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## Influence of interactional structure on patient's participation during interprofessional discharge planning meetings in rehabilitation centers

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### ABSTRACT

Interprofessional practice has become increasingly important. In addition, patients are expected to participate more actively in health-care decisions. While comprehensive discharge planning has been shown to be effective, it is unclear how interactional structure influences patients' participation during discharge planning meetings. The aims of this qualitative study were to examine the interactional structure of interprofessional meetings in two rehabilitation clinics and to identify patients' types of communicative involvement (patient participation) during discharge planning meetings. Using an ethnomethodological approach and Conversation Analysis, 121 interprofessional meetings were video-recorded (19 hours of recordings). Twenty-five patients (30–87 years) with neurological or musculoskeletal disorders and their teams were included. The findings revealed two types of meetings aimed at either (a) exchanging information with team members and patient ("information exchange meeting") or (b) negotiating care plans with patients and the team. "Negotiation meetings" were often led by allied health professionals or nurses and were characterized by active patient participation. Those meetings offered patients an opportunity to give additional information rather than only ask questions. The discussion includes reflections on how interactional analysis can help understand the social organization of meetings and how patient participation can be enhanced in this context and concludes with practice implications.

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### Introduction

Discharge planning involves the development of an individualized plan aimed at facilitating a patient's transition from a rehabilitation center to home and at preventing problems after discharge (Mistiaen, Francke, & Poot, 2007). Guidelines of discharge planning include the following principles: (1) early start of discharge planning (at admission), (2) the development of a clinical management plan (e.g. goal setting), (3) team coordination and collaboration, and (4) involvement of patients during the entire discharge planning process (Heath, Sturdy, & Cheesely, 2010). Organizational features (early start, clinical procedures, and team collaboration) and patient participation are at the forefront of optimal discharge procedures. If done properly, as suggested by a recent Cochrane Review, discharge planning can deliver benefits in terms of shorter lengths of hospital stays, lower rates of readmission, and increased patient satisfaction (Gonçalves-Bradley, Lannin, Clemson, Cameron, & Shepperd, 2016).

Interprofessional collaboration as a practice in discharge planning requires appropriate team communication and organizational structures to ensure successful collaboration. Team meetings are considered a prime site of the construction, negotiation, and dissemination of organizational culture (Boden, 1994), and "constitute one of the most significant arenas for

organizational communication" (Svennevig, 2012a; p. 3). It has been suggested that communicative behaviors follow an "interactional structure", i.e. health professionals are accountable for progressing through an ordered sequence of professional activities until completion (Robinson, 2003). Identifying a meeting's interactional structure is therefore important when trying to understand how team members and patients communicate with each other during discharge planning meetings.

As noted above, patient participation is crucial for successful discharge planning. While patients are encouraged to voice their expectations, and professionals are required to involve them in decisions regarding their care, this is not always straightforward (Efraimsson, 2004, 2006). According to Thompson, Ruusuvaori, Britten, and Collins (2010) five types of participation (i.e. levels of involvement) exist on a continuum from (a) non-involved; (b) information-seeking; (c) information-giving; (d) shared decision-making; or (e) autonomous decision-making (Thompson et al., 2010). Low level involvement (see (a) and (b) above) may be due to (a) patients' decision to adopt a passive role; (b) patients' emotional state (e.g. fear to ask questions); (c) patients' limited resources and sociodemographic characteristics (e.g. lack of technical and medical knowledge); (d) physicians' communication style and organizational variables; and (e) the interactional structure of consultations (Robinson, 2003). In addition to these reasons identified within patient–doctor interactions,

involving patients in team meetings poses an additional challenge. Leadership skills, team communication, or institutional care procedures can also influence patients' active participation in team meetings (Efrainsson, Rasmussen, Gilje, & Sandman, 2003; Huby, Brook, Thompson, & Tierney, 2007; Huby, Stewart, Tierney, & Rogers, 2004; Montori, Gafni, & Charles, 2006). It is therefore in a meeting environment where the process of patient participation needs to be at its best for an ultimately good outcome of discharge planning.

While patient participation has been advocated in policy papers (World Health Organization - WHO, 2013) and professional guidelines published by the World Confederation for Physical Therapy (World Conference for Physical Therapy - WCPT, 2011), patients themselves reported to feel powerless, treated like an object and without a voice during discharge planning meetings (Efrainsson et al., 2003; Huby et al., 2004). While the aforementioned studies identified obstacles to include patients' perspectives in team meetings, less is known about whether interactional features play a role in enhancing or limiting patients' involvement during discharge planning meetings. The objectives of this qualitative study were (a) to examine the interactional structure of interprofessional meetings in rehabilitation clinics and (b) to identify patients' types of communicative involvement (patient participation) during discussions related to discharge.

