“Pain talk” in hospice and palliative care team meetings: An ethnography

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Abstract

Background: Specialist palliative care nurses have considerable expertise in pain management and this expertise can contribute to tension in the boundary between specialist nurses and non specialist doctors.

Objectives: This article reports on how specialist palliative care nurses contribute to team talk about pain and the rhetorical strategies they use to develop their reputation and credibility in pain management

Design and settings: This is an ethnographic study involving the collection of naturally occurring data from eight palliative care team meetings. The study is concerned with team meetings in

hospice, community and hospital palliative care settings.

Methods: Data was collected by audio recording eight team meetings in hospice, hospital and community palliative care settings. The data were analysed using a grounded theory approach followed by application of the tools of discourse and conversation analysis.

Results: The findings indicate that specialist palliative care nurses use rhetorical strategies such as contrastive rhetoric, telling atrocity stories, veiled criticism and neutralism as a platform for building a reputation in managing pain. Furthermore they situate their expertise in pain management by direct contrast with problems related to non-specialist practice in pain management.

Conclusions: The team meetings are a safe place, a collegial setting for specialist nurses to challenge non-specialist medical practice and to manage the specialist/non-specialist boundary. The findings have implications for further research related to the specialist nurse/ non-specialist doctor boundary and for education of specialist nurses and GPs.

Keywords: Boundaries, community, pain, reputation, specialist palliative care

What is already known about the topic?

- Pain management is an area of tension in the negotiation of the nurse doctor boundary
- Specialist nurses are concerned with their credibility in relation to managing patients' pain but they are also concerned with maintaining professional relationships with medical staff.

What this paper adds

- Professional knowledge and credibility in pain management enables specialist nurses to develop their specialist identity and to challenge the boundary between them and non-specialist doctors in team meetings
- Specialist nurses use rhetorical devices such as telling atrocity stories, keeping a neutral positioning and veiled criticism to develop their reputation and to manage tensions with non-specialist medical staff

1. Introduction

This article reports on a study of palliative care team meetings with a focus firstly, on how the palliative care team talk about pain and, secondly, how such talk constructs professional knowledge and makes visible professional boundaries. The research literature identifies conflict between and across specialist and non- pain specialist services in palliative care (Seymour et al 2002; Street and Blackford 2001; Katz et al., 1999). Areas of conflict concern professional 'know how', in pain and symptom management and the credibility and expertise of individual practitioners (Arber 2004; Li and Arber 2006). The study reported on in this article enables insight in to how professionals construct knowledge about patients' symptoms; how disciplinary specific specialist knowledge and expertise is brought in to everyday talk and what this means for teamwork. This study adds to previous work conducted in relation to professional discourse and knowledge making in a variety of team settings (White 2002, Griffiths and Hughes 1994, Prior 1989, Atkinson 1995, Anspach 1988). First I explore how teamwork is positioned as a central component of specialist palliative care. Then I present data which explores boundary issues in specialist and non-specialist palliative care practice related to expertise in pain management. I conclude by discussing what the findings mean for the boundary between specialist nurses and non-specialist medical staff and I make recommendations for further research and education across professional boundaries, in particular the education of specialist nurses and GPs

2. Literature review

2.1. *Teamwork in palliative care*

Teamwork is a key principle informing much of the discourse related to palliative care. For example such teamwork proposes an interdisciplinary approach to mutual support, sharing expertise and providing patient-centred care and decision making (NCHSPCS 1995; Ajemian 1993; Vachon 1987). Teamwork according to Clark and Seymour (1999) is the model of interdisciplinary working effective in palliative care. However there are variations in team composition and referral patterns across different services in England and research suggests that context affects the performance of teamwork (Clark et al., 2002; Skillbeck et al., 2002; Opie 1997). There is little critique of the development of such teams in palliative care and the context in which such teams develop (Wittenberg-Lyles, 2005; Cox and James 2004).

