatey, 2000). Those are inevitably linked to a person's sense of social entitlements, stemming from the fact that face concerns positive evaluations of self-aspects and therefore being associated with its own set of sensitiviteies. As argued by Spencer-Oatey (2000), the social entitlements inked to face are thus often linked to issues surrounding consideration, fairness, and social inclusion and exclusion. Sociality rights are dichotomised into two corresponding aspects, equity and association rights (Spencer-Oatey, 2000). While the former is concerned with our entitlement to personal consideration and being treated fairly, the latter is associated with our entitlement to association-dissociation with others.

The model and the adopted notion of face are then used in the analysis of specific instances of interaction between members of the ad hoc team to examine how rapport is (mis)managed by the

specific candidates and to elaborate on the observation of patterns observed in the quantitative analysis.

5. *Analysis*

In this section of the chapter, the trainee doctors' performances of leadership – as realised through the employment of requests for action and active listenership – and the broader management of rapport are analysed vis-a-vis their relative success in the context of a trauma scenario in which clinical tasks are to be efficiently jointly achieved. Particular attention is paid to examining the extent to which these strategies place emphasis on establishing rapport, elucidating the extent to which person-orientation aids the efficient attainment of clinical tasks. This way, the validity of association of particular communicative strategies with greater efficiency and clarity will be tested as well.

5.1. *Delegation of tasks*

When examining how different trainee doctors delegate tasks to their subordinates, a great discrepancy was identified between the high and good performers and the trainee whose leadership skills were assessed less favourably. It was evidenced that those who completed the station quicker, receiving more favourable assessment of their leadership skills, delegated tasks to their team members relying to a greater extent on mitigation and being indirect (Figures 2 and 3).

Figure 2: Percentage of direct versus indirect requests employed by each trainee doctor (candidates ordered by evaluation of their leadership – highest to lowest score)

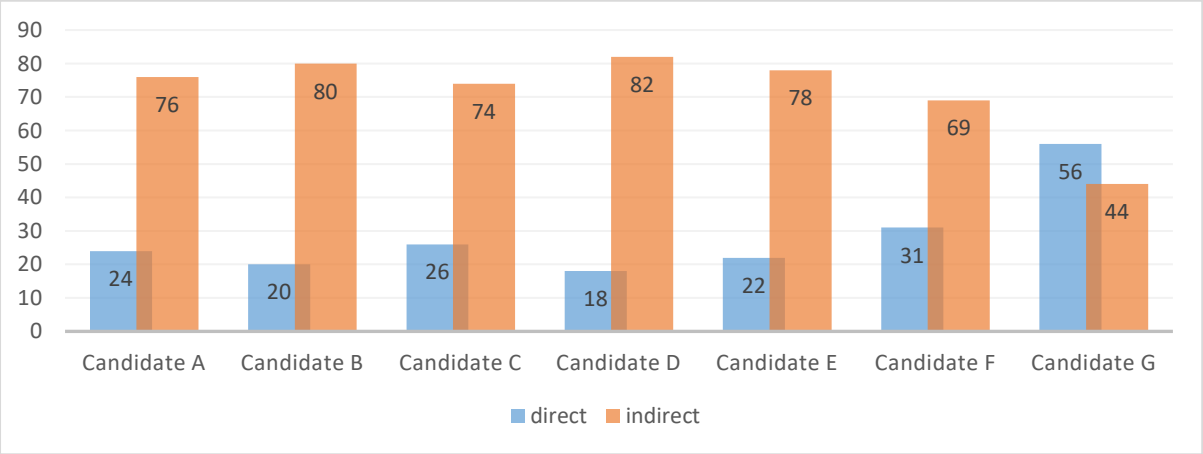
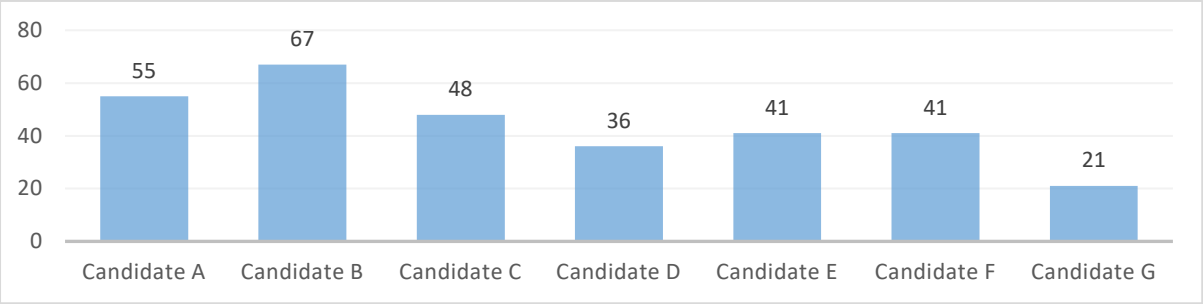


Figure 3: Percentage of instances when supportive moves (predominantly grounders) were used to modify requests by the trainees (candidates ordered by evaluation of their leadership – highest to lowest score)



In Figure 2, it is highlighted that, while high performing trainees showed greater preference for the utilisation of indirectness – using it between 69% and 82% of the time – the trainee whose leadership skills were evaluated less favourably used it only in 44% of instances when requests for action were employed. Even more pronounced differences in the communicative performance of trainee doctors was highlighted in the analysis of their employment of supportive moves (Figure 3). It was evidenced, thus, that the high performing trainees relied significantly more frequently on supportive moves, and in particular explanations relating to why specific tasks were delegated to members of their team, producing more elaborate requests than it was observed in the case of Candidate G.