## Method

Observing actual interactions enables one to better understand complex organizational processes (Llewellyn & Hindmarsh, 2010). Conversation analysis, a qualitative observational method inspired by ethnomethodology, has been widely applied to medical interactions (Heritage & Maynard, 2006) and allied health professions, such as nursing (Jones, 2009) and physiotherapy (Parry, 2004; Schoeb, Staffoni, Parry, & Pilnick, 2014). Ethnomethodology aims to explicate how people "create and maintain a sense of order and intelligibility in social life (pp.14)" (Ten Have, 2004). The particularity of this methodology is that the inquiry about the social world does not start with existing theories, but with experiences of the social world in daily life. While adopting a "bottom-up" approach it tries to "recover social organization as an emergent achievement that results from the concerted efforts of societal members acting within local situations" (p. 174, Maynard & Clayman, 2003). Ethnomethodology provides the intellectual framework for Conversation Analysis (hereafter CA) which was developed by Sacks, Schegloff, and Jefferson (Ten Have, 2004). CA has an important place to describe the **process** of the interaction between patients and practitioners (Drew, Chatwin, & Collins, 2001) and has shown its relevance towards understanding how meetings work in general (Boden, 1994; Svennevig, 2012a, 2012b; Asmuss & Svennevig, 2009) or specifically within healthcare (Keel & Schoeb, 2015; Nielsen, 2009). The philosophy underlying CA is that talk can be understood as sequentially organized and ordered, hence the interest for the analysis of interactional structure in team meetings.

Structural and sequence organization (i.e. how different phases of interaction are organized and followed-through), as well as turn-design and turn-construction (i.e. how a speaker constructs a turn at talk and what this turn accomplishes in the

interaction) are features of CA that can help describe the process of patient participation during discharge planning meetings (Heritage, 2004). Maynard and Heritage (2005) argue that "analysing co-construction is a direct research embodiment of patient-centredness, and it facilitates the biopsychosocial approach to the (medical) interview, as well as a more recent emphasis on relationship-centred care" (p. 433).

Only a few studies exist on team processes in healthcare that used ethnomethodology and CA (Barnard, Cruice, & Playford, 2010; Nielsen, 2009), and our study therefore fills this gap by identifying communication patterns used in interprofessional meetings.

## Study settings

Twenty-five patients from two rehabilitation centers in Switzerland were included in the study. There are 25 accredited rehabilitation institutions in Switzerland and the selected clinics represent two different languages, as well as different size and payment systems. The French-speaking institution (Clinic 1) is a stand-alone rehabilitation clinic with 112 beds while the German-speaking clinic (Clinic 2) is a small size rehabilitation center (28 beds) integrated within a district hospital. Clinic 1 constitutes three specialty units: (1) work-specific rehabilitation, (2) musculoskeletal rehabilitation, and (3) rehabilitation after spinal cord injuries. Initially, all units consented to participate in the study but Unit No 3 did not contribute much due to scheduling issues. Two types of interprofessional meetings were scheduled to discuss patients' progress and discharge plans: a weekly interprofessional team meeting and interprofessional visit. The team meeting included all staff involved in a patient's care and allowed health and social care professionals to exchange information about patients currently under their care. The interprofessional visit following the team meeting aimed to perform further clinical examination, to discuss treatment interventions, and finally to decide about discharge.

In Clinic 2, all units (geriatric rehabilitation, neurological, and musculoskeletal rehabilitation) participated in the study. Two interprofessional meetings in the presence of patients were part of the discharge planning procedure: an interprofessional entry meeting was held within three days of admission to discuss a patient's rehabilitation goals, while follow-up meetings were organized once a week during the patient's stay at the institution.

The focus of this qualitative study was to gather information from two different institutions in order to detect a variety of communicative practices regarding team organization and meeting structure.

## Selection of participants

All patients entering the clinics were invited by the admission officer to participate in this study. A convenience sample was selected using the following criteria: older than 18 years; sufficient cognitive abilities (Mini Mental State assessment  $\geq$  25 points); able to communicate verbally; and gave consent for video-recordings.

Ethics approval was granted by local Institutional Review Committees, and informed consent was obtained from all patients and staff prior to enrollment.