In an ethnographic study of interdisciplinary team meetings conducted in a hospice setting Wittenberg-Lyles (2005, p.1383) reports how case managers shared information and told stories about 'poor care', such as when a newly admitted nursing home patient was not 'safe as the level of care was not adequate or appropriate for his condition'. Li and Arber (2006) also found that staff tell each other 'atrocious stories' in team meetings about the poor care they observed in care homes. An atrocity story is an account, a story which explains the social world of the person telling the story. Such talk, is a marker of 'social friction' but also confirms the integrity of the teller (Webb and Stimpson, 1976; Dingwall, 1977). Thus

telling atrocity stories serves to emphasise the difference between one group and another and one profession and another. Such stories are a device to resolve conflict and to do boundary work by enabling social groups to work together and to voice their complaints at a distance (Dingwall 1977). Using an ethnographic approach, Li and Arber (2006) report how nurses maintain their own integrity and that of their patients by talk which elaborates the nurses' qualities of patience and caring in the face of difficult and demanding behaviour from the patient. Thus, stories about troubled patients can be used to display the caring qualities of nurses and to resolve tensions in a supportive team context.

Tensions have been identified between specialist palliative care medical and nursing staff around the medical and nursing boundary (Seymour et al., 2002). However Seymour et al. (2002, p.392) also found how a hospital palliative care team had good collaborative relationships over a period of 12 years and their working practices 'were highly conducive to shared medical and nursing care'. What these working practices consists of is not elaborated. One conclusion that may be drawn from this type of research is that contextual factors may influence collaborative working and this is an area that requires further research. In a study reported by Allen (1997) it was found that although staff may recount instances of contested boundaries in self-report data, she observed that medical, nursing and support staff carried out their work activities with little explicit conflict. Svensson (1996) also observed that negotiations between doctors and nurses are often about the ability to argue on the basis of assessment of patient need and the ability to create alliances. This work points to how strategies of negotiation are important in managing flexible boundaries between patients, nurses, doctors and other health care professionals but also underlying this is the knowledge base and 'know how' of the professional. Next I turn to issues of expertise and professional knowledge in pain management across specialist and non-specialist medical practice.

2.2. Situating specialist palliative care nurse expertise

In relation to professional expertise and knowledge of pain management specialist nurses have been found to have specific skills and knowledge equivalent to that of medical staff. For example Sloan et al (1999) studied 27 hospice nurses using an actor patient with severe pain caused by unresectable terminal rectal cancer. The researchers' found that hospice nurses completed items related to pain intensity, pain location and relieving factors very well and did well in relation to analgesic recommendations. They conclude that hospice nurses' performance in both cancer pain assessment and management recommendations exceeded that of resident house staff and family physicians (Sloan et al., 1997). The researchers therefore make the comparison between hospice nurses' skills in pain assessment and management and those of less specialist medical staff. In a study by Hunt (1989) where she audio-recorded naturally occurring data concerning two of the weekly inter-disciplinary meetings attended by specialist palliative care nurses, doctors and social worker; she found that nurses were quite open about indicating that they have more technical, specialist knowledge on drug prescribing than some doctors. There was some criticism of other services and this mainly concerned the prescribing habits of General Practitioners (GPs). In a study using participant observation in a hospice setting Wright (1981) discusses how nurses made decisions about medication, dosage and control of pain, and often doctors were consulted after a decision about medication had been made.

Managing the patients' distressing symptoms with medication constituted a major satisfaction and reward of the community palliative care nurse's job according to Hunt (1989). Similarly in studies using self-report data nurses highlight the importance of clinical credibility (Willard 2004) and expertise in symptom relief and communication (Seymour et al., 2002; Street and Blackford, 2001). I next turn to a theory of reputation which informs this article.

3. Theoretical Approach

3.1 A theory of reputation

A theory of reputation was developed by Wilson (1973) during anthropological fieldwork carried out on the island of Providencia in the Caribbean. Wilson argues that within Providencian society there is a dialectic between the two opposed principles of respectability and reputation. Wilson proposes that reputation is an indigenous counter-culture based on equality and personal worth in contrast to respectability which is based on one's social and economic position. Wilson views reputation as a solution to the scarcity of respectability within indigenous Providencian society. To Kanter (1989) the key variable of success in the professional career is reputation. She continues:

'Upward mobility in the professional career rests on the reputation for greater skill'. (Kanter, 1989, p.310).

