

Impact of Power Dynamics on Collaborative Practice:

A Foucauldian-Informed Discourse Analysis

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Abstract

Despite international initiatives to promote and encourage interprofessional collaboration in healthcare, research has identified barriers that hinder such practice in reality. Primary amongst these, are power relationships in multidisciplinary teams (MDT), which are described as hindering communication between professionals, and giving rise to stereotypical views, facilitating hierarchical relationships, limiting capacity for change, and impeding clinical decision-making.

To help understand why such practice exists, this research utilised Foucault's approach to discourse analysis, to study the effects of power dynamics on clinical decision-making and collaborative practices, within an MDT team of a Neonatal Intensive Care Unit (NICU). Data were collected from semi-structured interviews and direct observations of three multidisciplinary team meetings and two ward rounds. The interviews were conducted to uncover the rich descriptions associated with power relationships. Topics discussed, included MDT staff's understanding of collaborative practice, real workplace examples of collaborative practice, bicultural practice and solitary or unilateral practice, examples of interactions which portrayed or supported the exertion of power, and examples of gatekeeping of power. Observations included, but were not limited to, commentary on roles, body language, interruptions, and contributions, which were recorded in the form of field notes.

Transcripts were analysed using Foucault's understanding of power, knowledge, discourse, governmentality, and punishment. Four key discourses were identified to influence collaborative practice and power dynamics within the NICU MDT. These included the biomedical discourse, the culture of blame, the sanctity of life and collaborative practice. While all discourses were always in play, each rose to dominance in different situations. As each discourse came to the forefront of practice, it had a significant yet unique effect on staff behaviour, communication, power dynamics and collaboration. Although the biomedical discourse was a relatively dominant discourse, shaping the flow of power and the forms of communication that were favoured, collaborative practice was revealed to be a dynamic phenomenon, that was responsive to the changing situation in the NICU and to the various actors. Empowered with this

understanding MDT staff can better identify, engage in and encourage collaborative decision-making to improve health care delivery.

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List of abbreviations

ADHB	Auckland District Health Board
AUTEC	Auckland University of Technology Ethics Committee
DHB	District Health Board
MDT	Multidisciplinary Team
MOH	Ministry of Health
NICU	Neonatal Intensive Care Unit
WHO	World Health Organization

Attestation of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

15/12/2022

Signature

Date

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Ethics approval

Ethical approval from the Auckland University of Technology Ethics Committee (AUTEC) was gained on the 25th of June 2020. Ethics application number 20/154 (Appendix A).

An amendment to my Ethics application number 20/154 was approved on the 30th of April 2021 by AUTEC (Appendix B).

Chapter 1 – Introduction

Multidisciplinary teams (MDTs) are a mainstay of modern healthcare service delivery and a cornerstone of high-quality care (Ndoro, 2014). They consist of groups of professionally qualified individuals with varying skills and backgrounds, who collaborate to achieve shared objectives or goals (Ndoro, 2014). These often include doctors, nurses, occupational therapists, social workers, and many other healthcare professionals. In New Zealand, research and legislative guidelines both recognise the role of collaboration between MDT professionals to increase efficiency and quality of healthcare delivery (Ministry of Health, 2012). Despite this, many factors have a large influence over the ability of healthcare professionals to engage in collaboration. This research utilizes Foucault's approach to discourse analysis, to understand its effects on power dynamics, collaborative practice and clinical decision-making in the Auckland District Health Board's (ADHB) neonatal intensive care unit (NICU).

International views on collaboration

In 2010 the World Health Organization (WHO) recognised and published statistics about the burden health systems throughout the world bore, as populations increased at a rate unmatched by the rate of qualification of trained healthcare staff and funding (WHO, 2010). With increases in life expectancy and the size of the ageing population, evidence demonstrates a battle as healthcare workers fight to support increasingly complex health issues (WHO, 2010). Given the search for innovative strategies to best cope with this demand, the WHO created the Framework for Action on Interprofessional Education and Collaborative Practice. It is a guideline for policymakers around the world to provide strategies and ideas that will support the implementation of collaborative practice (WHO, 2010). According to WHO (2010), "collaborative practice happens when multiple health workers from different professional backgrounds, work together with patients, families, carers and communities to deliver the highest quality of care" (p. 7). Collaborative care seems to be the answer to improving health outcomes, delivering efficiency of care, and combating staff and funding shortages. Amongst such heavy promotion from the WHO, one would expect collaborative practice to be an integral part of service policy and MDT care in the New Zealand health systems. However, this is not necessarily the case.

Why collaborative practice

In my years working in an MDT for the Special Care Baby Unit (SCBU) at the Waitemata District Health Board, I realised that while collaboration was an essential aspect of service delivery, professionals' views and attitudes towards collaboration, especially during moments of increased work pressure, were largely unfavourable. As an Occupational Therapist shaped by holistic worldviews, I have often felt the effects of the medical gaze and dominant medical hierarchy when attempting to express my professional opinions regarding a client's care. My professional reasoning has sometimes been challenged by those who held decision-making power, sometimes due to an apparent lack of understanding of my professional role. At other times, it seemed that other team members perceived my knowledge to be insignificant or inferior in treating the disease. These views of disease and treatment have reduced collaboration amongst colleagues within my work settings and have often driven the care we deliver, to focus on those interventions most valued by doctors and nurses. However, as a clinician, I found myself asking whether this care is best practice for clients and for us as MDT members.

While there were many factors which hindered collaboration in my workplace (such as time pressures, lack of trust and lack of understanding of each other's roles), I was unable to understand why such factors were recurrent in literature and so challenging to address, given collaboration was the recommended global response to the rising pressures on healthcare. Over time, I began to observe the power dynamics, which seemed to override engagement in collaborative practice, and so I began to search for preliminary literature that could help me to understand the relationship between power and collaboration better.

In many healthcare settings, guidelines encourage shared decision-making in clinical practice. However, there is very little evidence of such decision-making in reality (McDonald et al., 2012). Although practitioners and legislation recognized the need for collaboration, there is also some acknowledgement that this does not entirely occur (McDonald et al., 2012). In a study exploring how power is exercised in interprofessional practice, Nugus et al. (2010) found that both collaborative practice and power dynamics co-exist in health services. According to Looman et al. (2022) power dynamics refers to the way in which power affects the interaction or

relationship between two or more people or groups. Looman et al. (2022) also acknowledged that while power dynamics based on traditional hierarchies are inherently present in interprofessional interactions and relationships, they are considered neither positive nor negative but neutral. Despite its neutrality, Nugus et al. (2010) found power within MDT settings was seen to be exercised during discussions regarding care, care delivery, decision-making and the evaluation of interventions delivered. At times this power was competitive and involved doctors authoritatively dominating nurses and allied health professionals, in line with a model which held them ultimately accountable (Nugus et al., 2010).

While I found a variety of information regarding some of the institutional factors which gave rise to power dynamics and barriers to collaboration, there was minimal information about what influenced these social and communication barriers, and why institutions were structured in ways which did not cater to collaboration. I found that existing research was often limited in its scope, focusing on specific settings or disciplines. In addition, much of the current research on this topic has been conducted outside of New Zealand and does not focus on the neonatal setting, which somewhat limits transferability to New Zealand neonatal settings, given that departments are structured differently and are likely to face different challenges in different countries. Given the limitations of existing literature, I realised that to truly understand what was guiding the physical, social, and institutional factors which impacted collaboration, I needed to assess the role power plays in MDT practice and the multimodal ways in which communication occurs in neonatal units in New Zealand. Hence the question asked in my research is:

“How do power dynamics interact with discourse to shape collaborative practice and clinical decision-making in the ADHB NICU?”

This research aimed to understand discourses which guide MDT practice, influence communication between staff and affect staff engagement in collaborative practices. To achieve that, I intended to explore the relationship between power, knowledge and discursive practices that shape health professionals' views within the ADHB NICU unit, to uncover the impact of such practices on clinical decision-making while generating recommendations to improve the collaboration and quality of care provided.

Context of research

To contain this study at a Master's level, I could only select one neonatal unit from which to collect data. To ensure my research findings would be relevant to neonatal practice in New Zealand, various neonatal units were considered suitable sites for data collection. While these included Counties Manukau DHB, Waikato DHB and ADHB, ADHB's NICU was ultimately selected. With a mix of staff who identified with diverse cultures, including Māori, ADHB's NICU is situated in the largest children's hospital in New Zealand, known as Starship hospital (Starship, 2019). Starship contains various medical specialties', and caters for children and neonates from around New Zealand, depending on their needs (Starship, 2019). It was thus determined that ADHB's NICU would most likely have a good variety of professionals with different experiences, along with neonates from diverse cultures and locations. Before beginning data collection, a literature review was completed, which identified the advantages of collaboration in medical diagnosis and treatment, the barriers which limit engagement in collaborative practice and the impact of power dynamics on collaborative practice. The ongoing literature review helped me identify the data I could collect to answer my initial research question.

Theoretical position

Communication and language are enormous aspects of successful collaboration. Thus, I needed a qualitative approach that aligned with my research topic and aim. Qualitative research focuses on the meaning of individuals' lived experiences in a particular context (Stake, 2010). While there are many types of qualitative research, the use of each method depends upon the type of research question, the degree of control the researcher wishes to exercise over behaviours or events, and the impact of the contemporary phenomena when compared to the historical portrayal of what is being studied (Stake, 2010). To understand the language, communication styles and building blocks of what informs the NICU staff's understanding of their environment and experiences, I needed to explore the discourses that shaped their worldviews (Hyland et al., 2021).

Given that Foucault's methodological approach to discourse analysis explores social phenomena and their relationship with knowledge and power, I found myself drawn to

his lens for my own research (Hyland et al., 2021). The appeal of Foucault's views on discourse lies in his ability to challenge everyday practices, with the suggestion that individuals' behaviours and experiences, were being shaped by invisible rules and regulations imposed by societies propagating an agenda (Oliver, 2010). Given that institutions such as DHBs have many unspoken rules and regulations, this aspect of Foucault's position aligned with my intention to uncover how and what discourses impact power dynamics and collaborative practice.

Foucault further believed that although power is fluid in nature, it has a symbiotic relationship with knowledge which often results in the two being viewed as existing together. This, however, is not the case (Oliver, 2010). As power cannot be created or destroyed, it has the potential to be exercised by anyone, depending upon the discourse driving it and the context of the situation (Foucault, 1980). When applied to the NICU, Foucault's insights on power helped me to understand the different levels at which power can be exercised, thereby challenging the commonly held view that power is always exercised by those who are at the top of the hierarchy. Using such understandings, this research aimed to critically analyse the flow of power in the NICU MDT, while exploring the discourse driving it.

As Foucault's ideologies and views scrutinised the impact of discourse on behaviour and social contexts, his work aligned well with the epistemology of social constructionism (Lock & Strong, 2010). From an epistemological perspective, social constructionism, like Foucault, also observed knowledge as being created through interactions between discourses that shape world views (Burr, 2015). As an epistemology, social constructionism enabled me to closely scrutinize the day-to-day interactions and communications between MDT professionals, therefore, aligning well with both Foucault and my research.

When considering the theoretical perspective, which aligns well with my research and Foucault's philosophies, one cannot ignore the perspectives of postmodernism. Despite his explicit refusal to identify his perspective as postmodern, Foucault's views often conflicted with the notion of modernism and often rejected logical thinking, in order to support the importance of critiquing texts, theories and political agendas which propagate capitalism (Hicks, 2019). When considering that hospitals in New Zealand are

generally run by government organisations, aligning this research with a postmodern perspective provided me with the opportunity to carefully critique government guidelines and organisations responsible for monitoring neonatal practice.

Overview of thesis

This thesis spans six chapters that each focus on a different phase of my research. Chapter one has provided an overview of the initial question and aim of this research, along with a brief discussion on how I approached my topic and research itself. The second chapter explores literature specific to this research in further depth, while also addressing gaps present in the literature review. Chapter three presents the theoretical perspectives and methodological approaches that informed this research and, more specifically, the analysis. It explores Foucault's philosophical views on many subjects, including power, knowledge, and discourse. This is followed by chapter four, which provides a detailed account of the methods used to complete this research, including strategies utilized to maintain confidentiality and anonymity. Chapter five presents the discourses discovered during the analysis, with illustrative quotes from participants' interviews and observations of MDT meetings and ward rounds. Finally, the sixth chapter discusses the findings, strengths and limitations of my research and its implications for practice and future research. Despite this research being informed by Foucault's understandings of discourse analysis the underlying intent of this study is to inform health practitioners about discourse analysis so that they more knowingly respond therefore, recommendations are offered in the final chapter.

Conclusion

This chapter has provided an overview of my qualitative study, which aims to explore the impact of the discourses that shape power dynamics and influence collaborative practice. While this research is motivated by my personal and clinical experiences, it is informed Foucault's approach to discourse analysis to analyze data collected from the ADHB NICU. A brief outline of my research question, methodological approach and relevant research methods have been provided, to establish my position as a researcher. Findings from my research are specifically relevant to the ADHB NICU, however, they may have relevance to other NICU units of New Zealand.

Chapter 2 – Literature Review

The government is much like Maslow's hierarchy of individual needs in the sense that without economic, social, military and health security, democratic institutions cannot flourish (Britnell, 2019). Cited as one of the top five political and economic issues of most governments, health is associated with laying the foundations for building hope, social cohesion, and a productive workforce (Britnell, 2019). As populations age, pandemics rise, and funding needs fall short of expectations, the capacity of the healthcare industry to deliver on such expectations is dwindling. While the WHO aims to discover ways to improve this situation, it continues to advocate for collaboration between professionals, patients, families and organisations to support the delivery of comprehensive healthcare and client-centred care (WHO, 2010). Given this high-level push for collaboration, this chapter provides an overview of literature which explores the effect and barriers of collaboration and the impact of power dynamics on collaborative practice.

This chapter begins with the national and international literature on collaborative practice, to foreground why this research is so essential for health care. The following section explores the global barriers to collaboration within the NICU. As literature based on practice within the New Zealand NICUs is limited, international literature was studied to ensure there was sufficient evidence to substantiate any claims about collaboration. Finally, the chapter concludes with studying/ assessing the impact of power dynamics on collaborative practice within the health field. Perhaps due to the confronting nature of this topic, literature on power dynamics within NICU practice is inadequate. It requires further investigation to provide diverse viewpoints of how power dynamics operate in such settings. Therefore, the scope of the review explores what is known about the way in which power dynamics shape collaboration in different fields of healthcare. While the results are not transferable, they provide insights into how power dynamics can shape practice.

Search strategy

A literature search was conducted through four different databases, which included peer-reviewed journals published between 2000-2020 from EBSCO, SCOPUS,

ScienceDirect and Google Scholar. The literature reviewed for this study spans two decades for two key reasons. Firstly, there was limited research focusing on the relationship between power and collaboration in the NICU. Secondly, the international push for collaboration in the form of the WHO international collaborative framework was not introduced until 2010. Therefore, to ensure that I captured enough relevant literature before and after the introduction of the international framework to gauge its effects on practice, I decided to span the literature review over 20 years.

A Google search was also conducted along with a search of relevant citations found in the literature. Search terms were: “power dynamic*” OR hierarchy* OR power* AND Multidisciplinary* OR interdisciplinary* AND “collaborat*” OR “interprofessional collabor*” OR “teamwork*” OR “shared care*” AND “NICU*” OR “Neonatal Intensive Care Unit*” OR Premature Baby Unit* OR Neonatal Unit*. Additionally, relevant books, the WHO website, and NZ government guidelines and frameworks were explored, to better understand the drive for collaborative practice in healthcare. The combined use of this literature enabled me to identify current gaps within research and ultimately supported the refinement of my research question.

Pressures on healthcare and the push for collaboration

The WHO anticipates a global shortage of 15 million healthcare staff by 2030 (WHO, 2022). While this is a reflection of the under-investment in the training and education of healthcare staff internationally, it is also the result of budget constraints along with the rising health needs secondary to an ageing population (WHO, 2022). Shortages in healthcare continue to coexist with suboptimal working conditions, unemployment, and underutilization of staff, all contributing to further shortages (Wendt & Naumann, 2018). Despite a call for investment in the healthcare workforce and education, the economic crisis resulting from the Coronavirus pandemic, may not be able to address funding needs in the foreseeable future (WHO, 2022). With this situation in mind, the WHO has provided several recommendations to support the strengthening of health systems worldwide (WHO, 2022). A key bid to support the effectiveness of the current workforce, as identified by the WHO, is for continual collaboration at all levels within governance and healthcare delivery (WHO, 2022). Similarly, given the burden the Coronavirus pandemic has created on the economic and health systems of New Zealand,

foreseeable spending on healthcare is likely to plateau, leading to increased pressure and demands placed on healthcare professionals.

A study of 11 countries (including New Zealand), that were coping with the significant rising healthcare costs found that reforming the healthcare system, instead of supporting privatisation, remained a very difficult task to accomplish (Wendt & Naumann, 2018). According to the New Zealand treasury, an analysis of trends in population ageing and growth revealed that the New Zealand government could not sustain constraining or cutting any expenditure on healthcare, if they were to meet the needs of population groups in 2050 (Davey & Cornwall, 2004; Ministry of Health, 2022). Without alternate ways of distributing this burden, spending pressures attributable to population ageing and health are likely to increase rapidly (Davey & Cornwall, 2004). The Ministry of Health (MOH) has reported that for healthcare services to continue meeting needs, it is essential for New Zealand to find new and sustainable ways of delivering services (Ministry of Health, 2022). With limited resources, reduced funding and limited staff, collaborative practice, as promoted by the WHO, seems to be an avenue to alleviate these pressures.

