Time for talk: The work of reflexivity in developing empirical understanding of speech and language therapist and nursing interaction on stroke wards

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Abstract

This chapter explores the contribution made by reflexive work to ethnographic findings with respect to time for interaction between speech and language therapists and nurses. The study explored information-sharing between professionals from these disciplines on three stroke units across three hospitals in the UK. The researcher was a member of one of these professions (speech and language therapy), making reflexivity a particularly important mechanism for approaching the perspectives of both disciplines in as egalitarian a way as possible. The ethnography provided an explanation for how the temporal-spatial context of stroke unit care influenced the nature of the information that was shared, with a privileging effect on information that was quick to share and relatively easy to use. Speech and language therapists needed to manage their information-sharing needs with nurses in a context where they perceived interaction to be interruptive to nursing work. The process of doing the research involved asking nurses to divert attention from patient care to participate in research activities, providing insights about time and space that mirrored aspects of empirical findings. Reflexive work thus served both as mechanism for accounting for subjectivities and as an additional lens for understanding the findings.

Key words: time; space reflexivity; communication; interprofessional

1. Introduction

This chapter explores the relationship between findings from an ethnographic study about speech and language therapist (SLT) and nurse interaction on UK stroke units and insights from reflexive work relating to research processes. SLTs in the UK are the key professionals responsible for assessing and managing stroke-associated swallowing and communication disorders. In executing their roles, they need to work with nurses, who share responsibility for these domains, in the context of providing care for the whole patient. The overall finding of the study was that time and space influenced the information sharing behaviours of SLTs and nurses (Barnard, Jones & Cruice, 2021). The temporal-spatial context created the conditions through which information about swallowing difficulties was privileged over information about communication difficulties, and relationships between SLTs and nurses could be hard to build. SLTs perceived interaction to be interruptive to nursing work leading them to prioritise information that could be conveyed in small windows in time, and that was understood by both disciplines as useful and important for patient safety. Findings contributed to research arguing for increased attention to patients' communication needs in acute care (Foster et al., 2015;2016; Carragher et al., 2020) by indicating that the prominence of swallowing may be being sustained by interactional factors.

The published account of the study carefully details the empirical bases for the findings (Barnard et al., 2021) but only lightly reveals the intricate relationship between the processes and the product of the research. Findings were reinforced by striking parallels between ongoing reflections on how research activities such as seeking consent, setting up interviews and sharing findings, mirrored observed differences between the two professions. My position as a SLT turned researcher shaped these reflections. The process of observing SLTs enter in and out of spaces predominantly occupied by nurses caused me to look on my own profession anew and reflect on the taken for granted ways in which I also had moved through wards as a SLT when working as a clinician. Jenkins asks: "how much does adopting the researcher's stance towards one's own social world change one's place and position within and towards that world?" (Jenkins, 1992:56). I was conscious of my researcher responsibility to

carefully capture the phenomena I was studying, yet *my* world was intricately connected, not only through professional history but also because undertaking the tasks of research reinforced differences in how the two professions navigated time and space. This chapter explores how these insights added depth to the knowledge generated.

The importance of reflexivity is well accepted in ethnographic work, so much so that ethnographers' attention to the relationship between the observer and the observed has been described as "an obsessive concern" (Bloor, 2001:179). Ethnographers aim to create a credible account through careful description and analysis of what is seen and heard, whilst also noting and reflecting on how identities and presuppositions influence where they direct attention (Hammersley & Atkinson, 2019). Reflexivity can be defined as "the process of a continual internal dialogue and critical self-evaluation of researchers' positionality, as well as active acknowledgment and explicit recognition that this may affect the research process and outcome" (Berger, 2015:220). Whilst there is wide agreement that it is not possible or desirable for qualitative researchers to be detached from the social worlds they study (Coffey, 1999), there is no consensus as to how reflexive work should be carried out or represented (Dean, 2017). Coffey argues for more attention to how the 'self' of the researcher "engages with the personalities, histories and subjectivities of others present in the field" (Coffey, 1999:57), and it is acknowledged that researcher position and biography impacts on every stage of the study: choice of topic, access to the setting, data collection, data analysis, and writing (Hammersley & Atkinson, 2019). However, researchers have been cautioned that *excessive* introspection risks accusations of naval gazing for self-indulgent as opposed to epistemic purposes (Bourdieu & Wacquant, 1992). That is, for purposes relating to the advancement of knowledge. Dean suggests that Bourdieu's attempt to separate epistemic from personal reflexivity is artificial and that both are required to create an honest account of how research findings have been constructed (Dean, 2017). The researcher is a critical social actor, who needs to create relationships in the field for effective fieldwork, and it is this criticality that is key when reflexivity is used to enhance the credibility of ethnographic texts (Coffey 1999; Dean, 2017).