Kanter describes success in employment as developing from the accumulation of human capital in the form of skills and reputation. Thus the professional career structure is defined by craft or skill with the possession of valued knowledge the determinant of occupational status and reputation the key resource for the individual. One way then of establishing one's reputation is skilful performance demonstrated to one's peer group in a collegial context such as team meetings. In a study of specialist cancer nurses (SCNs) Willard (2004, p.184) found that such nurses were concerned with building relationships with medical staff and presenting their expertise by developing 'medical language' and by learning to 'be more concise in your description of events and in your interpretation of facts'. This suggests a strategy of SCNs differentiating themselves by developing rhetorical skills more aligned with medicine. Atkinson (1995) describes how he came to think of medical work in terms of rhetorical skills and narrative performance. According to Griffiths and Hughes (1994) the 'natural rhetorics' evident in team talk aim to persuade and to justify the 'rightness' of a course of action using everyday talk that is generally tacit and taken-for-granted. Atkinson discusses the importance of analysing talk-in-action to build an understanding of collegial talk in the development of medical knowledge. He continues:

An understanding of collegial talk in medical settings, therefore, must include a careful mapping of these contrasting voices and orientations. This is not just a matter of the formal description of the pragmatics of medical discourse. It is fundamental to a micro-sociology of medical knowledge. It bears directly on issues of authority and expertise, and no less fundamentally - on the micro-politics of medical work. (Atkinson, 1995, p.131)

Thus the collection of talk in the meetings of the palliative care team enables the voices and concerns of speakers to be mapped and to illuminate what this talk consists of. It enables insight in to how specialist palliative care nurses position themselves in relation to issues of authority and expertise in dealing with difficult and complex pain problem reported in the meetings. Thus, the theoretical interest of this study is concerned with how expertise and authority is displayed in talk and how speakers develop a reputation for themselves and for the team through talk about difficult pain problems (Arber 2004).

4. Research Design

The study is framed within the naturalistic paradigm of an ethnographic study. Ethnographies are based on observational work in particular settings (Silverman, 2000). This approach was chosen because it gives priority to in- situ observations of activities and it is concerned with grounding the phenomena of interest in the observed field (Baszanger and Dodier, 2004). The strength of ethnographic research is that areas within health care only take on meaning or become categories by virtue of particular contexts and settings. Thus it is not possible to talk generically about teamwork and professional boundaries as different contexts affect these activities. More precisely I place the study as ethnography of institutional discourse (Miller, 1994). This type of ethnography focuses on the way in which everyday life is organised through language use. It involves focusing on the discursive practices used within a social setting and how discursive practices are used to meet practical goals (Miller and Fox, 2004). Thus, according to Miller and Fox settings provide members with the discursive resources to construct a social reality. The observed social reality, tells us about teamwork and how expertise, conflict, credibility and reputation is displayed in team talk about pain.

Theoretical sampling was used to identify sites for observation. In the exploratory phase of the study visits and observations were carried out in hospital palliative care and hospice settings (Figure 1). In phase 1 of the research the focus was on shadowing palliative care staff in hospital and community palliative care settings, attending and audio-recording team meetings in both these settings. This is when it was noted that talk about pain was a significant feature of team talk. In phase 11 of the study the focus was broadened to include shadowing of hospice staff and specialist community palliative care staff, and audio-recording team meetings in these settings. My approach is comparative as I have collected data in three settings. Ethical approval for the study was granted by the local ethics committee. Consent was negotiated on each occasion in relation to audio-recording team meetings.