The World Health Professions Alliance has also recognised multiple positive effects of collaborative practice, including improved access to healthcare for patients, comprehensive and well-coordinated health services, reduced prevalence and incidence of disability and increased job satisfaction for health professionals with reduced rates of burnout (World Health Professions Alliance, 2019). Like the WHO, the World Health Professions Alliance (2019) further reinforces the importance of developing policies within governance structures which support, promote and fund collaboration between healthcare professionals.

In spite of such global recognition of the importance of collaborative practice, New Zealand legislation continues to lack policies which encourage collaboration between staff from different professions. While legislation and policies do not campaign for collaboration between professionals, they do recognise a general need for collaborative practice between primary healthcare settings and DHBs. For instance, the NZ Health and Disability Act 2000 emphasises the need for DHB's to work collaboratively with each other to promote, protect, and improve the care of those individuals with

disability (Ministry of Health, 2018). This absence was further reflected in Starship's values, as despite citing collaborative care as a core value of their service delivery, there are no regulations or guidelines to formally support or promote this (Starship, 2019).

Collaboration in the NICU

Advantages

Although the case for interprofessional collaboration began as an initiative from the WHO to combat the worldwide healthcare personnel shortage, existing literature has found it contributes to a number of positive health outcomes for neonates admitted to the NICU (Gittell et al., 2013). Where once collaborative developmental care in the NICU was considered an adjunct to life-sustaining interventions, it is now recognized to support improvements in long-term neurodevelopmental outcomes for neonates, when compared to those who did not receive such care (Knudsen et al., 2021). These include improvements in the cognitive, motor, speech, and sensory processing functions of neonates (Knudsen et al., 2021; Spellman, 2019). Like the two quality improvement studies identified earlier, a larger qualitative focus group study which aimed to assess changes in the collaborative care of five different American hospitals post-specific education delivered to MDT staff, also found collaborative practice demonstrated significant benefits (Laudert et al., 2007). In congruence with Knudsen et al. (2021) and Spellman (2019), Laudert et al. (2007) also found that collaboration was essential for improving neonatal outcomes around feeding, maintaining good posture to support better developmental outcomes and improving bonding between parents and their infants. Furthermore, Laudert et al. (2007) suggested collaboration was essential when it came to identifying and altering the physical environment of the NICU, to better accommodate the needs of neonates, which subsequently produced improved sensory outcomes and reduced their length of stay. These findings were mirrored in another study, which found that the effective delivery of collaborative practice, reduced the total length of stay and rates of readmissions for neonates (Welch et al., 2017). Despite these studies varying in their date of publication and style of research, it was clear they all found collaboration improved neonatal outcomes in different ways.

According to Barbosa (2013), implementing MDT collaboration in NICUs can not only improve outcomes for neonates but can also contribute to significant cost-saving for

hospitals, along with improved outcomes for staff. In congruence, a survey study completed by Dunn et al. (2013) uncovered that there was a strong positive correlation between general collaboration in the NICU, collaboration in clinical decision-making, and high levels of satisfaction reported by staff in the decision-making process. Likewise, Barbosa (2013) and Dunn et al. (2013) were also in agreement, as they discovered that it was this improved satisfaction amongst staff that led to increased productivity, personal growth, increased job satisfaction and individuals feeling valued in their MDTs.

Barriers

Salih and Draucker (2019) found that while there were advantages to collaboration, there were also many barriers which require attention if collaboration within the NICU environment is to improve. Their findings revealed that current barriers to collaboration include poor communication, difficulties sharing professional opinions due to work culture prohibiting disagreement with those in positions of power, interpersonal conflicts and feeling undervalued (Salih & Draucker, 2019). Laudert et al. (2007) agreed with these findings and further highlighted factors which exacerbated such barriers, including increased patient volumes, acuity and lack of time for professionals to focus on collaborative developmental care and buy-in of staff. While both studies identified barriers to collaboration, neither was able to highlight the root cause of why such barriers existed in the first place.

Mirroring these findings Ohlinger et al. (2003) also identified similar barriers when attempting to facilitate collaboration. They found that as NICU MDT staff often varied in their views of what constituted collaboration, they disagreed on the degree and quality of collaboration that truly occurred (Ohlinger et al., 2003). For example, where doctors report a high degree of collaboration, their nursing colleagues reported the opposite, often feeling excluded from the decision-making process, along with reporting poor communication between the two (Copnell et al., 2004; Dunn et al., 2013). This mismatch in views was further reflected in different staff's ability to trust other team members to carry out their jobs effectively. While nurses were reported to be very trusting of other team members, doctors in comparison, were not (Masten et al., 2019). According to Masten et al. (2019) and Salih and Draucker (2019), while all team members in the NICU often report the presence of hierarchy, nurses and allied health members, unlike doctors, viewed it as detrimental to collaboration, as it hindered communication and

often limited inter-disciplinary interactions. Furthermore Masten et al. (2019) also found that the presence of hierarchy had the ability to affect the quality of patient care, as it made it increasingly difficult for team members to voice concerns and question the practices of one another.

The positive implications of increased staff productivity and job satisfaction, along with increased benefits for neonates, all support the push for collaboration in day-to-day NICU practice. However, while research has identified multiple positive outcomes, it also emphasizes the difficulties around creating and supporting such a culture in the NICU environment. Adoption of a collaborative culture, requires the entire MDT to share the same purpose, which builds accountability, good communication, trust and respect for one another's professional opinions; all of which enable MDT members to evolve, grow and better support a collaborative culture (Masten et al., 2019; Ohlinger et al., 2003). Facilitating collaboration is a complex process, which requires focused efforts, as perceptions of collaboration often vary among different members of the MDT (Ohlinger et al., 2003). These differences in perceptions have been consistently reported for over 20 years, with no apparent reason identified for the breakdown in the communication (Copnell et al., 2004). Much of the literature explored above was based on small quality improvement studies or larger qualitative research, conducted in different countries around the world. Despite their varying methods, each study was limited either due to its size, generalizability or transferability. Given that studies were specific to a particular hospital, location, population demographic or uniquely run NICU, the extent to which the findings can be transferred to New Zealand is difficult to judge. However, in order to better understand why these communication barriers exist, and observe what shapes the behaviors that influence collaboration, this research will delve into the discourses which guide communication and behavior.

Power dynamics and collaboration

As a result of there being limited literature exploring the relationship between power dynamics and collaboration, the next section will focus specifically on a few pieces of literature in some depth. A small number of researchers have contributed insights into the ways in which power operates in the medical context and as I report findings, I will provide a brief critique of the research methods used to generate these findings.

Power and hierarchy

Research evidence suggests that while health professionals often recognised that health care was not just medical care delivered by doctors, they admitted that day-to-day practice did not align with this view (Hills et al., 2007). A community participatory action research conducted by Hills et al. (2007) found MDT members of primary health care settings, felt that power dynamics created a hierarchy between professionals which not only gave doctors precedence above all other professionals, but also gave them the right to make the final decisions about a patient's care. Maddock (2015), McDonald et al. (2012) and Oborn and Dawson (2010) findings all mirrored this and further aligned with Foucault, as they identified that it was the biomedical model of care which facilitated these power dynamics, as it supported the stereotypical view of valuing medical knowledge above all else. They added that it was this view that led to MDTs being structured in a hierarchical working arrangement with doctors placed at the top.

These power dynamics and hierarchy were found to further induce professional gatekeeping, rivalry, stereotyping and role protectionism, which appeared to fragment collaboration (Maddock, 2015). In congruence, a survey completed by Masten et al. (2019), found that unlike doctors, MDT staff, such as nurses and allied health professionals, viewed these power dynamics and hierarchy as detrimental to collaboration, as they hindered communication and often limited inter-disciplinary interaction. The case study completed by McDonald et al. (2012) further discovered that doctors were likely to be more accepting of such dynamics as they used this power to preserve their professional autonomy, which subsequently influenced whom they collaborated with and how they participated in those relationships. Similarly, Masten et al. (2019) identified that the presence of such toxic power dynamics and hierarchy could also affect the quality of patient care, as it made it increasingly difficult for MDT members to voice concerns and question the practices of those in power, thereby limiting collaboration.

Power, knowledge and trust

While on one hand, power was seen to support hierarchy, it was also observed to create discrepancies between how different professionals viewed disease and broader determinants of health. Ultimately, these views shaped how professionals viewed and

valued the roles and practices of other team members and influenced whom they decided to collaborate with (Hills et al., 2007). Like Foucault (1980) and Hills et al. (2007), a case study completed by Oborn and Dawson (2010), emphasized that collaboration between MDT professionals was greatly dependent upon the level of medical knowledge professionals were seen to hold. Given that knowledge and power were viewed to be interdependent, the priority allocated to medical knowledge was observed to impact the perception professionals held of other disciplines, thereby influencing their trust in the abilities of their colleagues in situations of collaboration (Hills et al., 2007; McDonald et al., 2012; Oborn & Dawson, 2010). McDonald et al. (2012) discovered that doctors were observed to hold the greatest power over clinical decision-making and were found to be the most untrusting of all MDT members. Doctors were often reluctant to collaborate with professionals from different disciplines and clearly demonstrated the most trust and comfort, when collaborating with team members from their own discipline (McDonald et al., 2012). These findings align with Dunn et al. (2013), Hills et al. (2007) and Ohlinger et al. (2003), who all identified that this lack of trust had a significant influence on the quality of communication and, therefore, an individual's ability to participate in the process of collaboration.

Power and change

A phenomenological study exploring MDT practice recognised that the evolution of current healthcare practice has not only developed professional disciplines, but it has also further expanded the skills and expertise of different professionals (Maddock, 2015). While this has led to the blurring of professional boundaries, it has also given rise to role protectionism, as many MDT professionals were observed to fear losing their role and power in their MDT. McDonald et al. (2012) and Hills et al. (2007), concurred with these findings as they also noted that such evolution has created a lack of understanding of different professional roles, which has given rise to mistrust in the health service and has subsequently supported the reluctance of professionals to engage in collaboration. In contrast, Oborn and Dawson (2010) found that within the medical setting, professionals in power often demonstrated a reluctance to divert away from the stereotypical views of professional roles. They further noted that pre-existing views associated with professional roles, often led to reduced discussions and increased time spent validating fixed views, which ultimately reduced shared decision-making and

collaboration between different professionals. It appeared that collaboration was, therefore, not only seen as a threat to professional independence and power, but also posed a level of risk and uncertainty for certain groups.

The studies discussed above have all been conducted in different countries around the world and each demonstrates some strengths and weaknesses, which informs their findings. The degree to which the findings of the above studies are transferable to NZ is unknown. While Maddock (2015), McDonald et al. (2012) and Oborn and Dawson (2010) all adopted a case study approach, McDonald et al. (2012) conducted their research in Australia, but it was limited to a community rural community setting. Oborn and Dawson (2010) limited their location to a single urology department in the United Kingdom and Maddock (2015) explored a MDT setting in an Irish mental health context. All three utilised thematic analysis to produce thick descriptions and support data credibility, that were produced in countries with health systems comparable to New Zealand (Medical Council of New Zealand, 2022). Despite this, findings continued to be limited by their transferability to the NICU in New Zealand as a result of their varied settings (Medical Council of New Zealand, 2022). In contrast, Hills et al. (2007) conducted their study in Canada and to support rigour, utilised iterative cycles of reflection and thematic analysis, to increase the dependability, confirmability and transferability of their data. Thereby, they make their findings applicable to the New Zealand setting, given the two systems are comparable (Medical Council of New Zealand, 2022). While Masten et al. (2019) and Ohlinger et al. (2003) also both conducted their studies in America, they acknowledged selection bias and lack of transferability as potential limitations of their study. Despite this, both studies provided useful insights into how different professionals perceived both their roles and collaboration.

Conclusion

Despite the above research exploring different population groups, locations, and culture demographic, it is clear that they all agreed that existing power dynamics contribute to conflict, poor communication, and stereotypical views of professional roles, which had a subsequent effect on collaborative practice (Hills et al., 2007; Maddock, 2015; McDonald et al., 2012; Oborn & Dawson, 2010; Ohlinger et al., 2003). While previous study outcomes have found hierarchical power dynamics to diminish the quality of collaborative practice, researchers have often only focused on broad factors which

influence service delivery, patient experiences, or the ways in which MDTs function. While some literature has drawn attention to the way in which hierarchical power structures, in alignment with the biomedical model, impacts collaborative practice in MDTs, it is still limited by lack of identification of other potential discourses which may also be influential. Exploring discourses shaping practice in the NICU, will further support current and previous literature by identifying other dominant discourses that currently guide practice in New Zealand. As a large volume of the existing research has been conducted outside of New Zealand, it somewhat limits transferability to New Zealand settings, given that the organization of health systems varies in different countries. Research in a New Zealand setting is required, with a study design that is focused on achieving strong rigour and studying what shapes power dynamics, their effect on collaborative practice, and clinical decision-making. As demands on health systems continue to grow, a better understanding of what discourses shape collaboration in the NICU, may support the NICU services to make the necessary changes needed to continue providing an efficient and effective quality of healthcare. As suggested by the World Health Organisation, without reviewing such systems DHBs may struggle to cope with maintaining standards of care as demands increase.

Chapter 3 – Methodology

The earliest trace of qualitative research can be linked back to the mid-nineteenth century, when the term “to understand” or “to interpret” was introduced as a method, by German philosopher Wilhelm Dilthey (Lapan et al., 2011). While Dilthey used such a method to study and describe the ways in which humans understand their experiences, other philosophers added to his methods to further capture the processes that humans utilise to understand the world. By the 1970s, qualitative methods became one of the more pronounced approaches to research (Lapan et al., 2011). Characterized by its ability to interpret different individuals or groups' values, perspectives, behaviours and experiences, qualitative research has become an inductive process that enables us to better understand reality (Merriam & Tisdell, 2015). A qualitative approach was selected here, as this research aims to increase understanding of the power dynamics within the NICU unit and the discourses that guide such practice.

Depending upon the type of research question, the impact of contemporary and historical phenomena and the degree of control researchers exercise over data collection and analysis, there are multiple ways to conduct qualitative research (Merriam & Tisdell, 2015). With an array of methodologies and methods to select from, a qualitative researcher must seek some level of scaffolding to drive their research in a clear direction (Crotty, 1998). For this to occur successfully, it is essential for research to be rooted in epistemology, theoretical perspectives and a methodology which supports the method of any given research (Crotty, 1998). To explore the underlying factors guiding power dynamics, collaboration, language, and other modalities of communication in the NICU, discourse analysis was deemed to be the best methodology for this research. Derived from Foucault's ideas on discourse, discourse analysis aims to uncover the meaning which constitutes language, knowledge, and the social world (Burr, 2015). Rooted in critique, discourse analysis considers the impact of both historical and contemporary contexts on social practice (Burr, 2015). While it does not aim to pass judgement, it aims to expose discursive phenomena to uncover the underlying ideological message (Burr, 2015).

The following chapter will explore the epistemological and technical perspectives that underpin discourse analysis, before then delving into discourse as a methodology.

Epistemology: Social constructionism

According to Lock and Strong (2010), discourse analysis is heavily shaped by a social constructionist view of knowledge and the social world. Social constructionism is the view that knowledge and meaning within a social context are contingent upon human behaviour and practices as they interact with one another and shape social contexts (Crotty, 1998). As a result, social constructionism as an epistemology, views knowledge as something created and influenced by the interactions which shape the world around us. This is congruent with Foucault's views on knowledge stemming from individuals' conscious perceptions, bound by a given domain and time period (Foucault, 1976). With an emphasis on individual experience, social constructionism guides researchers to analyse behaviours and practices which are deemed to be "typical" and "standard", to understand what drives them and how they have become normalised in our social reality (Burr, 2015).

Medical knowledge is not produced by nature but instead constructed by interested factions that contribute their understanding of health and well-being, to their field of expertise (Conrad & Barker, 2010). When considering this, we must understand the social constructs that shape our views of health and illness to better understand the assessments and interventions used to treat diseases (Conrad & Barker, 2010). Social constructionism, therefore, lends itself well to research in the medical field (Conrad & Barker, 2010). Furthermore, given that a Foucauldian discourse analysis also aims to understand the construction of social actions, practices, and communication through the lens of power, it follows that a constructionist approach to research is appropriate (Bauer & Gaskell, 2000). Thus, to better understand the construct of collaboration in the NICU, it was important for this study first to explore the discourses and social constructs which shaped the day-to-day practice of clinical staff in the NICU.

Theoretical perspective: Postmodernism

Known as a prominent postmodern theorist, Michel Foucault challenged the notion of modernism, which viewed history as a single truth that could be learnt from in order to inevitably create a better future (Crotty, 1998). Heavily influenced by World War One, modernism rejected the ideology of realism and sought to gain knowledge from rational and logical means (Hicks, 2019). Unlike modernism, postmodernism rejected rational

and logical thinking and deliberately used scepticism and irony to reject grand narratives and view history as subject to perception. Postmodernism was not only influenced by the World War Two, it was also shaped by many prominent philosophers of the mid-twentieth century, some of whom included Jean-François Lyotard, Jacques Derrida as well as Michel Foucault (Hicks, 2019). While Lyotard's writings focused on the role of the post-industrial time and human culture, Derrida's writings were concerned with the deconstruction method and its use in criticising different texts and political theories (Grenz, 1996). Through his critiques, Derrida came to believe that reality was the perception of the individual who interpreted it. Foucault added that with every unique interpretation of reality came the assertion of power (Grenz, 1996). As Foucault understood knowledge and power to share a symbiotic relationship, he felt that to voice one's perception is to exercise power (Foucault, 1980). The works of such prominent authors have, therefore, convinced some audiences to shift away from the modernistic ideology that all knowledge is innately good (Grenz, 1996).

