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Breaking the rules: A conversation analytic study of hospice multidisciplinary team meetings

Abstract

Rule-breaking is found in healthcare settings and is typically pro-social. However, rule-breaking within a hospice setting has not been previously studied. This study investigates rule-breaking within hospice multidisciplinary team (MDT) meetings using Conversation Analysis. Eight video and audio recordings of approximately 45-minute-long MDT meetings at one UK hospice were systematically analysed to identify how staff break rules. Rule-breaking was present throughout the data and was characterised by the minimisation of accountability through collectivising pronouns, extreme formulations and laughables. These three features supported rule-breakers to voice potentially transgressive opinions and recommendations that may have provoked criticism from MDT members. Rule-breakers were therefore able to evade social and professional sanctions whilst carrying out pro-social actions that benefit hospice patients, meeting participants, as well as the organisation and progression of the meeting itself. These findings contribute to the existing understanding of rule-breaking and have implications for how institutions understand and address it.

Key words: Conversation Analysis, Breaking Rules, Multi-disciplinary Team, Hospice, Communication

Introduction

A hospice is an interdisciplinary healthcare institution that aims to maintain quality of life and wellbeing of people with terminal, chronic and life-limiting illnesses (Hospice UK, 2024). Several professions work together to support hospice patients such as doctors, nurses,

physiotherapists, occupational therapists, clergy and social workers (Borgstrom et al., 2021). These professionals form a multidisciplinary team (MDT) that aims to establish and maintain an effective and comprehensive package of care for patients through joint decision making (Taberna et al., 2020). Collaborative MDT working has been the gold standard in hospice care for decades (Borgstrom et al., 2021). It is a key part of hospice decision making (Wittenberg-Lyles et al., 2010) and is associated with improved clinical decision making and outcomes (Taylor et al., 2012).

MDTs have meetings to discuss and make decisions about patient care. However, meetings serve many purposes secondary to their stated aims and functions such as socialising participants into an institutional culture (Gravengaard & Rimestadt, 2012), supporting formal and informal learning (Bháird et al., 2016), as well as allowing participants to socialise and form social bonds (Lopez-Fresno & Savolainen, 2019). The diverse functions of meetings show that participants engage in more social and interactional work than might typically be recognized. Investigating interaction can reveal its underlying functions.

Rules are present in all aspects of everyday life and inform the way we understand the world (Goffman, 1983). Rules can be explicitly codified, like criminal law, or can be implicit and governed by an individual's understanding of acceptable conduct in a given context (Garfinkel, 1967). An example of these implicit rules in action was outlined by Garfinkel's (1967) breaching experiments, in which experimenters vigorously interrogated participants' commonplace remarks. Participants responded with shock and bewilderment as their understanding of the rules of interaction were challenged. This understanding is negotiated over time and forms part of our common sense understanding of the world (Garfinkel, 1967). Individuals may choose to break rules to acquire desirable things like wealth and status (Canton, 2016). They may also break rules pro-socially to benefit those around them (Malik &

Mishra, 2023). For example, a nurse may allow family members to stay official visiting hours to spend more time with their distressed loved one. Pro-social rule-breaking has often been observed in medical settings (Borry & Henderson, 2020) and has been shown to have positive implications for staff relations (Irshad et al., 2021) and patient outcomes (Borry & Henderson, 2020). Morrison (2006) identified three types of pro-social rule-breaking: rule-breaking for efficient working, rule-breaking to support colleagues, and rule-breaking to provide good service.

This study uses Conversation Analysis (CA) to investigate hospice MDT meetings. The data used in this study were first analysed by Bruun and colleagues (2024) who investigated prognostic decision making within a hospice MDT. They found that prognostication is embedded within other aspects of MDT discourse, time-to-death estimates are rarely explicitly referenced, and that prognostication is an interactionally delicate matter. Further CA-based research into medical MDT meetings have found that participants frequently flout or lack defined rules. Soukup and colleagues (2023) found that MDTs often failed to follow official Department of Health oncology meeting guidelines and occasionally refrained from following standard group decision making frameworks. Furthermore, Seuren and colleagues (2019) showed that emergency department MDTs followed no rule-based structure during meetings. This evidence suggests that explicit rules for MDT discussions may not always be delineated or followed in lieu of more implicit and pragmatic rules of interaction formed by some other means. Moreover, they also suggest that rule-breaking is not just a single event or behaviour and can manifest through interaction in sequences of talk. In this paper, we explore how members of a hospice MDT break rules during their meetings.

Study aim

This study aimed to explore how hospice MDT members break rules during meetings.

Methods

The study aim was addressed by using CA to analyse MDT meeting interactions. CA is a research method that aims to systematically investigate and describe the structure and organisation of social interaction (Sidnell, 2010). Analyses investigated where rule-breaks occurred in talk-in-interaction and their interactional function.

Setting

Data were collected from a UK hospice. The hospice comprised two 15-bed inpatient wards, as well as outpatient and day-care facilities. A weekly one-hour MDT meeting was held on each ward. The purpose of the meetings was to discuss and plan patient care.

Before meetings, the case handovers of patients that were due to be discussed were given to each MDT member and a meeting chair was assigned. Thereafter, current inpatients would be discussed individually by the team alongside their What Matters to Me self-report questionnaire. Each case presentation followed a basic format that proceeded with an overview of the patient, their current problems and a follow-up on the action points for that patient from the last MDT meeting. Meetings ended once all patients had been discussed.

Participants

Study participants were staff members and other visitors attending MDT meetings at the hospice. Each meeting had between 10 and 15 participants. All staff who attended meetings during the data collection period, and were willing to provide informed consent, were eligible for the study.

Sixty-five participants consented to participate in the study. These staff members did not consistently attend all meetings, and there was some variation in both individual and inter-disciplinary representation between meetings. Professionals that regularly attended MDT meetings included doctors, physiotherapists, social workers, ward managers, nurses, occupational therapists, chaplains and a bereavement coordinator.

Neither patients nor their family members took part in the meetings in line with local hospice policy.

Data collection

Study data were collected by Bruun and colleagues (2024) in their study of prognostic decision making within palliative care MDTs. The original dataset comprises 24 video-recordings of the hospice's weekly MDT meetings, collected between May and December 2021.

Meeting interactions were captured by two video cameras situated in different corners of the meeting room. The researcher was present in an observational role during all meetings in order to inform the many varied attendees about consent and field questions about the recording.

Ethical considerations

The original study received ethical approval from a UK NHS Research Ethics Committee (REC) on 04/12/2022 (REC Reference Number: 20/LO/1168). All participants in this study consented to being recorded and have their data used for future research. All identifiable patient information within the original video recordings were audibly masked.

Data management and analysis

Data analysis was conducted in line with conventional CA procedures in which multiple single instances of a specific phenomenon are identified and analysed individually and comparatively

in a case collection (ten Have, 2007). A case collection is an aggregate of single-case analyses that relate to the investigated phenomena (ten Have, 2007).