For ethnographers who are also clinicians, it is likely that interpretations will be filtered through their professional history, heightening the importance of examining the impact of their participation in the setting on interpretations of the phenomena of interest, as well as its effect on them as researchers (Allen, 2004). In this chapter I draw on extracts from reflexive diary entries to demonstrate how insights from research processes were put to work in substantiating findings. By making reflexive work transparent readers can judge how claims to knowledge have been derived, enhancing rigour (Dean, 2017). I will discuss how the persistent discomfort I experienced due to my fluctuating position between SLT and nursing worlds heightened my appreciation of differences between them. This will be followed by an explanation of the discordance observed between SLT and nursing experiences of time, before illustrating how specific research processes added insights to findings about the time available for SLTs and nurses to talk about patients.

2. Method

The study on which this chapter is based involved 40 weeks of fieldwork across three inner city stroke units in the UK. Data collected included fieldnotes from over 350 hours of participant observation and interviews with 43 members of SLT and nursing staff. Details about participants, data collection methods and analysis and ethical considerations are reported in full elsewhere (Barnard et al., 2021). This chapter is based on reflexive diary entries which were written whilst typing up fieldnotes at the end of each day. Reflections captured information pertinent to emerging interpretations as well as challenges relating to research processes, such as recruitment and field relationships. Reflections will be discussed in the context of published findings (Barnard et al., 2021).

3. Finding new meaning about interprofessional practice through researcher discomfort

Work on stroke wards is centred on the premise that specialist professionals working in coordinated ways will improve patient outcomes (Langhorne et al., 2020). Previous studies of interprofessional practice on hospital wards have revealed some of the barriers professionals face in marrying different roles and priorities to develop working relationships and accomplish common goals for patient care.

Such studies reveal that communication across professional groups can be challenged by unequal access to information through formal and informal routes, that roles are not always valued, and that disciplines differ in the amount of time they are present on wards (Barnard et al., 2020). The focus of the current study on just two disciplines, rather than the team as a whole, made it possible to apply focused attention to the mechanisms through which interaction occurred. In common with previously reported practitioner research on hospital wards, my membership of one of these disciplines and experience of stroke care conveyed benefits as well as costs (Allen, 2004; Jacoby, 2017; Wind, 2008). Benefits included access to the field, easy acceptance amongst the SLTs and conversance with the language of stroke care. The primary cost was that my aim to cast an egalitarian eye on both disciplines brought ethnographer concerns with familiarity and distance into sharp and continuous focus. I benefitted from the comfort of being amongst members of my own profession but needed to also create some distance to see SLT practice with more curiosity. It was important to increase familiarity with the nurses to understand their world and gain their trust, but without over-affiliating to the extent that I lost sight of SLT perspective.

In practice practitioner-ethnographers tend to slide back and forth along a continuum from outsider to insider status throughout the duration of a study (Allen, 2004; Jacoby, 2017; Wind, 2008). Jacoby, a nurse-ethnographer, reports on the insights she derived from deviating from the outsider 'visitor' role she had ascribed herself, when she felt compelled to draw on her insider skills to offer comfort to a patient in distress when others were not providing this. She felt that had she been present in her previous clinical role she might not have noted the significance of this episode of missed care and considered it important to incorporate such reflexive insights within her interpretations. Jacoby's is one example amongst many that indicate that occupying the idealised middle ground, where researchers are judged to be best placed to balance familiarity with analytic distance (Burns et al., 2012), may be unrealistic for practitioner-researchers (Wind, 2008). My equal interest in two professional groups heightened my sense of otherness. I obsessed about the lenses through which I observed, and through which I imagined others viewed me, and it was important to reflect on how my travels between familiarity and distance were informing my findings (Allen, 2004; Jacoby, 2017). The rate and speed with which I moved

between SLT and nursing worlds led me towards a state of "permanent sociological vigilance" that enabled me to notice things that may not otherwise have drawn my attention, had I observed from the perspective of just one of these professions (Bourdieu & Wacquant, 1992:209).

