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Trance-forming Collective Attention: How Interactions Can Support Attentional Structures. The Case of Hypnosis in Hospitals

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Abstract

How does a collective succeed in practicing the same kind of attention together? This is an essential question for organizations that need to develop a common focus of attention, but it is difficult to address because the objects are multiple and in competition with one another. The attention-based view (ABV) highlights the central role of organizational structures (roles, working spaces, social representation, etc.) in the formation of collective attention, whilst simultaneously acknowledging their limitations. Attention-based view thus encourages scholars to explore the complementary role of social interactions. The objective of this paper is to study precisely how interactions relate to structures in the formation of collective attention. To achieve this, we interviewed and observed professionals at a French university hospital over the course of 18 months. Using hypnosis techniques, the professionals sought to pay closer attention to patients' psychological states. We conducted 52 interviews, studied six observation sequences, and participated in a number of meetings; from this research, we selected and analyzed 29 situations in which hypnosis was practiced. Our results show that whilst cognitive, political, spatiotemporal, and material structures can contribute to the sharing of a collective focus of attention, they are in themselves not sufficient and at times even hinder such sharing. When structures enable, which is to say, when they facilitate sharing, interactions can complete or strengthen them to compensate for their insufficiency. When structures hinder, interactions can play a correctional role. By showing that structures do not act alone but are supported by social interactions that act either alongside or upon them, our research helps to expand the ABV model and contribute to better integrating structures and interactions.

Keywords: *ABV; Attention; Interactions; Structuring; Hypnosis*

A very young woman, who has come for a termination, arrives in the operating theatre looking withdrawn, crying, and clutching a tissue. She says that she is afraid of injections, afraid of being in pain, and does not 'want' this. Time is limited and operations are tightly scheduled. Will the medical team try to persuade her? Administer a tranquillizer? Give her a general anesthetic as quickly as possible? Should hypnosis be used to enable her to move into a more positive trance-like state? Among the possible solutions, hypnosis is finally selected. An operating room nurse warns the anesthetist of the patient's psychological state – 'she is in a negative trance'; the anesthetist changes the protocol and abandons general anesthesia; the team whispers, turns down the lights, and puts stressful objects out of sight. The anesthetist sits close to the patient's ear, seeking the right words that will allow disconnection; the surgeon holds back, waiting patiently for a sign from the anesthetist to intervene. At the end of the operation, the patient, who remained conscious throughout, thanks the anesthetist, and feeling very moved, says, 'this is what I wanted'.

This scenario, included in our data, illustrates how, when dealing with patients who are showing signs of distress, a collective of practitioners resorts to hypnosis. Yet, this recourse is not taken automatically. It depends firstly on each member of a collective group focusing their attention on the same object – in this case, the patient's psychological state – whereas assigned roles tend to direct individual attention onto specific objects, such as the patient's physiological state, availability of instruments, or the amount of time being spent in the operating theater. Then, one needs to arrive at an agreement on how to deal with the aforementioned psychological state. Consequently, we might wonder how a professional collective

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can succeed in focusing their attention on the same object when each individual is dealing with competing objects of attention.

One possible answer is to be found within the field of the *Attention-Based View* (ABV) studies, which offer a structural approach to attention. Building on the approaches of Simon (1947) and March and Simon (1958), ABV considers that attention depends on the organizational structure: professional roles and hierarchies, managerial instruments, physical spaces, and social representations. Attention is thus constructed and situated (Ocasio, 2011). The key contribution of ABV is nevertheless to highlight the fact that whilst these structures might facilitate the sharing of attention, they also hinder this process by dispersing attention. In fact, structures encourage the sharing of attention between individuals who work within the same structure, for example those who have the same organizational role or who share the same social representations. However, structures can be a hindrance when individuals evolve within different structures (Ocasio, 1997; Vuori & Huy, 2016). The ABV has since favored the study of the distribution of attention and the attentional divergences that result, but has demonstrated little interest in the sharing mechanisms that might compensate for this distribution, other than those that relate to structures (Laszczuk & Mayer, 2020; Ocasio & Joseph, 2018; Stevens et al., 2015).

However, more recently, Ocasio et al. (2018, p. 162) have proposed integrating social interactions into the ABV as processes that co-orient individual attention in a context of change, thus providing 'an important missing piece of the puzzle'. They outline a way forward rather than a research result, echoing their own calls (Ocasio et al., 2021) to better integrate the current transformation of organizing dynamics and the latter's consequences for the structural distribution of attention. Orvain (2014, p. 346) started this integration work by showing how managerial tools could support interactions in order to acquire a form of heightened attention referred to as 'an organizational Qui-Vive'. We propose to continue this integration project, while exploring the reverse relationship, through the following question: *how do social interactions relate to attentional structures to contribute to the formation of a shared collective attention?*

In the expression 'shared collective attention', the term 'collective' refers to the idea of structured attention, whilst 'shared' connects to the idea of coherent attention. In fact, the term 'collective' specifies that collective attention can be conditioned by supra-individual factors (Citton, 2016), in this case, structures. This is separate from 'joint attention', which is defined as being created through 'the coexistence of several bodies that are mutually aware of one another within the same spatiotemporal situation' (Citton, 2016, p. 162). The designation 'shared' connects to research into the continuity and coherence of objects of attention within a group (Cannon-Bowers & Salas, 2001; Rerup, 2009) and contrasts with divergent or incoherent attention. However, in this paper, we use the terms collective or shared attention interchangeably. We focus on structured, collective attention and look for the mechanisms that make it coherent and shared.

In this research paper, we understand attention as a practice and consider that to be attentive is to 'pay' attention, to 'practice' attention (Levinthal & Rerup, 2006; Théron & Cabantous, 2018). Attention is shaped by the practices that bring it into existence. We therefore study the formation of shared attention by looking at specific practices, such as hypnosis, that produce or even *enact* shared attention.

Through a series of 52 interviews, six periods of observation and participation in feedback meetings in four different care units of a French university hospital, we draw on and analyze 29 situations of collective attention during which healthcare practitioners practiced hypnosis. This hospital context is particularly relevant for exploring our research question. On the one hand, the practice of hypnosis is a different way of paying attention to a patient, that is, by focusing on their psychological state in addition to their physiological state. It is a practice that allows health professionals to move towards greater humanization of care, as requested by both professionals and patient associations (Gherardi & Rodeschini, 2016; Grover, 2014; Pascuci et al., 2017; Rogers & Ashforth, 2017). On the other hand, whilst structures are important within the hospital, which is a bureaucratic and professional organization, interactions are also required in order to work together in a complex and fragmented organization.

Our results show that whilst attentional structures – in this case, cognitive, political, spatiotemporal, and material – are certainly enabling, that is, contribute to a team's ability to share the same object of attention, they sometimes also prove insufficient and can even be a hindrance. When a collective successfully shares the same object of attention, interactions can either complete the structures, or act on these structures by strengthening or correcting them. When shared attention is not achieved, interactions fail to enable the sharing of attention because they are hindered by the structures themselves. In sum, by showing that attentional structures do not act alone but are supported by social interactions, we contribute to the structural model of ABV and continue the integrative work started by Orvain (2014).

Practicing collective attention: Structures and their limitations

Collective attention: A practice

In line with behaviorist approaches, we consider attention as not just a cognitive process, but also a practical one. As such, we share the view of those authors who argue that it is not

the meaning given to signals that produces action, but on the contrary, action that produces meaning and directs attention (Dewey, 1993; Weick, 2009; Weick & Sutcliff, 2006). The ABV builds on this fact by defining attention as the noticing, encoding, interpreting, and focusing of time and effort on the categories available to make sense of the environment, and the possible actions to adapt to it (Ocasio, 1997). Indeed, attention not only involves a cognitive activity of selecting and interpreting signals, but is subject to the actions that integrate the objects of attention. Therefore, actions bring attention into being, attention is *enacted*.