The analytical process began with the researcher [A1] engaging in unmotivated looking at the data by watching each meeting recording twice. During these initial watches, interesting sections of interaction were time-stamped and later transcribed.

These sequences were transcribed using standard CA conventions (Jefferson, 2004). Transcripts that related to the concept of breaking the rules were chosen and formed the case collection for this study.

Data were discussed in data sessions within the research team. Findings from these data sessions were then analysed, explored and expanded upon by the researcher [A1]. Initial findings of rule-breaking were identified in discussion of official hospice policy as these were verbally referenced and more obviously observable. However, this definition expanded in scope to encompass professional and social rules as the analysis progressed.

Table 1 contains the transcription conventions, adapted from Jefferson (2004), used in this study:

Table 1

Transcription conventions used in this study

Symbol	Meaning
(.)	Micropause (less than 0.2 seconds)
(0.3)	Timed pause (e.g. 0.3 seconds)
,	Slight rising intonation

?	Sharp rising intonation
.	Falling intonation
:	Prolonged sound (each additional : lengthens sound)
=	No pause in between where one turn ends and another begins
[word] [word]	Overlapping talk
°word°	Decreased volume
WORD	Increased volume
>word <	Fast rate of speech
(word)	Uncertain word
((word))	Analyst comments or descriptions
£word£	Smiley voice or suppressed laughter
Word	Emphasis
xxx	The number of syllables in uncertain words or phrases. One x indicates one syllable.

Results

Hospice staff members displayed differing practices to navigate rule-breaking during MDT meetings: collectivising pronouns, extreme formulations and laughables. These features were used to mitigate and minimise the potential risk of the participant being held accountable for the rule-breaking. These features are commonly featured in examples of rule breaking but may not all be present in each example.

Five extracts from MDT meetings that capture instances of participants breaking the rules are presented in this paper. Each instance of rule breaking will be explored in isolation as well as being highlighted and cross-referenced with other extracts at key junctures. In some instances, the responses of listeners will be analysed in order to better define and discuss aspects of the rule breaking turn itself.

Collectivising pronouns

MDT members minimised personal accountability when discussing breaking rules during their meetings by using collectivising pronouns such as "we". Doing so dispersed accountability across the team and individual rule-breakers were less likely to face sanctions from the MDT.

In Extract 1, Lovely Pinos, the MDT discusses a gift of wine given to them by the family of a recently deceased patient as a thank you to the staff for caring for their loved one. This Extract shows participants discussing breaking codified hospice rules about bribery and gift-giving.

Extract 1 – Lovely Pinos

Line no.	Speaker	Transcript
01	OT	and then there's ((bleep)) and erm. I spoke to: [her earlier,]
02	UNK	[↑wow thank you]
03	UNK	so: much,

04 OT and it's just routine, although.((bleep x2)) (so she's really x)=

05 WRD =they, by the way sent l- eh li- (.) hh. really lovely (pinos)

06 from this ((bleep)) was I guess it- like (.) lots of them.

07 [but]=

08 UNK [Oh wow,]

09 WRD =but i've quickly ((bleep)) >office because obviously< we have to

10 go throu:gh. ((bleep))

11 (.)

12 DR1 oh. °yeah°=

13 WRD =bribery. ((clicks tongue)) (1.4) hh. So: they are for the staff

14 but >we have< to figure out a way offf_

15 (0.6)

16 DR1 giving it up,

17 (.)

18 WRD giving them out.=

19 DR1 =°yeah.°

20 (0.5)

21 WRD but yeah very very very appreciative [(all right.)] ah: lovely=

22 OT [yeah definitely]

23 WRD =to have (her).

24 (0.7)

25 UNK yeah.

26 (1.8)

27 WRD so yeah there's >loads of< presents for us.

28 UNK ((multiple people £murmur£))

29 (0.3)

30 WRD £BUT IF WE CAN GET HOLD, [OF THEM]£

31 UNK [HAHA]

32 (.)
33 CHA £Heh£=
34 UNK =£huhuhu.£
35 (.)
36 OT £or just lovely presents to look at£,=
37 WRD =£to look a[t yeah£.]
38 OT [£yeah,] ~a know.~£
39 (0.2)
40 WRD and then they go in the rafters, and be like a don't kna.=
41 CHA =a li- (.) a little tip, is to look >at it< and say oh they were
42 bought off Ebay, just for a couple of [pence and so it-] (.) it=
43 WRD [((laughs))]
44 CHA =gets it below the donation.=
45 WRD =[yeah.] (.) yeah.
46 PHY [↑£hu:huh£]
47 (.)
48 CHA but the chaplain didn't say that as er.
49 [((room laughs))]
50 DR1 [((waves hand))]
51 WRD yeah [we'll figure a way uh] because obviously they are for the=
52 CHA [£HUHUHU£]
53 WRD =staff. °so we'll figure [out] how- [(how to do)]° (.) Yeah.
54 CHA [yeah]
55 DR1 [HHHHH.]
56 CHA £uh huh£
57 (1.3)
58 OT that's it,=
59 WRD =THAT'S it,

60 (.)

61 OT Yeah that's it.

The rule-breaking episode begins in line 05, whereby the ward nurse (WRD) positively evaluates the wine as "really lovely". Thereafter, WRD voices their intention for the group to conspire to find a loophole around hospice gifting rules to gain access to the wine in lines 13–18 and again in lines 51–53. The second instance of rule-breaking occurs between lines 41 and 48, as the chaplain (CHA) is informing the group of a technical loophole to the bribery rules. The rules, as outlined in Extract 1, oblige staff to forfeit personal gifts from patients or their families to the hospice to prevent bribery.

Throughout the rule-breaking sequence (lines 05-20 and 53-56), WRD makes notable use of collective pronouns to minimise personal accountability. The use of "we" (lines 09, 14, 51 and 53) repeatedly references collective responsibility. Plural pronouns share the burden of responsibility across the group, protecting WRD from taking individual ownership. This makes WRD appear less accountable, therefore presenting her actions as less sanctionable, because the MDT have all been grammatically implicated in WRD's supposed wrongdoing.

In line 36, the occupational therapist (OT) responds to WRD's rule breaking turn (lines 02-20) by referring to the wine as "presents". This indicates that OT also likely views the wine as being gifted to the staff, implying that OT agrees with WRD's aim to reclaim and redistribute the wine. WRD was not held accountable by members of the MDT for breaking the bribery rules. Furthermore, meeting participants did not appear to orient themselves negatively to the rule-break by, for example, sanctioning or questioning WRD's suggestion. The lack of negative responses could suggest that the MDT as a whole agrees with this pro-social rule-break. WRD's use of collective pronouns suggests that the MDT is a whole united group and the reactions of the MDT to her rule-breaking do not suggest differently.

Extreme formulations

MDT members could also navigate rule-breaking by using extreme case formulations (ECFs) (Pomerantz, 1986). ECFs are words and phrases that are semantically extreme (Whitehead, 2015). They have been found to have a wide variety of uses like justifying (Pomerantz, 1986), navigating accountability (Edwards, 2000) and recharacterizing events (Sidnell, 2004).