Bourdieu's concept of the habitus is helpful for understanding how the person I was when I entered the field was subtly altered through the experience of doing fieldwork, and how this influenced interpretations of my own profession in interaction with another. Habitus "designates the system of durable and transposable dispositions through which we perceive, judge and act in the world" (Wacquant, 2008:267). Dispositions are ways of being (thinking, talking, moving) that are unique to each individual, acquired from childhood, and built upon with new social experiences (Jenkins, 1992). Social and professional experiences are layered onto the habitus creating a durable structure; it can be added to, but conservatively, in thin 'onion like' layers (Dean, 2017). SLTs and nurses had shared experience of working on stroke wards yet had quite different temporal-spatial experiences of the ward as a field of work, which may have kept their experiences professionally distinct.

The unique habitus of each of the SLTs and nurses (and my own) would have been layered with their individual socio-economic biographies and a lifetime of personal, educational and work experiences and interests. As a SLT, experienced in working on neurology wards, I had much in common with the SLTs and took it for granted that shared training and experience would ease relationships with them. I mostly felt at ease with the SLTs, like a "fish in water" (Bourdieu & Wacquant; 1992:127). However, I knew I would have to jump out of the water in order to develop field relationships with the nurses. I needed to learn the names of a daily changing body of staff and find a point of connection with them as people. Attempts by individuals to fit into unfamiliar social settings can heighten awareness of dispositions that usually operate at a more taken for granted, unconscious level (Reay, 2010). Reay explains the potentially transformative effect of exposure to a new field on the habitus through exploration of how working-class students adapt when entering elite universities. She argues for spending time analysing these points of 'rupture', viewing them as powerful places in which pre-existing dispositions are questioned (Reay, 2010). Being in spaces occupied by nurses on the ward was

familiar to me from prior clinical experience. However, I was used to moving in and out of these areas, returning to therapist-dominated spaces once I had fulfilled specific patient-related purposes. As a researcher, my compulsion to fit in with the nurses meant often staying put, despite, feeling far more comfortable when moving about the ward with the SLTs. Jenkins argues that "most people, most of the time, take themselves and their social world for granted; they do not think about it because they do not have to" (Jenkins, 1992:70). Sticking with the discomfort created a rupture in my habituated ways of seeing and being (Reay, 2010) that led me to question the practices of my own profession. For example, when viewed from the position of nurses' busyness, it was hard to see how brief pieces of advice from SLTs about supporting patients' communication could be accommodated.

The experience of staying on the ward and observing others doing clinical work was very unsettling. There are few participant roles available for ward-based ethnographers, who can appear idle as professional activity whirls around them (Wind, 2008). Other ethnographers who are also clinicians have taken on clinical roles in the field, sometimes for the purpose of gaining first-hand knowledge of the researched phenomena (Clarke, 2009), and also as a response to feelings of isolation that can be generated by observing, rather than participating (Allen, 2004). Both purposes were attractive to me, however my desire to be acceptable to two separate professions presented particular challenges. In the early days I offered to assist the SLTs by scribing for them during language assessments but quickly realised that walking out together from behind the curtains reinforced my association with them and led to an exhausting push to re-affiliate with the nurses. Whilst over-affiliating is seen as something to be guarded against in ethnographic research (Burns et al., 2012), my in-between position made it hard to truly ally with anyone. Without a clinical role it was difficult to feel I had a legitimate reason to be hovering in predominantly nursing spaces. Diary entries in the first days of fieldwork on each new ward reveal deep unease and an overwhelming urge to escape.

> I found the experience as uncomfortable as I had been expecting. It is very difficult being on a ward without a function. I found myself writing quite noticeably in my pad because standing

> there doing nothing was too weird, it was a feeling that intensified rather than diminished. The question is do I ride the discomfort or is there something I can do to feel a bit less of an outsider?

I settled on the role of acceptable, marginal member (Hammersley & Atkinson, 2019), seeking acceptability by taking opportunities to be helpful whenever possible, such as by answering the phone. However, this could also create discomfort and mirrored challenges I was observing in SLT-nurse interaction. The following extract illustrates that whilst stopping a phone ringing was immediately helpful, it was difficult to take action without some level of relationship with the nurses, at the very least knowing their names. Acting on the call required me to find a nurse and interrupt what they were doing, adding new insight into what could influence a SLT to keep walking rather than take the more collegial act of answering the phone.