One of the most significant findings of the examination of the trainee doctors' delegation of tasks was the correlation found between the efficient attainment of clinical goals and the employment of indirect and often very elaborate requesting strategies. Despite the often lengthy ways in which high performing trainee doctors asked others to perform specific workplace tasks, those leading the teams managed to also achieve them efficiently in the strictly-timed settings in which the trauma simulation was carried out. The correlation between the discursive minimisation of power asymmetries observed in these cases also importantly challenged assumptions that efficiency and clarity in urgent settings can only be equated with being authoritative and direct. The analysis of the data suggested that flattening out hierarchies in emergency medical teams and communicating efficiently and effectively when completing joint actions are not necessarily incompatible and that rapport and particular types of indirect strategies can be performed successfully in a time-limited setting as well.

One such example of the employment of greater levels of indirectness and mitigation evoking positive evaluation of trainee doctor's leadership performance was observed in the case of the trauma simulation of Candidate B, as illustrated in the fragment of simulation presented in Extract 1. The extract presents an interaction occurring at the start of a trauma case. The selection of an opening sequence of such interaction was motivated by aiming to illustrate how rapport was established early on by the trainee and by those whom the trainee was managing. As argued by Baxter (2015), the initial phases of professional exchanges also frequently provide a crucial insight into the emergence and negotiation of leadership as well, this also being the focus of the discussion presented here.

Extract 1

Candidate B (Colin, 'CAN') greets members of his team. He listens to what one of its members, Linda ('NRS'), has to tell him about the patient who is soon to arrive in the ED before delegating tasks to Linda and another F2 junior doctor, Ganesh ('F2D'), in preparation for the arrival of the patient and paramedic. Real names have been changed here for anonymity.

```
50  CAN: hiya
51  F2D: hi
52  NRS: ⌜hi the:re ⌝
53  CAN: ⌞hi guys  ⌟
54  NRS: is it Colin↑
55  CAN: it is↓ ⌜yeah ⌝
56  NRS:        ⌞Colin ⌟ I'm Linda
57   (ges):  (Colin and Linda shake hands)
58  CAN: ⌜hi Linda             ⌝
59  NRS: ⌞I'm one of the nurses⌟
60  F2D: I'm Ganesh F2 doctor
61   (ges):  (Colin and Ganesh shake hands)
62  CAN: Ganesh excellent nice to meet you both ⌜so:⌝
63   (ges): (Colin points at Linda)
64  NRS:                                       ⌞cool⌟
65  NRS: I've just ⌜had ⌝
66  CAN:           ⌞erm ⌟
67  NRS: a phone call e:rm
68  NRS: so paramedics are bringing in abou- (.) man of about sixty
69  NRS: they don't know how old he is and
70  NRS: he was found next to a erm smashed car
71  NRS: he's got a head injury ⌜he's got a low GCS BP ninety⌝
72  F2D:                        ⌞he's had a serious accident⌟
73  NRS: ninety over seventy
74  NRS: the only other thing I know is he's gonna be here in two minutes↓
75  CAN: great have we put a trauma call out↑
76  NRS: no
77  CAN: okay can we put the trauma call ⌜out please⌝
78   (ges):  (points in the direction of Linda)
79  NRS:                                 ⌞yeah  ⌟
[…]
132 CAN: can we get erm a bear hugger- a warmer underneath↑
133 NRS: on the trolley↑ ⌜yeah            ⌝
134 CAN:                 ⌞if that's alright⌟ yeah (1.0) fantastic
135 CAN: make sure we've got the fluid warmer in case we need it as well
136 CAN: let's look at some tranexamic acid given his hypotension
137 CAN: and a pelvic binder
138 F2D: yeah we've got a pelvic binder
139 NRS: pelvic binder got that ready there it is
140 F2D: and I assume ⁇it's there⁇
141 NRS: yeah yes: (.) yeah tranexamic's ready (.) cool we're all set
142 CAN: everyone happy with ⌜what their role is ⌝
143 F2D:                    ⌞yeah I'm ready yeah⌟
144 NRS: yeah
145 F2D: mhm
146 CAN: super
```

In Extract 1, the trainee doctor's attentiveness to establishing rapport with the members of the medical team is visible in a number of discursive choices that Colin makes in the exchange. Early on in the interaction, for example, Colin completes a number of adjacency pairs in the form of greetings (lines 50-53, 56-58 and 60-62) before drawing upon an informal term of address 'guys' (line 53). The employment of such informal term can be interpreted as a means of minimising the power asymmetries stemming from the allocation of roles in the specific context analysed and also attending to the other interlocutor's association rights, where affective association is evoked

discursively. The utterance ‘excellent nice to meet you both’ which is produced by Colin (line 62), while formulaic, is also associated with similar orientation towards attending to the relational aspect of communication through its inclusion of two positive evaluative phrases ‘excellent’ and ‘nice’. These in turn demonstrate Candidate B’s attention to the positive social values that the other interlocutors may claim for themselves, so aspects of face relating to their self-esteem and assessment on one’s own competence and skills. More instances of positive evaluative language are also observed later on, in lines 134, 141 and 146, and are generally commonly used across the entire simulation of this particular trainee.