Mobilizing ABV therefore invites us to adopt, as Théron and Cabantous (2018) propose, a performative approach to attention, which considers that attention is achieved through a set of practices. The ABV does not specifically mobilize the notion of performance, preferring the notion of enactment, but the consequences are the same. To be attentive is to pay attention. Attention is then enacted through practice. For Ocasio, in light of the Garbage Can Model (March & Olsen, 1972; Ocasio, 2012), the practice of attention consists of coupling actions to signals, drawing on organizational repertoires of interpretation (problems) and action plans (solutions). In this sense, hypnosis is a practice of attention that consists of responding, through the use of verbal techniques (solution), to patients' signals of anxiety and pain (problem), thus paying attention to the patient's prior psychological experience.

Practicing shared attention: The role of attentional structures

In order to understand the practice of shared attention, ABV considers that structures play an important role; they condition the coupling between solutions and problems. In their absence, the *enactment* of attention depends entirely on the actors, their specific situations, and their capacity for attention. Conversely, in their presence, the individual's room for maneuver is reduced. Attention is therefore regulated and the sharing of attention is facilitated.

In fact, the ABV distinguishes between cognitive and concrete structures. Cognitive structures, first of all, are made up of schemas and scripts that people activate to select objects of attention, interpret them, and act. Schemas build a link between the problems towards which attention is directed, and possible solutions for dealing with them (Bartlett, 1932; Ocasio, 2011; Thornton et al., 2012). Scripts, on the other hand, specify these solutions, that is, describe appropriate behavior in given situations (Gioia & Poole, 1984; Schank & Abelson, 1977). For example, in the hospital context, *'an aggressive patient is an anxious patient',* is a possible schema that encourages acting on anxiety to reduce aggression. But there are other competing schemes, such as *'the aggressive patient is a demanding client'* or *'the aggressive patient is a disoriented patient',* which call for other responses.

Now if we look into scripts, therapeutic communication that specifies the words to say and not to say to enhance the patient's safety is a script for responding to anxiety. Prescription of anxiolytics is another. The scripts and schemas available in organizations are thus important levers for standardization (Barley & Tolbert, 1997; Dany et al., 2011; Weick, 1996) and coordination (Gagnon, 1973; Harris, 1994; Orvain, 2014). For example, Orvain (2014) shows that in the hospital, vigilance patterns and care scripts help to direct the attention of carers to bed sores, an object often forgotten in daily attention giving.

Alongside cognitive structures such as schemas and scripts, concrete structures (Barnett, 2008) also condition attention. They are political, exerting influence through actors' roles, statuses and resources, and through formal governance. They are also spatiotemporal, manifesting through the concrete organization of work, its procedures, and its premises. Finally, they are material, acting through all the artefacts that an organization constructs (Gebauer, 2009; Ocasio, 1997). Thus, concrete structures, like cognitive structures, are factors of standardization and coordination of attention.

Practicing shared attention: The limitations of structures, and interaction as a response

Although cognitive and concrete structures promote the sharing of objects of attention, this sharing is only partial. Indeed, at the same time as they coordinate and standardize, structures distribute attention, maintain individual margins of attention, stratify across time, and hinder the directing of attention towards new objects, all of which hamper the formation of collective attention. We detail these three obstacles below.

The limitations of structures in the practice of shared attention

First of all, structures disperse attention for all they allow it to be shared. Indeed, whilst they facilitate the sharing of attention in organizations when individuals are embedded in the same structures, sharing the same roles or working in the same space, they act as an obstacle when individuals are immersed in different structures. Attention then becomes dispersed between groups of actors (Joseph & Wilson, 2018; Ocasio, 1997; Vuori & Huy, 2016), for example, professional groups, and even more so in complex and pluralistic organizations like hospitals (Denis et al., 2001).

Moreover, in any structure, there is always some capacity for individuals to interpret where their attention should be directed and nothing ensures that this is employed in the service of shared attention. In fact, structures can be stronger or weaker, that is to say, they prescribe the objects of attention to a greater or lesser extent. This limitation, which has been noted

for cognitive structures (Barley & Tolbert, 1997; Dany et al., 2011; Weick, 1996), can be extended to concrete structures. For example, in relation to roles, a general practitioner has a wider margin of individual determination of the objects to which he or she pays attention compared to an ultra-specialized doctor whose attention is more directed. In addition, their possible contradictions (Seo & Creed, 2002) place individuals in situations of arbitration and assign them an individual capacity for attention.

Finally, structures become stratified over time, reinforcing the distribution of attention. Indeed, when new signals are not taken into account because they clash with the structures in place, an evolution of the structures is required (Scheytt et al., 2006). As environments are constantly changing, and objects of attention likewise, structures are continuously modified in a deliberate way by organizations, but this process is long, partial, and localized. The structures then form heterogeneous strata, depending on their period of transformation. Subsequently, the new objects of attention are unequally taken into account by individuals and the dispersal of attention is reinforced.

The use of interactions to complete the structural model of ABV

Faced with structures' inability to provide shared attention, proponents of ABV have called for interactions to complement the model (Ocasio et al., 2018, 2021). To date, this has remained more of an intention than a research outcome. The use of social interactions as a complementary lever is not coincidental since cognitive psychology recognizes their role in shaping joint attention (Aubineau et al., 2015). Thus, Hutchins (1994, 1995) and Cicourel (1987, 1994) borrow extensively from Goffman (1983) to show the role of interactions in situations of dispersed cognition, for example, when making a diagnosis about a patient's condition within a medical team in which the different professionals pay partial but complementary attention. Similarly, the collective mind advocated by Weick and Roberts (1993), mobilized in the notions of mindfulness (Vogus & Welbourne, 2003; Weick & Sutcliff, 2006) and resilience (Tillement et al., 2009), is a form of collective vigilance dependent on interactions that must be rebuilt when they have been destroyed by the unexpectedness of a situation. In the health sector, Kolbe et al. (2014) have shown how 'attentive interactions' contribute to the safety of interventions in operating rooms. Orvain (2014) does the same in his modeling of organizational 'Qui-Vive', considering that it is the interactions that produce a ward's vigilance over patients' bedsore status, though these interactions are not sufficient on their own and must be supported by flexible instrumentation. What all these approaches have in common is to suggest that

collective attention is dependent on individual interactions that offset its dispersal.

In summary, the ABV allows us to understand the levers of formation of collective attention. On the one hand, it helps us to consider the fact that the sharing of attention requires practices that incorporate objects of attention and reduce the individual margins of attention. On the other hand, it invites us to take into account the determining role of political, spatiotemporal, and material structures, as well as cognitive structures, in regulating the competition and multiplicity of objects of attention. These different structures effectively select, direct, and prescribe the objects of attention, and the appropriate actions to be taken. However, the ABV response is partial and needs to be completed. Structures promote shared collective attention, but they are not enough in themselves. In fact, they disperse attention as much as they facilitate its integration, leaving room for maneuver when it comes to individual attention. Moreover, nothing ensures that this individual freedom is harnessed in the service of shared attention. Finally, they stratify over time, producing an unequal consideration of new objects of attention. Although researchers within the field of ABV have suggested that social interactions should be considered as complementary levers to structures, this idea remains a statement of intent rather than the result of established research. Empirical research must be conducted to understand how interactions relate to attentional structures to produce a shared collective attention.

Research methodology: Study of situations of collective practices of hypnosis

Design and overall research context: Studying hypnosis situations in a French university hospital

We opted for a qualitative research method suited to dealing with mechanisms and processes. In the spirit of sociological inquiry (Boltanski, 2012; Paugam, 2010), we sought to understand how individuals within a collective practice their attention together, and studied the specific ways that structures and interactions are related.

We focused on the practice of hypnosis in hospitals, a possible solution for patients signaling pain, anxiety, aggressiveness, or sorrow, and as such, a vector of a renewed attention directed towards patients' psychological states. The evolution of collective attention is a particularly important issue in today's care units. Indeed, the technologization of care, demands for quality and safety, and pursuit of productivity gains tend to polarize attention towards finding 'cures'. This is experienced by professionals as a humanity trap (Weick & Sutcliffe, 2003) which then requires

rebalancing via 'care' in order to 'put the patient back at the center' and 'rehumanize the hospital' (Gherardi & Rodeschini, 2016; Grover, 2014; Pascuci et al., 2017; Rogers & Ashforth, 2017). Paying collective attention to patients' psychological states fits in with this idea and hypnosis is one manifestation of it.