### Data collection and analysis

Initial field visits provided an invaluable source of information. During the prolonged presence, observations were discussed with staff in an informal way, documents were collected, or questions raised regarding institutional practices (Heath, Hindmarsh, & Luff, 2010). Based on this information, interprofessional meetings were video-recorded and viewed in a systematic manner in order to identify the interactional structure. Each video was systematically watched and described according to the phases (e.g. opening phase) and actions accomplished (e.g. assessment; advice). This approach was then refined and condensed into the phase structure of the interprofessional meetings. Sequences of participants discussing goals or discharge plans were then transcribed using Jefferson's conventions (see Appendix; Jefferson, 2004) and analyzed using CA by focusing on patients' involvement and initiative actions. These "interactive initiatives", i.e. when a patient contributes to a course of action or discussion with a request for information or a comment without having been addressed as an active participant (Drew, 2001; Keel & Schoeb, 2017) can be understood as a resource for patients to accomplish participation. A particular emphasis was placed on turn structure and organization (e.g. wording of turn initiation), on sequence organization (e.g. how discharge discussion starts, continues and closes down), and whether asymmetries were observable (Heritage, 2004). The analysis was performed in the original language and translated into English for this article. Original transcripts are available on request.

### Findings

The findings section is structured as follows: firstly, participants and data corpus are described; secondly, an analysis of the interactional structure of discharge planning meetings is presented; and finally, patients' involvement in discussions regarding discharge is reviewed.

### Participants and video-recorded data

Over one hundred interprofessional meetings ( $N = 121$ ) were video-recorded (19 hours of recordings). Twenty-five patients (age range 30–87 years) with neurological and musculoskeletal problems were included in the study and followed over the course of their rehabilitation stay (Table 1). The difference between the two institutions was that in Clinic 2 all interprofessional meetings were held in presence of patients, while the team in Clinic 1 held first an interprofessional meeting followed by an interprofessional visit (nurse, medical doctor, and therapists at times) where discharge decisions and care plans were discussed with patients. In Clinic 1, 14 patients were included and discussed in interprofessional meetings ( $N = 46$ , without patient's presence) and video-recorded during interprofessional visits where patients were present ( $N = 47$ ). As this clinic has a younger clientele (70%

**Table 1.** Patients' background information.

Patients' reasons for rehabilitation stay	Total (25 patients)	Clinic 1 (14 patients)	Clinic 2 (11 patients)
Patients with knee problems	7	5	2
Patients with neurological problems	5	2	3
Patients with hip pain	4	2	2
Patients with low back pain	3		3
Patient with multiple traumata	2	2	
Patient with foot problem	2	2	
Unclear diagnosis	2	1	1
<b>Sex</b>			
Female		6	6
Male		8	5
<b>Age group</b>			
30–45 years old		9	
46–60 years old		3	1
61–75 years old		2	3
> 75 years old			7
<b>Employment status</b>			
Employed		10	
Retired		2	10
Housewife		2	
Invalidity insurance			1

employed), and patients usually will go back to work, discharge discussions often concerned "return-to-work" decisions.

In Clinic 2, eleven patients and their teams were video-recorded during interprofessional entry meetings ( $N = 11$ ) and 17 follow-up meetings. With an elderly and mostly retired population (90%), discharge discussions in Clinic 2 related to activities of daily living and patients' independence. In total, 121 professionals participated in video-recorded meetings, representing the following professional groups: medical doctors, nurses, physiotherapists, and occupational therapists, social workers, psychologists, speech therapists, dieticians, and work rehabilitation staff.

### Analysis of interactional structure of discharge planning meetings

The analysis revealed different interactional structures of discharge planning meetings in the two observed rehabilitation centers. Video-recordings allowed for multiple viewing to identify who was the chair of the meeting (leadership), how participants oriented to each other, and how turns were allocated and taken. Through this bottom-up inductive approach, two different interactional structures were identified. Some meetings were classified as "information-exchange" between professionals whereas others were oriented to as "negotiating meetings" by participants.

In Clinic 1, the initial team meeting was an "information exchange meeting" aimed at delivering information about rehabilitation progress to the medical staff (chair of the meeting). The interprofessional visit following the meeting, on the other hand, was a "negotiating meeting". The team meeting served as a site for information exchange amongst staff, whereas decisions were negotiated with patients during interprofessional visits.

In Clinic 2, there were two interprofessional meetings in which patients participated. The interprofessional entry meeting (chaired by one of the health professionals) aimed at initiating, elaborating, and deciding upon the patient's rehabilitation goals and was classified as "negotiation meeting". The follow-up (weekly

meeting was chaired by a physician and even though the patient was present, the purpose was to update the team about the patient’s progress and had clearly the character of an “information exchange meeting”.

These findings reveal that institutions do not have one predetermined structure but various practices that are designed purposefully within an organization. The interactional structures of each type of meeting are presented below.

**Information exchange meetings**

The interprofessional “information exchange meetings” followed a standard structure in five phases (Figure 1).

**Opening phase:** Meetings opened by physicians were usually very brief when team members were present (Clinic 1) or more elaborate when patients participated (Clinic 2).

**Medical reporting phase:** Consisted of updates on patient’s state from a medical perspective, and included presentation of test results or medical reports.

**Therapy reporting phase:** Physiotherapists, occupational therapists, and speech therapists reported on information about patient’s progress with regard to improvement, obstacles or suggestions for treatment interventions.