The levels of indirect and mitigated requests which are produced by Colin, which are also higher than it would have been the case with trainee doctors whose leadership skills were assessed less favourably, are in line with the patterns of production of requests of other well-evaluated trainee doctors. Extract 1 provides an illustration of how such requests are issued to other members of Colin’s team. As observed in lines 132 and 134, the requesting strategies used by Candidate B include, for example, a query preparatory ‘can we get erm a bear hugger- a warmer underneath […] if that’s alright’. Later on, in line 136, the suggestory formulae ‘let's look at some tranexamic acid given his hypotension’ has the function of a request for action as well. The indirect nature of the uttered requests can be hypothesised to be linked to the interlocutor’s attention to equity rights of other participants, so their entitlement to personal consideration and to not be unfairly imposed upon. The only instance of a direct request in this exchange is observed in line 135. In this particular instance, Colin says ‘make sure we've got the fluid warmer in case we need it as well’ but - even when drawing upon such direct means of expressing his wish for a certain task to be performed – Colin employs a mitigation strategy, the grounder ‘in case we need it as well’. The use of mitigation in this case is associated with justifying the reason for his request. This, again, can be interpreted as an attempt to attend to interlocutor’s equity rights, with the participants not being ‘unduly imposed upon or unfairly ordered about’ (Spencer-Oatey, 2002: 541).

The employment of mitigation strategies, particularly in the forms of grounders and plural personal pronoun forms such as ‘we’ – associated with participants’ equity and association rights, is a common feature of the leadership performance of those trainees whose leadership skills are assessed particularly well. Despite the use of these more elaborate and mitigated requesting strategies, high performing trainees complete the station ahead of others, highlighting a close link between emphasis placed on rapport-building and the efficient achievement of workplace tasks. The attribution of leadership to these more elaborate, indirect and mitigated strategies highlights the value placed by those assessing simulations on power being exercised in less coercive ways, with the

consideration of the cost-benefit and autonomy-imposition continua in how trainees interact with other healthcare professionals and with the greater employment of collaborative strategies being also the preferred option for the performance of leadership here.

In contrast with this more indirect and mitigated delegation of tasks is the production of requests for action of the least favourably assessed trainee, Candidate G (Extract 2).

Extract 2

Candidate G (Norbert, 'CAN') starts delegating tasks to members of his team ('NRS' and 'F2D') in preparation for the arrival of the patient.

```
62  CAN: okay so we need to put a trauma call out
63   (ges): (gestures in the direction of a whiteboard)
64  NRS: okay
65  CAN: okay we ⌜need an airway- yeah ⌝
66  NRS:         ⌞I'll go and do that  ⌟
67  CAN: put the trauma call out first
68   (ges): (follows Linda, initially has his back towards Stuart)
69  CAN: okay we organise our trolley (.) okay
70   (ges): (turns towards Stuart, gestures in his direction)
71  CAN: are you erh happy once the patient's come in
72  NRS: (speaking over the phone) hello trauma team to resus please
73  CAN: to quickly assess the airway
74   (ges): (points at himself)
75  CAN: okay (.) and give feedback to me↗
76  NRS: ⌜trauma call's out ⌝
77  CAN: ⌞okay↑             ⌟ (.) and sorry your name↗
78  NRS: Linda
79  CAN: Linda
```

Extract 2 provides a snapshot of interaction observed at a similar stage in the trauma simulation to Extract 1. Extract 2 nevertheless demonstrates a much greater reliance on putting forth one's wishes in more direct and unmitigated ways. Candidate G is thus less likely to express his wishes in more downgraded ways, relying instead on the employment of want statements (lines 62 and 64) and mood derivables (lines 67 and 69) - both of which are a frequent feature of this simulation overall. These in turn are hypothesised to place less emphasis on the equity rights of other interlocutors, and with the trainee placing greater emphasis on task-orientation as well. One instance of an indirect request is produced in line 71. Despite taking form similar to the ones observed in the simulations of the more positively-evaluated candidates, the request is not met with any response, this being interpreted as a dispreferred response to the request. Candidate G also later enquires about Linda's name despite being introduced to her at the start of the simulation, potentially transgressing Linda's

sociality rights. With this emphasis on more authoritative performance of leadership, the potential transgression of the team members' sociality rights and also instances of interruptions which are observed prior to the interaction, Candidate G is prevented from achieving clinical goals as efficiently and quickly as those whose leadership performance is assessed more positively. The analysis of his simulation demonstrates thus how the performance of authoritative leadership does not always correlate with the efficient attainment of workplace goals.