Within this data, speakers used ECFs to highlight the non-seriousness or wrongness of their rule-breaking turn. This non-seriousness minimised the potential risk of participants being held accountable for the rule-breaking behaviour.

In Extract 2, Burn the scores, the MDT discusses a patient who is presenting inconsistent reports of pain and discomfort to staff. As a result, a doctor (DR) recommends "burning" their Integrated Palliative care Outcome Scale (IPOS) score to conceal its potentially inaccurate contents from the Clinical Commissioning Group (CCG). This would potentially break many formal and informal rules, for example of data management and transparency at a local and national level.

Extract 2 – 'Burn the scores'

Line no.	Speaker	Transcript
01	CHA	ahh yeah (.) dear, (0.2) he- uh- he'd- he'd said kind of that
02		he was in pain and I just said oo: have you (.) just told anyone
03		and he's like no ((shakes head)) so [there:s] the- I think there's
04	DR	[yea:]
05	CHA	this fear. of- kind of upsetting people=
06	NUR	=yeah cos they were offered, erm if they wanted to go into a roo-
07		different room and he was like no. I'm fine and she was like I
08		don't think he will speak up about wanting those things, (.) but

09 he was saying no he's fine where he was=
10 DR =hmmm=
11 NUR =but (0.2) I think she thinks that he's- (0.2)_ yeah like=
12 CHA =yeah.
13 (.)
14 NUR repeating what you said before.
15 (.)
16 WRD I mean he's (xx)=
17 DR =okie dokie=
18 NUR =but he said no to pain and no to moving.
19 (.)
20 DR Yeah (0.3) well (.) he's in the right place.=
21 CHA =ye[ah]
22 WRD [yeah]
23 (.)
24 DR and (.) yeah burn his IPOS score (.) erm because we don't
25 want that seen by the CCG,
26 ((group laughs))
27 CHA ((pointing at DR)) and I only follow you round on Thursdays.
28 ((group laughs))
29 DR thats ok.

DR breaks the rules in line 24 when they advocate for the destruction of patient data through burning. Burn is an extreme lexical item in this context. Compared to other more contextually appropriate methods of destruction (such as ripping or throwing the document in the bin), burning is an extreme and rather absurd measure. ECFs can create maximal descriptions (Sidnell, 2004), and burning could certainly be viewed as maximally destructive.

Extreme formulations are not typical of interaction across the data and can be seen to downplay the seriousness of the rule-breaking turn they are deployed within. The extremity inherent in the suggestion of burning the document highlights the ridiculousness of the recommendation and makes it seem less worthy of interrogation. In this way, ECFs can be seen to function to minimise the severity of DR's suggestion in line 24. This may mean that DR will face lesser levels of admonishment for the suggestion than if he were to make it seriously. As such, they may also be able to avoid accountability for the rule break as they have manufactured a situation in which it appears like no rule has been broken at all.

In lines 24-25, DR states "we don't want that being seen by the CCG". The CCG is an organisation with authority over the hospice who controls their funding. DR implies that the CCG may disapprove of the patient's IPOS score, which may potentially affect the CCG's evaluation of the hospice. However, it is unlikely that one patient's inconsistent reports of pain would give the CCG cause for concern about the hospice and its practices. Therefore, it could be argued that the idea of concealing a singular score from the CCG is extreme, absurd, and much like the advocation of burning the score, leads the listener to disregard the seriousness of the suggestion.

The MDT's response to DR's rule-break is collective laughter (line 26). The members of the group do not immediately sanction or disaffiliate from DR which implies that his rule-breaking turn is not something egregiously problematic, incorrect or inappropriate. Furthermore, in the following line 27, the chaplain (CHA) calls back to a humorous episode of talk much earlier in the meeting that holds no semantic relevance to any topics discussed in this extract. CHA's instigation of topic change opposed to sanction and/or criticism further supports the hypothesis that DR's extreme formulation was not received as serious or concerning by the MDT.

ECFs are found in Extract 2 and the wider data set to frame a speaker's rule-break as non-serious to minimise accountability. They are presented as so ridiculous and extreme that listeners may assume a lack of intent in a speaker when they break rules. As there appears to be no intent to break the rules, the speaker may not have to take the same amount of accountability for their behaviour as if they signalled intent. This then helps to minimise potential social and professional backlash against the rule-breaking speaker for their actions.

Laughables

MDT members navigated rule-breaking by using laughables: turns or parts of turns that cause laughter (Glenn, 2003), for example the punchline of a joke. It is important to make the distinction between laughables and the concept of humour. Laughables are an empirical descriptor for parts of talk that invite or trigger laughter and aren't inherently humorous. Humour is a more abstract and culturally loaded concept and can prove difficult to objectively pin down (Jefferson, 1979). While sharing similarities with laughables, the analysis of humour does not fall within the analytical scope of this study.

Laughables in this context can make rule-breaking turns appear less concerning and worthy of criticism to the MDT members, thus, once again, mitigating and minimising speaker accountability.

As noted previously, rules do not need to be created and enforced by institutions; they are also jointly negotiated by individuals through their social activities. These social rules of interaction represent socially acceptable ways to behave and interact (Garfinkel, 1967). In Extract 3, Awkward questions, a rule of typical interaction is broken.

The MDT is discussing the What Matters to Me questionnaire of a frustrated patient who wants to return to their own home but may have to be discharged to a nursing home instead.

Extract 3 – Awkward questions

Line no.	Speaker	Transcript
01	OT	is he gonna be: like (.) yeah, I'm happy to go to a nursing home
02		or is he gonna be like (oh) I just wanna go home.
03		((WRD and DR laugh (0.2))
04	DR	well. (.) he was in a nursing home.=
05	OT	=yeah >I know [I know]< I'm just [wondering] if he'll be like I
06	DR	[prior] [(fine)]
07	OT	didn't like that just send me home I'll be fine (in my own place)
08		hhhuh. hhuh. Hhuh.
09		(.)
10	DR	yeah.=
11	WRD	=I think yeah. (0.3) let's see because=
12	DR	=STOP, ASKING awkward questions ((bleep)) >for gods sake<=
13		[((looks at OT and raises and lowers right eyebrow twice))]
14	OT	[AHUH, HUH, huh huh.]
15	NUR	=>PPC PPD.<
16		(4.0)
17	UNK	erm.
18		(1.2)
19	WRD	unable to really ascertain.

The doctor (DR) breaks a social rule in line 12 by instructing the occupational therapist (OT) to "stop asking awkward questions". This instruction breaks typical rules of social interaction by appearing to express exasperation and dismissiveness in a way that could be interpreted as rude, abrasive and highly face-threatening (Goffman, 1955) for OT. The use of OT's name in line 12 is selective and isolates them individually as worthy of criticism.