Many postmodernists view science and technology as instruments of established power, further perpetuating capitalism, mass media and marketing (Burrell, 1988). Foucault supported this post-modern view as he believed these modern systems could manipulate, control and surveil large populations (Foucault, 1977). Foucault was able to contextualise the effect of such manipulations on health, education, politics and the disciplinary systems of his time (Behrent, 2013). His views on the use of power through concepts of governmentality and biopower, shed light on how institutions and governments were able to observe, monitor and mould communities to control social behaviour (Behrent, 2013; Foucault, 2008). These post-modern Foucauldian views are very relevant when considering the discourses that govern health practice in New Zealand, as healthcare continues to be funded by the government and is inevitably tied to the political and disciplinary systems.

Discourse

According to Foucault, discourse is the result of languages, values and ideas which produce practices that reinforce the subject of such communication (Foucault, 1976). He recognised that discourse represented historical, social systems that organised and produced knowledge and were responsible for identifying context and meaning (Foucault, 1976). This ultimately significantly influences what individuals perceive as real

and their understanding of what shapes reality. Burr (2015) recognised that there may be several discourses at play surrounding any individual, object, or event, each representing a unique meaning of what it surrounds. However, despite many discourses being in play at once, not all are awarded the same prominence, as each carries a different portrayal of what knowledge is considered to be valid (Cheek, 2000). Therefore, each discourse has the ability to support or challenge other discourses, giving rise to a dominant discourse (Foucault, 1976). Finally, depending upon which discourse is dominant, the societal norms and practices are representative of that discourse at a particular point in time. In a specific context, discourse is therefore a reflection of the goals and purpose of that context, ultimately shaping what is believed to be the truth (Oliver, 2010).

Lacan and Grigg (2007) viewed discourse as a way of structuring social relations through collective understanding and participation in discursive logic. Discourse is therefore not just represented through knowledge but also through the principles and actions of regulating authorities which oversee everyday practices (Foucault, 1976). Foucault acknowledged that those individuals working for such authorities regulated practice by inspecting the behaviours of others, which ultimately handed them the power to control the behaviour of others through surveillance. Discourses are consequently not only associated with the power within social structures, but also with a framework which dictates a way of living (Cheek, 2000; Willig, 2013). Given that discourse can influence our understanding of reality, it can become near impossible for individuals to live and behave in a way that opposes dominant discourses. Upon applying this understanding of discourse to NICU service delivery, it is clear that the knowledge and day-to-day practice within the NICU is shaped by dominant discourses and it is important their influence in determining power dynamics and collaboration, needs to be further studied.

Power and knowledge

In both social and political contexts, the concept of power is ancient, ubiquitous, and often associated with the execution of control from a single, sovereign source (Dahl, 2007). Unlike his contemporaries, Foucault (1980) questioned this concept of sovereign power as he believed that power, like capillaries, were perfused through society and existed within every individual; but was exerted in different ways and forms. He felt that

power was infused in our day-to-day actions, choices and behaviours, and the micro tactics of power could shape one's choices and behaviour over time (Foucault, 1977). This contrasted with Marx, who believed that power was a resource used to oppress a subordinate class of individuals (Olssen, 2004). Marx felt power was always in limited supply and concentrated in the state, politics, and economy, thereby establishing control of individuals' ideas. For Marx, the origin of power was materialistic, and its ultimate goal was to obscure the truth (Olssen, 2004). However, according to Foucault (1980), power is not created or destroyed, but is only in existence because one individual exerts it on another. Foucault felt that the discourses of modern-day society, shaped power and acted as an advocate of power by convincing different members of society to accept the exertion of power in different ways (Dreyfus & Rabinow, 2014). Despite its ability to enforce change, Foucault (1980) felt that power was not negative or repressive, but instead a means of producing knowledge and change. It was fluid, productive, and exercised change through cultural norms and discourse (Dreyfus & Rabinow, 2014).

One of the most dominant discourses in modern-day society is the scientific discourse. Based on evidence gathered in the form of observation and surveillance, along with the need to prove or disprove a hypothesis, the scientific discourse is guided by scientific knowledge (Morrison, 2018). Foucault (1980) believed knowledge will always be intrinsically linked to power as the exercise of power not only creates knowledge but power itself is created by knowledge. Therefore, he alleged that the scientific discourse was a product of the power relations, that struggled to finally create knowledge associated with the field of science (Morrison, 2018). To accept this knowledge meant that society was privy to the scientific discourse and accepted it as the 'truth' (Dreyfus & Rabinow, 2014). Over time, increased acceptance of the scientific discourse demonstrated the power it held, as it facilitated further conformity and discipline towards the knowledge of science. Foucault identified this conformity as a shift away from the sovereign or episodic exercise of power toward a new kind of power which he labelled as bio-power (Foucault, 1977). With the development of hospitals, clinics, prisons and schools, the value placed on the discourse of surveillance, scientific knowledge and education gave rise to a new battle for the 'truth' (Dreyfus & Rabinow, 2014).

Biopower and governmentality

Foucault felt that the birth of the clinic caused a shift in the 'gaze' doctors utilised to view their human patients (Foucault, 2003a). As doctors began to view the human body as a collection of symptoms which required treatment, it gave birth to a view which compared the human body to a machine (Foucault, 2003a). The emergence of such a view meant that the body could be disciplined to make it both manageable and productive (Arnason, 2012). In order to successfully enforce this discipline, human life became the target of political power, which aimed to incorporate biopolitics and disciplinary techniques to regulate and manage entire populations (Foucault, 2008; Srinivasan et al., 2020). For example, the need for a productive workforce during the growth of capitalism in the eighteenth century, further reinforced the desire for a healthy population (Srinivasan et al., 2020). Biopower introduced the concept of normalisation and normality curves that plotted health on a graph and differentiated the normal from the abnormal (Nilsson & Wallenstein, 2013). Healthcare in the NICU continues to follow this biomedical norm of plotting health indicators on a curve, in this case one representing European normative values. Normalisation has, therefore successfully created a need for both individuals and healthcare practitioners, to meet norms that propagate a particular view of health and well-being and align with the ultimate goals of biopower. Falling outside of such biomedical normative indicators has become a way for healthcare staff to identify problems. However, even within biopower, the concept of death continues to fall outside of all norms. While healthcare exercises power over life and how best to foster it, it cannot disallow death. Foucault believed that death was the most private aspect of existence. Therefore, this required organisations of power, to exercise discipline around death, by controlling an individual's body through the regulation of populations (Foucault, 2003b). As the role of death and biopower in medicine continues to influence practice in the NICU, I have used these philosophical underpinnings to support my analysis in the later chapters of my thesis.

As Foucault's thinking progressed from biopower, he recognised that the governing bodies were utilising administrative bureaucracies to control and monitor fertility, life expectancy, public health, housing conditions and other demographics (Li, 2007). He named this power, and way of governing, governmentality (Foucault, 1997).

Governmentality utilised tactics and other structures to align and conduct the behaviour of individuals or groups (Foucault, 1997). It utilized political and economic subjection to structure and to regulate institutions and fields of action in order to exercise a complex form of power, which works alongside the disciplinary institutions' power (Li, 2007). In modern healthcare, the use of educational boards and disciplinary tribunals in New Zealand, is a prime example of how governmentality has been executed to monitor, discipline and align health practices. Although subtle, such execution of governmentality has a significant effect on the working culture in healthcare settings, with practices occurring outside of such regulations risking severe and punitive consequences for the practitioner (New Zealand Health Practitioners Disciplinary Tribunal, 2009). Despite not monitoring daily practice, the existence of such administrative bodies, is often enough to ensure that health practitioners' practice in accordance with their regulations, as a form of self-regulation.

Punishment

In cases where health practice fails to meet the standards set by governing bodies such as disciplinary tribunals and health boards, disciplinary power in the form of a carceral system, is often utilised to discipline and penalise those who fail to meet regulations (O'Farrell, 2005). With governing bodies dictating the norm, the carceral system utilises legality, prescription and structure to exercise this new economy of power (Foucault, 1977). Furthermore, the subtle use of observation and surveillance has become the way in which other professions, such as teaching, both at secondary and tertiary levels, have normalised such exercise of power (O'Farrell, 2005). Foucault described the most effective form of surveillance as a panopticon (Foucault, 1977). Initially conceptualised by Jeremy Bentham as a way to surveil prisoners in the 18th century, the panopticon advocates for the hidden and constant surveillance of individuals in order to generate self-monitoring behaviours (Foucault, 1977). This dehumanizing gaze and loss of liberty, Foucault suggested, was worse than the punishment itself (Beiner, 2014). Foucault felt that this omnipresent gaze of authorities was a constant exertion of power in a manner which normalised certain behaviours, while discouraging others (Beiner, 2014). Although Foucault's suggestion of such surveillance was simply a conception of what modern-day society could become, in today's time this has become our reality (Beiner, 2014). When considering day-to-day practice in the NICU, the use of swipe cards,

security cameras and timed note recording are but a few forms of surveillance that influence both staff and patient behaviours. Such disciplinary power in the context of governmentality and the carceral system has a large effect on practice within healthcare, and my analysis will further explore this in the context of the NICU.

Conclusion

This chapter has provided an overview of the key methodological, theoretical and epistemological perspectives that have informed the methods utilized for the data collection, and analysis processes of this research. To ensure my methodology aligned with the subject of my research, I chose to utilize a Foucauldian approach to discourse analysis. Rooted in post-modernistic views, Foucault's understandings of discourse align well with social constructionism and support the critical observation and analysis of typical day to day communications and practices, which occur in the NICU. His views on discourse, power, knowledge, governmentality and punishment, are analytical tools which have been utilized to uncover and study the discourses shaping the social constructs of the ADHB NICU. The following chapters will demonstrate the use of these guiding principles, by defining the methods utilized to generate the text for analysis and by summarizing the process of analysis itself.

Chapter 4 – Method

This chapter provides an overview of the methodological principles and how they guided my research, before outlining the process through which participants were recruited, data collected and then analysed. As this research involved interviews and observations of healthcare professionals, the ethical steps taken to maintain confidentiality and anonymity are clarified. Finally, the chapter provides an overview of how rigour was maintained to establish the legitimacy of this research.

Methodological principles

In order to study the everyday interactions and practices that occurred in the NICU, this study utilised Foucault's approach to discourse analysis to complete data collection and analysis. Derived from a subjective outlook, discourse analysis is a qualitative, interpretive, constructionist approach to exploring social phenomena (Shanthi et al., 2015). The interpretive constructionist paradigm enables researchers to study everyday phenomena in their natural environments while helping us make sense of how individual staff members allocate meaning to them (Shanthi et al., 2015). To facilitate this, data can be collected through various methods, including memos, documents, field notes, interviews and observations (Shanthi et al., 2015).

Embedded within the belief that no singular truth exists, discourse analysis aligns with postmodernism as it recognises that discourses change and are very much dependent upon the place, time and individuals who reinforce them (Johnstone, 2018). Unlike other approaches, discourse analysis examines language and other multimodal resources to understand how social reality is created (Johnstone, 2018). Furthermore, it recognises that meaning and knowledge are created as a result of the interactions between multiple discourses, hence making it essential to understand which discourses are at play when considering their impact on the meaning of collaboration and clinical decision-making in the NICU. Foucault's discourse analysis focuses on the role of power in the health, justice, sexuality and governance systems (O'Farrell, 2005). Foucault believed that the productive nature of power creates social constructs and discourses which guide individuals to behave in particular ways (Foucault, 1978). Drawing specifically on Foucault's principles on biopower, surveillance and knowledge enabled me to consider the historical, political and social implications of the site from which I

ultimately chose to collect my data. Located in the largest and most diverse city in New Zealand, the Starship Hospital in Auckland was built exclusively for children in 1991 (Starship, 2019). With its vast specialist services and sole focus on children, I selected the Starship NICU as the site for my data collection, given the likelihood of it comprising professionals from a variety of different cultures. As I was employed within the Special Care Baby Unit (SCBU) at the Waitemata DHB, I purposely chose to exclude this site as a potential source of data collection, to avoid conflicts of interest, including the risk it posed to maintaining the confidentiality of my colleagues and the risk it posed for me to function in my team post the completion of my research. I participated in on going self-reflections about these risks before submitting the ethics application to the AUTC.

Ethical approval

Before the commencement of participant recruitment on 3 November 2020, ethics approval was granted from the Auckland University of Technology Ethics Committee (AUTC), reference number 20/154 on the 25th of June 2020 (Appendix A).

Further strategies applied to reduce any potential risks to participants and maintain participant confidentiality, anonymity, and informed consent, are discussed in detail as this chapter progresses.

Reflexivity

Qualitative research is known to be contextual. Therefore clearly acknowledging and describing the intersecting contextual relationships between researchers and participants, increases the credibility of research findings and supports the reader to better understand the implications of those findings (Dodgson, 2019). A primary consideration for this research was the role my culture and subsequent upbringing had, on informing my thoughts and views. As a female of Indian descent, I felt that I had a good understanding of how cultural values, colonisation and community participation can significantly shape one's worldview. This became a big reason behind my decision to focus especially on recruiting Māori participants. Given that there is a stark contrast between the European and Māori views on health and the delivery of healthcare, I felt that having both perspectives would add tremendous value to my research.

Additionally, working in a setting similar to that of the NICU provided me with a deep understanding of the NICU environment, the medical interventions and the MDT process in the NICU setting. I was also familiar with the use of medical jargon, the ways in which prioritisation of interventions is likely to occur, and the roles and responsibilities of the different professionals involved. Furthermore, this familiarity enabled me to capture subtle practices that were unique or outside of the general day-to-day operations. Perhaps this was the reason it was so difficult for me to identify the discursive practices that shaped my worldviews and my practice as an MDT staff member. However, I found that because NICU staff recognised me as an allied health MDT member they demonstrated great frankness in conversation, sharing some of their more intimate and sensitive encounters with power dynamics. Such open communication was highly advantageous to my research.

Data gathering strategies

According to Sharan and Elizabeth (2016), data collection in qualitative research consists of asking, watching and reviewing the information shared by participants and observed by the researcher. The specific information acquired during data collection was informed by Foucault's understanding of discourse analysis and multimodal ways of communication that influence and inform behaviour (Arribas-Ayllon & Walkerdine, 2017). Hence to capture the different modes of communication, body language, tone of communication, and individual experiences, the methods of data collection initially chosen, were individual interviews of MDT members and observations of MDT meetings.

Interviews and observations are the most popular sources of data collection in qualitative research (Flick, 2007). Individual interviews offer an opportunity to capture a unique perspective by facilitating participants to share their experiences, feelings, opinions, and knowledge related to specific topics (Arribas-Ayllon & Walkerdine, 2017; Sharan & Elizabeth, 2016). To ensure that data collected from individual interviews captured diverse aspects of practice while allowing participants to introduce topics I had not thought to ask about, a semi-structured style of interviews was chosen for this research. According to Bourgeault et al. (2010) and DeJonckheere and Vaughn (2019), semi-structured interviews are highly valuable when researchers are attempting to uncover the meaning behind participants' experiences and interpretations of how they view and organise their world. While such forms of interview align well with Foucault's

understanding of discourse analysis, they further provide flexibility, adaptability and a sense of comfort that supports two-way communication between the researchers and participants, enabling the sharing of personal or sensitive experiences (DeJonckheere & Vaughn, 2019).

According to Sharan and Elizabeth (2016), observations allow the researcher to capture environmental factors, behaviours, habits and ways of communication, which have become routine for participants. This not only supports researchers in understanding the context of the participant's experiences but, in conjunction with individual interviews, helps to substantiate the findings (Sharan & Elizabeth, 2016). To ensure I captured the decision-making process, data collection took place over several months from January 2021 to June 2021.

Recruitment strategy

Participants were recruited to ensure that the data gained from individual interviews and observations, represented varied perspectives from different members of MDT. The initial aim was to collect data from direct observations of 3-4 MDT meetings and 5-8 individual interviews with members of the NICU MDT. This typically includes: neonatal consultants, ward manager, registered nurses, social workers, dieticians, lactation consultants, speech-language therapists, and occupational therapist/physiotherapist/neurodevelopmental therapists. The aim was to recruit staff from different disciplines to ensure individual interviews were representative of the diverse professions that form the NICU MDT.

Once data gathering began, three MDT members voiced the importance of observing ward rounds and handover meetings. As these meetings often occurred prior to MDT meetings, specific professionals present at handovers did not attend the MDT meetings. To capture these interactions, the MDT observations were extended to capture ward rounds, after gaining ethical approval from AUTEK to amend my original application. Application for an extension of the initial ethical approval was requested and granted (Appendix B).

Inclusion and exclusion criteria

Inclusion and exclusion criteria were created for participants who volunteered for individual interviews, in order to capture relevant staff members. Inclusion criteria included the aim to recruit staff with a working experience of at least six months within the neonatal team, with priority given to Māori staff (as their experiences of colonisation were likely to uncover different views regarding the discourses at play). This is explained in further detail later in this chapter.

Exclusion criteria specified professionals who did not have a permanent role or had less than six months of working experience in the NICU, such as visiting specialists, students, and rotating health professionals, because it limited their experiences and interactions with other MDT members.

Recruiting participants

Foucault believed power never ceases but instead flows from individual to individual as situations and circumstances change (Foucault, 1980). To understand this flow of power in the context of discourses as different MDT individuals experienced them, it was important to ensure that my recruitment of both individual interview participants and observations, targeted a variety of different MDT professionals on different days. Therefore, recruitment began with presentations to the NICU team on two different occasions in November and December 2020, to ensure a variety of staff members had the opportunity to meet me face-to-face. Information sheets, which included my photo, were distributed at meetings and flyers were posted on team information boards to promote further participation (Appendices C and D). These efforts made to ensure members of the NICU team could recognise me, had a twofold purpose; for security, so that staff would recognise me as a researcher as I moved around the ward, and in an effort to initiate relationship-building with Māori staff members to promote their participation in the study.