At the time of the research, the practice of hypnosis within the studied hospital was at an intermediate stage, neither totally new nor totally routine. The intermediate stage is interesting both because it is a common stage in organizations, which are constantly renewing themselves, and also because it makes the play of structures and interactions particularly visible. The intermediate stage occurs after structures have begun to assimilate a new object of attention, which is then no longer dependent solely on individual attention capacities, but before it is totally incorporated by these structures and transformed into attentional routines.

Our unit of analysis is the situation. We use Girin's definition (1990, 2011) which characterizes a management situation as one in which people must accomplish, in a given time, a collective action leading to a result that is subject to an external judgment. We thus analyzed 29 situations in which the members of a working collective practiced hypnosis within a given time frame, and with the idea that regardless of how well the process went, it was the right course of action at the time. Each of the 29 situations is summarized in Appendix 1.

Detailed research context: The introduction of hypnosis in four hospital units

Hypnosis takes the forms of formal hypnosis, conversational hypnosis, and therapeutic communication – they form a continuum until the patient reaches an altered state of consciousness via the words of the caregiver. Formal hypnosis seeks to achieve a profound dissociation between the psychological and physical states. The patient must be able to disregard external stimuli, in particular interventions made to their body, and transform their meanings positively. The process is based on a script that precisely describes the actions required, paired with an equally strong schema based on the importance of building and maintaining a 'bubble' around the patient. Conversational hypnosis seeks to activate the patient's resources through a conversation in order to put him/her in a state of focus on positive events and sensations. Here, the associated script is less prescriptive; professionals have a lot of leeway to converse, but the schemas are strong, connecting to the notions of positive and negative trance states. Therapeutic communication uses specific words to support the patient and excludes others in order to avoid focusing on negative perceptions. The script associated with therapeutic communication is very prescriptive, because a certain number of typical

situations are associated with 'words to say', for example, 'how do you feel?', and 'those not to say', such as, 'are you in pain?'. The schemas, which are equally strong, support the script, since 'words can be a placebo or nocebo'.

We worked in four units of the hospital: the gynecological surgery unit (GSU), the day surgery unit (DSU), the ambulance service (AS), and the emergency medical service (EMS). These situations were chosen by opportunity (Girin, 1990), because the managers of these services opened their doors to us. These four units allowed us to diversify the contexts of hypnosis practices, offering us a great variety of situations.

The practices of hypnosis took the following forms within the different units. In the gynecological unit, hypnosis is mainly practiced by doctors or nurse anesthetists, or sometimes by the ward nurses. Conversational hypnosis can be used alongside a light general anesthetic, or formal hypnosis can be chosen to replace a stronger general anesthetic. At the EMS, the three forms of hypnosis are practiced by any member of the team – doctor, nurse, or ambulance driver – to manage pain or fear during technical care, whether it be at the place of intervention, residence, or public space. In these two units, successful hypnosis is hypnosis that ensures the coherence of the attention given to the patient by the different carers who work simultaneously. In the DSU, a unit that takes care of patients before and after their operation, therapeutic communication is introduced to manage the potential anxiety and aggressiveness of patients. Sharing therapeutic communication practices aims to ensure continuity in the way of paying attention to patients' emotions, even though care is subject to time pressure and is dispersed between various caregivers who work as a relay team for only a few minutes each. Finally, in the ambulance unit, therapeutic communication and conversational hypnosis are practices that provide paramedics with ways to manage patients' pain and anxiety, even though the former are not caregivers and cannot use conventional means of intervention such as administering medication. They practice hypnosis during the transportation journey and this is considered particularly successful when, during transfer of the patient to the downstream department, there is no break in communication during handover to the next professional who continues the hypnosis.

Data collection

Two of the authors had access to a French university hospital as part of a research project financed by the *Fédération Hospitalière de France*[1] relating to innovation in approaches to patients' treatment. Here, we only include the data concerning hypnosis. Our data collection work combines interviews (52), direct observation sequences in the units (6), and meetings (3), as presented in Table 1.

[1.] The FHF unites and represents all public health care institutions.

Table 1. Type of data collection in the four units

Units	Type of collection
Gynecological unit	**10 interviews**
	1 doctor anesthetist (interviewed twice), 2 nurse anesthetists, 2 operation room nurses, 2 surgeons, 1 executive manager, 1 trainer
	On-site observations
	3 half-days. We were present in the operating room, seated near the patients' head next to the anesthetist, and then in the recovery room. We debriefed continuously with the anesthetists.
DSU	**20 interviews**
	1 center manager, 2 unit managers, 7 nurses, 3 care assistants (2 of whom were interviewed twice), 1 hospital service agent, 1 trainer (interviewed twice), 1 center manager, 1 trainer
	Feedback meetings
	8 people present
	On-site observations
	2 days. We followed nurses and care assistants attending to patients. We debriefed at the end of the observations.
EMS	**2 interviews**
	1 health executive (2 interviews)
	2 good practice sessions
	2 doctors, 2 nurses, 2 ambulance drivers
Ambulance service	**15 interviews**
	1 service manager (interviewed twice), 2 paramedics, 1 regulator, 5 paramedics in group interviews (twice)
Other	**5 interviews**
	1 anesthetist in the cardiac unit, 1 nurse anesthetist in the cardiac unit, Innovation Department (twice), Continuing Professional Development Manager
	Meeting observations
	Training session on therapeutic communication, 'hypnoCome' workshop, participation in the 'good treatment practice' steering committee (6 committees)

Data analysis

We began with a first-order coding and identified the different types of organizational structures for the 29 situations, whether cognitive (e.g., typical words), political (e.g., hierarchy), spatiotemporal (e.g., organization of work), or material (e.g., forms to be filled in). We connected the situations with what our interlocutors deemed to be successful instances of hypnosis or, on the contrary, failed attempts. Success or failure does not refer to the effect on the patient, but to its shared dimension, that is, to the impression of achieving coherence or continuity in the practice of hypnosis. At the same time, we coded sequences of interactions according to their elementary function: coordination in and out of hypnosis practice, emotional support or restraint, and distancing from the political.

The second-order coding identifies the role of these structures and interactions in the hypnosis practice situation. Structures were coded as enabling or hindering in relation to attention sharing. Interactions were coded as complementing, reinforcing, or correcting structures or as being inhibited by structures. This allows us to distinguish (via third-order coding) the influence of structures on shared attention and the ways in which interactions are linked to structures. This coding is presented in Figure 1.

Results: Four ways interactions relate to structures in the practice of shared attention