5. Methods

In this study ethnographic fieldwork was conducted in palliative care team meetings across hospice, community and hospital palliative care teams in the South of England. I kept a field diary recording my observations and interactions with staff. I audio-recorded eight palliative care team meetings. This consisted of four community palliative care meetings in two locations, two hospital palliative care team meetings and two hospice team meetings. The meetings occurred regularly on each site and lasted between one to one and half-hours. In total 54 members of staff were observed attending the meetings. The staff attending the

meetings consisted of consultant medical staff, specialist registrars, hospice, community and hospital palliative care nurses, chaplains and social workers. Observations of practitioners during visits to patients' homes and observations of ward rounds in the hospice were also part of the fieldwork (Arber, 2006), but these observations were supplementary to the main focus of the research, which was the observation and audio-recording of the PCT meetings.

This study is influenced by the grounded theory approach advocated by Glaser and Strauss (1967). This means that theories are grounded in and generated from naturally occurring data collected from a natural environment. The constant comparative method is used, consisting of the analysis of data collected in one setting and comparing it to the data collected in the other settings. This method was used to test the reliability of a single phenomenon generated from one setting to see whether it is supported in the other settings (Hammersley & Atkinson, 1983). Constant comparison helps to enhance contextual sensitivity (Silverman, 1997). It also enables the identification of persistent patterns in talk for example to reveal differences and similarities in talk about pain and how this was directed at the medical and specialist nursing boundary. This was followed by a microanalysis of talk by breaking the data down using the analytic tools of discourse and applied conversation analysis. These techniques enabled further insight into how expertise, competence, and professional boundaries are accomplished in team talk (ten Have, 1999; Hutchby and Wooffitt, 1998; Coffey and Atkinson, 1996; Drew and Heritage, 1992; Sacks, 1984). The data presented identifies:

- 1) typical features concerning tension across professional boundaries;
- 2) the strategies used by staff to construct their competence and expertise when talking about patients' pain.

6. Findings

6.1 Practice with patients in care homes

In the following data extracts a number of problems are highlighted about palliative care in care homes. One of the issues identified by specialist nursing and medical staff is the lack of knowledge and ability in pain and symptom management within care homes. The community palliative care nurse (CPCN) in extract a) is highlighting a problem related to patient assessment:

(a) Well *I rang* the nursing home and *they said* no his speech was *no better* but it was a bank nurse on there but when *I went* in there he was *much better* with his 60 MST rather than his 90. (CPCN 1)

A direct contrast is made between the bank nurse's assessment of 'no better' and the CPCN's assessment of 'much better'. The CPCN uses 'they' which avoids naming an individual or individuals and this works to mitigate direct criticism of care home staff. I have found that although specialist nurses highlight problems related to assessment and prescribing for pain by non-specialist practitioners they do use a degree of caution when attributing blame for the situation. Thus the CPCN makes visible her expertise in marked contrast to the bank

nurse by use of the authoritative 'I'. 'I rang', 'I went' in contrast to what 'they said'. The CPCN following her visit concludes the patient is much better on 'his 60 MST rather than his 90'. The contrast identified between what 'I' did and 'they' said emphasises the specialist and non-specialist component of practice. The 'I' voice according to Silverman (1987 p.57) is authoritative because it is able to 'formulate proper action'. In this situation the CPCN identifies her expertise in the assessment and pharmacological management of pain in contrast to 'they' the generalist (non-specialist) care home staff, who are not able to accurately assess the patient's response to analgesic medication.

In extract (b) there is reported an inability of care home staff to act appropriately in relation to a patient's pain reported by a patient's daughter:

(b) she {*patient's daughter*} couldn't get the nursing home to do anything constructive about the pain. (CPCN 2)

The CPCN is being cautious by attributing the criticism of the nursing home to 'she' the patient's daughter. Thus, the CPCN avoids direct criticism of care home staff by presenting the daughter's difficulty in getting the nursing home staff to do anything about the pain. Thus, the CPCN avoids giving her own opinion on the difficulties in the care home. It is reported that speakers may use 'interactional caution' to minimise interpersonal disagreement while maximising agreement in contexts such as family mediation (Greatbach and Dingwall, 1999). Thus accounts of emotional problems may be reported in a factual manner with the avoidance of blame for the situation. By not giving an opinion on the events in the nursing home, by reporting the daughter's experience enables the CPCN keep a neutral position in relation to what she is reporting as she does not give her own opinion on these events she reports what others have said.