To maintain confidentiality, all presentations, information sheets, emails and flyers specified that participation was voluntary and offered all prospective participants two different private and secure means of communicating with me. These included a password-protected email address and a private cell phone number which was used on a password-protected phone for research purposes only. Emails were sent to the entire

department offering information regarding my research (Appendix E). Once composed, I sent them to the NICU manager for approval and for distribution to the entire NICU team with my contact details, attached copies of the information sheets and consent forms, all with the aim of offering different modes of communication should staff wish to volunteer or ask further questions. Recruitment efforts ceased once five participants from different professional backgrounds volunteered for individual interviews. This was because by the fifth interview it was clear that data produced from individual interviews, all identified the same core discourses.

Through these methods of recruitment, I was able to observe three MDT meetings, two ward rounds and interview five volunteers, each from a different discipline and with varying degrees of experience in the NICU. Having collected rich data from multiple perspectives and given there were no other volunteer, further recruitment of participants and meeting observations was not deemed necessary.

Recognition of Māori

As Western medicine and Rongoā Māori, otherwise known as the traditional Māori healing system, differ in their approach and understanding of health and wellbeing, it is important to understand how power dynamics both flow through and affect those who identify as Māori (Ahuriri-Driscoll et al., 2008). For Māori staff members, their cultural experiences, the effects of colonisation, and their views on health care may significantly influence their communication with other MDT members and the clients they serve (Hudson & Russell, 2009). The initial aim was to recruit at least two interview participants of Māori descent, in order to better understand the impact of power from the Māori cultural perspective. In line with the foundation principles of Te Tiriti o Waitangi, I met with the Faculty of Health and Environmental Science's Mātauranga Māori committee for a consultation before beginning participant recruitment. This was done to explore how my research design, recruitment and interactions could be tailored to support the *kāwanatanga*¹, *tino rangatiratanga*² and *ōritetanga*³ of the Māori participants (Waitangi Tribunal, 2019). To facilitate *tino rangatiratanga* I ensured that all Māori staff members could make their own decisions about whether they wanted to

¹ The governing of Aotearoa New Zealand by the Crown (Article 1).

² Māori, iwi and hapū having control over their own culture, communities and resources (Article 2).

³ Māori having equal rights as citizens of Aotearoa New Zealand (Article 3).

participate, without any additional pressure from myself (Reid et al., 2017). I made sure that initial attempts at recruitment were always through a secure email account and were sent by the manager to enable participants to volunteer, only if they felt comfortable.

Furthermore, I consulted the ADHB Māori committee who connected me with a Māori cultural advisor, whom I could consult during my research to better understand the Māori participants' responses. Recommendations from both committee consultations were applied where possible, to support the recruitment and analysis process. Consultation on the data collected with a named ADHB Māori cultural advisor, was also disclosed, with opportunities for volunteers to decline to have their deidentified transcripts shared if they wished to do so. This helped to ensure that Māori participants had the same opportunity to decline consultation should they wish, while also ensuring that their views and experiences would be correctly interpreted and understood. This ultimately supported both the tino rangatiratanga and ōritetanga of Māori participants (Reid et al., 2017).

Guided by Te Tiriti o Waitangi, I aimed to facilitate increased participation and equitable distribution of information and resources by engaging with the MDT in person, and distributing information sheet flyers which contained my photo to foster relationship building (Reid et al., 2017). I made several visits to the NICU unit with kai (food) for both the formal presentations identified above and for informal question and answer sessions, which included spending time in the staff room during staff breaks and lunch times. To ensure there was appropriate protection for Māori participants, there were opportunities for anonymous interactions to answer any questions (Reid et al., 2017). Despite my best efforts I was unsuccessful in recruiting any Māori participants to this study, which I have later identified as a consideration for the implications of my study.

Gathering data

Semi-structured interviewing is often viewed to be a complex interaction which requires a range of communication and interpretation skills (Sharan & Elizabeth, 2016). According to Banner (2010) a qualitative researcher needs to ensure that questions are open-ended, non-judgemental, not leading interviewees and reflect the aim of the research. Questions for my semi-structured interviews were open-ended and designed to draw

out the experiences of MDT members during their day-to-day practice. The purpose of such a line of questioning was to reduce the risk of leading interviewees through direct questions and allow for any and all discourses to be identified. To ensure that these aspects were incorporated along with maintaining the flow of questioning, identifying questions that might yield irrelevant information, and questions that require rewording for clarity, it is essential to complete practice or pilot interviews (Banner, 2010; Sharan & Elizabeth, 2016). This ensures that the data collected is robust, while ensuring success during the interview process.

Prior to the start of data collection, I conducted three practice interviews with work colleagues who volunteered to assist me. These practice runs enabled me to sift irrelevant and leading questions, while establishing my skills as an interviewer and generating a question bank, which drew out stories of interactions that were likely to be shaped by discourses. Ultimately, individual interviews with NICU staff were conducted sporadically between January 2021 and June 2021 as and when volunteers expressed an interest in proceeding with one-on-one interviews, were screened against the inclusion and exclusion criteria, and had signed the individual consent forms (Appendix F). As a result of the risk of COVID-19 transmission, some interviews could not be conducted in a face-to-face manner and were completed over Zoom.

During face-to-face interviews, after arranging a location away from the NICU and at a time that was convenient for the volunteer, individuals were given time to read and sign a written consent form. Zoom participants were emailed a copy of the consent form prior to the interview, so that they had an opportunity to read the consent form prior to the commencement of the interviews. For both Zoom and face-to-face interviews, the individual consent forms were read out loud, and responses for every statement were recorded and then later transcribed.

As discussed previously, a semi-structured interview format was utilized in order to allow for follow-up questions and the addition of clarification or probing questions, where needed (Appendix G). To alleviate discomfort at any point, participants were informed of their right to decline to answer questions without needing to provide a reason, ask for the recorder to be turned off, stop the interview at any point and remove anything they had said, if they changed their minds, providing analysis had not

commenced. To further mitigate any distress interviews might have caused, all participants were offered three free counselling sessions at AUT, which they were free to use at their own will and without needing to inform me.

All interviews were audio-recorded and then transcribed by a contracted transcriber, who was required to sign a confidentiality agreement and complete the transcriptions of all individual interviews by replacing the participant's name with a pseudonym, to ensure that participant confidentiality was maintained (Appendix H). Once data were gathered, transcripts and field notes were stored on a password-protected device. Signed consent forms were stored in a locked room and cupboard located in the NICU. During a water leak, as two interview consent forms were damaged, these consents were verbally reobtained and transcribed.

The scheduled MDT meeting observation dates only occurred on Mondays between 9am to 10am therefore different MDT meetings were selected from different weeks and months between January 2021 and May 2021, to capture the participation of a variety of staff members, based on different shifts and rosters. Once dates were selected, they were emailed to the NICU team and manager, to gain consent from management for my attendance. To ensure that MDT meetings were not delayed by the process of obtaining individual written consent from all those attending, I arrived at the ward one and a half hours before every meeting and gained consent from individuals as they became available (Appendix I). Observations associated with communication styles, body language, structure and topics of discussion, the layout of seating arrangements, were captured in the form of written notes (Appendix J).

As ward rounds occurred every morning during the weekdays, two random days were selected to conduct ward round observations. Like MDT observations, the dates selected were emailed to the NICU team and manager in order to inform staff and gain consent for my attendance. Consent from MDT staff was obtained an hour and a half prior to the ward round and written notes were captured, based on the observation protocol (Appendix J).

Data collection via individual interviews, ward rounds and MDT meeting observations was transparent, and all participants were informed prior to the commencement of interviews and observations of their rights to withdraw from the research at any point.

I explained that data collected were removable, as long as the analysis process had not begun and that data included in the research would be deidentified in order to maintain confidentiality. There were no participant withdrawals during this research.

Data analysis

As Foucault does not prescribe a particular method for analysing behaviour and communication, this research utilised his views on power, knowledge, and discourse to uncover the discursive conditions that guided practice for the NICU staff. Given that the focus of this research was to uncover the discourses guiding collaborative practice among staff, my analysis took on an approach guided by author, Sally Wiggins.

According to Wiggins (2009) discourse analysis is a valuable tool when exploring social interactions and relationships due to its dialectical, relational, and transdisciplinary nature. Foucault (1976) believed that discourse could not be understood without the analysis of human relationships and that without discourse, there would be no meaning to relationships. Meaning is not just a matter of what is said or what we think but rather what is within ourselves, how we say something and how our words are interpreted by others (Wiggins, 2009). The ultimate aim of discourse analysis is to study how language and other modes of communication, such as body language and tone of voice, interact with discourse to accomplish goals and social change (Wiggins, 2009; Wiggins, 2017). While it relies on language and communication, a discourse analysis also utilises observations, interviews, examination of policy documents and other techniques to explain how discourses are guiding practice in a particular community (Wiggins, 2017). Wiggins (2017) further proposed that to successfully implement a discourse analysis, it was essential to identify the context of the setting, the means by which it is produced and the cultural and socio-historical conditions that govern it. In addition, she identified a six-part process to accomplish this. The first two steps include reading and describing the transcribed data, then identifying social and psychological constructs before then focusing on specific analytical issues. Finally, Wiggins (2017) identified the importance of collecting other forms of data which identified the same constructs, before refining the analysis.

Keeping in line with this method, once data were collected from the different sources, I proceeded to immerse myself in it by reading it multiple times to identify the different

social/psychological constructs and potential historical discourses governing people's experiences and behaviours. This included the transcripts from individual interviews, notes about the construction of the NICU space, and my observation notes on body language, tone, discussion topics and dominance of individuals during the MDT meetings and ward rounds. Having pre-read Foucault's ideas on power, biomedicine, the shift towards clinic-based medical practice, governmentality and biopolitics, I was able to begin to identify language which categorically aligned with Foucault's views during the initial readings of my transcriptions and MDT notes. Through the identification of such language, patterns began to emerge, which I categorised, based on their desired outcomes and social practices as recommended by (Wiggins, 2017).

With every iteration of analysis, and as guided by Foucault and the works of Wiggins (2017) I began to ask, "what are the dominant discourses?", "who is exercising power and how?" and "how is this impacting practice?" By placing the answers to these questions into current practices and their historical roots, I was able to begin to identify emerging discourses. As I progressed through each set of data keywords and similar interactions found were highlighted and grouped before identifying the discourse which was driving their use. For example, I found the words "apologize," "blame," "responsibility," "risk," and any interactions associated with the concept of taking ownership of clinical decisions were all associated with the culture of blame. Having initially identified several operating discourses, including biomedicine, a culture of blame, preserving the sanctity of life, collaboration, colonial discourse, and gender dominance, I was able to comb through all my sets of data to identify those that were dominant across all sources. At this stage I reviewed broader literature which discussed these discourses in the health context, in order to ensure that my data truly aligned with the discourses I had identified. Through this process, I was able to identify that I did not have enough data to truly identify the discourse of gender dominance and the literature on the colonial discourse did not match my data or my understanding of it. Ultimately four discourses were identified to be dominant and these were the biomedical discourse, the culture of blame, preserving the sanctity of life and collaboration. As the dominant discourses became evident, I was able to consider how power and knowledge came into play within each discourse to influence practice. When analysing the observational data, I utilised the same process and categorised MDT practices, body

language, moods, tones of communication, organisational structures and the creation of spaces into the discourses they represented and perpetuated.

Finally, when summing and incorporating my analysis, I chose quotes from individual interviews and MDT interactions to demonstrate each discourse in play, the direction in which power was exercised and provided the historical context to which they belonged. Where individual interview quotes were utilised, I identified the interviewee, by a randomly allocated participant number and removed all gender-identifying pronouns to maintain confidentiality.

Rigor

Recent years have seen a significant increase in the use of discourse analysis as a qualitative research method. Over time, it has slowly become a highly valued form of research, both as a methodological and theoretical approach (Tracy, 2019). According to Koch (2006), rigor in qualitative research can be optimized through the use of strategies which support credibility, dependability and confirmability. It is widely recognized that the primary demand for all qualitative research, is attentiveness to the research process via systematic and rigorous data collection and analysis to enhance a study's trustworthiness (Greckhamer & Cilesiz, 2014).

To establish this dependability in my research, I maintained transparency during the description of my methodological processes by providing a detailed, step-by-step account of the data collection and analysis process (Tracy, 2019). Furthermore, I have clearly explained the theoretical and epistemological underpinnings guiding my analysis and findings in the previous chapter. In order to improve the credibility of this research, I submerged myself in the day-to-day workings of the NICU by spending a prolonged length of time observing the NICU environment both before and after MDT meetings and ward round activities (Tracy, 2019). This supported me to become familiar with the NICU culture, identify inconsistencies, develop a positive rapport with participants, reflected in their honesty during individual interviews, and enabled me to obtain a better understanding of the context in which discourses were operating (Houghton et al., 2013). In addition, I provided participants with the opportunity to review the transcription of the data collected from their interviews, to support the process of member checking, reduce risks of misrepresentation, and ensure accuracy (Tracy, 2019).

Finally, to establish some sense of confirmability, I engaged in a process of reflection prior to the start of my data collection, to acknowledge my personal experiences, and feelings. I often shared these with my supervisors in order to ensure that my experiences did not hinder my ability to identify the different discourses at play. Moreover, before data collection began, I engaged in practice interview sessions with colleagues that worked in a similar field to the NICU so that I was able to establish the skills necessary for a good interviewer, which included following the stories shared by participants rather than leading them (Nixon & Power, 2007). This not only further supported confirmability, but also ensured that the findings generated new insights (Nixon & Power, 2007).

Conclusion

This chapter has provided a detailed account of the research methods deployed for this research. Each step of the data-gathering process, from recruitment to data analysis, has been discussed in depth with justifications provided for the techniques employed. Considerations taken to mitigate risks to participants, obtain informed consent, and ensure maintenance of confidentiality and anonymity, have all been individually addressed. Furthermore, steps taken in an attempt to recruit Māori participants have also been described to shed light on the ways in which I have fulfilled my obligations to the Treaty of Waitangi. The final segment of this chapter has clearly identified the strategies taken to support rigor in the form of dependability, confirmability and credibility. The following chapter will discuss the findings produced from this research with excerpts from observations and individual interviews.

Chapter 5 – Findings

The focus of this chapter is to present the findings of the study, which explored the impact of power dynamics on collaborative practice in the NICU. Foucault's concepts of power and biopower informed the analysis of data collected from individual interviews, ward rounds and MDT observations. Four dominant discourses were revealed: the biomedical discourse, culture of blame, preserving the sanctity of life and collaboration. Although the discourses appeared to influence practice concurrently, some assumed dominance in particular situations, based on the shift in the power dynamics and neonates' needs, as prioritised by members of the MDT. From the physical structure of the ward to time constraints, many factors contributed to the shaping and ongoing presence of the identified discourses. However, despite limitations and fluctuations in power dynamics, the notion of interprofessional collaboration was continually present in the underlying current of interactions. The following paragraphs will explore this in further detail; first presenting the origins and characteristics of each discourse and then explaining how it shaped collaborative practice in the NICU.

Biomedical discourse

Examination of biomedicine

Biomedicine was a term first used to label the scientific research being completed to understand the properties of radioactive material (Löwy, 2011). Over time it became a term used to promote biology-based medical science that tasked doctors with utilizing laboratory research to develop and test knowledge, to prevent and cure disease (Löwy, 2011). However, it was not until the post-World War II era that biomedicine was propelled to the forefront of Western medical practice, with public funding poured into population health and medical research, to expanding the health and pharmaceutical industries (Löwy, 2011; Quirke & Gaudillière, 2008). Increased state funding sealed the merger of biology and medicine. It intensified the collaboration between biologists, clinicians, and industrialists, further facilitating its association with academia and the expansion of hospitals (Quirke & Gaudillière, 2008). With time, medicine shifted from its traditional reliance on the clinical experience and individual acumen of doctors, to relying on studying the role of amino acids, proteins and the life phenomena of disease (Löwy, 2011). The combination of research, evidence and academia, along with

knowledge of health and disease, reduced health into its primitive, biological, chemical, physical and psychosocial components.

Biomedicine in the medical context

Foucault suggested that the crude view of health and disease facilitated doctors to categorise information about their patients, into the functional biomedical paradigm and the not-so-useful non-biomedical paradigm (Misselbrook, 2013). According to Foucault (1973), the role of medicine was to restore people to health by neutralising disease. Paradoxically, in seeking to accomplish this, practitioners utilised the 'medical gaze' to segregate the disease from the individual so that its characteristics could be studied further (Foucault, 1973). Doctors were, therefore, not aligned with patients but instead with other doctors. The use of complex terminology to describe the primitive components of disease, eased the communication between medical professionals while simultaneously excluding the participation of patients or other laypersons, thereby making it very difficult for them to understand the nature of such discourse (Oliver, 2010). While this displacement of the person supported the identification of symptoms that both defined and became the focus of treating the disease, it also gave rise to the view that the sick individual is a body of knowledge that, in its existence, contributes to medicine and its language (Foucault, 1973). This categorisation separated an individual's social and pathological aspects, which in many ways dehumanised healthcare, because the focus to this day, remains to uncover the set of combinations and permutations required to treat the disease.

Biomedicine in NICU

While the values espoused by the ADHB NICU prioritize working together as a team, practice in the NICU continues to be heavily driven by a biomedical discourse (Starship, 2019). The following data analysis demonstrates how the biomedical discourse shapes current practice and influences day-to-day communication in the NICU.