**Clarification phase:** All health professionals could inquire about specific issues related to the patient. Medical doctors might seek information from nurses (e.g. the patient’s weekend) or health professionals might inquire about staff members’ experience (e.g. a psychologist requesting information about patient’s pain experience during physiotherapy). The clarification phase and therapy reporting phase could be chronologically interchangeable (Clinic 1) or follow a strict order (Clinic 2).

**Closing phase:** The physician provided a short summary of arrangements.

The interactional structure of the “information exchange meeting” can be an efficient way to update teams about a

patient’s progress as shown in the short duration of these meetings (Clinic 1: mean duration: 7.15 min., range: 2.23– 12.43min.; Clinic 2: mean duration: 8.6 minutes; range: 3.52– 15.5 min.).

**Negotiating meeting**

The five-phase “negotiating meeting” was organized differently (Figure 2). Due to the patient being present, s/he was also integrated in the discussion and there was room for discussion. They usually took longer when health professionals discussed topics raised by the team or by patients during interprofessional visits (mean duration: 11.39 min., range: 4.48– 16.44 min).

**Opening phase:** The chair introduced professionals and stated the meeting’s purpose to patient.

**Clarification phase:** This phase, directed at the team, consisted of medical updates.

**Transition to goal setting phase:** The chair addressed the patient directly and gave the floor to the reference profes-

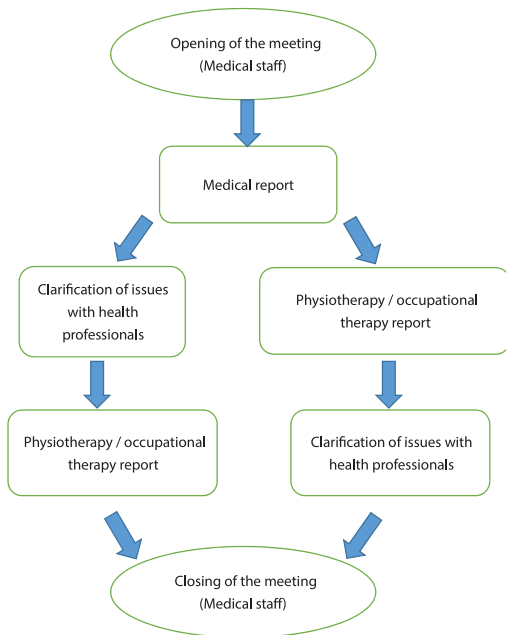


Figure 1. Information exchange meeting structure.

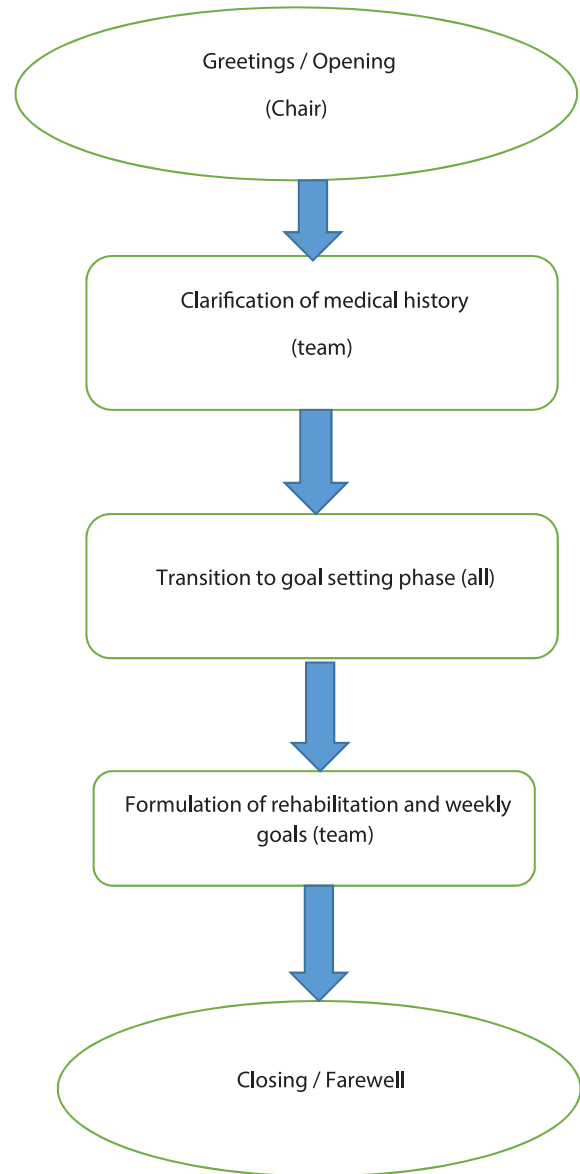


Figure 2. Negotiating meeting structure.



sional to present previously discussed goals. The patient's task was to confirm or amend this information. This phase required the patient's participation and agreement.