5.2. Active listenership

The discrepancies in how leadership is performed by different trainees is further evidenced in the trainee doctors' employment of active listenership. The trainee doctors accordingly placed varying degrees of emphasis on either collaboration or authoritativeness and autonomy, highlighting different levels of orientation towards other interlocutors' sociality rights. Particularly in the case of their responses to Linda's (the nurse's) handover, which occurs early on in the interaction and also provides a vital means of establishing rapport with a member of a trainee doctor's team, it is the high performing trainees that employ the higher number of markers of active listenership per every second of Linda's talk (Table 4).

Table 4: Markers of active listenership employed by trainee doctors in response to Linda's handover

	Can A	**Can B**	**Can C**	**Can D**	**Can E**	**Can F**	**Can G**
Number of markers of active listenership	10	10	10	6	11	10	4
Length of Linda's handover	11.5s	12s	11.5s	10s	15s	14.5s	9s
Markers per second	**0.87/s**	**0.83/s**	**0.87/s**	0.60/s	0.73/s	0.69/s	**0.44/s**

As evidenced in Table 4 above, those trainee doctors whose leadership is evaluated more positively employ markers of active listenership twice as frequently as Candidate G. Candidates A, B and C in particular index their attention to what is being said by Linda more visibly than those whose leadership is assessed less favourably. The use of eye contact and also verbal response tokens – both of which can be interpreted to be linked with attending to other interlocutors' association rights, is particularly increased in the case of high performing trainee doctors as contrasted to the

employment of such active listenership markers by Candidate G. Extract 3 below illustrates the interaction between Candidate G and Linda early on in the simulation, and after the team members introduce themselves to one another.

Extract 3

Candidate G (Norbert, 'CAN') introduces himself to the team ('NRS' and 'F2D') before starting to delegate tasks.

```
32 CAN:  hello and you are↑
33 NRS:  Linda
34 CAN:  Linda (.) and you are↑
35 F2D:  I'm Simon ⌜I'm the⌝ F2
36 CAN:           ⌞Simon⌟
37       you are F2 ⌜Linda you are   ⌝
38 (ges): (points in Linda's direction)
39 NRS:             ⌞are you the regis-⌟ I'm a nurse- ⌜staff nurse ⌝
40 CAN:                                              ⌞and you are= ⌟
41       =the staff nurse
42 NRS:  nurse are you the reg in here today↑
43 CAN:  I am the reg here
44 NRS:  okay great have you heard about our red phone's coming in
45 CAN:  yes I have heard that erm (.) about this ⌜red come-      ⌝
46 NRS:                                          ⌞sixty year old=⌟
47       =chap ye:ah (.) maybe an RTC
48 CAN:  that's ⌜fine⌝
49 NRS:         ⌞head⌟ injury low GCS might need ⌜some ATLS⌝
50 CAN:                                          ⌞it looks like it's⌟
51       quite significant injury we need to organise our team
52 NRS:  ⌜okay ⌝
53 CAN:  ⌞okay↑⌟
```

In Extract 3, Candidate G is observed not only not to give Linda any eye contact when she delivers the handover (lines 44-49) – something which is not observed in any of the simulations of other candidates and also something that is explicitly commented on by the participants of the simulation during the debrief after the simulation – but also interrupts Linda in lines 49-50, cutting the handover short. This also results in Linda not providing him with all of the information received by other trainees. Candidate G specifically does not receive information about the patient's blood pressure and also the time left before the arrival of the patient, something that can be seen in Extract 1 in lines 71-74 and other opening sequences of the trauma simulation as well. Candidate G's minimal employment of markers of active listenership, with limited use of verbal markers and headnods, contributes to his authoritative performance of leadership, which - in the context of the studied trauma simulation - is not closely linked to efficiency with which the station is completed.

6. Conclusions

With the aim of the chapter being the elucidation of the relationship between leadership, rapport-building and clinical performance, the findings of the analysis of situated behaviour observed in the context of an ad hoc medical team presented in the chapter indexed a close relationship between the three. Rapport-building and goal-interaction in particular were evidenced to be closely interconnected. There was evidence thus of the greater employment of rapport-building strategies correlating with efficiency and attainment of clinical goals, also as outlined in the marking sheet. The analysis of data presented here revealed that – even despite the high-pressure nature of the context – using indirect and mitigated forms of requests and employing more markers of active listenership correlated with the trainee's relative success, as evidenced by both the positive evaluation of their leadership practices and the station completion times. Despite drawing upon often lengthier and more time-consuming verbal and non-verbal means, the high performing trainees – who simultaneously often closely attended to the other interlocutors' sociality rights - were also evidenced to complete the station ahead of other trainees, highlighting how those more elaborate strategies employed by them did not have a detrimental effect on the team's efficiency but, in fact, coincided with its greater increase. Despite claims about the more efficient nature of more direct and unmitigated use of language, particularly when warranted by urgency, the linguistic findings presented here suggested that the use of certain types of indirectness and other rapport-building strategies might be much more efficient than previously thought, both in the pragmatics (Brown and Levinson, 1987) and medical communication literature (Apker et al., 2005; Orasanu and Fischer, 2008). That in itself provides an important finding and also challenges previously asserted claims about communicative behaviour displayed in urgent settings as well.