Our results show that structures can promote the sharing of attention within a collective; in such cases, we refer to them as *enabling*. Conversely, when they create obstacles to attention sharing, we designate them as *hindering*. Interactions thus relate to structures in four ways. When structures are enabling, they are mostly not sufficient in themselves, thus interactions complete or reinforce them. When structures are hindering, interactions either correct them or are inhibited by them. In the first three cases, shared attention occurs through the shared practice of hypnosis. In the fourth situation, individual attention might be given to the patient's psychological state, but there is no shared practice of hypnosis. Figure 2
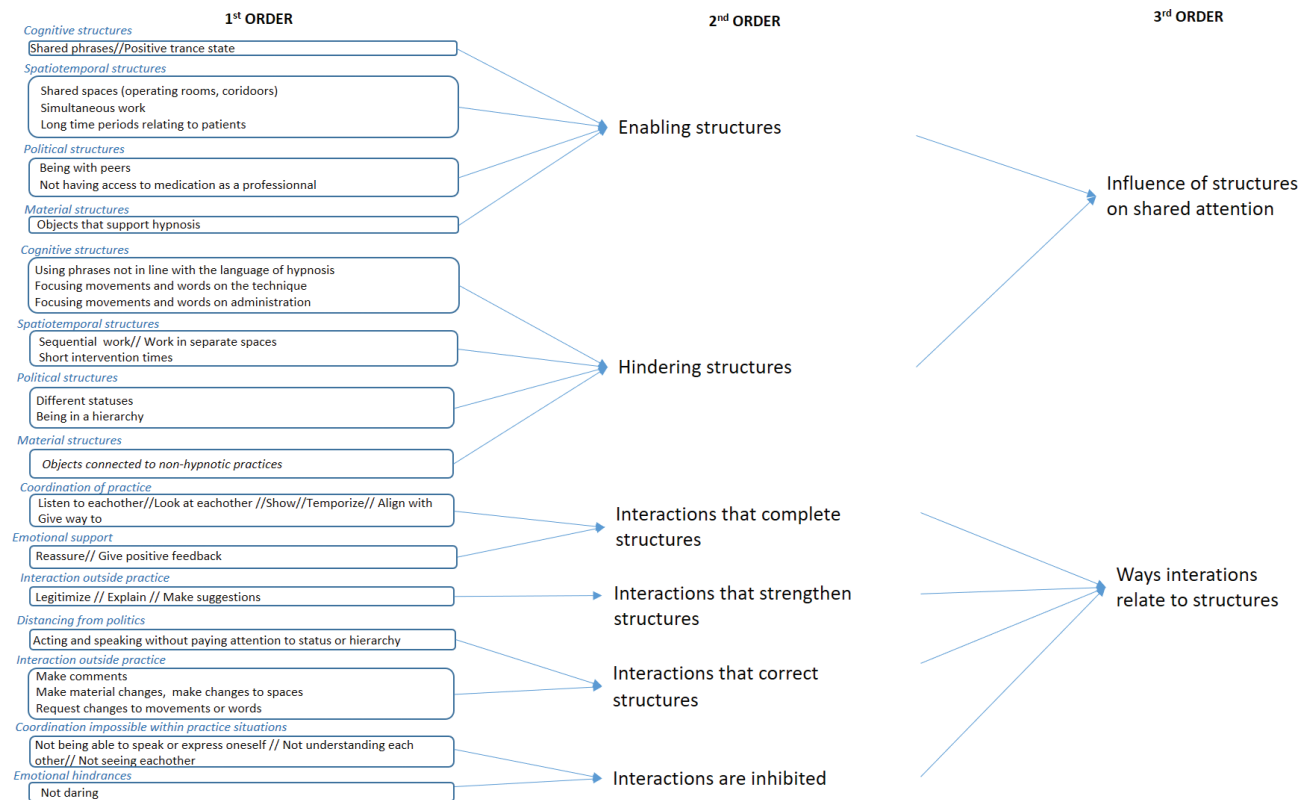
1ˢᵗ ORDER

2ⁿᵈ ORDER

3ʳᵈ ORDER

Cognitive structures
Shared phrases//Positive trance state

Spatiotemporal structures
Shared spaces (operating rooms, coridoors)
Simultaneous work
Long time periods relating to patients

Political structures
Being with peers
Not having access to medication as a professionnal

Material structures
Objects that support hypnosis

Enabling structures

Cognitive structures
Using phrases not in line with the language of hypnosis
Focusing movements and words on the technique
Focusing movements and words on administration

Spatiotemporal structures
Sequential work// Work in separate spaces
Short intervention times

Political structures
Different statuses
Being in a hierarchy

Material structures
Objects connected to non-hypnotic practices

Hindering structures

Influence of structures on shared attention

Coordination of practice
Listen to eachother//Look at eachother //Show//Temporize// Align with
Give way to

Emotional support
Reassure// Give positive feedback

Interactions that complete structures

Interaction outside practice
Legitimize // Explain // Make suggestions

Interactions that strengthen structures

Distancing from politics
Acting and speaking without paying attention to status or hierarchy

Interaction outside practice
Make comments
Make material changes, make changes to spaces
Request changes to movements or words

Interactions that correct structures

Coordination impossible within practice situations
Not being able to speak or express oneself // Not understanding each other// Not seeing eachother

Emotional hindrances
Not daring

Interactions are inhibited

Ways interations relate to structures

Figure 1. Data coding tree.

summarizes these results. We also discuss the cases further, offering illustrations using examples that seem particularly significant. Some are highlighted in the form of vignettes, as they are particularly clear and illustrative, while others are presented more briefly in the body of the text to enhance our analysis.

When enabling structures are still insufficient, they are completed and strengthened by interactions

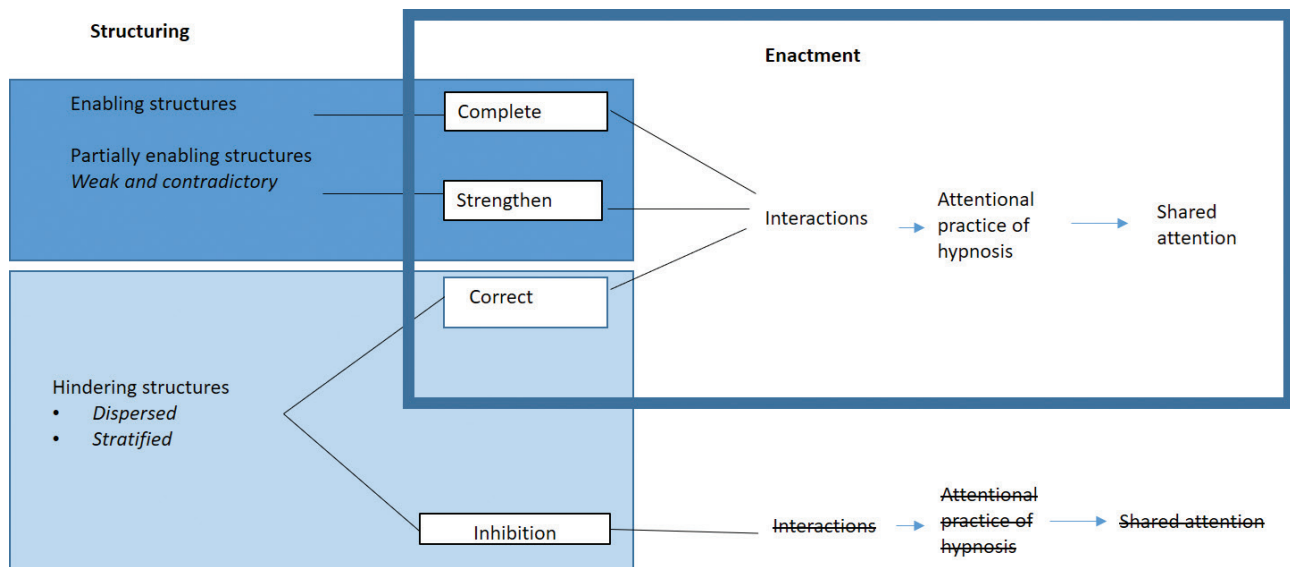#### Enabling structures completed by interactions

In the first set of situations, the structures largely promote shared attention – they are enabling, though insufficient, and therefore need to be completed in the specific situation.

The vignette discussed here shows that the structures, both concrete (spatiotemporal and political) and cognitive, enable shared attention. However, the interaction, in the form of reciprocal listening during the handover between Jean and a radiologist, ensures the continuity of attention to the patient, thus complementing the structures.

Here, the spatiotemporal organization of the work, with a long period of one-to-one contact between the paramedic and the patient, facilitates the reception of the signals sent by the patient and the autonomy of the paramedic in his practice of hypnosis. The political structure, characterized by an ambulance driver whose status is not that of a caregiver and who cannot therefore administer conventional forms of care, favors hypnosis as a 'means of doing something when nothing else can be done' when faced with distressed patients. Finally, the cognitive structure, in play in this situation, also bears an important role; both the paramedic and the radio operator know the importance of maintaining the bubble, the schemas of negative and positive trance, as well as the conversational hypnosis scripts which prescribe a certain way of conversing with the patient. They have the skills to put them into practice independently.