**Goal setting phase:** All professionals formulated weekly goals. The patient played only a marginal role. However, at times, patients took the opportunity to clarify or agree on some issues.

**Closing phase:** Initiated by the chair, it included a summary of goals discussed. The closing was accomplished in a very explicit manner and gave a last opportunity for patients to contribute.

When patients were explicitly included in phases 1, 3 and 5 (addressed verbally or non-verbally, e.g. gaze), they were required to confirm and ratify the agreed upon goals. Including patients in discussions required time, and meetings lasted on average 17 minutes (range: 11.39–27min.).

The difference between the two types of meetings was that in "information exchange meetings" physicians received detailed reports from team members, while "negotiating meetings" team members were able to bring their own perspective to the table in a more flexible manner. The different meeting objectives made relevant the different interactional structures as shown in the previous section. The next section reports on how patients contribute in the different types of interactional structures.

### Patient participation in discharge discussions

Table 2 summarizes the types of patient participation during meetings in which patients were present (Clinic 1: interprofessional visit; Clinic 2: entry meeting and follow-up meeting). Overall, "negotiation meetings" tend to have more active patient involvement (i.e. information-giving behavior or shared decision-making, Thompson et al., 2010). Furthermore, "negotiating meetings" have more instances in which patients contributed to the discussion by providing additional information or clarifying specific issues (Clinic 1: 59%; Clinic 2: 57%). Information-seeking behavior (e.g. request for more information) was more pronounced in "information exchange meetings", with 74% of all patient-initiations falling into this category (follow-up interdisciplinary meeting). The meeting aim was therefore in line with the communicative practices and patients' opportunity to participate: information-giving behavior was more often observed in "negotiating meetings", whereas patients were asking for additional information in "information exchange meetings".

The following two examples, one from a "negotiating meeting" (Table 3 - Extract 1) and the second from an "information exchange meeting" (Table 4 - Extract 2) illustrate how patients interacted with the interprofessional team.

The first extract exemplifies a patient's active involvement during the interprofessional visit. This sequence sheds light

on how physicians negotiate the consent to (pre-)agreed decisions that were discussed during the preceding interprofessional team meeting. It further shows that important interactive work is required to negotiate agreement. Various types of patient participation are observable in this extract, from patient's information-seeking behavior, information-giving behavior to shared decision-making, concluding the negotiation with mutual agreement.

Explicit reference to interprofessional meetings: The physician acknowledges her knowledge about the patient's previous discussion with the psychologist (line 1).

Misalignment between the physician's assumptions and the patient's desires: The patient asks first for clarification (line 4 - information-seeking behavior) and then insists on receiving more information (line 7). The physician renders the information more explicitly (line 9 and 10), yet the patient disagrees by making her wish evident (information-giving behavior) (line 13 - laughing). After the patient's hesitation (line 17), the physician initiates the next phase.

Collaborative decision-making: With the physician's open question "how do you feel?" (line 18), the patient states her wish. The physician closes down by stating the accomplishment of common ground (line 23 - "the same idea" - shared decision-making) which allows for the sequence's progression.

In Clinic 2, both "negotiating meetings" and "information exchange meetings" were taking place with various degrees of patient participation (see Table 2). Patients' contribution was more frequent during "negotiating meetings", but patients

**Table 3.** Patient participation during interprofessional visit.

EXTRACT 1 (CRR10_2v_EXDPT - simplified transcript)	
1	MDI We have retained the message that you are (2.1)
2	<u>against</u> the therapeutic weekend.
3	(0.9)
4	PA10 Against the what?
5	MDI The therapeutic weekend.
6	(1.0)
7	PA10 What does it mean? ((low voice))
8	(0.4)
9	MDI You don't want to go back to see how it goes because you apprehend[ the re] turn.
10	[ h]
11	PA10 [ h]
12	(0.2)
13	PA10 I- (h) <u>I would like to go back.</u> ((laughing))
14	(0.2)
15	MDI But for good or a therapeutic weekend?
16	(0.6)
17	PA10 Well let's say-
18	MDI How do you feel?
19	PA10 The idea is I would have liked to go back this weekend well the- the one that is coming in any case.
20	(0.6)
21	PA10 To see how (0.3) and then if it goes well uh.
22	MDI .HH but that's perfect because we get to the same idea.
23	MDI .HH but that's perfect because we get to the same idea.