Given the evidence of the distinct nature of simulations in comparison to real-life interactions observed in healthcare settings (Atkins, 2019), further research is needed to establish whether the observations made in the simulation context presented here map onto real life practice. The fact that the evaluations of leadership performances of each of the trainee doctors are provided by experienced healthcare professionals suggests that the observations made here can be predictive at least to a certain extent in relation to the types of leadership enactments – and as part of them rapport management – that are assessed more positively also in ad hoc team interactions that are not simulated.

With the practices that are more likely to be attributed to the prototypical enactment of leadership in the analysed data being context-specific, another important issue that needs further exploration with regards to the analysis of the data recorded in the context of emergency medicine training is

the extent to which the pragmatic competence expected of the candidates in the simulation puts certain trainees at a disadvantage. In the case of the findings of research presented in the chapter, many leadership performance strategies evaluated positively in the study, and also associated with the wider management of rapport, can be associated with normative ideas about British English politeness, and more specifically British English politeness tied to a specific social class (for discussion, see Mills, 2017). In the context of the observed study, candidates who do well are all native speakers of British English. The candidate who is evaluated less favourably is not. Information about the trainees' social class background was not elicited in the study but the initial observations made in relation to the data instigate further exploration of the extent to which normative ideas about what constitutes effective leadership in this context are influenced by who worked in the UK emergency medicine traditionally and what influence this has on, for example, trainees who are non-native speakers of British English and also trainees from working class backgrounds – with there being some evidence of those groups being often disadvantaged in other contexts in healthcare (Roberts et al., 2000).

While the chapter clearly highlights that effective leadership can involve an increased level of rapport building strategies - those also involving mitigation and indirectness – without negatively affecting efficiency or clarity of what is being said, some of the strategies tied to more positive evaluation of leadership are, as discussed above, also context-specific. This in turn is associated with trainee doctors having to poses a level of pragmatic awareness in their performance of leadership. A tentative recommendation that can be drawn from this small-scale study then is the need for the integration of pragmatics into communication skills training of both future and current healthcare professionals, with all healthcare professionals developing a pragmatic awareness (see also Roberts, 1998) allowing them to develop flexibility in how they communicate. There needs to be also a recognition of the increasing heterogenisation of both clinical teams as well as patients more generally, with politeness research in this setting being able to contribute to developing a more nuanced understanding of the range of the different practices employed by healthcare professionals in that sphere.

7. References

Adolphs, Svenja, Atkins, Sarah, and Harvey, Kevin, 2007. Caught between professional requirements and interpersonal needs: Vague language in healthcare contexts. In: Joan Cutting (ed.) Vague Language Explored. pp. 62-78.

Apker, Julie, Propp, Kathleen M., Zabava Ford, Wendy S., 2005. Negotiating status and identity tensions in healthcare team interactions: an exploration of nurse role dialectics. Journal of Applied Communication Research 33 (2): 93–115.

Arber, Anne, 2008. Team meetings in specialist palliative care: Asking questions as a strategy within interprofessional interaction. Qualitative Health Research 18 (10): 1323-1335.

Atkins, Sarah, 2019. Assessing health professionals' communication through role-play: An interactional analysis of simulated versus actual general practice consultations. Discourse Studies 21 (2): 109-134.

Backhaus, Peter, 2009. Politeness in institutional elderly care in Japan: A cross-cultural comparison. Journal of Politeness Research 5: 53-71.

Ballinger, Claire, Ashburn, Ann, Low, Joseph E., and Roderick, Paul, 1999. Unpacking the black box of therapy: A pilot study to describe occupational therapy and physiotherapy interventions for people with stroke. Clinical Rehabilitation 13: 301–309.

Baxter, Judith, 2010. The Language of Female Leadership. Basingstoke: Palgrave Macmillan.

Baxter, Judith, 2015. Who wants to be the leader? The linguistic construction of emerging leadership in differently gendered teams. International Journal of Business Communication 52 (4): 427-451.

Blum-Kulka, Shoshana, and Olshtain, Elite, 1984. Requests and apologies: A cross-cultural study of speech act realization patterns (CCSARP). Applied Linguistics 5: 196-213.

Blum-Kulka, Shoshana, House, Juliane, Kasper, Gabriele, 1989. Cross-Cultural Pragmatics: Requests and Apologies. Norwood: Ablex.

Borges, Stefanie, 1986. A feminist critique of scientific ideology: An analysis of two doctor-patient encounters. In: Sue Fisher and Alexandra Todd (eds.) Discourse and Institutional Authority: Medicine, Education and Law. pp. 26-48.

Bromiley, Martin, 2008. Have you ever made a mistake? Bulletin of The Royal College of Anaesthetists 48: 2442–2445.

Brookes, Gavin, and Baker, Paul, 2017. What does patient feedback reveal about the NHS? A mixed methods study of comments posted to the NHS Choices online service. BMJ Open 7: 1-11.

Brown, Brian J., and Crawford, Paul, 2009. Politeness strategies in question formulation in a UK telephone advisory service. Journal of Politeness Research 5: 73-92.