Later on in the CPCNs' report the daughter's conversation with the GP is reported:

(c) And the daughter rang the nursing home this morning to see if the GP would come out today, and *apparently it is Doctor J* and he was doing admin today and, *according to the daughter, he wasn't keen to come out.* (CPCN 2)

In this talk the GP is presented as reluctant to visit as he is busy with administrative matters. This talk suggests that visiting patients in care homes may not be a priority for busy GPs and this is a gap in service provision being filled by community palliative care nurses. Again the CPCN is using a strategy of reporting what the daughter has said and she uses the daughters active voice, 'he wasn't keen to come out'. By using the daughter's voice she avoids criticising the GP herself. In a study of morning rounds in a paediatric intensive care unit Prince et al (1982) found that medical staff used 'attribution shields' such as 'according to' and 'apparently' and Prince et al say that these shields work to indicate that knowledge and beliefs have been derived from the report of others and in using an attribution shield nothing is explicitly stated about the speaker's own view of what is being reported. Thus CPCN 2 uses 'apparently' and 'according to' to position herself as an observer and reporter of the situation described to her by the patients' daughter.

In contrast to the careful and cautious talk by the CPCNs the palliative care consultant in the next extract of talk is more direct in his criticisms of a GP. The patient discussed is being cared for in a cottage hospital under her GP:

1	CPCN 3	The next patient Susan is still in (). You
2	HPCN 4	remember her.
3	CPCN 3	She still in ()?
4		She is still in there and there is no plan for
5		her to
6		go home. The thing about her she is
7		becoming a lot more drowsy and lethargic, not
8		having any pain but she is having a lot of
9	CPM 1	Oramorph. She is having 10 mg four times a
10	CPCN 3	day. Not in particular in any pain.
11	CPM 1	Yeah, but who is giving it to her?
12	CPCN 3	The ward, which I think might
13	CPM 1	But who prescribed it?
14	CPCN 3	One of the doctors going in just getting
15	CPM 1	Who is?
16	CPCN 3	Well, she sees various GP's. Dr J was the
17		last one who went in and upped it. But she
18		did
19		go home for the weekend. I spoke to her
20		daughter before she went, and over the weekend
21		the daughter didn't give her any and she
22		wasn't
23		in any pain at all, and she did wake up. So
24		I'm
25		going to see her today and then talk to her
26		again
27		about that. I think she is genuinely going
28		down
29		hill, but I don't think it's helping, because
30		she is
31		sleeping all the time.
32	CPM 1	Mm. Speak to the nurses by all means but you
33		need to talk to whichever GP it is who keeps
34		on

Extract (d) CPCN= Community Palliative Care Nurse, HPCN=Hospital Palliative Care Nurse, CPM=Consultant in Palliative Medicine

In data extract (d) CPCN 3 is being cautious and using veiled criticism in contrast to the consultant. The CPCN says, 'she is having a lot of Oramorph' (line 6/7) and 'I don't think it's helping, because she is sleeping all the time' (line 23/24). However the consultant is keen to know the identity of the GP who has prescribed the medicine 'Yeah, but who is giving it to her?' (line 9), 'But who prescribed it ? (line 11) and 'Who is?' (line 14). The nurse appears to be more discrete in her approach. She seems to want to protect the identity of the GP by being reluctant to name him or her. However eventually she names the doctor responsible for the prescription (line 15). This talk suggests the sensitive boundary that exists between the CPCN and the GP. One of the ways that the CPCN seems to get around the boundary problem with the GP is by speaking with the patient's daughter (line 17/18) and the result was 'the daughter didn't give her any' (line 19).