Legend: MDI = Medical Doctor I; PA10 = Patient 10

**Table 2.** Types of patient participation.

Contribution to action sequences	Interprofessional visit – Clinic 1	Interdisciplinary entry meeting – Clinic 2	Follow-up Interdisciplinary meeting – Clinic 2
	Negotiating meeting	Negotiating meeting	Information exchange meeting
<b>Instances of patients' contributions</b>	27 instances	64 instances	19 instances
Information-seeking behaviour	11 (41%)	27 (43%)	14 (74%)
Information-giving behaviour	16 (59%)	37 (57%)	5 (26%)

**Table 4.** Patient participation during discharge discussions.

EXTRACT 2 (RRZ3_2_IA29 - simplified transcript)		
1	OTR	Uhm with dressing you are so far independent with putting on
2		the- the prosthesis you still need supervision, you are still
3		alone a bit un- uncertain[ so (a bit)]
4	PA3	[ Yes then] I' ve- when I cannot
5		straighten the knee like this (( <i>demonstrates with elbow</i> ))
6	(0.4)	
7	PA3	When I am let' s say now a little bit (0.9) like this on it (0.5)
8		then I am just a little insecure.
9	OTR	Yes yes you have also told me that it gives in sometimes.
10	PA3	But there-
11	OTR	Exactly.
12	PA3	If I can hold myself on a bed or another place (0.8)
13		then I can take a small step just with this leg sideways or (0.5)
14		and then it works then I can put on the prosthetic again perfectly.
15	(0.3)	
16	OTR	Exactly.
17		(( <i>PTG looks at OTR who then turns to PTG</i> ))
18	OTR	I think that we can build up the strength [ and-]
19	PTG	[ I believe] that he can do this independently.
20		
21	(0.3)	
22	OTR	Pardon?
23	PTG	I believe that he can do this independently ([ ] ).
24	OTR	[ Ah o] kay.
25	(0.3)	
26	OTR	Alright even better.
27	OTR	Yes in this case it is certainly achievable within the coming week

Legend: OTR = Occupational Therapist R; PA3 = Patient 3; PTG = Physiotherapist G

were also able to provide additional information or ask questions during follow-up meetings. Yet, in order to achieve this, patients used different communicative strategies (e.g. overlap in talk, embodied resources) to make their opinion heard as we can see in the following extract. Extract 2 is from a weekly interprofessional meeting (“information-exchange meeting”), starting with the occupational therapist’s report about the patient’s handling of a prosthetic limb. This sequence illustrates the patient’s effort (verbally and non-verbally) to provide additional information regarding his competence and the support he received from the physiotherapist to reach an agreement collaboratively.

**Reporting to team while orienting to patient:** The occupational therapist’s report is directed to the team but addressed to the patient (lines 1– 3 – “you”). The patient takes this opportunity to add some details (information-giving behavior) by interrupting the occupational therapist’s assessment (line 4).

**Misalignment between the therapist’s assessment and the patient’s competence:** The patient first agrees with the therapist’s assessment and acknowledges his difficulties (lines 4– 8), but then explicates his ability to don his prosthetic limb “perfectly” both verbally and non-verbally (line 12– 14). The verbal account here is accompanied by bodily movements to emphasize the importance of the information given.

**Collaborative decision-making:** However, it is only at that moment when the physiotherapist glances at the occupational

therapist (line 17) that the patient’s perspective is taken into consideration. The occupational therapists (line 18) makes a statement of professional assessment intended for the physiotherapist (turns to PTG). This gives the physiotherapist the opportunity to support the patient’s competency (line 19– 20, line 23) countering the occupational therapist’s previously reported assessment. The occupational therapist finally aligns with the patient-physiotherapist dyad and closes the sequence by summarizing the arrangements (lines 28– 31).

This extract illustrates that collaborative decision-making during information-exchange meetings requires effort from both the patient and the team to achieve patients’ involvement. The patient’s use of verbal and non-verbal resources and building of alliances with professionals allows countering the interactional structure of information-exchange meetings. In this context, communicative skills are more than ever required in order to integrate patients’ perspectives in decision-making while orienting to the team.

## Discussion

This paper identified different types of interactional structures of interprofessional discharge planning meetings with patients and focuses on how the interactional structure influenced the way patients were involved in discharge discussions. Based on the interactional analysis, we identified two types of meetings: “information exchange meetings” and “negotiation meetings”. We argue that important interactive work is required to integrate patients into discharge discussions during interprofessional meetings, and more so in “information exchange meetings”. The following sections first discuss the interactional structure within the context of interprofessional meetings before reviewing aspects related to patient participation in this context. Finally, the article concludes with implications for practice.

### *Interactional structure of interprofessional meetings*

In this study, the activity of discussing and planning discharge with patients occurred in different meeting environments. While professionals in Clinic 1 used interprofessional visits to negotiate with patients issues related to discharge, professionals in Clinic 2 invited patients to take part in two meetings: initially, patients participated in an entry meeting (“negotiation meeting”) to formulate goals collaboratively with professionals and then, they were invited to the weekly follow-up meeting (“information exchange meetings”). Differentiating the two types of meetings shed light onto how participants themselves orient to the organizational setting and shape the organization through their interaction and communicative practices (Boden, 1994).