Brown, Penelope, and Levinson, Stephen C., 1987. Politeness: Some universals in language usage. Cambridge: Cambridge University Press.

Cicourel, Aaron V., 1999. The interaction of cognitive and cultural models in health care delivery. In: Srikant Sarangi and Celia Roberts (eds.) Talk, Work, and Institutional Order: Discourse in Medical, Mediation and Management Settings. pp. 183–224.

Coates, Jennifer, 1986. Women, Men, and Language: A Sociolinguistic Account of Sex Differences in Language. London: Longman.

Coupland, Justine, 2000. Small Talk. Harlow: Longman.

Crawford, Paul, Brown, Brian, and Nolan, Peter, 1998. Communicating Care: The Language of Nursing. Cheltenham: Nelson Thornes.

Delbene, Roxana, 2004. The function of mitigation in the context of a socially stigmatized disease: A case study in a public hospital in Montevideo, Uruguay. Spanish in Context 1: 241-266.

Dwyer, Judith, 1993. The Business Communication Handbook. New York: Prentice Hall.

Fairclough, Norman, 1989. Language and Power. London: Longman.

Fairhurst, Gail T., 2007. Discursive Leadership: In Conversation with Leadership Psychology. Thousand Oaks: Sage.

Fisher, Sue, 1984. Doctor-patient communication: A social and micro-political performance. Sociology of Health and Illness 6: 1-29.

Fraser, Bruce, 1990. Perspectives on politeness. Journal of Pragmatics 14: 219-236.

Gawande, Atul A., Zinner, Michael J., Studdert, David M., and Brennan, Troyen A., 2003. Analysis of errors reported by surgeons at three teaching hospitals. Surgery 133 (6): 614–621.

Graham, Sage, 2009. Hospitalk: Politeness and hierarchical structures in interdisciplinary discharge rounds. Journal of Politeness Research 5, 11-31.

Grainger, Karen, 2002. Politeness or impoliteness? Verbal play on the hospital ward. [Online resource] Available at: https://extra.shu.ac.uk/wpw/politeness/grainger.htm [Accessed at: 14 May 2019].

Grainger, Karen, 2004. Verbal play on hospital wards: solidarity or power? Multilingua 23: 39-59.

Goffman, Erving, 1967. Interaction Ritual: Essays in Face to Face Behavior. New Jersey: Transaction Publishers.

Harmer, Michael, 2005. Independent review on the care given to Mrs Elaine Bromiley on 29 March 2005. [Online resource] Available at: http://emcrit.org/wp-content/uploads/ElaineBromileyAnonymousReport.pdf [Accessed at: 14 May 2019].

Harrison, Sandra, and Barlow, Julie, 2009. Politeness strategies and advice-giving in an online arthritis workshop. Journal of Politeness Research 5: 93-111.

Heritage, John, and Maynard, Douglas W., 2006. Communication in Medical Care: Interaction between Primary Care Physicians and Patients. Cambridge: Cambridge University Press.

Heritage, John, and Sefi, Sue, 1992. Dilemmas of advice: Aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers. In: Paul Drew and John Heritage (eds.) Talk at Work. pp. 359–419.

Hollenback, John R., Beersma, Bianca, and Schouten, Maartje, 2012. Beyond team types and taxonomies: A dimensional scaling conceptualization for team description. The Academy of Management Review 37: 82-106.

Holmes, Janet, 2000. Politeness, power and provocation: How humour functions in the workplace. Discourse Studies 2: 159-185.

Holmes, Janet, 2009. Men, masculinities and leadership: Different discourse styles at work. In: Pia Pichler and Eva Eppler (eds.) Gender and Spoken Interaction. pp. 186-210.

Holmes, Janet, and Stubbe, Maria, 2003. Power and Politeness in the Workplace: A Sociolinguistic Analysis of Talk at Work. London: Longman.

Iedema, Rick, 2005. Medicine and health, inter and intra-professional communication. In: Keith Brown (ed.) Encyclopaedia of Language and Linguistics. pp. 745-751.

Jameson, Jessica Katz, 2003. Transcending intractable conflict in health care: An exploratory study of communication and conflict management among anesthesia providers. Journal of Health Communication 8: 563-581.

Kasper, Gabriele, 1990. Linguistic politeness: Current research issues. Journal of Pragmatics 14: 193–218.

Knight, Dawn, 2011. Multimodality and Active Listenership: A Corpus Approach. London: Continuum.

Knight, Dawn, and Adolphs, Svenja, 2008. Multi-modal corpus pragmatics: The case of active listenership. In: Jesús Romero-Trillo (ed.) Pragmatics and Corpus Linguistics. pp. 175-190.

Kuziemsky, Craig E., Borycki, Elizabeth M., Purkis, Mary Ellen, Black, Fraser, Boyle, Michael, Cloutier-Fisher, Denise, Fox, Lee Ann, MacKenzie, Patricia, Syme, Ann, Tschanz, Coby,

Wainwright, Wendy, Wong, Helen, and Interprofessional Practices Team, 2009. An interdisciplinary team communication framework and its application to healthcare 'e-teams' systems design. BMC Medical Informatics and Decision Making 9: 43.