Despite the supposed rudeness of DR's rule break in line 12, OT responds to the rule breaking turn with laughter (line 14), indicating that an aspect of the rule breaking turn was interpreted as a laughable. The emphatically loud production of DR's directive "STOP ASKING" and the quick production of "for god's sake" in their rule breaking turn are rather excessive in the given work-related meeting context. Coupled with the exaggerated non-verbal bodily communication (i.e., raising and lowering of the right eyebrow twice) directed towards OT in line 13, DR is indicating that their criticism is to be taken humorously rather than seriously. Indeed, OT's response affiliates with the non-seriousness of DR's turn with an extended period of laughter in line 14. Laughter often orients to minor transgression (Stokoe, 2008), and OT's laughter could suggest that DR's rule-break was received as minor and not something OT would challenge or criticise. By producing the rule-break in the form of a laughable, DR is able to dilute potential problems his rule-breaking turn may cause and demonstrates the utility of laughables when breaking rules to navigate accountability.

Laughables may also serve a wider interactional function in this context to support topic termination (Glenn & Holt, 2017; Hoey, 2018). The action completed by OT prior to the rule breaking turn in lines 01, 02 and 05 is not to seek advice, but instead to express worries about how the frustrated patient will react. In line 05, OT confirms that they know the patient had previously been in a care home, but still "wonders" what "he'll be like" when he is told. DR uses the directive "STOP" at the beginning of his rule breaking turn in line 12, explicitly commanding OT to cease talking about this topic. As discussed above, in isolation, this directive may be viewed as face threatening, rude and abrasive which would break normative rules of typical polite social engagement within the MDT meeting. Therefore, DR's the use of laughables in lines 12 and 13 supports his ability to break the rules without taking personal accountability for doing so. Laughables may also allow DR, as a senior member of the team, to avoid taking accountability for answering OT's difficult question and moving on without

having to do so and DR's elicitation of laughter from OT through use of laughables may signal that OT has nothing more to say on the topic of the patient's discharge location. As such, DR's use of laughables in his rule-break could function to support the implementation of a wider meeting-oriented action of topic change whilst minimising the accountability DR would take for abruptly instructing OT to "stop asking awkward questions".

An accumulation of features

Data showed that the three individual features (i.e., collectivising pronouns, extreme formulations and laughables) could be used in combination as well as independently. In Extract 4, it is demonstrated how the doctor (DR) is breaking an informal rule of their profession (i.e., patient-first care) by using all three features in one rule-breaking turn.

In Extract 4, We don't know that ok, the MDT discusses the repatriation of an imminently dying patient to their home "300 miles away" after the conclusion of the meeting. DR expresses their surprise that the registrar is available to sign death certificates in the middle of the night. This could expediate the patient's repatriation process post-death, but DR attempts to suppress this information so that the hospice staff would not be inconvenienced by also coming in at this time to sign the certificate.

Extract 4 – We don't know that ok

Line no.	Speaker	Transcript
01	DR	so first one in does the death cert (2.0) hh. The registrar
02		doesn't open till 9:30,
03		(.)
04	UNK	((bleep)) (no) ((points at SWK)) ((bleep))
05		(.)
06	SWK	they're on call=

07 UNK =(xx)
08 (.)
09 SWK on call (.) there's a registrar [on call]
10 DR [no erm] (0.2) but (0.2) monday
11 to friday
12 (0.3)
13 SWK monday to friday there's always someone on call=
14 DR =IS THERE,=
15 SWK =yea:h. ((bleep)) registration services when i was=
16 UNK =they can do it out of hours:.=
17 DR =OH FUCK THAT we don't >we don't know that okay<.
18 ((NUR and SWK laugh (0.2)))
19 NUR [£to late, (.) we already do,] hh. .hh hhh.,£
20 DR [no one told us. no one told us.] I've been doing
21 I've been doing this job for 17 years and no one has ever told me
22 that they're out of hours (.) on a weekday.
23 (1.2)
24 SWK yea:
25 (0.3)
26 UNK sh::
27 (.)
28 DR what for religious burials,
29 (0.2)
30 SWK the- the- the sai- I was told that there was always one registrar
31 available.
32 (0.2)
33 NUR £hhhuh.£
34 (.)

35 UNK (x x)=

36 DR =that's news to me.=

37 SWK =yea:h (.) I'm surprised as you

38 (.)

39 DR FOR gods sake don't let that out=

40 NUR =HA, HA, (0.2) its too late for it hahaha =

41 DR =cuz I mean I'm not having docs coming in at 3 in the morning to

42 do a bastard certificate.

43 (.)

44 NUR uh- and in the hospitals. ((shakes head)) like=

45 DR =never happens.

46 (.)

47 NUR like yea:=

48 DR =no:. (.) cuz we always tell them there's no point (.) cuz the

49 registrar doesn't open £til 9:30£ ((group £murmurs£)) so that's

50 The story (.) the first person in does a death cert.

DR initially breaks the informal rule of patient-first care in line 17, and the rule-breaking episode continues until line 50. As this rule is informal, its existence must first be proven before it can be investigated. The UK's General Medical Council and National Health Service highlight patient-first care as a professional standard of good medical practice (General Medical Council, 2013; National Health Service, 2009). While this value is more comparable to a guideline than a codified rule, it is an expectation held of those practicing under it. It plays a role in influencing one's professional reputation and conduct. It is expected that if a practitioner consistently behaves contrary to this guideline, they would face social or professional consequences, much like if an encoded rule were broken. Therefore, this guideline functions as an informal rule that governs behaviour. DR's advocacy for a delay in completing

a patient's death certification constitutes evidence for DR breaking the informal rule of patient-first care.

Extract 4 hosts many examples of collective pronouns being used to minimise accountability. DR uses "we" twice in his line 17 when he initiates the rule-break, as well as once more in line 48. Furthermore, DR uses "us" twice in line 20. This lexical item, similarly, to those in the previous extracts, highlights collective collusion and thereby minimises the individual speaker's accountability for their rule-breaking.

Extreme formulations found in this extract also play a similar role to that of Extract 2. DR uses expletives ("fuck" in line 17 and "bastard" in line 42), loud speech ("IS THERE" in line 14, "OH FUCK THAT" in line 17 and "FOR god's sake" in line 29) and rapid speech (">we don't know that okay<" in line 17) to stress the seriousness and significance of the situation. Expletives further emphasise this as their use can exaggerate one's emotional state (Jay & Janschewitz, 2008). The use of extreme formulations and expletives exaggerates the importance of what is being discussed, and in turn leads the group to underplay that importance and view it less seriously. This lessens the likelihood of DR receiving negative feedback from the MDT. A lack of negative feedback can be seen through the frequent presence of laughter and a happy tone of voice from the nurse (NUR) in lines 18-19, 33 and 40, which indicates that they see the transgression as more humorous than serious because laughter often orients to minor transgressions (Stokoe, 2008).