“Information exchange meetings” were usually brief and medical staff-oriented, while “negotiation meetings” tended to last longer and were led by health professionals other than physicians. While the patient’s presence during meetings demonstrated the institutions’ consideration for their participation, the patient’s participation was more restricted during “information exchange meetings” compared to “negotiation meeting”. During the latter meetings, the patient’s agreement was ultimately required to finalize discharge plans (Extract 1)

while participation in “information exchange meetings” required more effort by patients and a strategy of alliance-building with health professionals (Extract 2). This analysis indicates that it is the *relevance* of the activity itself that enhances patient participation. Comparing the observed inter-professional meetings from this perspective, it becomes evident why more patients chose to participate actively in discharge discussion in a “negotiating meeting” where the team does not have all answers or openly disagree with each other, therefore providing patients an opportunity to contribute (Keel & Schoeb, 2016, 2017). It is argued here that while institutional procedures might constrain patient participation (Efrainsson et al., 2003; Huby et al., 2007), it is the participants’ communicative strategies that enact the interactional structure of discharge planning meetings. We were able to show that patient participation depended on opportunities provided to patients to voice their preferences, but this was contingent on the interactional structure of the meetings. Asmuss and Svennevig (2009) argue that meetings are situational in character and involve participants with particular roles and responsibilities who “engage in specific activities” in order to reach agreement or exchange information.

Our findings confirm the “orderliness of meetings” (Svennevig, 2012b) indicating that a pre-established agenda can be used to manage progressions and transition between agenda items. While the agenda in Clinic 1 was referred to implicitly, the agenda for meetings at Clinic 2 was introduced explicitly, and transitions were made intelligible to all participants. This might be important for patients as it allows them to learn the procedural practices on an *ad hoc* basis (Nielsen, Nielsen, Gravengaard, & Due, 2012). Enacting the interactional structure of these meetings, participants were held accountable to the different types of interprofessional meetings (information exchange versus negotiation).

Meetings are important when trying to understand organizational communication because team members construct and negotiate meaning about their understanding of organizational culture (Boden, 1994; Svennevig, 2012a). The detailed interactional analysis presented here helps in understanding “how social relations and the division of labor between participants are oriented to and practically resolved moment by moment” (p. 22; Llewellyn & Hindmarsh, 2010). Furthermore, micro-level analysis is important to understand meso-structural aspects of interprofessional collaboration (Goldman, 2015). While it has been documented that appropriate infrastructure (meeting room, equipment) and logistics (organizations of meetings) are needed for well-performing teams, it is often the team governance (e.g. expertise, leadership, culture) that is an obstacle to successful teams (Soukup et al., 2018; Tarling & Jauffur, 2006). The next section will discuss how patient participation was enhanced or hindered during the two different interprofessional meetings identified in this study.

### **Patient participation in discharge discussions**

Patient participation in discharge discussions happened in both clinics and in both types of meetings (Table 2). Interprofessional meetings aiming at information exchange, however, did not engage patients to participate as much as in “negotiating

meetings” where patients were able to contribute more actively by seeking or giving additional information (Thompson et al., 2010). In “Information exchange meetings” chairs (mostly physicians) took a more authoritative role in view of the short time available (Asmuss & Svennevig, 2009). It should be noted that the type of chairing style has less to do with professional membership than with leadership style, enacting and reinforcing teamwork either in a cooperative way or an authoritative way (Asmuss & Svennevig, 2009). We were able to show in this study that it is not necessarily power differences between health professionals and patients (i.e. medical dominance) that contributed to limited patient participation, but rather the activities and interactional meeting structure that accounted for asymmetries (Robinson, 2003). Interactional asymmetry is co-constructed by patients and the team by not challenging the social order of information-exchange meetings. While “negotiating meetings” enabled active patient involvement by giving place to patients’ perspectives and shared decision-making (Extract 1), “information exchange meetings” required more effort from patients (and support from professionals) to shift their participation from information-seeking to information giving behavior or even shared decision-making (Extract 2).

The reviewed literature on patient participation in health-care emphasizes individual or interpersonal aspects (Angel & Frederiksen, 2015; Longtin et al., 2010), whereas the social and intersubjective aspects seem to be forgotten when tackling patient involvement in healthcare. Using the concept of *participation framework* (Goffman, 1981), participants’ role within an interprofessional meeting can be made explicit which helps broaden the understanding of patient participation in discharge planning meetings.