Lambert, Bruce L., 1995. Directness and deference in pharmacy students' messages to physicians. Social Science and Medicine 40: 545-555.

Lambert, Bruce L., 1996. Face and politeness in pharmacist-physician interaction. Social Science and Medicine 43: 1189-1198.

Leathard, Audrey, 1994. Going Interprofessional: Working Together for Health and Welfare. London: Routledge.

Leonard, Michael W., Graham, Sean A., and Bonacum, Doug, 2004. The human factor: The critical importance of effective teamwork and communication in providing safe care. BMJ Quality & Safety 13: 85-90.

Lingard, Lorelei, Espin, Sherry, Whyte, Sarah, Regehr, Glenn, Baker, G. Ross, Reznick, Richard, Bohnen, John, Orser, Beverley, Doran, Diane, Grober, Ellen, 2004. Communication failures in the operating room: An observational classification of recurrent types and effects. Quality and Safety in Health Care 13 (5): 330-334.

Linguistic Politeness Research Group, 2011. Discursive Approaches to Politeness. Berlin: Mouton de Gruyter.

Locher, Miriam A., and Schnurr, Stephanie, 2017. (Im)politeness in health settings. In: Jonathan Culpeper, Michael Haugh and Dániel Z. Kádár (eds.) The Palgrave Handbook of Linguistic (Im)politeness. pp. 689-711.

Locher, Miriam, and Watts, Richard, 2005. Politeness theory and relational work. Journal of Politeness Research 1: 9-33.

Locher, Miriam, and Watts, Richard, 2008. Relational work and impoliteness: Negotiating norms of linguistic behaviour. In: Derek Bousfield and Miriam Locher (eds.) Impoliteness in Language: Studies on Its Interplay with Power in Theory and Practice. Berlin: Mouton de Gruyter. pp. 77-99.

Mattingly, Cheryl, 1994. The concept of therapeutic employment. Social Science and Medicine 38: 811-822.

Maynard, Douglas W., 1992. On clinicians' co-implicating recipients in the delivery of diagnostic news. In: Paul Drew and John Heritage (eds.) Talk at Work. pp. 331-358.

McCarthy, Michael, 1991. Discourse Analysis for Language Teachers. Cambridge: Cambridge University Press.

Mills, Sara, 2011. Discursive approaches to politeness and impoliteness. In: Linguistic Politeness Research Group (eds.) Discursive Approaches to Politeness. Berlin: Mouton de Gruyter. pp. 19-56.

Mills, Sara, 2017. English Politeness and Class. Cambridge: Cambridge University Press.

Mills, Sara, and Grainger, Karen, 2016. Directness and Indirectness Across Cultures. Basingstoke: Palgrave Macmillan.

Mishler, Elliot George, 1984. The Discourse of Medicine: Dialectics of Medical Interviews. Norwood: Ablex.

Mullany, Louise, 2007. Gendered Discourse in the Professional Workplace. Basingstoke: Palgrave Macmillan.

Mullany, Louise, 2009. Introduction: Applying politeness research to health care communication. Journal of Politeness Research 5: 1-10.

Newble, David, 2004. Techniques for measuring clinical competence: Objective structured clinical examinations. Medical Education 38: 199-203.

Ng, George Wing Yiu, Pun, Jack Kwok Hung, So, Eric Hang Kwong, Chiu, Wendy Wai Hang, Leung, Avis Siu Ha, Stone, Yuk Han, Lam, Chung Ling, Lai, Sarah Pui Wa, Leung, Rowlina Pui Wah, Luk, Hing Wah, Leung, Anne Kit Hung, Yeung, Kin Wah Au, Lai, Kang Yiu, Slade, Diana, and Chan, Engle Angela, 2017. Speak-up culture in an intensive care unit in Hong Kong: A cross-sectional survey exploring the communication openness perceptions of Chinese doctors and nurses. BMJ Open 7: e015721.

Nicotera, Anne Maydan, and Clinkscales, Marcia J., 2010. Nurses at the nexus: A case study in structurational divergence. Health Communication 25: 32-49.

O'Leary, Kevin J., Ritter, C. D., Wheeler, H., Szekendi, M, K., Brinton, T. S., and Williams, M. V. 2010. Teamwork on inpatient medical units: assessing attitudes and barriers. BMJ Quality & Safety 19: 117-121.

Orasanu, Judith, and Fischer, Ute, 2008. Improving healthcare communication: Lessons from the flightdeck. In: Christopher Nemeth (ed.), Improving Healthcare Team Communication. Chicago: University of Chicago Press. pp. 23-46.

Pilnick, Alison, 1998. 'Why didn't you say just that?' Dealing with issues of asymmetry, knowledge and competence in the pharmacist/client encounter. Sociology of Health & Illness 20: 29-51.

Pilnick, Alison, 1999. 'Patient counseling' by pharmacists: Advice, information, or instruction? Sociological Quarterly 40, 613-622.

Rider, Elizabeth A. and Keefer, Constance H., 2006. Communication skills competencies: Definitions and a teaching toolbox. Medical Education 40: 624–629.

Roberts, Celia, 1998. Awareness in intercultural communication. Language Awareness 7: 109-127.