The physical design of the inpatient NICU ward is such that it divides the space into three sections, each designed to cater for neonates with specific levels of medical needs, from mild to high. As one advances from where mildly unwell neonates reside to where severely ill neonates reside, there is a significant shift in the staff-to-neonate ratio, with one nurse looking after two neonates in each room as opposed to four in a room. In

addition, there is an increase in the number of machines used to monitor the status and changes in the physiological function of the neonate. Observations such as the neonate's heart rate, respiratory rate, and oxygen saturation are more regularly recorded with an increase in the number of tools used to deliver specific interventions, such as continuous positive airway pressure for providing oxygen.

The constant machine monitoring of physiological values, reveals how medicine depends on these values to assess a neonate's wellness. In turn, normal values set on these machines, based on the results of biomedical research, are also responsible for alerting staff of abnormal readings or a decline in the neonate's status. Such alerts help the team to identify the need for sudden lifesaving intervention and who needs to be called to deliver such care. Thus, the power of the biomedical model is aligned with the numbers and machine alerts, that hold the authority to determine an infant's wellness and the urgency of care. Nonetheless, despite the dominance of the biomedical model and the importance placed on biomedical data, the speed at which the consultant doctor may choose to intervene, relies heavily on the effective communication of nursing staff, who are often the first responders to such alerts. The sharing of this pertinent information and the consistent communication between nursing staff and other professionals, ensures that the biomedical information is effectively and accurately conveyed to the appropriate person. While quietly occurring in the background, these interactions validate the critical role interprofessional collaboration plays in the care of neonates, irrespective of who ultimately holds the power to make decisions regarding the neonate's care.

Foucault (1977) expressed that while space is a reflection of a discipline, the arrangement and behaviour of those who occupy that space represent the discourse perpetuated by that discipline. Given that families that spend a significant amount of time with their neonates occupy the same biomedical space, they too are exposed to the alerts, machines, and constant monitoring that form their neonates' lived experiences. However, despite being hypervigilant of these monitors, they cannot act on alerts and are often left powerless, sitting beside their neonate with an abnormal experience of caring for their baby. In addition, even though family members often spend the most time observing their neonate, there is no space in formal documentation for parents to write their observations of their child. This firm delineation separates staff

from families/neonates and again demonstrates the precedence for biomedically informed observations made by a qualified staff member instead of a neonate's family member. This ultimately presents as a duality of practice that can be challenging for parents in particular, as while on the one hand, parental input is desirable, their knowledge of their neonate, does still not provide the same level of importance.

Most staff in this environment did not demonstrate an awareness of the consequence such experiences produce. During a ward round, a consultant suggested to parents that;

"It's really important that you breastfeed your baby as it's really beneficial."

Such interactions clearly demonstrated the consultant's power and their lack of insight into the impact of the biomedical discourse on the family's lived experience. Their encouragement not only promotes the notion that families are not involved in their child's medical care but also limits the family's engagement to only those activities that they usually would have done if there were at home. Furthermore, the statement proves the lack of consideration the medical gaze has for women participating in a natural process, such as breastfeeding within the confines of a medical space

While all staff members are engrained in this system, some recognized the impact of such a discourse. In their interview, a senior nurse in the NICU conveyed the institutionalization such families experience, which reduces their confidence and generates the need for approval from doctors to take their infant home, even when they know their baby is ready to leave. They stated that many parents felt they needed

"to gain permission to take their baby home." (Participant 2)

The need to seek the doctor's approval reflects the power dynamic associated with the knowledge that parents perceive doctors to hold. In the NICU, such power flows through the biomedical discourse, empowering those who accept the approach and apply it in day-to-day practice, that is doctors and nurses.

My initial observations of team meetings and ward rounds further confirmed that information presented when discussing each neonate, always began with sieved medical information, which seemed to include only that which doctors viewed to be pertinent to inform their medical diagnosis and prescribed intervention. Most staff appeared to

collude with this prioritisation of the biomedical perspective, as they often followed the same format and consistently presented information in a way in which it would be better accepted by colleagues. A senior nurse expressed her feelings as being

“nervous as the ward around approaches... depending upon which consultant or registrar is on.” (Participant 2)

As the quote above suggests, despite being highly experienced and knowledgeable, the varied NICU professionals can only hold a certain level of autonomy, as the ultimate decision and power is perceived to be with the consultant doctor. At each handover and ward round, staff were expected to submit their observations, assessments, investigations, and interpretation of patient symptoms to the consultant present, to assist them in making sound medical decisions.

This was especially evident during ward rounds, where each consultant doctor, along with their entourage of junior doctors, would walk to the bedside of each neonate, and the allocated nursing staff member would present their assessments and observations of the neonate. The discussion of each neonate consistently started with the nursing staff providing the neonate's name, and gestation at birth before offering a brief list of ongoing medical issues, recent weight gain/loss, and current medications. A brief discussion with the consultant followed, which included changes that may be required to medications or dosage, decisions made based on the outcome of assessments and a list of further assessments or observations required from the nursing staff or junior doctors. This mechanical process occurred every morning and often involved the consultants asking for additional information they required, clarifying ongoing difficulties and then creating a medical management plan for the day. New and additional medical information was recorded by a junior doctor who, while operating a mobile computer, was also responsible for sharing any test outcomes that were entered online against the neonate's medical file.

These regimented handovers shed light on the direction in which power flowed through each professional group, as each had a designated role, with only the consultant having the final say regarding the neonate's management plan. Despite the flow of power, it was clear that all nursing staff continued to participate in the ward round, following its designated format and sharing information in order to collaborate with doctors, thereby

perpetuating both discourses simultaneously. During these ward rounds, if the parents of the neonate were present, it was the consultant that would speak to them about their baby's management, at times even instructing parents to engage in feeding or physical contact to promote bonding.

"The chest x-rays were normal, so that's good... it's really important to read to your baby, give him lots of cuddles and continue to do other things that you might typically do if you were home."

The above interaction between the consultant and parent at the ward round, demonstrates the channel of power, as the doctor gently permits the parents to engage in the activities they might have engaged in had their baby been at home. The sequencing of this polite encouragement, with x-ray result presented first, again emphasizes the priority given to biomedical indicators that are measurable, as opposed to information which supports the less measurable aspect of bonding between a parent and their neonate. Operating in the biomedical discourse, the influence of such power has the capacity to project a single truth which, for parents in the NICU, is the notion that 'medicine is keeping their neonate alive' as medicine can cure disease. Day in and day out this truth is actively exercised through the environment, the actions of staff, the endless sounds of machines, and processes which operate like clockwork.

Within the NICU, the need to keep a neonate alive is the ultimate goal of the biomedical discourse and, as a result of this, measurable information and intervention were prioritized above other interventions. The delivery and priority of unmeasurable interventions changed, according to the medical needs of neonates, often being considered only when absolutely necessary despite their positive effects. In an interview a senior allied health member stated

"When a baby is sick with something like necrotizing enterocolitis, everyone can't wait to get their hands on breast milk for that baby, and it's the most important thing. It's like medicine and it's like gold, but... there are other times when it's just brushed over, or ignored, or forgotten, or even mocked a little bit I think." (Participant 4)

This quote from an allied health professional, emphasizes the power of the biomedical discourse and the hierarchy of its priorities. According to Oliver (2010), the relationship between power and knowledge is symbiotic, as knowledge feeds power and power is

most effective with the support of knowledge (Oliver, 2010). Giving an intervention importance at a specific point in time appeared to be associated with the consultant's biomedical knowledge on the effectiveness of an intervention, to treat or cure the symptoms the neonate presented with. By reducing a neonate to their medical issues, the doctors essentially aim to utilize the medical gaze to separate the biology from the human, which enabled them to isolate the medical issues and treat them in order of their severity. In this scenario, it seemed that the positive effects of breast milk, which included bonding with the parent, resolution of necrotizing enterocolitis and development of feeding skills, were only important if other life-threatening issues were first resolved. Such a persistent focus on medical information not only reduces the neonate to their medical issues but also applies a magnifying lens to different parts of their body, rather than viewing the neonate as an individual who deserves an improved quality of life.

This medical gaze, in combination with the reduced amount of time spent understanding the neonate, their personality, and their family emphasizes that while medical professionals have understood the neonates in terms of their biology, it is not their priority to understand the neonate as an individual. While such practice continues to be governed by the biomedical discourse, it also propagates the hierarchical power structures that sit at the core of biomedicine.

The culture of blame

Examination of the culture of blame

Early documentation of blame in Judeo-Christian doctrine can be dated to 4000 BCE where, in the creation story in the bible, we encounter Adam blaming Eve for giving him the forbidden fruit and Eve subsequently blaming the serpent for tempting her (Campbell, 2011). While in this situation, God condemns both Adam and Eve, viewing them as equal partners of disobedience, such acts in healthcare are often not considered in the same light. Historically, blame was often directed towards God, nature, and people. However, according to Campbell (2011), the various loci towards which blame can be directed, have increased with the development of science and technology. Although the combination of science and technology has helped individuals to find solutions and answer questions that often began with why, who, what and how,

technology has also become an avenue for the shifting of blame, which has further enabled individuals to cast-off responsibility for their actions (Locke, 2009). The simple act of blaming God can no longer convince the modern mindset. Instead, individuals need to blame others to not only protect their reputations, but also feel good in the moment (Fast & Tiedens, 2010). Even though blaming others in the long run often leads to negative consequences, such as reduced health and well-being, it is a culture easily adopted by employees to defend a positive self-image and protect their role in an organization (Locke, 2009). However, blame culture in a workplace cultivates a culture of fear-driven practice. It can also nurture defensive, narcissistic, and insecure personalities who are quick to redirect the blame towards someone else in order to absolve themselves of any potential repercussions (Fast & Tiedens, 2010).

Culture of blame in the healthcare context

In healthcare, the biomedical paradigm demands a high standard of practice and often, when practice falls below this standard, blame is assigned to a practitioner (Radhakrishna, 2015). In an attempt to uphold the highest level of health practice and protect quality assurance, the New Zealand government created the Health Practitioners Competence Assurance Act (HPCAA) in 2003 (Ministry of Health, 2018). The HPCAA legislation requires all health practitioners to be registered under a regulatory body (Ministry of Health, 2018). In turn, it not only requires those regulatory authorities to certify the competence of a practitioner, but also requires them to monitor practice in order to ensure practitioners do not practice outside of their scope (Ministry of Health, 2018). This legislative structure illustrates how, over time, a culture of blame has been increasingly structured into society and health practice, through such legislation and regulatory bodies. While legislation such as the HPCAA was initially created to provide the patient relief, reassurance, and closure, the other party involved in medical error is generally not given due consideration, which may be the potentially anguished practitioner who made the error (Radhakrishna, 2015). For practitioners, the fear of having their competence to pursue their careers questioned at a disciplinary tribunal, has the potential to sow the seed of fear-driven practice, which over time may lead to risk-averse practice.

Both formal and informal complaints against a healthcare professional exist within this culture of blame, carrying the subtext of someone being responsible and “to blame” for

bad outcomes. In particular, complaints escalated to the New Zealand Health Practitioners Disciplinary Tribunal, can result in a disciplinary proceeding brought against the health practitioner, which aims to identify whether the practitioner is to be held responsible for the health outcomes investigated. In addition, the disciplinary tribunal also seeks to investigate the individual, which may damage their reputation and career. With consequences for the individual, ranging from close supervision and suspension, to loss of license, one can understand why health practitioners become risk averse. Foucault once suggested that while prisons may resemble schools and hospitals, they too resemble prisons (Foucault, 1977). Similar to the carceral system, hospitals have adopted the same concepts of control, surveillance, and classification that operate within the walls of a prison. According to Foucault (1977), modern-day surveillance has become an accepted form of social control and while it has been utilized for patients within the hospital, it has equally been adopted for the monitoring of staff and the care they deliver.

Culture of blame in the NICU

At each level of the ADHB NICU, the concept of the few watching the many, is implemented as patients are surveilled by staff, staff by management, management by DHB board members and so on. Based on the prison descriptions of Bentham (1995), the concept of the panoptic gaze has extended into hospitals and aims to surveil staff through documentation, charting signatures, and swipe card entry systems for example, often forcing clinicians to practice in a cautious, defensive and self-protective manner (Catino, 2009). Given the culture of blame that exists in health care practice, staff in the ADHB NICU have accepted such surveillance by actively participating in the activities which support the culture of blame (Ries et al., 2022).

Strategies utilized by NICU staff to combat this risk of being blamed for causing harm and ensuring complaints do not result in severe consequences, include written documentation of encounters, joint meetings or sessions, audits, weekly team meetings and Datix. This is a system for registering errors made in practice as a result of being short staffed, under-resourcing of medical equipment, and equipment related errors. Such strategies also supported staff to mitigate the risk of error, false accusations and reduplication of work, which has provided a chain of evidence that management are able to utilize, when investigating errors and accusations. Some of these strategies were

very evident during family meetings, where there was always a designated team member specifically responsible for scribing exactly what was discussed at every meeting. Despite such strategies, staff continued to feel insecure if patients or their family members began to adopt the same documentation strategy, essentially reversing the direction of surveillance. This discomfort was well demonstrated by a concerned medical professional during an MDT meeting when they expressed their clear dislike of such behaviour and a colleague responded.

“The parents are writing down everything that is being discussed, word for word... while I understand that it is their coping strategy, it’s extremely off-putting... and if I was in their position, I would not want the doctor looking after my baby to feel like that.”

“I will clarify their intentions and will let the family know that it’s disconcerting for staff.”

The medical professional’s response to such behaviour clearly highlights the apprehension they felt from the potential repercussions of such surveillance. Despite being surveilled by the DHB management on an ongoing basis, it is the reverse surveillance from the families of patients, that is of concern to the medical professional and such concern stems from the potential for this information to be used as the basis for a formal complaint. Despite being from different disciplines, it was clear from the second professional’s response that this is a fear shared by others. Their offer to work collaboratively in order to manage this situation, highlights the unity collaborative practice provides as a discourse.

Even though the culture of blame drives practice, staff feel the need to unite through their shared feelings of apprehension and fear in order to reduce the risk of dealing with a complaint. The immediate offer of support from colleagues not only reflects the collaborative discourse, but also demonstrates how such actions of families, along with the already intensifying level of surveillance, and the risk of being blamed for poor practices or outcomes, can push professionals to become defensive and further endorses the need for risk-averse practice. For some professionals, such behaviour can also elicit an accusatory response, where professionals almost blame families for how they feel about reverse surveillance.

This concept of the many watching the few, otherwise known as the synopticon, is becoming increasingly prevalent in health care with the support of modern-day technology and media (Mathiesen, 1997). Through media, patients and their families are able to project their narratives of healthcare experiences to a wide range of audiences. Such mass media reach is able to act as a synopticon by enabling those consuming such content to contemplate and judge those discussed in the narrative. An allied health professional acknowledged the pressure this level of surveillance can have, stating:

“Some people are thinking about the media or a patient complaint... and that might actually be influencing their decisions... It can be quite a public job and you are making very high-risk decisions. Once you get burnt, you can become quite risk averse to making those kinds of decisions.” (Participant 3)

Their view on the changes in practice once the media projects your clinical decisions in a negative light demonstrates the power the media hold. Despite not having any formal power to prosecute health professionals, in the court of public opinion, accusations against a health professional or a particular service, have the power to alter careers, impact confidence and shift practice to becoming increasingly risk averse (Ries et al., 2022). While the culture of blame is propagated by legislation, society and those individuals who seek out someone to hold responsible, it is equally propagated by those individuals or ‘victims’ affected by the medical error, which can at times be seen in the New Zealand media. In many informal scenarios, complaints that produced a generic apology for an individual’s experience of a service or for a systems fault or a resource issue, are often not considered to be a good enough explanation for the patient. During an interview, a senior allied health professional expressed how important it is for someone “to front up early and apologise even if it's not their fault”.

“Whether or not that person feels blame is not relevant for the family... what is relevant is actually when they feel heard and they feel someone’s actually finally apologized, even if it’s not their fault. When people don’t do that and won’t do that, families get more and more irate.” (Participant 3)

This quote emphasizes how important accountability in the form of an individual is for patients and their families. Even though a medical mishap could be the result of a cascade of technological and human errors, the expectations that society has created,

may instigate patients and families to seek out a sole individual to blame (Timimi, 2012). Such expectations of health professionals further contribute to risk-averse practice, pushing doctors to take the final responsibility for most medical interventions and decisions surrounding patient care. Furthermore, as long as professionals feel the pressure of such responsibility, the fear induced by the culture of blame will continue to drive some elements of their practice. However, from the quotes above, it is clear that collaboration supports unity and partnership, when making difficult clinical decisions, even in great times of pressure, stress and fear.

Sanctity of life

Examining the sanctity of life

In religion and ethics, the term sanctity of life propagates the idea that human life is an inherent gift delivered to this world by God (Rakowski, 1994). Whether in death or birth, life is considered to be precious, as it is perceived to be beyond the control of humankind. Thus, the process of dying for many is associated with pain, distress and sadness, often leading to feelings of fear, anxiety and vulnerability, which all contribute to the need to avoid death (Palmer, 2000).

While killing a person is viewed as sinful and a rejection of God's gift to humankind, preserving life is recognising it as inherently sacred, such that all human life is accorded value, dignity, and respect (Wyatt, 1998). This discourse of preserving the sanctity of life, particularly in relation to babies and children, is often associated with concepts such as 'innocence' and being 'created in the image of God' (Pierucci, 2019). Under the religious umbrella, such associations promulgate the view that taking the life of a child is a despicable act.