Providing quality care to all patients is at the heart of practitioners’ everyday work in rehabilitation. It has been argued that external healthcare environment as well as institutional processes (i.e. patient care process, interprofessional collaboration) have a direct impact on patient outcomes, hence influencing the place of discharge (Jesus & Hoenig, 2015). Our study illustrates how the interactional structure can enhance or limit patient’s involvement. Applying an inductive approach to the interactions during discharge planning meetings helps us understand the social actions and “predict moments where patients are more ‘free’ to initiate sequences of action” (Robinson, 2003, p. 51). Once a better understanding of the social organization of discharge planning meetings and the opportunities for patient participation has been reached, shortcomings can then be addressed.

### **Implications for practice**

Interprofessional collaboration has received increased attention in institutions such as rehabilitation centers where health professionals are required to give their opinions and perspectives on a patient’s care plan and discharge. This type of study has high value by giving patients a voice (Peräkylä, Ruusuvoori, & Vehviläinen, 2005) but also because professionals can gain a better understanding of their own practice (Peräkylä & Vehviläinen, 2003) thereby improving the quality of services provided (Gonçalves-Bradley et al., 2016).



The project may have significant contributions not only to health-care practice but also to health-care policy. While a better understanding of discharge planning might shed light on best practice and thereby help define essential characteristics of optimal team performance, our study also highlighted differences inherent to the organization. An evaluation of the costs and benefits of current practice could give insight about not only what works best for participants, but also what could potentially be the most cost-effective procedures in a highly costly environment. However, the first step is – and this is the contribution of this study – to identify practices of discharge planning in interprofessional meetings. This topic is therefore of relevance to policy-makers and health insurance funders, to health professionals and last, but not least, to patients, as they will get the best care and long-term benefit. Based on this study, our recommendations to interprofessional teams would be (a) to identify whether an interprofessional meeting is an “information exchange meeting” or a “negotiation meeting”; (b) to make the meeting structure explicit to participants at the start of the meeting; (c) to decide whether the patient is encouraged to be an active participant; (d) to evaluate the process by video-recording the meetings, as well as reflect on the expected outcome; and (e) to take steps to improve if outcome is not achieved. These steps could help a team refine their approach to interprofessional teamwork and their engagement with patients during discharge planning meetings.

### Study limitations

Video recordings shed light on processes of care and help understand the social organization of practice and illustrate models of quality care (Heritage, 2011; Jesus & Hoenig, 2015). Using recordings in combination with transcripts enhances the reliability of findings providing for detailed representations of institutional interactions (Peräkylä, 2004). Even though they do not represent *all* practices health professional will do, the sequences illustrate *possible* practices employed by professionals in real-life interactions (Peräkylä, 2004). A different study design could have been chosen in order to enhance the generalization of study findings but Peräkylä (2004) insists on this different understanding of generalizability for interactional research and argues that practices are likely to be generalizable, not as what all health professionals *will* do in institutions but generalizable as descriptions of what any professional *can* do in this situation. Using this line of argument, the different health care context is indeed not a problem. While Clinic 1 is a big rehabilitation hospital with over 250 employees, Clinic 2 is a 28-bed clinic with a smaller team who knows each other, thereby making collaboration easier. As the purpose of a qualitative study is to identify structures as well as communication strategies that have never been described before, results do not need to be generalizable to a wider population. Yet, to enhance the quality of qualitative studies, detailed description of data production and analysis are provided to allow transferability of findings (Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998).

Observational studies using naturally occurring data have the advantage that the interaction is not specifically set up for research, and that phenomena are not coded with pre-defined categories allowing therefore for richness of data analysis (Drew, 2005). Nevertheless, including interviews with

participants would allow for better understanding of patients’ and health professionals’ perspectives and perceptions regarding their participation in discharge meetings. Future studies could combine both qualitative methods (observation and interviews) to address this shortcoming.

### Conclusion

This study investigated the interactional structure of discharge planning meetings in rehabilitation clinics with a specific focus on communication within interdisciplinary teams and with patients, including patient participation. The findings indicate that the structure and organization in clinics have an influence on team processes as well as opportunities given to patients to participate in discharge discussions. “Information exchange meetings” are usually physician-led meetings with the purpose of gathering relevant information about a patient’s progress in an efficient manner. “Negotiation meetings” allows for more patient participation and is often led by health professionals other than physicians. Overall, patients participating in interprofessional meetings can seize opportunities to influence discussions. This study shows that video recording is a useful tool for professionals to reflect on and learn from practice.

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## Appendix

**Transcription conventions** (adapted from Jefferson, 2004)

Symbol	Description
[text]	Overlapping speech
(# of seconds)	Timed Pause (in seconds)
?	Rising pitch
-	Cut-off (an abrupt halt or interruption in utterance)
TEXT	Increased volume speech
(hhh)	Laughter, audible exhalation
(text)	Unclear speech
( <i>italic text</i> )	Non-verbal activity