Whilst these structures offer a favorable basis for shared attention by ensuring its continuity, they do not compensate for all the uncertainty linked to its practice within a collective. Thanks to the interaction, though short, the radio operator is able to listen, observe the practice, and see the effects produced on the patient, recognizing that conversational hypnosis is in progress and drawing clues from it to know how to adapt to the work begun by Jean. Thus, by completing the structures, interactions play a role in the implementation of shared attention by filling in the margins of uncertainty inherent in concrete situations of its use by a collective.

Figure 2. How interactions relate to structures to produce shared attention.

Similarly, another situation, taken from a DSU intervention, showcases another form of interaction that completes enabling structures. Audrey, a young paramedic at the EMS (#25), intervenes alongside a doctor and nurse at a road accident site; a motorcyclist is lying on the ground, his femur twisted. In the noisy chaos of the sounds of metal being cut, she asks the doctor, who is in the middle of serious medical procedures, if she can practice hypnosis. With his approval, she lies down next to the injured man, her whispers contrasting with the surrounding tension. Despite 'looking like an idiot', Audrey is encouraged under the watch of her colleagues. Later, they tell her, 'it was great what you did'.

In this case too, the cognitive structure is enabling because the whole team shares the hypnosis schema, and in particular the importance of the bubble, whilst Audrey masters the formal hypnosis script, which allows her to be confident.

The spatiotemporal structure, with work simultaneously being conducted in the same place, allows Audrey to consider how to fit into the collective to find a useful place alongside the patient. But it is the interaction between Audrey and the doctor that gives her legitimacy and symbolic authorization in a field where professional roles remain divided and hierarchical. When Audrey feels doubt and shame because her position of kneeling down 'at the patient's ear' contrasts with the chaos of the scene, it is the collective which implicitly encourages her and respects the non-intrusion. She confided to us later that 'the biggest barrier is often ourselves'. Interactions–in this case, the tacit authorization of the doctor and the emotional support of teammates–completed what the structures had initiated and facilitated.

A handover to the radiology department (#12)

Jean, an ambulance driver, transports an anxious and withdrawn child. Alone with him on the way to the hospital, Jean tries to break the child's isolation. He asks him about his favorite games on the iPad. Eventually, Jean is able to connect the child with his favorite characters, which he suggests they reconnect to in their minds when they arrive in radiology: 'now you're going to continue it in your head, and as you're lying on that bed, you're going to think about your game, your character, how you're running in the forest, jumping, but you're not moving'. Listening to Jean, the radio operator who welcomed them immediately noticed that the child was in a hypnotic bubble; she continued the work begun by Jean by using his words. Jean concludes, 'It's great (…) because I found that the radiologist went even further into conversational hypnosis with the child and she followed up with the right words, the right phrases. I asked her if she was trained, she said yes, that she had trained with another experienced colleague. The scan went perfectly and we brought the child back. The dad said, "That was really great"'.

The debriefing (#9)

An operation has just taken place in the gynecological unit. When the patient leaves the room on the stretcher, the nurse anesthetist, Marie, comes to see the operating room (OR) nurse, Pascale, who is cleaning the operating table. She asks her how the hypnosis went. The OR nurse tells us [researchers] that this is now a common practice in the department: 'After a hypnosis session, Marie always asks for our feedback. She asks for the patient's, the surgeon's, and ours. How we felt about it, how we found things'. Today, while the surgeon gave an evaluation of 10/10, Marie gave 8/10: 'Because I found that there were moments that were a little more complicated'. Pascale shares with Marie the elements on which she thinks the collective could have improved. 'At one point, we didn't understand each other. Maybe, at the moment the bubble is created, we don't want to pierce the bubble by saying "I'm going to apply the solution"'. For Pascale, these exchanges allow her to adjust and improve her skills. In fact, it is following this kind of debriefing that the team has developed a communication technique. For situations where the noise level is too high, a team member 'when he/she sees that there is too much noise, will say, "I am pre-oxygenating the patient"'. That means we get back to being quiet'.

A hole in the drape to communicate in silence (#10)

During a mastectomy operation, the caregivers are positioned around a surgical drape stretched between the anesthetist, who is practicing hypnosis close to the patient's head, and the surgeons, who are bent over the area of intervention. This constitutes a barrier to visual communication; the anesthetist cannot see the surgeons. We learn later that the team agreed to make a hole in the drape to compensate for the visual blockage that risked compromising the bubble. A hole was seen as a good solution to allow everyone, whatever their position, to maintain visual contact, without the need for speaking.

'The nurse is going to talk to you' (#21)

Nicole, an EMS nurse, arrives with three colleagues – a doctor, an intern, and an ambulance driver – at the home of a man in his fifties who has had a severe fall. The patient is in intense pain. The doctor and the student begin the initial interview, the paramedic monitors the vital signs, and Nicole, aware of the patient's pain, attempts to insert a catheter. She tries four times, without success. Faced with the bitter realization of a technical failure, she decides to ask the doctor to take over. While the doctor immediately succeeds in inserting the catheter, he tells the patient, 'the nurse is going to talk to you'. This instruction to enter into therapeutic communication disconcerts Nicole, who is in shock at her failure to insert the catheter. She wonders about the doctor's motives: does he want to put her on the spot and make her feel worse because she failed? Nicole wonders how this doctor could be unaware that 'it was going to be difficult for her to focus on the human side when, professionally speaking, she had failed to accomplish what she was there for'. Nicole would have preferred that the doctor ask her beforehand if she was ready to carry out hypnosis, or that he himself engage in therapeutic communication, having completed the same training as she had. Or he could have asked the paramedic, who was also trained. In the end, she was left with a feeling of failure and a sense of not having been part of the collective; her personal attention was focused on her difficult practice and not on the patient and the other caregivers.

Partially enabling structures strengthened by interactions

In the second set of situations, the structures promote shared attention, but without being strong enough to condition its practice; they are said to be partially enabling. Interactions can then reinforce these structures.

In this situation, the structures seem enabling. The schemas are strong, the bubble makes sense to the whole team, the formal hypnosis scripts are well known, and working at the same time in the same space is conducive to sharing attention. However, the structures are only partially enabling, as the scripts do not cover all the concrete situations encountered. In order to avoid verbal exchanges, which are disruptive to the bubble, it is necessary to construct phrases that are self-evident in terms of the implicit meaning they convey together. The scripts are then reinforced by other scripts, co-constructed by interactions between peers during moments of reflection on their practice.

Cognitive structures are, in this case, reinforced by feedback. They can also be reinforced by imitation or transfer of the right ways of speaking. Imitation can mean observing a more experienced practitioner, such as Alice, a nurse in the gynecological unit (#1) who explains that she has long listened to and imitated the anesthetists trained in hypnosis, but that now it is the young anesthetists who imitate her. The transfer can take place during formal or informal interactions, such as this remark by an anesthesiologist to an intern (#7) regarding the use of the word 'little' during a procedure in which the intern had practiced hypnosis: 'You are developing bad habits, ''little injection'', ''little nap'', ''little…''. You know that one day in a conference, I got pulled up on it!'. This informal interaction will contribute to enriching and standardizing the use of scripts in the team. It also reinforces a political structure that normalizes the transfer of skills between doctors and interns.

In this first section of results, we can therefore see that complementarity and reinforcement are two effects of interactions when the cognitive, political, socio-temporal, and material structures are enabled. Interactions mean feedback, imitation, listening, and emotional support. This contribution via interaction is necessary for the sharing of attention, that is

to say, to enable continuity in the case of segmented work, or coherence in the case of work conducted by different actors simultaneously. In terms of the first effect, interactions complement the structures and fill in the margins of uncertainty characteristic of real situations of attention sharing. They allow for better coordination between the care providers in order to adapt to signals sent by the patients and to risks associated with the practice. With the second effect, interactions reinforce cognitive structures that are not strong enough to ensure standardization of how attention is practiced.

When structures are hindering, they are corrected by interactions, or inhibit them

Whilst structures can be enabling, they can also hinder shared attention. Interactions can then play a corrective role to produce shared attention. But sometimes the structure that prevents shared attention also inhibits the necessary interactions; the individual attention paid to the patient's psychological state cannot, under these conditions, be shared through the practice of hypnosis.