The sanctity of life in medical contexts

According to Foucault (2008), religious views projected by the dominant discourse of Christianity and sovereignty, seeped into discourses which governed European politics, healthcare, and institutional practices. With time, as dominant discourses have evolved and changed, so has Western society's views on death. However, where society has begun to acknowledge death as an integral part of life, death continues to be a topic rarely discussed. Similar to the unobtrusive placement of the obituaries in a newspaper,

death is a topic which is still often hidden and shunned to avoid drawing attention to it (Palmer, 2000).

Given it is the purpose of medicine to treat, heal and cure, death in its nature is incongruous in the medical environment. Medical doctors are expected to epitomize religious views of the sanctity of life by upholding the Hippocratic tradition and placing the highest value on preserving and protecting all human life (Hajar, 2017). Therefore, the act of taking a human life by omission or commission becomes a redundant option. However, in Western medicine, there are particular situations where the withdrawal of life-preserving treatment, which makes death inevitable, is considered the most humane and dignified form of care.

Despite the risks of neurological and long-term impairments in premature infants, it is only when there is incontrovertible evidence that death cannot be evaded, that treatment withdrawal is considered. Nonetheless, selective management of dying neonates, continues to present as an ethical and practical challenge (Wilkinson et al., 2006). The following paragraphs explore how the discourse of preserving life continues to guide decision-making during such convoluted circumstances.

Sanctity of life in the NICU

The discourse of the sanctity of life is particularly relevant to the ADHB NICU, as decisions are made in the best interest of parents and family members. To avoid directing too much attention to such sentiments, the ADHB NICU has a process, ways of communication, and specific structural layouts that help to preserve the sanctity of life in a hushed and concealed manner. While the physical space of the NICU is designed for parents and their neonates to share rooms with at least one other family, for those neonates who are deemed to be actively dying, particular consideration is given to creating private spaces or allocating individual rooms, so that families can spend time with their neonate without disturbance and away from the view of others. Furthermore, while most neonates are only able to have two visitors at a time, neonates who are dying, do not have restrictions on visitation, allowing for many family members to come in and cherish their last few moments with their neonate. In an interview with a senior nurse, they expressed the difficulties they experience when trying to explain this dichotomy to other families.

“Whānau, they just won’t understand. They’ll be like ‘Well how come that person needs 20 people?’... and you can’t say to them their baby’s dying so they get 20 people, you need to just be happy with your 2, your baby’s well.’ But you can’t say that.” (Participant 2)

This experience emphasizes the importance placed on the care of the dying, as despite staff finding it difficult to manage the conflict these opposing rules create, they continue to disregard the usual rules and regulations and instead, prioritize providing as many family members with the opportunity to grieve as the space will allow. Such flexibility demonstrated by staff, displays the power that preserving the sanctity of life holds over practice and DHB protocols and regulations. Despite coming from different professional backgrounds, it was observed that regardless of who made these decisions, staff collaborated to carry out such practices to protect families whose neonates are critically unwell. The collaborative discourse appeared to function hand in hand with preserving the sanctity of life, as staff could agree and align practice according to the priorities for such neonates. While preserving life emerges as the dominant discourse, service delivery shifts away from biomedical or defensive practice. Staff aptly demonstrated this through their collaborative disregard for the consequences associated with overlooking DHB regulations and protocols and the complaints from other families.

It is widely agreed that neonates at the end of their life, experience significant agitation, pain, secretions and distress (Cortezzo & Meyer, 2020). End-of-life care in the NICU prioritizes interventions which align with holistic care, that promotes comfort, bonding and the emotional well-being of the neonate and their family members. This is a stark contrast to the usual biomedically driven care, which values interventions that achieve the best medical outcome, as staff attempt to keep the neonate alive, regardless of its excessive intrusion, frequency and dominance over other psychosocial and allied health interventions. By providing holistic care and enabling family members to spend as much time as possible with their neonate, it is evident that staff are attempting to preserve the last few moments of the neonate’s life for interactions that matter most, thus aligning with the discourse that suggests life is a precious gift over which no one has any control.

Preserving the sanctity of a life that will shortly end generates a level of privacy and confidentiality that is not usually accorded to neonates and their families. Again, this

situation illustrates how the sanctity of life as a discourse, surpasses the biomedical discourse to come to the forefront of care. During my ward round observations, the dominance of this discourse became abundantly clear when the consultant requested myself and the pharmacists to

“please wait out here for the next patient.”

Once his meeting with the family was finished, the consultant stepped outside of the room which housed a family along with their critically unwell neonate and, with a solemn head bow apologized, stating:

“I’m sorry you were asked to wait outside for the previous baby, however the baby will not make it and we needed to speak with the family privately.”

The need to protect the grieving family from strangers and practitioners who could not provide any further support, was a sharp contrast to our encounter with every other patient. The shift from the dominant biomedical discourse also encapsulated the shift of power as the consultants prepared to relinquish the power they held, in order to preserve the sanctity of the neonate’s last few moments. The use of casual yet sensitive language such as the ‘baby will not make it’ further demonstrated this very shift from medicine to comfort cares, an area in which doctors do not hold power as they can no longer prevent or change what is about to occur. To withdraw medical treatment and facilitate the end of life to happen in a confidential and protected manner, further embodies the respect the MDT staff hold for the spiritual process of supporting a bereavement. During the ward round, staff appeared to work together to determine which professional groups were essential for the family to interact with based on the needs of the neonate and the family’s wishes. By working together to align interventions and by practising only that which is essential, staff demonstrated the ease with which the discourse of collaboration was able to function alongside the discourse of preserving the sanctity of life.

Collaborative practice

Examining collaborative practice

Collaboration as a word was first used in 1871 to describe the concept of the labour workforce working together to achieve a specific goal to fulfil a task. While there are

many different forms of collaboration, healthcare refers to the combined efforts of two or more health professions to problem-solve and achieve a goal, as interprofessional collaboration. According to the WHO (2010), interprofessional collaboration offers an innovative strategy to combat the global crisis of a rising shortage of health care workers, while still delivering a high level of care. Even in NICU settings around the world, interprofessional collaboration is upheld as an integral value of clinical practice and is strongly supported by international research evidence, which has proven it to improve procedural pain management and reduce readmission rates and length of stay for infants admitted to NICUs (Balice-Bourgeois et al., 2020; Welch et al., 2017). Given that interprofessional collaboration is a key value of service delivery within the ADHB NICU, as identified in their service vision, the following paragraphs identify the extent to which interprofessional collaboration guides practice within the ADHB NICU and its impact on the underlying power dynamics (Starship, 2019).

Collaboration in the NICU

In the NICU, to gain complete knowledge of a particular neonate's situation, members of the MDT must collaborate to gather and share information, in order to make sound clinical decisions. However, the quality of these collaborative interactions observed, was heavily influenced by the personal and professional dynamics guiding their practice. Along with battling with other discourses for dominance, collaborative practice was affected by time, communication, trust, respect and building partnerships. During an interview with a senior nurse, they identified how poor working relationships with registrars that did not know them, affected their ability to work collaboratively.

"I've seen the reg [registrar] skip through my notes to go to the other reg notes... the reg has no idea if you've just been there three months or if you've been there 10 years. Whereas the consultants, they know you and they're more familiar with you and they might have more trust in you, so that does play a huge difference, yeah." (Participant 4)

As the quote suggests, the capability to take up the collaborative discourse, can be an active choice of staff and the absence of trust in someone's professional opinion as a result of a new or unfamiliar relationship, can significantly affect a team member's ability to work in a collaborative manner. The nursing staff identified how the registrars trusted the notes and professional opinions of other registrars, perhaps due to a shared education, work experiences or trust in the other's professional skills, thereby making

collaboration within the same profession a natural and comfortable process. However, to work with other professionals from different professions, is something that the nursing staff understood requires trust, which takes time to develop. In this interaction, the power to make decisions regarding a neonate's care sits with the registrar therefore, their lack of engagement in this interprofessional collaboration, demonstrated how entering into an unfamiliar interprofessional collaboration between different professional groups, can be viewed as a risk to one's practice. Therefore, practice may revert to the safety of the biomedical discourse. Given that building trust takes time, for disciplines that rotate through NICU, being unfamiliar with other staff on the ward and their areas of expertise, appeared to serve as a deterrent to working collaboratively.

In addition to the influence that lack of trusting relationships had on opportunities for collaboration, time pressures created by the biomedical discourse also had an impact on an individual's ability to take on the collaborative discourse. The following quote is a representation of these constraints, as a consultant explained how time effects their ability to engage with those in the MDT.

"Time pressure definitely makes a difference. Wednesday has very limited time for ward rounds so I'm much less likely to offer the making of a plan to the registrar on that day... We tell our junior doctors what's going to happen to a certain extent... We'll look at a chest x-ray [and] I'll go 'There's a pneumothorax. We need to put a chest drain in'." (Participant 1)

Collaboration becomes much easier within a discipline, as there is an understanding of each other's roles and responsibilities and a shared knowledge base, and therefore collaboration within the medical discipline should be much easier to attain. However, in this case, despite the senior consultant acknowledging their role in the education and coaching of the registrars and junior doctors, the increase in time pressure results in a shift from working collaboratively to working in a directive manner, within a biomedical discourse. This is a situation where the consultant makes decisions and prescribes treatment, without creating an opportunity for listening to the contributions their juniors may have to offer. The consultant acknowledges that true collaboration takes time, and while seeming to favour taking up a collaborative discourse to enhance the registrar's learning experience, admits that on Wednesdays, the registrars will have to learn through observation. The dominant biomedical discourse in play, unequally

distributes the vital responsibilities of patient care to sit with consultants, and due to the risks of errors that may result in career-ending and life-altering experiences, the expectation of working collaboratively when under such pressure becomes observably unrealistic.

Despite such constraints, and per the NICU's service values, there are plenty of opportunities allocated for the purpose of formal interprofessional collaborations in the NICU team. From the multidisciplinary meeting at the start of every week to the handover meetings, ward rounds, clinical safety meeting, service meetings and senior team meeting, all encourage communication between the MDT members to facilitate collaboration. Some meetings were typically guided by a biomedical approach, where the focus remained on obtaining data about biological markers of the neonate's overall health, while others encouraged collaboration by inviting discussion on all markers of health: cultural, spiritual and familial. During one MDT meeting, the senior consultant facilitating the meeting often made it a point to ask questions such as;

How is breast feeding progressing? ... and... what do we need to do to get this family home?"

With a pause at the end of each question, the consultant looked to up engage in eye contact with team members to urge discussion from every individual involved in the neonate's care and also provide an opportunity for everyone to present their ideas and perspectives. The direct questions asked, appeared to facilitate the participation of individuals who remained notably silent during the majority of MDT sessions. The communication style of the consultant enabled the shift in both discourse and power as they moved towards empowering the clinical decision made, post obtaining the views of the different MDT professional rather than from one individual. At another MDT meeting a senior consultant facilitated collaborative discussion by making a statement which demonstrated their concern for the family members of a neonate.

"I'm really concerned about this mum. I think [she] really needs some support."

The concerned consultant then looked to all present team members with a long pause waiting for other to add their perspectives. Another professional responded with;

“There is a visitation plan in place to support mum but I’m not sure what’s been going on.”

To which an allied health professional added;

“I agree, mum is not coping. We have a family meeting scheduled for tomorrow. Should we re-evaluate post that meeting?”

The ensuing discussions between professionals, supported them in creating a plan where the burden of decision-making no longer lay with just one individual the consultant, but instead was made with the support of the entire team. The consultant’s audible sigh of relief demonstrated the alleviation of stress they experienced from struggling to find a way to support this family. In addition to this, the suggestion offered by the allied health professional again facilitated a shift in power and responsibility as the team made a clinical decision in agreement rather than leaving the consultant to make that decision on their own. Through these discussions, it was clear that when decisions were separate from biomedical concerns, consultants felt much more comfortable sharing the risks of making decisions in collaboration, as opposed to sharing the risks of decisions associated with what an infant might need, to survive the next 24 hours.

In contrast to this, when MDT’s were pressured for time, there was a shift in the pace and communication style where questions were open-ended but without direction.

“Is there anything else anyone wants to add?”

During such occasions, the speed of the questions, shortened pauses and lack of eye contact often only invited those individuals who were confident and were able to communicate efficiently, to collaborate. Those individuals who failed to read the situation or were unable to communicate in a time-efficient manner were often unable to enter into this collaboration.

In the quote below, a consultant highlights the importance of having the opportunity to hear the perception of the other team members as being essential to informing clinical decision about an infant’s care.

“I would never plan to extubate a patient from the ventilator onto CPAP without asking the bedside nurse if they thought the baby was

ready. They spend 12 hours with the baby and they're also going to have to spend the next 12 hours caring for that baby who's extubated and I'm going to come in and maybe see the extubation and not be back for a couple of hours and so their knowledge is really key to the success of that extubation." (Participant 1)

The quote above demonstrates that despite the ultimate decision and power lying with the consultant, by inviting other staff to participate in this decision-making process through contributing observations, they were able to practise inclusivity and create a space for further collaboration. Such collaboration builds trust, generates mutual respect for one another's professional roles and clinical reasoning, and thereby improves collaboration between colleagues.

This was further reinforced by a senior nursing staff member who stated:

"I feel that I do get my point across, and I do get respected by what I have to say. If I do come up with something that's maybe a little bit out there, sometimes they'll be like 'Oh, okay we hadn't thought of it like that. That's a good idea, let's try that.'"

The willingness to listen to the contributions of others and act on their professional advice, as suggested by the quote above, shifts practice from a biomedical discourse to a collaborative discourse, as it creates the space for the sharing of alternative perspectives, thoughts, and views. This in turn again empowers collaboration, within the bounds of the biomedically driven health system, as it validates the professional opinions of others and ensures the care informed by multiple perspectives. Although the power to make the final decision remains with the consultant, collaboration creates a space where everyone feels their professional opinion is valued and heard.

Conclusion – All discourses interact together

During an interview with an allied health team member, they identified how the weight of decision-making can guide a clinician's choice to collaborate with others.

"the decisions in NICU are life and death and there is someone who's going to make that as an ultimate decision. In my discipline we don't make decisions in isolation, I would always write my notes or talk to my supervisor and we would write what we decided so it's not brought down to the individual to make the final decision. Ultimately I see the consultant eventually get everyone together, have a bit of a chat and then they go, I'm going to do this. So they also seem to

*know that their decision at the end of the day does lay with them.”
(Participant 5)*

This quote clearly highlights that while collaboration exists, the need to preserve the sanctity of a neonate's life by utilising the interventions accepted by the biomedical discourse, are ultimately the most essential and accepted aspects of NICU practice. Due to the culture of blame, the consultant ultimately carried the burden of being responsible for any consequences that came with making the decision. From this quote, it was clear that while all discourses were at play, in life or death situations, two discourses came to the forefront of NICU practice: the culture of blame and preserving the sanctity of life.

While the biomedical discourse was still informing practice and guiding interventions, it was no longer leading practice. Decisions were not just about utilising any evidence-based intervention to 'attempt' to accomplish the best result, but instead about saving or preserving life. In such situations, collaboration occurred, but as suggested by the second half of the quote, it was not to support decision-making but instead to add any additional information, that would support the consultant in making a final decision. In this interaction, the participant describes how the ultimate power in life and death circumstances, is often situated with the consultant due to the responsibility they hold. Although this is not always the case, unlike for consultant doctors, other disciplines have an opportunity for consultation and collaboration within their discipline, in order to share both the power to make the final decision and its potential consequences. Even during these interactions, the discourse of collaboration does not act in isolation. As such discussions are captured in the form of writing formal notes, they emerge from the panoptic surveillance that begins from the moment one enters the NICU to provide a chain of evidence in the event of a complaint. Like surveillance, biomedicine and blame are two discourses that will always guide practice. With the education of the NICU, MDT professionals stemming from medicine, research, or evidence-based practice, all interventions, to some degree, are moulded by the biomedical discourse. Furthermore, as governing bodies ensure that practice remains within the scope of a professional's education, there will always be a level of accountability for all decisions of care that are made. Given the responsibilities consultants carry for critical decisions, it is natural for

practice to shift towards becoming risk averse, as the culture of blame places emphasis on measuring success based on the outcomes of care and not its processes.

Despite there being no formal legislation in New Zealand about the quality of collaborative care that MDTs must practice, there are guidelines for implementing high-quality MDT meetings, to support the team which cares for those diagnosed with cancer (Ministry of Health, 2012). Even in such a guideline, there is no clear explanation regarding the degree of collaboration that is expected to occur in such meetings, apart from an overarching statement that states MDT members are expected to work together to achieve a high quality of care (Ministry of Health, 2012). The ADHB Starship guidelines are no different. While there is no formal guideline around collaborative care in the NICU, the Starship values clearly identify the importance of working together (tūhono) to deliver a high level of care, as a governing principle. When one considers the lack of legislation and the power of these discourses in their individual form and once overlapped, it does not come as a surprise that the action of collaboration is not as frequent as it is advertised or encouraged.

Regardless of its definition, it was clear from the data collected that different professionals had different views on what constituted collaboration and it was often situation dependent. At times, professionals often viewed specific interactions as lacking collaboration, despite sharing information. On other occasions, a similar interaction during a high-risk situation was considered as collaborative. It seemed that professionals were more aligned with their views on collaboration when practice shifted to preserve the sanctity of a neonate's final days or when in a life or death situation. In both scenarios, it was observed that there was a shift in practice as the biomedical discourse or preserving the sanctity of life both seemed to create clarity in the roles professionals had and alignment in the delivery of care. Such a shift in practice may emerge from the fundamental education that all health professionals receive. Given that training and education of all health professionals stem from biomedicine and evidence-based practice, it is highly likely that the training for handling high-risk and high-stress situations follows principles that align with collaborative practice.