DR's rule-breaking instruction to withhold information in line 17 also contains a laughable, as indicated by NUR's and OT's laughter response to the rule breaking turn in line 18. DR also breaks a rule of professional conduct in line 39 where he instructs the group to not tell anyone about the new information and advocates for delaying administrative procedure at the detriment of a patient's optimum care. Again, his rule-break features laughable as it is followed by

laughter from NUR in line 40. The two laughables discussed here function to minimise DR's accountability for breaking the rules.

Collectivising pronouns, extreme formulations and laughables are all present in the example of rule-breaking in Extract 4. Furthermore, each of these features are consistent in their function across Extracts 1-3. This pattern demonstrates that features of rule-breaking can be used in combination and interchangeably to break the rules in different contexts. In this extract, DR used all three strategies to support him to break rules, which highlights the degree of potential challenges with accountability that arise when breaking rules in sensitive environments like hospice MDT meetings.

When rule-breaking goes awry

Until now, only instances of rule-breaking that were positively received by the MDT have been examined. However, Extract 5 presents a deviant case illustrating someone being challenged for breaking the rules. Both this extract and Extract 3, Awkward questions, demonstrate a doctor (DR) appearing to break social rules of politeness and professionalism by openly criticising an MDT member. DR also appears to utilise this rule break to perform a pro-social action. The difference between the Extract 3 and 5 is the response of the recipient to DR's critical turn.

In Extract 5, You're so pedantic, the bereavement coordinator (BRC) performs their scheduled task of listing the recently deceased patients and the support that their families require. BRC asks the group to check the spellings of names on official forms. DR calls BRC "pedantic" for this suggestion, and BRC challenges DR's assessment.

Extract 5 – You're so pedantic

Line no.	Speaker	Transcript

01 BRC I've got ((bleep)) husband (.) ((bleep)) e- eh- husband's
02 cousin (.) ((flips paper)) and a request from ((bleep)) if we can
03 get (.) details from them we haven't been able to get hold of erm-
04 (.) an address for ((bleep)) (.) who's looking after ((bleep))
05 (2.0) °then we can look at°=
06 NUR =if you em ((gestures writing with hand)) (0.2) I can look at the
07 spelling of the name after.
08 (.)
09 BRC yeah.=
10 NUR =yeah,=
11 BRC =we'll try to- we'll try to call up again but just that i- yeah
12 call out again (.) to record.
13 (.)
14 NUR Yeah.
15 (.)
16 BRC people's details (when you miss) if possible (2.0) yeah, ((looks
17 BRC at NUR (0.2)))
18 (.)
19 DR [honestly] you're so pedantic ((bleep)) ((shakes head and grins))
20 NUR [yeah]
21 ((group £murmurs£)) (0.4)
22 BRC ((shrugs shoulders)) it jusst ((gazes blankly at DR (0.2))) helps.
23 BRC real[ly if you want] us to ((looks at notepad)) sort of talk to=
24 CHR [no. yeah.]
25 BRC =people
26 UNK £hhh£
27 (.)
28 BRC ((bleep)) I've got ((bleep)) (the) husband.

On the surface, DR's rule-breaking turn in line 19 appears to show exasperation and disapproval at BCR's fastidiousness. However, DR's non-verbal communication (smiling and shaking their head) could suggest that they are being non-serious. This idea is supported by the group's "£murmuring£" in line 21 immediately after DR's turn. These features are also found in Extract 3, potentially framing the turn as a laughable. It is possible that DR's rule breaking turn functioned to alleviate the nurse (NUR) of some of the social pressure of being singled out by BRC through their gaze and their checking of NUR's understanding (line 16) about the mistakenly spelled name. This appears to be the more accurate appraisal because the hospice has been unable to contact the people that they need to in order to do their job effectively. It seems unlikely that DR would criticise this desire solely out of disapproval for accurate record keeping. Again, we see DR's rule-break extending pro-social support to a co-worker. This is all strikingly similar to DR's rule-break in Extract 3, but DR fails to achieve a positive reaction from his conversation partner.

BRC's response (line 22) to the rule-break comprised a verbal response justifying her request and two instances of embodied behaviour; shrugging of the shoulders and fixed gaze on DR. These responses do not align with the laughable framing of the rule breaking turn provided by DR, nor does it align with responses to laughables in the rest of the data. Other responses to laughables in the data include laughter and positive orientation to the speaker who produced the laughable. The lack of these features in this example may indicate that BRC perceived DR's rule-breaking turn as critical of her attention to detail.

In this extract, DR attempted this signalling through a laughable encompassing gesture and body language. While the turn may have been designed as a laughable, through the next turn-proof-procedure (Sacks et al., 1974) it was clear from BRC's response that it was not a

laughable. Indeed, embodied behaviour has been used for this purpose successfully by DR in Extract 3.

This indicates that there may be more to the successful production and receipt of a laughable than simply using similarly designed turns. It may be the case that the successful framing of a laughable may require differing styles of intensity and turn construction when communicating with different conversation partners.

Discussion

This study investigated the interactive and collaborative nature of rule-breaking during MDT meetings in a hospice setting. Three features of rule-breaking were identified: collectivising pronouns, extreme formulations and laughables. These features were used independently of one another as well as in combination. It might be hypothesised that collectivising pronouns are being used to instil a sense of collective collusion and culpability within the MDT to implicate them in the rule-breaker's actions, which minimises personal accountability for the rule-break. Extreme case formulations were used to make the rule-break appear non-serious and minimised being potentially sanctioned for breaking the rules. Laughables were used in the data to frame speakers' rule-breaking turns as non-serious as well as, in one instance, to encourage topic termination and promote the progression and expediency of the meeting.

The three features identified in this study frame rule-breaking as potentially face-threating, necessitating mitigation to minimise accountability during the MDT meeting. It was demonstrated how the MDT members uphold both implicit and explicit rules though talk. Within the data, there are four examples of rule-breaking that can be argued as having a pro-social purpose. There were no examples of anti-social rule-breaking or rule-breaking for solely personal gain. Within these examples we can see instances of each of Morrison's (2006) types

of rule-breaking (rule-breaking for efficiency, to support colleagues and provide a good service). Rule-breaks can be inferred as to having a positive effect on staff relations within the MDT. Irshad and colleagues (2021) found this to be the case within nursing teams. Teams who broke rules pro-socially often enjoyed better supervisor-supervisee relationships because it supported them to provide better care to their patients when they may have been prevented from doing so by inconsequential rules and procedures. Breaking rules pro-socially within this data may imply support and collective collusion between the rule-breaker and the other members of the group. This could act as a form of team building which may help the MDT to foster improved interpersonal relationships and work-based outcomes (Klein et al., 2009). In this study, the MDT used collectivising pronouns to minimise accountability for rule-breaking. The use of collectivising pronouns amounts to a Bystander Effect (Fischer et al., 2011) of sorts. This is not to say that it is impossible to sanction a rule-breaker, but it is less likely to be done. This tactic allowed the rule-breaker to conduct their often-pro-social action with less risk of being sanctioned by the group.