Hindering structures corrected by interactions

We begin by reporting situations in which a structure that hinders the practice of hypnosis is corrected. In the following situation, collective feedback on the practice leads to an agreement to correct an element of the material structure that hindered the continuity of attention.

This situation in the gynecological unit shows that, despite the presence of cognitive structures that facilitate shared attention (knowledge and mastery of hypnosis scripts and schemas), the collective is blocked in the practice of hypnosis by a material object. The drape produces a spatial division of labor in which vision is obstructed, even though vision is the main form of communication in hypnosis. These structures are then corrected via interactions in the form of suggestion, debate, and group agreement. The interactions lead to an innovation, and also to a transgression of sanitary standards, since the drape is supposed to guarantee a strictly sterile space, but with an end goal of facilitating the continuation of hypnosis for future operations.

Interactions can allow, as in this case, to correct material structures, but they can also affect political and cognitive structures. This is the situation illustrated by Nina (#2), a nurse anesthetist, who, during an operation, is dismayed to hear a doctor, who is not trained in hypnosis, say to the patient, 'get ready, you're going to feel a prick'. In saying this, he bursts the bubble that she had built and runs the risk of making the patient fall into a state of 'negative trance'. Nina reacts by 'widening her eyes' at the doctor. After the procedure, she talks to the doctor to remind him of the good practice she learned in training, and in particular the appropriate vocabulary in this situation. This interaction not only corrects the cognitive structure, as Nina shares the appropriate scripts and schemas, but it also corrects the political structure. In fact, when Nina, a nurse, educates the doctor, she reverses the traditional hierarchy of roles. A similar situation was observed when David, a surgeon, following numerous exchanges with doctors and nurse anesthetists, agreed to review his role and his way of working (#11). Previously, he was used to talking during operations, commenting on his actions and relating the different stages of his work, whereas he now remains silent to follow the hypnosis script. He tells us that he is 'obliged to be a little autistic, which means I must not speak, or not too loudly, I really have to carry out my actions efficiently […] I must not do things that could interfere with the hypnosis that is taking place. I really need to be at the service of the work that the nurse anesthetist is doing. I become an executor'. The nurse anesthetist, traditionally at the service of the surgeon's work, becomes the one who guides his practice. The surgeon, immersed in the collective work, is willing to review his habits to promote the collective success of hypnosis.

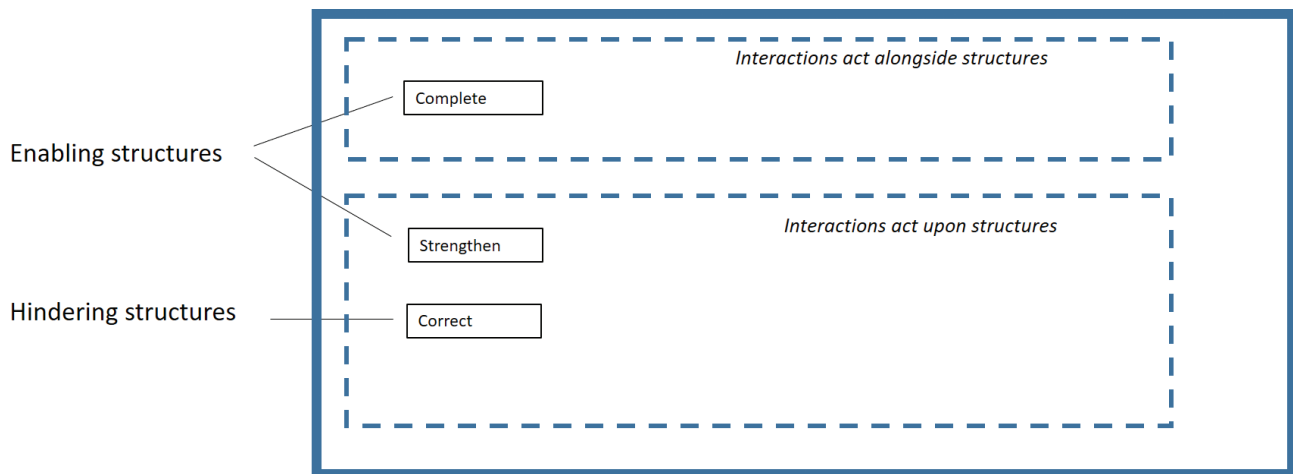**Hindering structures inhibited by interactions**

Finally, in our last series of situations, attention is not shared, because the structures not only prevent this sharing, but also inhibit the interactions that could have corrected them. The vignette (#21) is an illustration of this.

In this situation, despite strong cognitive structures (shared schema and scripts) and a favorable spatiotemporal structure (simultaneous work within the same time and space), shared attention was inhibited by political structures that impeded a collective practice of hypnosis. The hierarchy of professional roles, with a doctor making a request to Nicole that was interpreted as an order, reinforced her initial discomfort and sense of technical failure. Nicole was disoriented by this request, which diverted her attention from the patient and weakened her ability to apply her hypnosis skills. The political structure that weakened the practice of hypnosis could not be corrected by interactions because they were inhibited by the structure itself. Indeed, a satisfactory practice of hypnosis would have required interaction between the protagonists: the doctor checking Nicole's state and her readiness to practice, an opportunity for Nicole to express her emotions and reservations, or her preference for another person to practice. However, these interactions were not possible because Nicole did not allow herself to express her feelings and preferred to respect the hierarchy of roles.

Other types of structures can also inhibit interactions. Remi's situation illustrates the significance of cognitive and concrete structures. Remi is an ambulance driver for a hospital ward (#13). During an ambulance journey, Remi begins a hypnotic conversation with the patient that he continues when he arrives at the hospital, but it is interrupted by the caregiver who greets them. Not only does the caregiver, who is not trained in hypnosis, not recognize the practice used by Remi (she doesn't know the scripts and schemas required to interpret the situation), but she is struggling with an administrative formality (a competing object) and is worrying aloud about the availability of a bed. This protocol diverts her attention on her own tasks, preventing her from paying attention to the condition of the patient, who is worried about Remi and asks 'where he's gone'. Here, shared attention is not possible because of a wide dispersal of cognitive structures reinforced by material objects. Schemas and scripts are not shared and individual attention is focused on different objects – the patient's psychological state, the beds, and the document to be filled in. The interaction, which must be completed in a very short time, that is, during the patient's handover, is not able to correct this wide dispersal, and Remi leaves the hospital very frustrated.

In this second set of results, the structures that impede the coherence or continuity of collective attention could be corrected, but may not be when they exert a significant inhibiting effect on interactions. In the first case, the interactions, which include appeals, remarks on individual practices, and decisions on collective practices, correct the political, spatiotemporal, material, and cognitive structures to adjust them to what is required for the practice of shared attention. In particular, they correct the distribution of space, roles, power, and the stratification that leads to unequal access to new scripts and schemas. In the second case, shared attention is not exercised because the interactions—checking a readiness to act, harmonizing with current or previous actions—that would be necessary to correct the

Figure 3. Acting *alongside* or *upon* structures: Two ways of understanding interactions within the ABV puzzle.

impeding structures do not take place. They are inhibited by the distribution and stratification of structures, differences in status, hierarchy, specific procedures, formal division of labor, and unequal knowledge of the new hypnosis scripts and schemas.

Discussion: Interactions that support attentional structures

This study is inspired by an important question for organizations seeking to develop their members' objects of attention: how does a collective succeed in practicing the same shared attention? Following a review of the literature, we were able to answer this question by looking at how interactions relate to structures in the service of shared collective attention.

The study of 29 situations of hypnosis practice that enact shared attention focused on patients' psychological states shows that the cognitive, political, spatiotemporal, and material structures can certainly favor shared attention – they are therefore enabling shared attention – but they can also hinder it. In cases of successful sharing, interactions contribute to this sharing by completing, reinforcing, or correcting these structures. In cases of failed sharing, the structures not only prevent the sharing of attention, but also inhibit the interactions that might have corrected them. Based on these results, we are able to make three contributions, as well as formulate implications for practice, and finally outline avenues for further research.