Chapter 6 – Discussion

The purpose of this Foucauldian-informed discourse analysis, was to uncover discourses which guide day-to-day interactions, motivate communication and help us to understand what truly influences practice outside of legislation and protocol. This chapter will draw on the discourses that impact collaborative practice in the NICU, while exploring the journey of collaboration through research and its importance and relevance today. While four key discourses were identified, it was clear that none acted in isolation and instead each discourse ascended to dominance as the situation required. To understand their relevance, this chapter will explore how discourses can aid or hinder interdisciplinary collaboration. It will further explore the impact of power that is exerted through individuals, society and surveilling bodies and the implications for practitioners who work in the NICU.

Findings from the discourse analysis

Data gathered from individual interviews, MDT observations and ward rounds uncovered four key discourses: the biomedical discourse, the culture of blame, preserving the sanctity of life and collaborative practice. Despite staff identifying time constraints, personality clashes, functioning above capacity, lack of trust and other factors as also influencing collaboration, it was clear that each of these interpersonal or institutional factors stemmed from a deep-rooted discourse. Discourse, therefore, not only influenced interpersonal skills and the way in which institutions are designed, but also guided and shaped practice into what it is today.

Biomedical discourse and communication

From my findings, it was clear that the biomedical discourse often rose to dominance in particular situations. Linked to time-pressured interventions, the need for a high level of medical care and life-or-death situations, there seemed to be an unspoken understanding between staff that within these situations it was doctors who had the final say in the interventions delivered. Doctors were viewed by staff to hold the highest level of knowledge, and this belief seemed to give way to a clear hierarchy that drove practice during these times. This finding aligns with Foucault's views on the symbiotic

relationship between power and knowledge as he also believed that knowledge holds the power to influence the behaviour of others (Foucault, 1980).

According to Lyons and Chamberlain (2006), the biomedical discourse has historically acknowledged the knowledge held by doctors to be at the highest level, thus propagating the value of such knowledge, by enabling doctors to hold the greatest decision-making power in the NICU services. Over time this has been further reinforced by the government through educational institutions and professional registration boards, that distribute specific knowledge to specific disciplines, outline scopes of practice and reinforce the division between health professions. In addition, it was clear from my findings that this hierarchy not only drove communication styles during MDT situations, but also dictated which information was considered pertinent enough to be discussed when engaging in collaboration. As a result, while professionals were fearful or cautious in expressing their views, others found it challenging to engage in the communication style driven by the biomedical discourse. Thereby reducing the quality of their collaboration.

This was congruent with the qualitative research conducted by Haruta et al. (2021), who also found that the traditional hierarchy driven by the biomedical model, hindered collaboration with doctors. Haruta et al. (2021) concluded that the biomedical model was centered around doctors and projected them as figures who could not be challenged. This resulted in many MDT staff struggling to engage in discussions with doctors, due to the lack of a common language or platform for communication, along with feelings of disregard for their professional opinion (Haruta et al., 2021). A literature review by Janss et al. (2012) agreed with this finding and further found that the perception of who holds power in MDT settings, can influence the motivation for members to participate in collaboration in the present moment as well as in future tasks, therefore hindering collaboration on an ongoing basis.

Culture of blame and fear-driven practice

Exploration into the discourse of blame culture uncovered the impact it has on several interpersonal skills required to support healthy collaboration between MDT members. Under the pressure of social and news media, the Health Practitioners Disciplinary Tribunal and the constant surveillance by DHB management, health professionals were

often observed to be driven by fear rather than collaboration. Foucault identified such practice as being the result of biopower exerted by the government and health institutions through various forms of surveillance and punishment, to dictate and manipulate behaviour (Foucault, 1977). In the instance where the culture of blame became the dominant discourse, practice diverted away from MDT collaboration and towards risk-averse practice. This included strategies such as filling out excessive paperwork, delivering care driven by the outcome rather than the family's needs, and propagation of hierarchy, whereby doctors took on the ultimate responsibility for all decision-making. This often resulted in defensive behaviours such as refusal to offer an apology, reduced trust amongst MDT members and reduced job satisfaction.

A review of health management literature conducted by Khatri et al. (2009), supported my findings as they too found that fear of criticism and admonishment gives rise to an unwillingness to accept responsibility for errors or mistakes and further forces professionals to protect themselves, by using unnecessary paperwork. Such practices also aligned with the finding from an experimental study conducted by Gorini et al. (2012), who found that the fear of being blamed was far greater than the fear of punishment for all professional groups; however, it was most prevalent in students and junior staff. Gorini et al. (2012) felt this fear not only exacerbated over-reporting but an experience of being blamed for a poor outcome further intensified fear-driven practice and feelings of guilt. A qualitative case study completed by Davidson et al. (2015) concurred with this evidence and further added that for doctors, such feelings of guilt often lead to burnout, reduced job satisfaction, cynicism and compassion fatigue. The repeated exposure to such stressful situations where the culture of blame was the dominant discourse, reduced collaboration between doctors and other MDT professionals and gave rise to lateral violence in the form of unprofessional behaviour, such as rudeness, yelling, eye rolling and ignoring those seeking help (Davidson et al., 2015). When considering the power imbalance blame creates, the repeated exposure to situations driven by such a discourse, has the ability to collectively reduce teamwork, exacerbate emotional distress and isolate professionals even within their MDT.

Sanctity of life and unanimous shift in practice

In contrast to the effects of the biomedical discourse and the culture of blame, the discourse of preserving the sanctity of an infant's life, was observed to bring about a

huge shift in MDT practice. Foucault (2008) suggested that such shifts in practice were initially guided by the dominant discourse of Christianity, whose values slowly seeped into healthcare and politics. My findings demonstrate that as this discourse came into dominance, the views of MDT professionals also seemed to align as they all understood life to be a precious gift. The process of preserving the final days of the infant's life created a domino effect and aligned the goals and values of MDT members, as they shifted practice towards end-of-life care. The shift to value the family's privacy, communicate in a sensitive manner, reduce the number of staff involved in the infant's care, and practice outside-of-service regulations to accommodate families, all seemed to align the delivery of care provided by all the different professionals involved.

A phenomenological study of end-of-life care in an Australian NICU conducted by Kilcullen and Ireland (2017), found that despite stringent policies and guidelines, MDT staff valued flexibility and often practised in a flexible manner by changing their model of care to support families of dying neonates. Furthermore, they discovered that all staff agreed on the importance of privacy for such families to spend their last moments in undisturbed and quiet spaces (Kilcullen & Ireland, 2017). Staff acknowledged that outside of their rooms, families found the lack of private shared spaces to be very limiting, especially when wanting to take their infant outside for a short while (Kilcullen & Ireland, 2017).

A qualitative descriptive study conducted in a South Korean NICU focusing on nursing perspectives to end-of-life care also concurred with these findings (Kim et al., 2019). Kim et al. (2019) revealed that despite policy restrictions, nursing staff practised in a flexible manner and often allowed for more visitors to spend time with the infant, supported lots of physical contact between parents and infant and made arrangements for parents to take the infant outside to support the infant and their family regardless of repercussions. Moreover, they acknowledged that as practice changed, there were improvements in communication between MDT staff and families, as the language shifted away from medical terms to accommodate for parents' wishes, while maintaining respect and dignity around the infant's care. Similarly, nursing participants in a study by Kilcullen and Ireland (2017), voiced the value of ensuring communication with families and colleagues remained honest yet sensitive, to be very effective in decision-making situations. The trust in the shared belief of preserving the sanctity of

life not only promotes collaboration, but also demonstrates the underlying existence of the sanctity of life discourse guiding this practice.

The reality of collaboration in practice

Prior to beginning this research, my understanding of collaborative practice aligned with the generic yet global definitions of the WHO, and often these views left me disappointed, as my personal experiences were far from this textbook definition. By delving into the observational and interview data collected during this research, I was surprised to discover that, in reality, collaboration is much more nuanced than the global descriptions that have appeared in peer-reviewed literature. Collaboration within the ADHB NICU was not organically representative of constant MDT interactions to support decision-making, it was instead situation driven and often existed alongside other discourses which were guiding practice. Depending on the dominant discourse at play, there were instances when MDT members chose whether they had the capacity to participate in collaborative practice, despite both the WHO and research propagating it to be more time-efficient (Maddock, 2015; WHO, 2010). While Bosque (2011); Simms et al. (1984), and WHO (2010) all acknowledge and identify that collaborative practice often leads to an increase in the efficiency of care delivery, they were unable to identify that participation in collaboration that also involves a time component.

My findings acknowledge that during the dominance of the biomedical discourse, time becomes a constraining factor and can hinder collaboration for those individuals who are expected to take responsibility for decision related to the survival of the neonate (Laudert et al., 2007). In situations where doctors were ultimately responsible for making decisions for many neonates, they actively chose to avoid collaboration as a result of the sheer number of responsibilities they were expected to fulfil. A meta-ethnography conducted by Steihaug et al. (2016) agreed with these findings and also identified time constraints as a huge barrier to collaboration. However, they too were unable to identify the discourse which determined such division of time. In other instances, it was clear that collaboration occurred even when hierarchy was at play and in spite of doctors making the final decision regarding a neonate's care. In such situations, doctors were observed to make decisions after receiving information gathered by other team members, to ensure the selected interventions would be tolerated by the neonate involved. Although there was no requirement for consensus,

such contribution of information, regardless of the final decision, was by WHO definition, collaborative practice. A recently published qualitative research conducted by Noyes (2022) agreed with this reality and highlighted that collaboration, respect and power sharing, are not incompatible with hierarchy. Furthermore, Noyes (2022) noted that health practitioners have the capacity to perpetuate and challenge hierarchy, so that opportunities are created to enable participation in collaborative practice. During other interactions where decisions were separate from biomedical interventions, collaboration through the sharing of responsibility, tasks, and risk, appeared to alleviate the stress and burden carried by individual MDT members when dealing with difficult situations. In such circumstances, decisions made in consensus were observed to build trust, and improve communication and respect for each other's professions, all of which promotes collaborative practice. The views from Bosque (2011) aligned with this as they highlighted that trust between professionals leads to true collaboration, which not only improves communication but also the efficiency of service delivery. Bosque (2011) added that respect for each other's professions in neonatology helps align professionals towards one goal, even if their overall responsibilities and clinical decisions are not valued equally.

Implications for practice

When considering the benefits of collaborative practice in the context of improving health outcomes for neonates, it continues to represent the future of health care. Research has found that power dynamics and hierarchically driven medical practices have not only hindered communication and information sharing, but have also detracted practice away from collaboration (Masten et al., 2019). In spite of what it may seem, collaboration exists in current practice but not always in the way most health professionals expect. In order to support active participation in collaboration, it is essential that staff are supported to develop an awareness of the discourses that guide practice. By gaining an understanding of how discourses interact, staff and management will be able to identify and target different ways of encouraging the discourse of collaboration, in situations where it is likely to be overshadowed by other discourses. One such example includes prompting colleagues to share knowledge in a way that will be accepted by their colleagues, to enhance decision-making and improve service delivery. Without an understanding of the discourses in play, it will remain challenging

to change or shift current practices, as behaviours guided by other discourses will be viewed as barriers to collaborative practice.

Furthermore, this increased awareness would enable staff to better appreciate the dynamic nature of power, which in most literature is described to be solely hierarchical and sitting with consultant doctors, as they are often seen to be the decision-makers. Once staff understand the flow of power in the context of dominant discourses at play, they may feel increasingly emboldened to challenge it or even accept its direction, given the implications to clinical decision-making. Empowered with the knowledge of discourses that guide practice, staff will be able to identify collaborative interactions that do not follow the global or textbook definitions of collaboration. This has the potential to feeling increasingly valued for their contributions, regardless of who makes the final decisions about a neonate's care.

Implications for future research

To better understand collaborative practice, it is essential that future research first replicates this study in other NICU settings, especially those with a higher ratio of Māori staff, in order to increase the likelihood of capturing the views of Māori participants. It must then explore discourses in the different settings that deliver health care. Practice within inpatient settings is often bound by the medical acuity of conditions they treat, high volumes of patients, increased time pressures and a quick patient turnover. In contrast, community-based services with smaller patient volumes and reduced medical acuity, may offer more opportunities for colleagues to establish relationships, which are known to foster collaboration. Given different settings are likely to face different challenges, the complexities surrounding collaborative practice are likely to be unique to each setting. As a result, it would be extremely valuable to study the discourses that guide practice GP settings, community practices and in inpatient settings located in rural settings, where funding and resources are likely to be limited as the future of healthcare is also likely to be understaffed and underfunded (WHO, 2010).

While this research did not explore the personal responsibility that individuals felt towards engaging in collaborative interactions, it is an area which requires further consideration. There were several instances during this study where individuals who struggled with specific communication cues or styles used by the MDT staff, missed out

on collaborative interactions. Their lack of participation often influenced ongoing relationships with professionals from other disciplines. With interpersonal interactions having a direct influence on the trust that professionals have in one another and their choice to collaborate, it does not come as a surprise that research exploring the impact of interprofessional education on collaboration is increasing. Existing research has found that interprofessional education, which focuses on skills that support collaborative practice environments, supports a significant improvement in collaboration, attitudes towards other disciplines and even improved knowledge around the roles of other disciplines (Spaulding et al., 2021). However, such education often does not cover understandings of discourses which shape practice in various healthcare settings. Without incorporating the importance of discourses, such education can be considered as naïve. Future research needs to explore whether educating students about discourses at play in health settings, improves their ability to engage in collaborative practice. Additionally, research needs to assess whether such education makes students more skilful in responding to the flow of power in different situations.

Along with individual factors which can be altered to support collaboration, there are further organizational factors that services may benefit from reviewing. During the data collection process, there were many structural issues identified that were specifically associated with how the NICU was run. The time at which MDT meetings were scheduled, lack of orientation of registrars rostered for short periods of time to the members of the MDT and their respective areas of expertise, working over capacity in order to cater for the large volume of neonates, are examples of factors that have an effect on the ability of staff to engage in collaborative interactions. In my experience most services in healthcare are staffed and resourced according to budgets, which fail to account for the time and resources it takes to prioritize collaborative interaction. Future research should explore the impact on collaboration when structural aspects are set up to prioritize collaborative interactions. This would have a significant impact on the resources allocated for other service provisions and may promote the culture of collaboration, thereby challenging the dominance of current discourses at play.

Strengths of this research

The recruitment goal of this research was to have at least one professional from five different disciplines. Achieving that was a strength of this research, as it enabled a

variety of different perspectives to be captured. This not only enriched the findings but also widened the applicability of this research. As a researcher with no working experience in the Auckland Starship NICU unit, I was perceived as a neutral individual and it was very easy for me to establish honest and open relationships with participants who volunteered for this study. This was reflected greatly during individual interviews as participants spoke with frankness and shared insightful stories of both their positive and negative experiences.

With prior knowledge of supporting vulnerable neonates, I was able to better understand the roles of the different staff members, the severity of certain situations, jargon used to describe medical events and the context of the experiences that staff shared. This not only supported the flow of conversation during the interview but also enabled me to ask further clarifying questions as needed. In addition to this, my familiarity with the work processes of the NICU, helped me to identify and understand the flow of power during my observation sessions, despite how subtle they were in nature.

By spending time immersing myself in the NICU environment, I was able to establish respectful relationships with most staff, who became comfortable with my presence during observations. This was particularly evident when they directly shared their recommendations about widening the scope of my data collection to ensure a range of interactions were captured. Such openness could not have been achieved had I not spent long periods of time in the NICU itself. Furthermore, by demonstrating flexibility in capturing different days of ward rounds and MDT meetings, I was able to observe a wide range of staff members, thereby ensuring the data captured a variety of personalities and different communication styles.

Limitations of this research

Discourse analysis as a methodology usually explores the discourses within society. Therefore, it considers historical, sociopolitical, economic, and biomedical factors that may impact the research (Aydin-Düzgit & Rumelili, 2018). However, as this research was performed at a smaller scale with only one NICU unit as the site for all data collection, aspects of the sociopolitical and economic implications on discourses were not explored. This not only limits the transferability of these results but also does not reflect how

sociopolitical and economic discourses may affect collaboration in the NICU. In addition to this, the limitations posed by the size of my study, my personal experiences as a health professional and the lack of a prescribed method for discourse analysis have all affected the rigor of this research.

This research initially set out to survey not only a variety of disciplines, but also individuals who identified as Māori, to explore the impact of culture and colonization on underlying discourses, that influence practice. Despite seeking and following the advice of the Mātauranga Māori Committee and a Māori cultural advisor, I was unsuccessful in recruiting Māori staff. Without their input, this research lacks insight into collaborative partnerships formed by Māori staff in a health system which contradicts their cultural beliefs about health and well-being. This was strongly reflected in the findings, as all the interview participants shared European views about health and well-being, thereby normalising the biomedical model adopted by healthcare.

Claim to unique knowledge

Initially, the aim of the study was to better understand the impact of power dynamics on collaborative practice and clinical decisions by conducting a Foucauldian-informed discourse analysis. However, by identifying the dominant discourses which shaped power dynamics and MDT practice in the NICU, I uncovered a unique view of collaborative practice that I had not come across before. Collaborative practice is an intrinsic practice that exists no matter the level of hierarchy, power dynamics or the dominant discourse at play. The way in which collaboration is viewed and enacted, changes depending on the context, what is happening moment to moment and how an individual views interaction. While the smallest of opportunities has the ability to support collaboration, without an understanding of what is driving our communication and behaviours, we are not likely to identify these moments of collaboration and how they might shift as circumstances change. University education and workplace training needs to begin identifying the discourses that are shaping practice, in order to shift currently espoused views on collaboration. With increasing pressures on the healthcare system, the future of collaborative practice is likely to evolve, depending on the changes in the discourses which guide its dominance. Hence, as health professionals, we must be prepared to adapt our communication to the dominant discourses at play in order to actively participate in collaboration.