The use of collectivising pronouns has also been explored in other studies. For example, Battle (2023) identified how the use of collective "we" in teachers' peer observation sessions signalled affiliation to other teachers and aligned speakers to their identity as part of the same professional group. It may also be the case that "we" functions similarly in this data to signal a professional in-group identity as a healthcare worker or as part of an MDT.

In this study, the use of ECFs functioned largely to highlight the non-serious nature of a speaker's rule-break and to reduce a speaker's accountability for their rule-breaking turns. ECFs (Pomerantz, 1986) are useful tools that support the creation of non-literal meaning through devices like metaphor and exaggeration (Edwards, 2000). These devices can call into question the factual accuracy of speakers' turns and speakers often reformulate their turns to

be more precise when challenged by their conversational partners (Edwards, 2000). Typically, institutional interactions such as medical consultations and courtroom examinations rely on factual accuracy to facilitate the goals of their interaction and speakers who use exaggerations are typically challenged to increase the precision with which they communicate (Drew, 2003). The lack of challenges to ECFs in rule-breaking turns may suggest that talk within this MDT is less typical of formal institutional interactions (see Heritage, 2005) and more typical of ordinary everyday interaction. In everyday interaction there is more tolerance for exaggeration and non-seriousness and challenging their accuracy may be seen as pedantic (Drew, 2003). This feature of more ordinary interaction affords speakers the opportunity to use devices like ECFs to accomplish actions like reducing personal accountability. Further research into this topic could explore whether MDT talk is more similar to ordinary speech than institutional speech.

Shapin (1994) also highlights the normative link between precision and accuracy. He asserts that different groups have different normative expectations of how precise a statement must be to be accurate. ECFs are empirically imprecise (Sidnell, 2004), yet they are precise enough for this MDT not to challenge their factual accuracy in rule-breaking turns. It may be that hospice MDTs, or perhaps this specific MDT, tolerate ECFs where other institutional contexts of interaction like medical consultations (Drew, 2003) would not.

Another key finding of this study was the presence of laughables in rule-breaking. Laughables, supported speakers to break rules and reduce the personal accountability they take for doing so by framing rule-breaks as non-serious. Laughables may also have had additional effects on the relationships between the members of the MDT. Hospice MDT meeting-talk concerns serious and dispiriting topics such as death, grief and pain. Coser (1959) described laughter in hospitals as “a rebellion against routine” (p.176). In the context of this study, routine is the pre-planned

meeting agenda that obligates participants to talk about such topics. In this way, laughter can be seen to rebel against this routine and create a positive atmosphere (Nikopoulos, 2017), frame serious situations as non-serious (Holt, 2013) and support social cohesion (Wood & Niedenthal, 2018) between team members. Moreover, breaking the rules using laughables to induce laughter in others may therefore have a secondary function of building rapport between colleagues. As discussed in the analysis of Extract 4, We don't know that, laughter orients to transgression (Stokoe, 2008). Indeed, children laugh at transgressive behaviour to signal affiliation between the individual and the transgressor (Walker, 2013). Laughter could share a similar affiliative function within the MDT meeting.

Rule-breaks in Extracts 3 and 5 had many notable similarities but their outcomes were very different. These outcomes highlight the intricacies of rule-breaking and the thin line rule-breakers walk when engaging in sanctionable activity. Embodied interaction is important in meetings as it can signal unspoken meaning, like intent and emotional state to the group (Pelekis et al., 2015). In Extract 3, the doctor raises and lowers both eyebrows, whereas in Extract 5 they smile and shake their head. While the intended function of the eyebrow movement in Extract 3 is unclear, and beyond the remits of CA, unusual facial expressions often indicate that the producer is teasing the recipient (Keltner et al., 1998). In Extract 5, a different understanding appeared to be reached by the recipient. Smiling usually indicates some sort of positive feeling, but it can also relay negative emotions like incredulity or condescension (Nikopoulos, 2017). Furthermore, shaking one's head typically signals rejection or negation (Bross, 2020). In combination these two embodied signals could be received differently in comparison to the teasing, less-serious eyebrow raising in in Extract 3. The role that facial

expressions, and other multimodal features, play in rule-breaking turns requires further research.

Within the data DR produces notably more instances of rule-breaking than any other MDT member. It is acknowledged that DR's role as primary rule-breaker may be influenced by institutional and/or social power dynamics in this MDT. The role of power in rule-breaking is beyond the scope of this paper but does represent an intriguing avenue for further research. For further discussion on the influence of power dynamics in teams in medical settings please see Kearns et al. (2021); Noyes (2021); Rogers et al. (2020) and Saxena et al. (2019).

Study strengths and limitations

The data in this study reflects typical MDT meetings held in this hospice. Meeting structure and content was not altered by the presence of the researcher. Researcher and camera presence may have influenced participant behaviour. However, the presence of rule-breaking suggests genuine conduct rather than intentional image management by the interlocutors, which would likely manifest in hyper-professional conduct.

Studying a single hospice MDT limited the comparability and generalisability of the results found in this study. Investigating different hospice MDTs would provide insight into patterns of rule-breaking behaviour across MDTs.

The scope of the analysis in this study, as is typical of CA-based studies, is restricted to describing observable patterns and features of conversation, rather than explaining them. This is useful in that this analysis is highly detailed and systematic. However, this analysis neglects discussion of more abstract features of interaction that can't obviously be observed in the data. In striving for descriptive objectivity this analysis does not explore topics like interprofessional

power dynamics that may have a significant influence on the communication patterns and features observed within the data but are not expressed explicitly.

Conclusion

Throughout the MDT meetings in this study, participants broke rules. They broke different types of rules, from official codified rules to ephemeral rules of conduct like patient-first care. These rule-breaks often shared common features of collectivising pronouns, extreme formulations and laughables. The findings provide valuable insight into how MDT members navigate meeting interactions and accountability for their potentially sanctionable contributions within them. They may also affect how institutions understand and deal with rule-breakers within their own MDTs. However, more research into rule-breaking within hospices and other medical MDT settings is needed to establish more conclusive generalisations about rule-breaking behaviour.

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Declaration of conflicting interests

The author(s) declare that there is no conflict of interest.

References

Anderson, R.J. *et al.* (2021) "Transitioning out of prognostic talk in discussions with families of hospice patients at the end of life: A conversation analytic study," *Patient education and counselling*, 104(5), pp. 1075–1085. Available at: https://doi.org/10.1016/J.PEC.2020.10.009.

Atkinson, J.M. and Drew, P. (1979). *Order in Court*. London: Palgrave Macmillan.

Batlle, J. (2023) "Hosting collectivity: 'We' as a person reference in interactional reflective practice in peer observation sessions," *Linguistics and Education*, 73, p. 101147. Available at: https://doi.org/10.1016/J.LINGED.2023.101147.

Bháird, C.N. *et al.* (2016) "Multidisciplinary team meetings in community mental health: A systematic review of their functions," *Mental Health Review Journal*, 21(2), pp. 119–140. Available at: https://doi.org/10.1108/MHRJ-03-2015-0010/FULL/XML.