Acting alongside or upon structures: Two ways of placing interactions in the ABV puzzle

Our results firstly allow us to answer a call from Ocasio et al. (2018, 2021). These authors have recently acknowledged that structures, once fragmented, cannot by themselves explain how

shared attention is created, particularly in changing contexts. They therefore invite us to integrate social interactions, and organizing dynamics more generally, into the structural model of attention, in order to place 'an important piece of the puzzle' (Ocasio et al., 2018, p. 162). However, they do not specify how this should be accomplished. Our work makes a proposal in relation to this latter point. It shows three ways in which interactions relate to structures when sharing is successful: via completing, reinforcing, and correcting. This allows us to propose two ways of understanding interactions in the ABV puzzle: they act *alongside* structures or *upon* structures (see Figure 3).

Interactions can be placed 'alongside structures' when they relate to structures by completing them. Indeed, even when the structures largely contribute to the sharing of attention in typical situations, interactions organize the collective adaptation to the characteristics of a concrete situation. Thus, the professional profiles that standardize roles, the organization of work that facilitates simultaneous action, and the scripts and schemas that propose common representations all contribute to the creation of shared attention. However, it is still necessary to adapt and interpret signals specific to a particular case of attention sharing, which requires colleagues to listen to each other, look at each other, encourage each other, and reassure each other. Citton (2016, p. 162) states that joint attention is conditioned by 'the co-presence of several bodies mutually sensitive to each other within the same space-time', whereas collective attention is 'the product of supra-individual factors'. Thus, we can say that collective attention and joint attention are not independent. Structure is the basis of collective attention, but it must be complemented by the interactions that organize joint attention. Joint attention extends collective attention to better adapt to concrete attentional situations.

However, there is a second possible place for interactions in the ABV puzzle, whereby they do not only act alongside structures, they also act upon structures. They do so in two ways – when they reinforce and when they correct. Social interactions reinforce structures to increase their capacity to direct attention, and correct structures to compensate for their fragmentation and stratification. Thus, in practice, interactions enable an adjustment of the structures to the needs of shared attention. They do not simply complete the structures, they also modify their effects. Joint attention therefore not only extends collective attention, it transforms the conditions under which it operates.

Establishing that interactions act *alongside* or *upon* structures allows us to build a bridge, as Orvain (2014) has done, between structural and relational approaches to attention. However, whereas in the 'organizational Qui-Vive' model, Orvain shows that structures support relationships between actors, we establish that the reverse relationship also exists: interactions support structures.

Structures enacted in specific attention-related situations

Our second contribution focuses more specifically on the action of interactions on structures, as mentioned above, and allows us both to propose a more dynamic approach to ABV (Ocasio et al., 2021), and to respond to Weick (2003, 2009) for whom formal structures are a blind spot of *enactment*. We show that in concrete attention-related situations structures are not always fixed, they are sometimes adjusted, and in this case, reinforced and corrected. We are therefore not just dealing with practices that *enact* collective attention, as underscored in the first section, but also practices that *enact* the structures themselves to shape them according to the needs of attention-related situations. Can we go further and say, as Soderstrom and Weber (2020) propose, that interactions give rise to new structures that survive concrete attention-related situations? For these authors, interactions experienced as successful by the collective leave their own trans-situational footprints which accumulate over time, becoming provisional tracks, then informal paths, until they become part of the structure. In our results, the enactment of structures, where provisional tracks are established, occurs in intermediate situations, when the interactions are no longer new, but not yet routine. Can we hypothesize that over time these repeated interactions, experienced positively, expand and end up formally transforming the structures at the same time as the practices become routine? (Feldman & Pentland, 2003). Our observations and interviews testify to the positive emotion always felt after the success of hypnosis, which practitioners connect to the new value that their profession and their place in the collective takes on. The feeling of success is undoubtedly a driving

force for the continuation of hypnosis and its dissemination beyond the team. However, in order to determine whether the replication of structural adjustments is likely to make the structures evolve, we would have to differentiate them according to their plasticity. It is highly likely that repeated action to reinforce and share scripts and schemas in a variety of situations will eventually leave formal pathways and develop the cognitive structure for a wider number of people. This was the case for the script relating to mutually respected silence during operations, which was extended from hypnosis situations to any type of operating situation within the gynecological unit. Indeed, the script was first established to protect the hypnosis 'bubble', then reinforced by 'silence – hypnosis in practice' signs placed outside operating rooms, and finally extended to any type of gynecological operation after less fatigue was reported by the teams. In the same way, interactions that shape working methods during an intervention under hypnosis can end up affecting the material structures more deeply. This is the case for hypnosis practices that begin in the pre-operative reception room, which is then appropriately arranged and benefits any type of intervention. That said, roles and hierarchies are more difficult to change. For example, the lack of differentiation between roles, which is very present in EMS interventions, does not survive beyond the hypnosis practice situation; colleagues very quickly return to their traditional roles.

A cognitive, political, material, and spatiotemporal trance-formation of collective attention

The third contribution of this work is the illustration of the political, cognitive, material, and spatiotemporal dimensions of collective attention, as previously modeled by the ABV. It allows us to extend research showing how the selection of objects of attention in an organization depends on the power of the actors, thus integrating the political dimension into cognition (March & Olsen, 1976; Simon, 1947). It also extends the work that has shown how attention distributed between actors is coordinated by material aspects, thereby integrating the material dimension into cognition (Cicourel, 1987, 1994; Hutchins, 1994, 1995). The political and the material have therefore been integrated together with the cognitive. Moreover, focusing explicitly on issues of sharing allows us to illustrate the specific form that these different dimensions can take. Thus, we have found that the sharing of attention is strongly determined by the following aspects: the organization of work, which enables or, on the contrary, prevents the sharing of time and place; the hierarchy of statuses and differentiation of roles that disperse objects of attention to a greater or lesser extent; new scripts and schemas, which may or may not feature in each actor's repertoire of recognized problems and solutions. We also show that whilst the cognitive, material,

spatiotemporal, and political dimensions of attention are played out through structures, they are also played out through interactions that complete and adjust them.

Practical implications

These findings have implications for practice. Deliberately influencing individuals' attention to promote shared attention, that is, undertaking *issue selling* (Dutton & Ashford, 1993; Holm et al., 2020; Mayer, 2016, 2017), requires acting on how attention is regulated (Ocasio & Wohlgezogen, 2010). It seems from our results that action could relate to concrete but also cognitive structures, or interactional ones, for example, coordination, feedback, imitation, symbolic support, etc. In our case, hypnosis training, but also sharing between professionals in the form of good practice groups, are powerful vectors for the diffusion of scripts and schemas. Therefore, such practices promote the evolution of the cognitive structure, which will ultimately allow greater attention to be given to patients' psychological states. This action on cognitive structure cannot be achieved without transforming concrete working methods, which must facilitate simultaneous working and offer opportunities for interaction. We have also shown the significance of allowing the political structure to be adjusted to the needs of attention sharing. For example, it is important that actors recognize the value, in certain situations, of stepping out of their prescribed role, that they feel competent and legitimate when they do so, and that they authorize the same for their colleagues. Encouraging attention to be paid to patients' psychological states in order to rehumanize the hospital experience is therefore not simply a matter of acting on individual behaviors, but must be embodied in collective practices that have cognitive, political, spatiotemporal, and material dimensions requiring support.

Limitations and avenues for future research

This research has its limitations and suggests certain avenues for future research. This study is limited to interactions observed in concrete situations — where attention is *enacted*, as opposed to strategic situations. However, data not used in this article show that in more strategic situations, actors with different representations, interests, and action logics interact and cause attentional structures to evolve. For a more complete approach, it would therefore be appropriate to broaden the study to look at governance and strategic practices, as well as at institutional fields and legitimization practices. At these levels, as with the actual practice of attention, interactions with specific forms relate to structures to transform collective attention.

Finally, we worked on attention-related situations in hospitals that are very formalized organizations. The hospital thus invites us to seek to understand attentional mechanisms

through structures, even if it also shows their limitations and inadequacies. Studying how interactions are supported by structures, or vice versa, is not only a matter of viewpoint. It is also a matter of context that should be made explicit.