> I'm often reluctant to pick up the phone, because I know I won't be able to answer what is asked, and what I end up having to do is go and take a nurse away from her task to respond to the call (…). It is very hard to just leave it ringing and by picking it up I am helping out the nurse in the bay closest to the phone (…). There is no culture of taking messages, it requires an immediate resolution of what is being asked. However today I know most of the nurses on the shift by name, so I feel ok with going and getting people.

Finding common ground with nurses required sustained effort and often centred more on what we had in common in our personal lives than shared experience as healthcare professionals. Many of the nurses were close to me in age and life stage, opening up a route for fostering relationships. Moments of connection with nurses felt earned and had a powerful effect on me personally.

> I brought in cakes this week, and this, combined with the calmer ward environment made for a much more social and enjoyable time on the ward. Several of the nursing staff initiated communication with me and for the first time I felt at ease on the ward.

The advantage of adopting a more marginal position rather than taking on a clinical role was that I remained sufficiently distant to be curious about both the familiar and the strange (Hammersley and Atkinson, 2019), and on the whole participants remained alert to my position as a researcher. Nevertheless, being marginal meant that I never fully relaxed despite gradually becoming more at ease as familiarity increased. I felt over stimulated and commonly had a headache as I left the ward.

> Are these headaches related to the stresses involved in the unresolvable discomfort of sitting between two cultures? I feel broadly comfortable on the ward now, but unlike other ethnographies I can never actually immerse myself in a culture because I have to hop between two, is it actually methodologically possible?

Observing nurses as they worked gave me an understanding of their experience that brought me closer to them. I became aware that my identity as a clinician with a strong interest in interprofessional practice had been built on much stronger connections with other therapists than nurses. I began to worry that my strengthening desire to understand nursing risked me privileging their understandings over those of the SLTs (Bloor, 2001). However, the following extract written at the end of fieldwork on one of the wards reveals that despite my efforts, I remained most at ease with other SLTs and therapists.

> The nurses now know me, and I enjoy their easy banter, but I was never as easy with them as I was with the therapists. Knowing them and being known by them gave me a real buzz. I have rarely achieved a similar closeness with the majority of the nurses I have worked with as a clinician.

Bourdieu suggests that researchers "play the game while waiting to leave it" (Bourdieu, 1990:77). Thus, although new experiences led me to feel that my habitus was undergoing some change, it was possible that on leaving the field I would return to more habituated ways of understanding SLT practice in relation to nurses. My reflexive diary was a critical tool for holding onto what the experience of

conducting the research was telling me about SLT-nurse practice, in particular the impact of the temporal-spatial context on interaction.

4. Discordant time

Understanding how various people in a field of study experience temporality is important for appreciation of how social life is ordered (Bourdieu, 1990). It is taken for granted that the work of professionals on hospital wards is constrained by time. However, emphasis on lack of time misses nuances in how professionals navigate around it. Time is also a resource (Jenkins, 1992). In my ethnographer role, having time to observe instead of do gave me new insights into the differing dispositions of SLTs and nurses towards time that were not available to me when I worked as a clinician. I found myself preoccupied with time, both empirically (how SLTs and nurses used the windows of time available for interaction and how nurses worked around SLTs' intermittent presence on wards), and for the purposes of completing the study (the impact of nurses' lack of time on participation in my research).

SLTs and nurses differed in their relationship to the ward as a field of work, with the temporal-spatial experience of SLTs being more similar to that of other therapists than nursing staff. There was a constant nursing presence on the ward and nursing staff remained proximal to patients, whereas SLTs were present intermittently and could operate in spaces away from the bedside (Barnard et al., 2021). Nurses and SLTs working full time were contracted to work the same number of hours. For nurses these hours were covered in three long shifts across the seven-day week, days and nights. SLTs worked a shorter clinical day, Monday to Friday (with rotating four-hour cover on Saturdays on one ward). There were thus long periods of time when there was no SLT presence on the wards. In an attempt to experience the ward through nursing perspective, I covered a full nursing shift. This gave me a sense of what it was like to be at work for 12 hours. The experience also helped me appreciate how the shorter working day of the SLTs could be experienced by nurses seeking resolution to an immediate concern.

> I really noticed it when the nurse came into the office looking for SLT at about five and she said she was about to go home. It's not that the therapists aren't also spent, they do the same hours over a longer week, just that it marks a difference between them.