Borgstrom, E. *et al.* (2021) "Multidisciplinary team meetings in palliative care: an ethnographic study," *BMJ supportive & palliative care* [Preprint]. Available at: https://doi.org/10.1136/BMJSPCARE-2021-003267.

Borry, E.L. and Henderson, A.C. (2020) "Patients, Protocols, and Prosocial Behavior: Rule Breaking in Frontline Health Care," *American Review of Public Administration*, 50(1), pp. 45–61. Available at: https://doi.org/10.1177/0275074019862680.

Bross, F. (2020) "Why do we shake our heads?: On the origin of the headshake," *Gesture*, 19(2–3), pp. 269–298. Available at: https://doi.org/10.1075/GEST.17001.BRO.

Bruun, A. *et al.* (2024) "Time estimates in prognostic discussions: A conversation analytic study of hospice multidisciplinary team meetings," *Palliative Medicine*, 38(5), p. 593. Available at: https://doi.org/10.1177/02692163241248523.

Button, G. and Casey, N. (1985) “Topic nomination and topic pursuit,” *Human Studies*, 8(1), pp. 3–55. Available at: https://doi.org/10.1007/BF00143022/METRICS.

Canton, R. (2016) “Why Do People Commit Crimes?,” *Probation: 12 Essential Questions*, pp. 9–34. Available at: https://doi.org/10.1057/978-1-137-51982-5_2.

Coser, R.L. (1959) “Some Social Functions of Laughter: A Study of Humor in a Hospital Setting,” *Human Relations*, 12(2), pp. 171–182. Available at: https://doi.org/10.1177/001872675901200205/ASSET/001872675901200205.FP.PNG_V03.

Drew, P. and Heritage, J. (1992) “Analyzing talk at work: an introduction,” in P. Drew and J. Heritage (eds) *Talk at work: interaction in institutional settings*. Cambridge: Cambridge University Press, pp. 3–65.

Drummond, K. and Hopper, R. (1993) “Some Uses of ‘Yeah.’.,” *Research on Language and Social Interaction*, 26(2), pp. 203–12.

Edwards, D. (2000) “Extreme Case Formulations: Softeners, Investment, and Doing Nonliteral,” *Research on Language and Social Interaction*, 33(4), pp. 347–373. Available at: https://doi.org/10.1207/S15327973RLSI3304_01.

Enfield, N.J. (2012) “Reference in Conversation,” *The Handbook of Conversation Analysis*, pp. 433–454. Available at: https://doi.org/10.1002/9781118325001.CH21.

Fischer, P. *et al.* (2011) “The bystander-effect: a meta-analytic review on bystander intervention in dangerous and non-dangerous emergencies,” *Psychological bulletin*, 137(4), pp. 517–537. Available at: https://doi.org/10.1037/A0023304.

Garfinkel, H. (1967) *Studies in Ethnomethodology*. Hoboken: Prentice-Hall.

Garfinkel, H. (1974) “The origins of the term ‘ethnomethodology,’” in R. Turner (ed.) *Ethnomethodology*. London: Penguin, pp. 15–18.

General Medical Council (2013) *Good medical practice*, *https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors#:~:text=these%20core%20principles.-,Good%20medical%20practice,the%20foundation%20on%20which%20the%20rest%20of%20our%20guidance%20is%20built.,-Confidentiality%20(7)*.

Glenn, P. and Holt, E. (2017) “Conversation analysis of humor ,” in S. Attardo (ed.) *The Routledge handbook of language and humor*. Abingdon-on-Thames: Routledge, pp. 295–309.

Goffman, E. (1955) “On Face-Work,” *Psychiatry*, 18(3), pp. 213–231. Available at: https://doi.org/10.1080/00332747.1955.11023008.

Goffman, E. (1983) “The Interaction Order: American Sociological Association, 1982 Presidential Address,” *American Sociological Review*, 48(1), p. 1. Available at: https://doi.org/10.2307/2095141.

Gravengaard, G. and Rimestad, L. (2012) “Elimination of Ideas and Professional Socialisation: Lessons learned at newsroom meetings,” *Journalism Practice*, 6(4), pp. 465–481. Available at: https://doi.org/10.1080/17512786.2011.642243.

Hadi, A. (2013) “A Critical Appraisal of Grice’s Cooperative Principle,” *Open Journal of Modern Linguistics*, 03(01), pp. 69–72. Available at: https://doi.org/10.4236/OJML.2013.31008.

ten Have, P. (2007) *Doing conversation analysis*. 2nd edn. London: SAGE Publications Ltd.

Heritage, J. (1998) “Conversation Analysis and Institutional Talk: Analyzing Distinctive Turn-Taking Systems,” in *Proceedings of the 6th International Congress of IADA*, pp. 3–17.

Hoey, E.M. (2018) “How Speakers Continue with Talk After a Lapse in Conversation,” *Research on Language and Social Interaction*, 51(3), pp. 329–346. Available at: https://doi.org/10.1080/08351813.2018.1485234.

Holt, E. (2013) “‘There’s Many a True Word Said in Jest’: Seriousness and Nonseriousness in Interaction,” in P. Glenn and E. Holt (eds) *Studies of Laughter in Interaction*. London: Bloomsbury, pp. 69–91.

Hospice UK (2024) *What is hospice care?*, *https://www.hospiceuk.org/information-and-support/your-guide-hospice-and-end-life-care/im-looking-hospice-care/what-hospice*.

Howe, M. (1991) “Collaboration on Topic Change in Conversation,” *Kansas Working Papers in Linguistics*, 16, pp. 1–14. Available at: https://doi.org/10.17161/KWPL.1808.421.

Hutchby, I. and Wooffitt, R. (2008) *Conversation Analysis*. 2nd edn. Cambridge: Polity.

Irshad, M. *et al.* (2022) “When breaking the rule becomes necessary: The impact of leader–member exchange quality on nurses pro-social rule-breaking,” *Nursing Open*, 9(5), pp. 2289–2303. Available at: https://doi.org/10.1002/NOP2.979.

Jefferson, G. (1972) “Side Sequences,” in D. Sudnow (ed.) *Studies in Social Interaction*. London: Free Press, pp. 294–338.

Jefferson, G. (1979). A technique for inviting laughter and its subsequent acceptance/declination. In: G. Psathas, ed., *Everyday Language: Studies in Ethnomethodology*. London: Irvington, pp.79–96.

Jefferson, G. (2004) “Glossary of transcript symbols with an introduction,” in G.H. Lerner (ed.) *Conversation Analysis: Studies from the first generation*. Amsterdam: John Benjamins Publishing Company, pp. 13–31.

Kearns, E., Kurshid, Z., Anjara, S., De Brún, A., Rowan, B. and McAuliffe, E. (2021). P92 Power dynamics in healthcare teams – a barrier to team effectiveness an patient safety: A systematic review. *BJS Open*, [online] 5(Supplement_1). Available at: 10.1093/bjsopen/zrab032.091

Keltner, D. *et al.* (1998) “Teasing in hierarchical and intimate relations.,” *Journal of personality and social psychology*, 75(5), pp. 1231–1247. Available at: https://doi.org/10.1037/0022-3514.75.5.1231.