Conclusion

Like the parable of the blind men who each touch different parts of an elephant, individuals of an MDT hold pieces of critical information required to provide care for their patients. While collaboration is the canvas that brings all those pieces of information together, it is also one of the innate discourses that guides MDT practice. This thesis initially set out to uncover the discourses that influence power dynamics and collaborative practice in the NICU. However, it has uncovered the unique reality that collaboration is in itself a discourse which functions alongside the biomedical discourse, culture of blame and preserving the sanctity of life, all of which rose to dominance as the situation required. Despite influencing the quality of collaboration and flow of power, these discourses have highlighted that without an understanding of what shapes our views, behaviour, communication and practice, we may never truly understand how changes can be made to improve practice in future.

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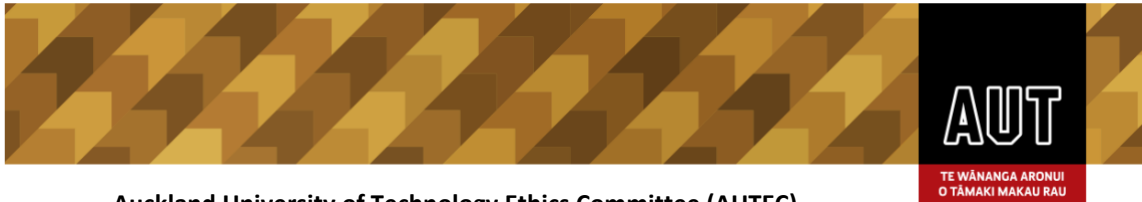
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Appendices

Appendix A: Ethics Approval



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

25 June 2020

Rhona Winnington
Faculty of Health and Environmental Sciences

Dear Rhona

Re Ethics Application: **20/154 Impact of team dynamics on collaborative relationships in neonatal multidisciplinary practice and clinical decision making.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 25 June 2023.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: riarika07@hotmail.com; Clare Hocking

Appendix B: Amended Ethics



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

30 April 2021

Rhona Winnington
Faculty of Health and Environmental Sciences

Dear Rhona

Re: Ethics Application: **20/154 Impact of team dynamics on collaborative relationships in neonatal multidisciplinary practice and clinical decision making.**

Thank you for providing clarification on the amendment to your ethics application.

Amendment 2 - to extend observations of the multidisciplinary teams to include 1-2 ward rounds is approved.

I remind you of the **Standard Conditions of Approval**.

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: riarika07@hotmail.com; Clare Hocking

Appendix C: Participant Information Sheet



Participant Information Sheet

Date Information Sheet Produced:

01/10/2020

Project Title

Impact of team dynamics on collaborative relationships in neonatal multidisciplinary practice and clinical decision making.



An Invitation

Tēnā koe, my name is Niharika Singh and I am a Visiting Neurodevelopmental Therapist from the Waitemata DHB. My work on the neonatal unit at North Shore hospital has inspired me to study collaborative practice and clinical decision making in neonatal teams. This study will involve 1-1 interviews and structured observations of team meetings.

If you have been working in the ADHB Neonatal Intensive Care Unit for longer than six months, I would like to invite you to participate in an interview to discuss team dynamics in your work place. I would also like to ask for your agreement for me to observe staff interactions at a few team meetings. Multidisciplinary teams (MDT) are culturally diverse and in order to ensure that this study reflects its Aotearoa New Zealand context I would especially like to request individuals who identify as Māori or Pacifica to participate.

This research has been approved by Auckland DHB and Auckland University of Technology (AUT).

What is the purpose of this research?

Known as the cornerstone of high quality healthcare, Multidisciplinary teams (MDT) consist of groups of individuals with varying skills and backgrounds who collaborate to achieve shared objectives or goals. Collaborative MDT's have been proven to improve outcomes for patients, staff and organisations. From increased knowledge sharing to improved symptom and psychosocial management, collaborative practice improves staff satisfaction, engagement and decision making. In order to support collaborative practice it is essential to understand the determinants of collaboration. Organisational structures such as policies and procedures along with the behaviours and interactions of staff contribute to the efficiency and effectiveness of a collaborative MDT. Collaborative practice is becoming increasingly important to manage the worldwide shortage of health care workers, limited financial resources and rising complex health needs, while still providing a high quality of care. Therefore, the purpose of this research is to explore the effects of team dynamics on collaborative practice in order to identify ways in which collaborative practice can be further encouraged. Additionally, it will attempt to understand the efficiency and impact of current collaborative practice on clinical decision making in an inpatient setting. This study is for my Master's degree and outcomes may be reported in academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

Due to the increasingly diverse population the Auckland NICU serves, ADHB has been purposively selected for this study. If you have been working in this team for longer than six months and are permanently based on the neonatal unit we would appreciate your participation.



What will happen in this research?

Data will be collected from semi-structured interviews with neonatal multidisciplinary team members who agree to be interviewed, and through structured observation of team dynamics at 3-4 MDT meetings. The meetings will be observed by myself, consent for each meeting from each member will be obtained prior to the meeting and detailed fieldnotes will be created from observations of collaborative practice and shared decision making. All participants who participate in individual interviews will be emailed a copy of their transcript in order to provide them an opportunity to check the transcript of their interviews and make a decision about whether there is information that they may like to withdraw prior to data analysis commencing. There may be brief follow up interviews to clarify/extend points discussed in order to ensure accuracy of analysis. The data gathered will be analysed to identify the impact of team dynamics on collaborative practice.

How do I agree to participate in this research?

Please get in touch with me via email (riasmasters@gmail.com) or telephone (+64 02040908634) if you agree to be interviewed. You will need to complete a consent form prior to the interview. Your written consent to being observed in team meetings will be obtained prior to each meeting, so as not to interfere with meetings starting on time.

Your participation in an interview and/or having fieldnotes made about your contribution to collaborative practice and clinical decision making in team meetings is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, you will be offered the choice between having any data that is identifiable as belonging to you removed, or allowing it to continue to be used. However once data analysis has commenced removal of your data may not be possible.

What are the discomforts and risks?

Sometimes in the process of engaging in an interview, sensitive topics or personal experiences might be discussed which could cause emotional distress (similar to what you may experience in professional supervision). While this is uncommon, should you feel uncomfortable or distressed, you have the right and freedom to immediately end the interview. It is unlikely that any discomfort will be associated with team meeting observations, as nothing about the normal team meeting process should change apart from my presence in the room.

How will these discomforts and risks be alleviated?

At any point you can decline to answer questions, without giving a reason, ask for the recorder to be turned off, remove anything you said if you change your mind (as long as analysis has not commenced) or you can stop the interview.

Furthermore, AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at Level2 WB building city campus or AX building at North campus or MB107b at South campus or phone +64 921 9292.
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet



You can find out more information about AUT counsellors and counselling on <http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling>.

What are the benefits?

While there may not be any immediate benefits to you as a participant, the findings of this study will be used to make recommendations in order to reduce barriers to collaborative practice, create supportive working environments, improve clinical decision making and support policy changes which promote collaborative practice. Your participation will support my Master of Health Science Research project at the Auckland University of Technology, supervised by Dr Rhona Winnington and Professor Clare Hocking.

How will my privacy be protected?

The interview will be held away from the NICU, and whether or not members of the NICU team agree to participate in an interview will not be disclosed to other team members or ADHB personnel. Participant contact details will be stored in a secure and locked location, separate from interview recordings and transcripts. Data will only be available to the AUT research team. Typists who transcribe the interviews will sign a confidentiality contract and identifying data will be deleted from transcripts. No personal information identifying you as a participant will be included in any academic publications. Pseudonyms will be utilised for any direct quotes used and identifying details will be omitted or altered to obscure the speaker's identity.

Findings from team meetings will not be linked to specific meetings and will be reported anonymously, for example as observed behaviours, seating arrangements, and patterns of communication between unidentified meeting participants. The nature of the clinical decisions and child or whanau information, will not be recorded or reported, as that is not the focus of the study.

What are the costs of participating in this research?

If you choose to be interviewed for the study, there will be a 30-90 minute commitment. I can either arrange a zoom video appointment or can meet you at a place and time that is easily accessible for you, such as at an ADHB office or meeting room outside the NICU or a study room at the University of Auckland library (accessible to ADHB staff), or Auckland central city library meeting rooms. Should you incur any travel cost, you will be reimbursed for mileage. There are no costs to you associated with observations of team meetings.

What opportunity do I have to consider this invitation?

You will have a minimum of two weeks from the date I send you this information sheet before I contact you to answer any questions you may have and confirm your interest in participating in an interview.

For the team meeting observations, I will confirm with each team member prior to the team meeting about whether they consent for their data to be included in the study.

Will I receive feedback on the results of this research?

Feedback, should you request it, will be provided in the form of a summary of the findings. Once these are available (about 24 months after your interview), the summary will be sent to you via the contact details you provide. In addition, you may wish to attend an information meeting given by the research team and advertised via notices displayed in the NICU.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Dr Rhona Winnington*, rhona.winnington@aut.ac.nz, + 64 9 921 9999 ext 7123.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK Dr Carina Meares, ethics@aut.ac.nz, +64 9 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Niharika (Ria) Singh Wadhwa

riasmasters@gmail.com

ph. 02040908634

Project Supervisor Contact Details:

Dr Rhona Winnington, rhona.winnington@aut.ac.nz, + 64 9 921 9999 ext 7123.

Approved by the Auckland University of Technology Ethics Committee on 25th June 2020, AUTEK Reference number 20/154.

Appendix D: Flyer



Do team dynamics affect collaborative practice?

Team members of the Neonatal Intensive Care Unit are invited to join the study!

Given the worldwide shortage of health care workers, limited financial resources and

encouraged. Data will be collected from semi-structured interviews and observations of multidisciplinary team meetings. The data will be analyzed to identify the impact of team dynamics on collaborative practice.

Are you eligible?

If you have been working in the NICU team for longer than six months and are a permanently based on the neonatal units then we would appreciate your participation!

You will be asked to take part in a 30-90 minute interview with Niharika Singh Wadhwa (or else known as Ria). She will meet you at a place and time that is easily accessible for you!

riasmasters@gmail.com or ph. 02040908634

Niharika Singh Wadhwa
riasmasters@gmail.com
Ph: 02040908634

Niharika Singh Wadhwa
riasmasters@gmail.com
Ph: 02040908634

Niharika Singh Wadhwa
riasmasters@gmail.com
Ph: 02040908634

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Ph: 02040908634

Niharika Singh Wadhwa
riasmasters@gmail.com
Ph: 02040908634

Niharika Singh Wadhwa
riasmasters@gmail.com
Ph: 02040908634

Appendix E: Recruitment Emails

EMAIL 1: sent to NICU manger

Subject: Permission to distribute research flyers

Tēnā koe,

My name is Niharika (Ria) Singh, I am a Visiting Neurodevelopmental Therapist from the Waitemata DHB. You may remember me from last year where I presented my collaborative practice research proposal to the NICU unit. I'm really excited to convey my research is about to get underway and I wondered if there would be a suitable day for me come and distribute/put up flyers and participant information sheets on the ward in order to attract potential participants. Attached to this email is the flyer and participant information sheet which contains additional information with regards to what this research will entail.

Additionally I would really like to speak to the staff for a few minutes at the next available team meeting in order to invite them personally. Please let me know whether this would be possible and if so, when I could meet with them.

Ngā mihi,

Niharika Singh

Visiting Neurodevelopmental Therapist

NZROT

EMAIL 2

Sent out to individual staff ADHB emails from NICU manager.

Subject Line: Collaborative practice research invitation

Tēnā koe,

My name is Niharika (Ria) Singh and I am a Visiting Neurodevelopmental Therapist from the Waitemata DHB. My work on the neonatal unit at North Shore hospital has inspired me to study collaborative practice and clinical decision making in neonatal teams. If you have been working at the ADHB NICU for longer than six months, then I would like to invite you to participate in a semi-structured individual interview to discuss team dynamics in your work place. While there may not be any immediate benefits to you as a participant, the findings of this study will be used to make recommendations in order to reduce barriers to collaborative practice, create supportive working environments, improve clinical decision making and support policy changes which promote collaborative practice. This research has been approved by Auckland DHB and AUT ethics committee, and I welcome participants who identify as Māori or Pacifica to ensure the study reflects the Aotearoa New Zealand context.

Attached to this email is a participant information sheet which contains additional information with regards to what this research will entail.

Please reply to this email if you are interested, have question or would like further information. Alternatively you can also text me on my research phone number:02040908634

Your participation would be much appreciated!

Ngā mihi,
Niharika Singh
Visiting Neurodevelopmental Therapist
NZROT

Email 3

Sent out to individual staff ADHB emails depending upon the MDT meeting selected for observations.

Subject Line: permission to observe MDT

Tēnā koe,

You are receiving this email as I would like to ask for your consent to include you in my observations of the selected MDT's in order to gain data for my research on collaborative practice. Notes will be taken during the MDT which will later be transcribed. The observations will solely focus on staff interactions and collaborations. Client information is not the focus and therefore will not be included. If you do not consent to direct observations about your interactions, these will not be included in the data recorded and will not disadvantage you in any manner.

Attached to this email is the participant information sheet and a consent form for you to sign and return to me prior to the MDT meeting agreeing to participate. Please contact me if you have question or would like further information. Alternatively you can also text me on my phone number: 02040908634

Your participation would be much appreciated!

Ngā mihi,
Niharika Singh
Visiting Neurodevelopmental Therapist
NZROT

Appendix F: Individual Consent Form



Consent Form (Individual Interviews)

Project title: Impact of team dynamics on collaborative relationships in neonatal multidisciplinary practice and clinical decision making.

Project Supervisor: **Dr Rhona Winnington and Professor Clare Hocking**

Researcher: **Niharika Singh Wadhwa**

- I have read and understood the information provided about this research project in the Information Sheet dated 01/10/2020.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced or incorporated into the analysis removal of my data may not be possible.
- I agree to take part in this research.
- Do you agree for de-identified data to be shared with a cultural advisor Dr Helen Wihongi :
Yes No
- I wish to receive a summary of the research findings (please tick one): Yes No
- If an informal session is held where findings will be discussed I wish to receive in invitation via email (please tick one): Yes No

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

Date:

**Approved by the Auckland University of Technology Ethics Committee on 25th June 2020, AUTEK
 Reference number 20/154.**

Note: The Participant should retain a copy of this form.

Appendix G: Semi-structured Interview Guide

Semi-structured interview guide

What is your understanding of how an ideal multidisciplinary team should function?

Tell me about how your multidisciplinary teams functions?

Probing Question: Does this change when the ward is full/busy/quiet?

How well does your team understand the roles and perspectives of other team members?

How well does your team understand your role or contribution?

Can you give me an example of when your team picked up on your perspective or the information you had to offer?

Can you give me an example of when what you had to offer was ignore or not picked up on. Or can you talk about when you saw this happen to someone else.

Probing questions: Does that happen to everyone on the team?

From your experience on this team how would you describe the quality of communication that happens between team members?

Probing question: Is this consistent for all team members or does the quality of communication change depending on the team member.

Can you give me an example of how the team reached a decision regarding the care of a client where team members had differing opinions.

How does this team account or respond to the different cultures or diversity within the team?

How does this team account or respond to the different cultures or diversity amongst clients?

Appendix H: Transcribers Confidentiality Agreement



Confidentiality Agreement

Project title: Impact of team dynamics on collaborative relationships in neonatal multidisciplinary practice and clinical decision making.

Project Supervisor: Dr Rhona Winnington and Professor Clare Hocking

Researcher: Niharika Singh Wadhwa

- I understand that all the material I will be asked to transcribe is confidential.
- I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber’s signature:

Transcriber’s name:

Transcriber’s Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Project Supervisor’s Contact Details (if appropriate):

Dr Rhona Winnington, rhona.winnington@aut.ac.nz, + 64 9 921 9999 ext 7123.

.....

.....

.....

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTEK Reference number *type the AUTEK reference number*

Note: The Transcriber should retain a copy of this form.

Appendix I: MDT Consent Form



Consent Form

Project title: Impact of team dynamics on collaborative relationships in neonatal multidisciplinary practice and clinical decision making.

Project Supervisor: **Rhona Winnington and Clare Hocking**

Researcher: **Niharika Singh Wadhwa**

- I have read and understood the information provided about this research project in the Information Sheet dated 01/10/2020.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced or incorporated into the analysis removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings (please tick one): Yes No

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

Date:

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTEK Reference number *type the AUTEK reference number*

Note: The Participant should retain a copy of this form.

Appendix J: Observation Protocol

Researcher will be looking for patterns of interaction, such as:

- Where is the meeting held?
- When is the meeting started? Is it when all professionals arrive or does it start at the set time?
- How is the meeting started?
- Where are all members seated (if observing more than one meeting, do they all sit in the same places? Is there a hierarchy of seating positions?)
- Who directs the meeting (is this always the same person/profession?)
- Is there a “usual” process for each case discussed? – e.g. who comments about each neonate/family first, or going round the room with everyone adding their comments?
- Who writes the notes?
- Who ask questions and who answers them?
- Are professionals still accessible to staff/families? Is this protected time?
- Are families involved in the meeting despite it being about their babies?
- Are individuals directly asked for their input? Are they addressed by name?
- Does everyone seem to know who is working with each neonate/family discussed?
- How do people indicate that they want to add something? Is it the same for everyone?
- Body language of staff
- Tone of voice
- Facial expressions
- Interruptions
- Who is speaking the most and the longest?
- Who makes the final decision?
- How is the meeting is concluded?