Roberts, Celia, Sarangi, Srikant, Southgate, Lesley, Wakeford, Richard, and Wass, Val. 2000. Oral examinations-equal opportunities, ethnicity, and fairness in the MRCGP. BMJ 320: 370-375.

Sarangi, Srikant, 2004. Towards a communicative mentality in medical and health care practices. Communication and Medicine 1: 1–12.

Sarangi, Srikant, 2006. The conditions and consequences of professional discourse studies. In: Richard Kiely, Pauline Rea-Dickens, Helen Woodfield, and Gerald Clibbon (eds.) Language, Culture and Identity in Applied Linguistics. pp. 199-220.

Sarangi, Srikant, and Roberts, Celia, 1999. Talk, Work, and Institutional Order: Discourse in Medical, Mediation and Management Settings. Berlin: Mouton de Gruyter.

Sarangi, Srikant, 2016. Editorial: Teamwork and team talk as distributed and coordinated action in healthcare delivery. Communication & Medicine 13 (1): 1-7.

Schmidt, Richard W. 1980. Review of Esther Goody, ed., Questions and Politeness: Strategies in Social Interaction. Regional Language Centre Journal 11: 100-114.

Schnurr, Stephanie, 2009. Leadership Discourse at Work: Interactions of Humour, Gender and Workplace Culture. Basingstoke: Palgrave Macmillan.

Searle, John R., 1975. Indirect speech acts. In: Peter Cole and Jerry L. Morgan (eds.) Syntax and Semantics, Vol. 3: Speech Act. New York: Academic Press.

Silverman, David, 1987. Communication and Medical Practice: Social Relations in the Clinic. London: Sage.

Slade, Diane, Scheeres, Hermine, Manidis, Marie, Iedema, Rick, Dunston, Roger, Stein-Parbury, Jane, Matthiessen, Christina, Herke, Maria, and McGregor, Jeannette, 2008. Emergency communication: The discursive challenges facing emergency clinicians and patients in hospital emergency departments. Discourse & Communication 2 (3): 271-298.

Spencer-Oatey, Helen, 2000. Culturally Speaking: Rapport Management through Talk across Cultures. London: Continuum.

Spencer-Oatey, Helen, 2002. Managing rapport in talk: Using rapport sensitive incidents to explore the motivational concerns underlying the management of relations. Journal of Pragmatics 34: 529-545.

Spencer-Oatey, Helen, 2007. Theories of identity and the analysis of face. Journal of Pragmatics 39: 639-656.

Spencer-Oatey, Helen, 2008. Culturally Speaking: Culture, Communication and Politeness Theory. London: Continuum.

Spencer-Oatey, Helen, 2009. Face, identity and interactional goals. In: Francesca Bargiela-Chiappini, and Michael Haugh (eds.) Face, Communication and Social Interaction. London: Equinox. pp. 137-154.

Spencer-Oatey, Helen, and Franklin, Peter H., 2009. Intercultural Interaction: A Multidisciplinary Approach to Intercultural Communication. Basingstoke: Palgrave Macmillan.

Spiers, Judith, 1998. The use of facework and politeness theory. Qualitative Health Research 8: 25-47.

Sutcliffe, Kathleen M, Lewton, Elizabeth, and Rosenthal, Marilynn M., 2004. Communication failures: An insidious contributor to medical mishaps. Academic Medicine 79 (2): 186–194.

Thomas, Judith, Pollard, Katherine C., and Sellman, Derek, 2014. Interprofessional Working in Health and Social Care: Professional Perspective. London: Red Globe Press.

US Joint Commission, (2014). America's Hospitals: Improving Quality and Safety – The Joint Commission's Annual Report 2014. [Online recourse] Available at: www.jointcommission.org/tjc_annual_report_2014/ [Accessed at: 30 March 2018].

Villagran, Melinda M., and Baldwin, Paula K., 2014. Healthcare team communication. In: Heidi E. Hamilton and Wen-ying Sylvia Chou (eds.) The Routledge Handbook of Language and Health Communication. pp. 339-354.

von Raffler-Engel, Walburga, 1989. Doctor-patient Interaction. Amsterdam: John Benjamins.

West, Candice, 1984. Routine Complications: Troubles with Talk between Doctors and Patients. Bloomington: Indiana University Press.

Woolhead, Gill, Tadd, Win, Antoni Boix-Ferrer, Josep, Krajcik, Stefan, Schmid-Pfahler, Barbara, Spjuth, Barbro, Stratton, David, and Dieppe, Paul, 2006. 'Tu' or 'Vous?': A European qualitative study of dignity and communication with older people in health and social care settings. Patient Education and Counseling 61: 363-371.

Zayts, Olga, and Kang, M. Agnes, 2009. 'So, what test do you prefer?': Negotiating politic behaviour in an L2 prenatal genetic counselling setting in Hong Kong. Journal of Politeness Research 5: 33-52.

Zayts, Olga, and Schnurr, Stephanie, 2013. '[She] said: "take the test" and I took the test': Relational work as a framework to approach directiveness in prenatal screening of Chinese clients in Hong Kong. Journal of Politeness Research 9 (2): 187–210.