I found being present for a full day physically tiring. Experiencing time in this way gave me a stronger sense of nurses' temporal experience, demonstrating the importance of bodily, as compared to intellectual experience to my developing understanding of nursing practice: "what is 'learned by the body' is not something that one has, like knowledge that can be brandished, but something that one is" (Bourdieu, 1990:73). This has relevance when considering the implications of the research for practice. For example, SLTs may better appreciate the impact of the long nursing day by experiencing a full nursing shift, rather than reading about it.

The differing temporal-spatial experience of SLTs and nurses was further illustrated during observations of the first part of the morning. Nurses started the morning shift with handover around 0730 and began work with patients half an hour to 45 minutes later. The next two to three hours were intensely busy as they provided breakfast, washed patients and completed medication rounds. On one of the wards (hyper-acute stroke unit), SLTs were located on the ward and often began work with patients by 0900. However, on the other two (stroke rehabilitation units), the start of SLT clinical activity tended to occur towards the end of the nurses' busy period, coinciding with commencement of nursing breaks. I learnt how relentless time was for the nurses and noticed the discordance between SLTs' eagerness to get started and nurses' fatigue following the heavy physical work of the morning. I also recognised in the SLTs my own previous feelings of mild irritation when on entering the ward nurses were beginning their breaks and unavailable to talk, yet I now understood how needed that break was. Temporality was strongly illuminated through my dual experience; sometimes I entered the ward with SLTs, on other occasions I had been positioned there for quite some time as the SLTs entered.

> I don't think I really understood the importance of breaks for the nurses when I was working as a SLT; the nurses today were full on from 8-12 (in the morning) doing heavy work with patients,

only two out of four of them managed to get a break. I think it's really difficult for others who arrive on the ward and perform less manual roles to appreciate the unrelenting nature of the work, and it is in this context that the SLT is asking for time from the nurses.

A further illustration of disciplinary differences in the experience of time relates to an observation during a period on one of the wards in which there were few new patient admissions. The number of nurses on a particular shift was usually reduced when patient numbers were lower, whereas therapist numbers were fixed. The SLTs took advantage of their lighter patient load to complete projects and catch up with paperwork. I experienced the therapy office as more relaxed during this time. The differences between the two groups was starkly apparent when the nurse in charge was reprimanded by the visiting matron for not notifying her about the empty beds. Prior to this I had been observing two nurses and an assistant struggling to work with one patient and it was evident that despite the reduced number of patients, the nurses were as busy as ever. My unique position moving between these two worlds caused me to be highly attuned to this lack of parity. Whilst rationally I could see the financial sense in matching nursing numbers to patient numbers, I experienced a visceral reaction of unfairness that is likely to have been less intense had I been observing just one professional group.

5. Time to participate in research

A key finding from the research was that the temporal-spatial context favoured fast, functional exchanges of immediately usable information for keeping patients safe from physical harm and this was a better fit with information about swallowing than communication. SLTs perceived interaction to be disturbing to nursing work and the need to convey information in brief windows in nurses' time influenced what they talked about (Barnard et al., 2021). The perception that interaction was disturbing was mirrored in my experiences of recruiting and interviewing participants and in sharing findings.

5.1 Recruitment

On all the studied wards recruitment of the SLTs to the study was fairly straightforward. I was offered time in meetings prior to commencing to explain the study, I gave them information sheets to read and

they signed a consent form at the start of the fieldwork. The process with the nurses was much more cumbersome. There was no similar forum in which the entire nursing body routinely came together, hence although I presented at multidisciplinary team meetings prior to commencing and nurse leads emailed their staff, most nurses were unaware of the study until fieldwork began. I explained the study and distributed information sheets repeatedly at nursing handovers, but these were time-pressured occasions with very little time for active engagement. The process of gaining nursing consent took several weeks on each new ward. Some of these difficulties could be attributed to being an outsider to nursing, however, they also relate to nurses' challenges in giving time to research processes (Ledger, 2010), and resonated with my prior experience of seeking nurse attention as a SLT.

> I spent quite a lot of time today loitering on the ward, trying to get a nurse to give me a couple of minutes so she could sign the consent form. I felt very much how I used to feel as a SLT trying to get the attention of nursing staff. They are always doing something behind curtains or clearly in the middle of something as they go between the utilities. I used to feel that what I wanted to discuss with them would be low on their list of priorities (unless it related to the immediate of yes or no to whether the patient could swallow). At least then my query related to something that could be in our mutual interest to resolve, now what I want from them, brings no benefit to them whatsoever.