Acknowledgments

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Appendice: List of situations

#	Summary	Type of situation	Unit
1	Fabienne, as a nurse anesthetist, is in charge of putting the patient to sleep according to the classic care protocol. However, during this operation, it is Alice, the operating room nurse, who prepares the patient to fall asleep by 'quietly guiding her into her bubble'. During this time, Martine, the 2nd OR nurse, is responsible for the technical tasks.	Individual interview	Gynecology unit
2	When Nina, a nurse anesthetist, hears the doctor say 'get ready, you're going to feel a prick', she 'widens her eyes at him' and goes on to explain to him after the procedure that she considers his words inappropriate, because they pierce the bubble she is creating.	Individual interview	Gynecology unit
3	The intervention team takes charge of a restless and very anxious patient. A general anesthesia is planned for her termination. In view of the patient's condition, the team changes the modus operandi and people adjust to each other to substitute hypnosis for the initially planned anesthesia.	Observation + group interviews	Gynecology unit
4	A patient comes in for an egg retrieval The nurse anesthetist performs a hypnosis induction. The extern surgeon is a bit clumsy in her gestures. The nurse anesthetist juggles to find the right balance between anesthetics and words to keep the patient in her bubble, and thus limit any pain.	Observation + group interviews	Gynecology unit
5	A patient comes in for a termination. She shows a fear of injections. The nurse anesthetist creates a bubble by talking to the patient about her native country, the warm and cold sea. While the patient seems to be asleep, the surgeon warns with a slight eye signal that the patient is not in fact sleeping. The nurse juggles medication and words to give the minimum dose while taking into account the patient's fear.	Observation + group interviews	Gynecology unit
6	A patient arrives in tears for a termination. The nurse anesthetist talks to the patient about her tattoos, then about music. She searches her phone for music the patient likes and asks the surgeon if she can play it for her, and dims the lights. Meanwhile, the rest of the team communicates by signaling to adjust how the operation is carried out.	Observation + group interviews	Gynecology unit
7	The anesthetist and an intern are dealing with a termination. During the procedure, the intern talks to the patient to induce her to fall asleep; the anesthetist light-heartedly rebukes the intern about the misuse of the word 'little', which she considers a 'bad habit'. She shares her experience by telling her that when patients complain, it is important to talk to them before considering painkillers.	Observation + group interviews	Gynecology unit
8	Surgeons not trained in hypnosis intervene for a complicated medical procedure. They talk during the procedure, which wakes up the patient and breaks the bubble that the nurse had created. The anesthetist is called in to help because of technical procedures, but this is in vain - the operation will have to be rescheduled for the next day.	Observation + group interviews	Gynecology unit
9	At the end of an operation that apparently went well, the OR nurses and an anesthetist discuss their collective practice of hypnosis. They share the obstacles they encountered in creating the bubble in order to improve their collective practice.	Observation + group interview	Gynecology unit
10	During a mastectomy procedure under formal hypnosis, we find that the team has made a hole in the surgical drape that separates the patient's upper and lower body. This hole allows the team to communicate silently without breaking the bubble.	Observation + group interview	Gynecology unit
11	After an operation where he participated in a formal group hypnosis, surgeon David explains that he has to act as if he's 'autistic' and follow the rhythm, duration and silence required for hypnosis.	Interview	Gynecology unit
12	Jean transports an anxious and withdrawn child. He successfully manages this anxiety by talking to him about his favorite games and invites him to 'join' his heroes. The radio operator who greets the child on arrival at the hospital recognizes the practice and continues the 'journey'. The father is very pleased.	Group interview	Ambulance
13	While Remi is driving a patient to a hospital ward, the caregiver on their arrival is focused on an administrative task that prevents her from realizing the patient's state of panic as he wonders where Rémi has gone. Rémi, who has been trained in hypnosis, tries to deal with the patient's distress alone by giving meaning to the chaos of the situation.	Group interview	Ambulance
14	Fabien and Nicolas together transport a patient in great physical suffering. Nicolas' jokes annoy the patient, who tells him as much. Fabien, feeling uncomfortable, asks his colleague to be quiet, but notes with frustration that it is too late to calm the patient.	Group interview	Ambulance

Appendice (Continues): List of situations

#	Summary	Type of situation	Unit
15	Gabriel transfers a patient with hip pain. He manages to alleviate his pain by making sure he substitutes newly learned words for his old ones that he now feels are more appropriate.	Individual interview	Ambulance
16	Celia is used to transporting 4-year-old Mary, who is often very withdrawn and clings to her father. During one of the journeys, Celia notices that it is actually the father's anxiety that she must 'focus on'. She then looks for the right words to soothe the father.	Group interview	Ambulance
17	Aïda, an assistant nurse trained in hypnosis, hears a colleague in a corridor telling a patient that the bed is not ready. Aïda later suggests other, more positive ways of speaking, so that the 'patient feels that they're expecting her' and that her needs are respected. She says that she herself is regularly picked up on issues by another nurse.	Individual interview	DSU
18	A caregiver should have had a therapeutic conversation with a patient in his room, which she cannot do because she's not available. Later on, she is stunned when she asks the patient, 'How are you?', but the patient stays silent and prostrate. She says during the interview that she did not know how to use the right words.	Observation + interview	DSU
19	A nurse, Hélène, tells her colleague at the reception desk that she did not use the right words to deal with a patient who arrived in the middle of the day and was put in an extra bed.	Individual interview	DSU
20	Milena, a hospital service agent, is preparing a room with one of her colleagues who tells her that 'the elderly are difficult'. She rebukes her, because she has had training in therapeutic communication and therefore feels aware of the issues and in the right.	Individual interview	DSU
21	A nurse leaves for an intervention with a doctor. Having just failed to insert a catheter, the doctor asks her to perform therapeutic conversation. Uncomfortable, but not wanting to say no to the doctor, the nurse performs with difficulty, unconvinced of the effectiveness of her communication. Later, the paramedic who accompanied them tells the nurse that she had also not dared to go against the doctor's request in a similar situation	Observation of an experience feedback meeting	EMS
22	An ambulance driver explains how, on a call-out, she adjusted her gestures, words, and spatial positioning to the nurse in order to practice therapeutic communication alongside the nurse's technical actions. This discursive interaction is not part of the classical role of an ambulance driver.	Observation of an experience feedback meeting	EMS
23	In a doctor's office, when a nurse has to give an injection to a patient who is very anxious, the ambulance driver explains how she started talking about football while her colleague was putting in a catheter. This was a departure from the classic role of the paramedic.	Observation of an experience feedback meeting	EMS
24	When the EMS ambulance arrived, a radiologist realized that the paramedic had practiced hypnosis. As he was also trained in hypnosis, he continues it with the patient.	Observation of an experience feedback meeting	EMS
25	A newly trained paramedic arrives at the scene of a car accident and asks the doctor if she can practice hypnosis. As she lays next to the victim and whispers in his ear, she realizes that the biggest barrier was her own shame in speaking in front of a crowd of people, including firefighters, police officers, etc. Later, the positive feedback from these onlookers encourages her.	Observation of an experience feedback meeting	EMS
26	A paramedic starts to talk to an accident victim to create a bubble; she is interrupted by a young doctor who does not want to lose contact with the accident victim and talks to him too. For the paramedic, the discontinuity of her speech undermines the effectiveness of her care.	Observation of an experience feedback meeting	EMS
27	During an intervention, a doctor tells the patient 'we are going to give you an analgesic that will make you anxious'. At the end of the intervention, the nurse and the ambulance driver take him aside and tell him 'we don't say that'.	Observation of an experience feedback meeting	EMS
28	A doctor intervenes in a psychogenic crisis of a young person who has lost contact with his entourage. The doctor talks to him, and the young man wakes up - the firemen look at the doctor speechless, admiring his work.	Observation of an experience feedback meeting	EMS
29	A nurse performs hypnosis while inserting a catheter on a young teenager who has fallen off his bike. The doctor postponed an abdominal ultrasound for a few minutes to let her work.	Observation of an experience feedback meeting	EMS