Klein, C. *et al.* (2009) “Does Team Building Work?,” 40(2), pp. 181–222. Available at: https://doi.org/10.1177/1046496408328821.

López-fresno, P. (2019) “Training Meetings - Not Mere Knowledge Sharing - Perceived Socialising Function and Trust,” *ECKM2019. Published Paper. LopezFresnoP, SavolainenT In Proceed.Vol2, pp.691-699, ACPI Ltd.* Available at: https://www.academia.edu/62609187/Training_Meetings_Not_Mere_Knowledge_Sharing_Perceived_Socialising_Function_and_Trust (Accessed: November 17, 2024).

Malik, L.R. and Mishra, M. (2024) “Prosocial rule-breaking: a systematic literature review,” *Journal of Hospitality and Tourism Insights*, 7(2), pp. 763–782. Available at: https://doi.org/10.1108/JHTI-11-2022-0561/FULL/XML.

Morrison, E.W. (2006) “Doing the Job Well: An Investigation of Pro-Social Rule Breaking,”, 32(1), pp. 5–28. Available at: https://doi.org/10.1177/0149206305277790.

National Health Service (2023) *The NHS Values*, *https://www.healthcareers.nhs.uk/working-health/working-nhs/nhs-constitution* .

Nikopoulos, J. (2017) "The stability of laughter," *Humor*, 30(1), pp. 1–21. Available at: https://doi.org/10.1515/HUMOR-2016-0062/PDF.

Norrick, N.R. (2004) "Non-verbal humor and joke performance," *Humor*, 17(4), pp. 401–409. Available at: https://doi.org/10.1515/HUMR.2004.17.4.401/MACHINEREADABLECITATION/RIS.

Noyes, A.L. (2021). Navigating the hierarchy: Communicating power relationsips in collaborative healthcare groups. *Managament communication quarterly,* [online] 36(1), pp.62-91. Available at: https://doi.org/10.1177/08933189211025737

Peleckis, K., Peleckienė, V. and Peleckis, K. (2015) "Nonverbal Communication in Business Negotiations and Business Meetings," *International Letters of Social and Humanistic Sciences*, 62, pp. 62–72. Available at: https://doi.org/10.18052/WWW.SCIPRESS.COM/ILSHS.62.62.

Pino, M. and Parry, R. (2019) "How and when do patients request life-expectancy estimates? Evidence from hospice medical consultations and insights for practice," *Patient education and counseling*, 102(2), pp. 223–237. Available at: https://doi.org/10.1016/J.PEC.2018.03.026.

Pomerantz, A. (1986) "Extreme case formulations: A way of legitimizing claims," *Human Studies*, 9(2–3), pp. 219–229. Available at: https://doi.org/10.1007/BF00148128/METRICS.

Rogers, L., De Brún, A., Birken, S.A., Davies, C. and McAuliffe, E. (2020). The micropolitics of implementation; a qualitative study exploring the impact of power,

authority, and influence when implementing change in healthcare teams. *BMC Health Services Research*, [online] 20(1). https://doi.org/10.1186/s12913-020-05905-z.

Sacks, H., Schegloff, E.A. and Jefferson, G. (1974) "A Simplest Systematics for the Organization of Turn-Taking for Conversation," *Language*, 50(4), p. 696. Available at: https://doi.org/10.2307/412243.

Saxena, A., Meschino, D., Hazelton, L., Chan, M.-K., Benrimoh, D.A., Matlow, A., Dath, D. and Busari, J. (2019). Power and physician leadership. *BMJ Leader*, 3(3), pp.92–98. Available at: https://doi.org/10.1136/leader-2019-000139

Selting, M. (2000) "The construction of units in conversational talk," *Language in Society*, 29(4), pp. 477–517. Available at: https://doi.org/10.1017/S0047404500004012.

Seuren, L.M. *et al.* (2019) "Multidisciplinary meetings at the emergency department: A conversation-analytic study of decision-making," *Social Science and Medicine*, 242. Available at: https://doi.org/10.1016/J.SOCSCIMED.2019.112589.

Sidnell, J. (2004) "There's Risks in Everything: Extreme-Case Formulations and Accountability in Inquiry Testimony," *http://dx.doi.org/10.1177/0957926504046503*, 15(6), pp. 745–766. Available at: https://doi.org/10.1177/0957926504046503.

Soukup, T. *et al.* (2021) "Degrees of Multidisciplinarity Underpinning Care Planning for Patients with Cancer in Weekly Multidisciplinary Team Meetings: Conversation Analysis," *Journal of multidisciplinary healthcare*, 14, pp. 411–424. Available at: https://doi.org/10.2147/JMDH.S270394.

Stokoe, E. (2008) "Dispreferred actions and other interactional breaches as devices for occasioning audience laughter in television 'sitcoms,'" *SOCIAL SEMIOTICS*, 18(3), pp. 289–307. Available at: https://doi.org/10.1080/10350330802217071.

Taberna, M. *et al.* (2020) "The Multidisciplinary Team (MDT) Approach and Quality of Care," *Frontiers in oncology*, 10. Available at: https://doi.org/10.3389/FONC.2020.00085.

Taylor, C. *et al.* (2012) "Measuring the quality of MDT working: an observational approach," *BMC Cancer*, 12(1), pp. 1–10. Available at: https://doi.org/10.1186/1471-2407-12-202/TABLES/3.

Timothy, J. and Janschewitz, K. (2008) "The pragmatics of swearing," *Journal of Politeness Research*, 4(2), pp. 267–288. Available at: https://doi.org/10.1515/JPLR.2008.013/MACHINEREADABLECITATION/RIS.

Walker, G. (2013) "Young Children's Use of Laughter After Transgressions," *Research on Language and Social Interaction*, 46(4), pp. 363–382. Available at: https://doi.org/10.1080/08351813.2013.810415.

White, S.J. (2018) "Conversation Analysis: An Introduction to Methodology, Data Collection, and Analysis," *Handbook of Research Methods in Health Social Sciences*, pp. 1–20. Available at: https://doi.org/10.1007/978-981-10-2779-6_107-1.

Wittenberg-Lyles, E. *et al.* (2010) "Interdisciplinary Collaboration in Hospice Team Meetings," *Journal of interprofessional care*, 24(3), pp. 264. Available at: https://doi.org/10.3109/13561820903163421.

Wood, A. and Niedenthal, P. (2018) "Developing a social functional account of laughter," *Social and Personality Psychology Compass*, 12(4). Available at: https://doi.org/10.1111/SPC3.12383.

Wu, Y. (2020) "Pain talk in hospice care: A conversation analysis," *BMC Palliative Care*, 19(1), pp. 1–8. Available at: https://doi.org/10.1186/S12904-020-00625-X/PEER-REVIEW.