The above extract indicates how presuppositions about nursing priorities were brought into focus through writing my reflexive diary. Reflections served as a reminder that I would need to ask questions that might appear obvious, as it was likely that knowledge considered to be implicit and shared would not be offered (Berger, 2015). This meant probing SLTs and nurses for their perceptions of information they wanted to hear from each other, rather than accepting taken for granted understanding about the prominence of swallowing over communication information.

Recruiting nurses required social exchange and trust building as I worked to build my social capital. This was a much slower process than I had expected, as shift working meant that it could take weeks to

meet all the nursing staff. Gestures like bringing in biscuits and cakes certainly helped. I also needed to work within time frames that suited nurses' priorities for patient care. This involved the same kind of waiting for appropriate moments to interact that I observed with SLTs as they sought to gain nurses' attention for information sharing.

> It's very rare for any of the nurses to have actually read the information sheet and today I explain that I will come round to people and discuss it individually. In practice this is often difficult to do, but certainly easier when they have seen me a few times. I manage to consent two nurses, one who initially seemed a bit distant (I asked her if she had a minute and she said "can you see I'm on my own"). I realised then that she had no assistant in the bay. When she was free, she was actually very enthusiastic.

New appreciation of nursing perspective helped me understand that what could be perceived as an unfriendly response might simply reflect bad timing. The work involved in building relationships with nurses as a researcher resonated with the finding that SLTs considered relationships with nurses to be weaker than those they had with other therapists, and the indication that this may have its origins in differences in the extent to which they came together in space and time.

5.2 Interviews

The process of arranging and conducting interviews reflected differences in the capacity of the two disciplines to schedule time away from the ward. Nurses were more constrained by time than SLTs, who would respond to a request for an interview by opening their diaries and scheduling an appointment within the working day. Shift working patterns and their need to remain responsive to patients, oriented nurses towards the 'here and now' of the current shift. On each new ward my diary is replete with entries during the first weeks of fieldwork worrying that I will be unable to get enough interviews with nurses and on each, there tended to be a snowball effect towards the end of the fieldwork. I gained a reputation for keeping to a promised half an hour for interviews and this encouraged other nurses to

spare time. The cost was that interviews with nurses were shorter than those with SLTs. Some of the nurses offered interviews on their days off, preferring that to taking time away from patients. In contrast, all SLTs were interviewed during work hours. When I asked a charge nurse for advice for when to organise interviews, it was evident that there was no reliably optimal time.

> (He) suggested catching people at their breaks, I expressed that I would prefer not to take up their breaks and he suggested that the best way then would be to formally schedule people in on a day when staffing is looking good. I said I could come in at night, but he felt that it wasn't until midnight that things quietened down.

Nurses operated in the immediate. When I asked them for an interview, they tended to assume I meant *now*, hence most interviews occurred at opportune moments fitted around patient care. This had implications for the research as these interviews were more time pressured and, on occasion, interrupted, as nurses were called back to deal with a ward emergency. When nurses attempted to schedule an interview for a specific time, their capacity to meet the appointment was closely linked to their need to remain responsive to the demands of ward. In the following extract I had gone in on a Sunday to secure interviews because I had been advised that this would be quieter. One nurse agreed to an interview but was currently dealing with a patient with behavioural issues that required his attention. He suggested I try again at three o clock when everyone had taken their lunch break.

> I returned at three and they all looked at me in a kind of shock. The ward had become more difficult. Now two patients were taking up a lot of time and security had had to be called. He suggested I come back at five. When I returned, he was just taking his break. It had been a very difficult shift and there was no possibility of an interview as new patients had now arrived and needed to be admitted in preparation for Monday when everyone was back in.

This whole episode had involved several hours going back and forth to the hospital. My research on this ward was complete, but for these interviews, so I spent the waiting time in cafes. This level of

accommodation of nursing priorities would be less feasible in a clinical context. These examples matched field observations of SLT and nurse experience of time and space. SLTs had capacity to be away from the ward, coming and going intermittently. In contrast direct care-giving nurses were often tied to the ward and the needs of their patients. My experiences of trying to hold the attention of nurses for the purpose of fulfilling research roles resonated with the interactive effort SLTs needed to invest in order to share information. SLTs made judgments of nurse capacity when determining what information to share, with swallowing information being considered more worthy of the effort than communication information (Barnard et al., 2021).

As a SLT asking questions of nurses, it was evident that I was situated by professional role. This can be illustrated by an occurrence a few days after I had interviewed one of the nurses. During the interview I had asked questions to understand more about why nurses rarely discussed patients' communication difficulties with SLTs, and the process of being interviewed had alerted the participant to her tendency to neglect communication needs. This appeared to influence subsequent behaviour when at nursing handover she gave an unusually inclusive account of a patients' communication. I understood this as reactivity because she ended with "and that concludes my research" (meaning handover). Everyone laughed and looked my way. I did not view this as undermining the validity of the research however as it added depth to emerging findings about inattention to communication. The incident illustrated that amongst their busyness, nurses could 'forget' patients' communication need. However, of potential value to application of the findings is that it also indicated that they could be supported to remember.

5.3 Time to hear findings

On completing fieldwork in each of the wards, I presented preliminary findings to SLTs and nurses to hear their perspectives. The SLTs offered me an hour to present my findings and they engaged in animated discussion. In order to catch a large number of nurses I was constrained to ten to fifteen minutes tagged onto times when nurses came together to hear about patients; handover or safety huddles. This required me to condense findings and made it impossible to have the kind of expansive

discussion that had been possible with the SLTs. The limited time nurses had available to engage with the emerging findings of the research was mirrored in their infrequent attendance at weekly scheduled interprofessional teaching sessions that were offered on two of the wards.

> They are unable to plan their day in the way that therapists are able to and even with the will to do so they are at the mercy of events on the ward. In this context it is hard to see how nurses can possibly match the level of in-service training that the therapists enjoy. My initial plan had been to run workshops for the staff to share the findings of the study, I realize that this may be naïve.

Nurses' lack of time and their disposition towards getting things done in the here and now resonated strongly with the SLTs who attended the feedback presentations. SLTs at one of the events suggested that SLTs could increase temporal-spatial alignment by conducting work relating to patients' communication needs whilst also assisting nurses with personal care tasks. I shared this suggestion at a feedback session for nurses and they welcomed the idea but found it hard to place within their conceptualisation of the SLT role. Bourdieu suggested that through the habitus "the most improbable practices are excluded as unthinkable" (Bourdieu, 1990:54). This indicates complexities in changing habituated ways of acting. Whilst the SLTs could envisage bringing more of their work into nursing space, changing practice would require both professions to adopt and embed new ways of conceiving the interdependency of their roles on stroke units.

6. Conclusion

This chapter has demonstrated how reflexive work influenced emerging interpretations about how SLTs and nurses shared information on stroke units. Fastidious recording of reflexive notes helped me reflect on the interaction between subjectivities and interpretations of observed practice. My experiences of moving in and out of SLT and nursing spaces, of feeling uncomfortable and of research processes heightened appreciation of temporal-spatial differences between the disciplines. The published account

of this research presents measured interpretations of SLT and nursing practice based on careful analysis of observations and participant perspectives (Barnard et al., 2021). However, as a practitioner-researcher I was also invested in the field. Through discussion of the habitus, I have shown that trying to fit in with two professional groups created some rupture to my habituated ways of seeing my own profession in interaction with the nursing profession. Attention to the researcher, the research processes and the research outputs has revealed the intricate relationship between them and demonstrated how this served to strengthen understanding of SLT-nurse practice.

The process of conducting ethnographic research on busy stroke wards was intense, yet highly illuminating and rewarding. Reflexive diary writing is well established in ethnography and I would urge novice ethnographers to be conscientious in contemporaneously recording process-related issues as well as analytic insights. During fieldwork, writing about my own experiences of conducting the research felt more personally than empirically useful, however, it became apparent that as well as helping me work through research challenges, these reflections were part and parcel of the knowledge generated. For example, my *in the body* learning about the physicality of nursing gives me confidence to suggest that it would benefit SLTs to experience this as part of interprofessional education, perhaps by experiencing a long nursing shift or acting like an ethnographer and observing how frequently nurses are interrupted. I also learnt to appreciate that uncomfortable experiences made me hyper-vigilant. It was important to sit with them because the more comfortable I became, the less I noticed. Overall, exploring interprofessional practice using ethnography created much deeper knowledge about how professionals operated than would have been possible through less immersive research methods.

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