This talk suggests that the expertise held by specialists in palliative care is more important to the palliative care consultant than individual professional status such as being a GP as the

nurse is being urged to 'talk to whichever GP' (line 26). However, although the boundary is being blurred in the team talk in relation to who has and has not got expertise in managing pain this cannot be extrapolated to the context of practice between the GP and CPCN. In this context the CPCN has got around the problem by speaking with the patient's daughter and this may indicate an avoidance of the issue with the GP as this is sensitive territory in the CPCN/GP relationship. The nurse may not want to challenge the boundary and disturb relationships with the GP. This concern with maintaining relationships and acceptance with medical staff was also found in Willard's (2004) study.

Next I examine the boundary between the CPCN and GP in relation to reports of patients who are visited in their homes.

6.2 Specialist practice with patients in the community

In the data extract (e) the CPCN does not understand the GPs' rationale for analgesic therapy:

(e) He's on Sevredol 50 four hourly, *which he says doesn't really work that quickly for him* and so he also, the GP was giving him Oramorph as well, which he takes with a sweet (laughs). *I couldn't make head nor tail of that one* and then wondered why Doctor M hadn't changed him over to a slow release one. (CPCN 2)

In extract (e) the CPCN does not understand the rationale for the GPs prescription, 'I couldn't make head nor tail of that one'. The CPCN also animates the patient's voice, 'which he says "doesn't really work that quickly for him"'. So patient reports of effectiveness can be used to support criticisms of a prescription, which is also a feature in extract (f).

In extract (f) the CPCN is critical of a GP who is continuously treating a patient for pain even though she is not improving.

(f) She presented in Jan, January 2000 with pains in her legs, to her GP, and she was treated for arthritis. Ahm continuously, going back and saying *'I've got all this pain'* and she was continuously being treated. (CPCN 4)

The CPCN is using a degree of caution by activating the patient's words: 'I've got this pain' and avoids giving an opinion on this situation. However, the veiled criticism can be found in 'she was continuously being treated'. In effect this patient was treated for arthritis over a period of months and was eventually diagnosed with a recurrence of breast cancer.

Other difficulties reported by the CPCN concern the length of time to get the GP to act (extract g) despite speaking with the GP in the past.

(g) Doctor R is her GP and he has dragged his heels over this lady and I have known him to do that. I've spoken to him about other people and he takes a long time to do anything. (CPCN 4)

GPs may also be reluctant to visit and not supportive:

(h) He doesn't come and see her? (Hospice Registrar 1)

(i) *He's not*, he'll do the prescriptions but *he's not he hasn't* seen her for a long time and *he's not* particularly somebody that will be that supportive even if I asked him to visit. (CPCN 4)

The result of this talk is the construction of a busy GP who does not have time to visit and the lack of support that the GP provides. However, the GP in extract (i) does do the prescriptions presumably on advice from the CPCN. This talk positions GPs as lacking in expertise of symptom management and knowledge of the patient in direct contrast to that displayed and performed by PCT members. I suggest that the tensions identified in relation to some GPs draws attention to the problems GPs have in providing services within care homes and in the community. Perhaps this is not surprising as there is evidence that GPs have concerns about using opioids to manage pain and they have been found to lack knowledge, skills or interest in how to meet the palliative care needs of residents in care homes (Katz, 2003; Seymour and Hanson, 2001). Furthermore they visit terminally ill patients less often than in the past and they attend far fewer deaths than hospital doctors for example (Seale and Cartwright, 1994; Seale, 2006). Although specialist nurses may be filling a gap in service provision their contribution to palliative care in care homes has been described as generally reactive (Froggatt, 2001). However, the data suggests that specialist palliative care services are being negotiated by care home staff and by patients' relatives so the input of specialist palliative care in such settings may be underreported.

One of the strategies used in the talk is contrastive rhetoric which enables the identification of specialist and non-specialist practice and insider/outsider identities constructed. According to Hargreaves (1981, p.309) contrastive rhetoric constructs the boundaries between 'normal and acceptable practice'. Thus, the palliative care teams develop their unique occupational identity rhetorically. They use terms such as 'he's not', 'he hasn't', 'he doesn't' and 'he has dragged his heels', in contrast to what 'I' did, such as 'I rang', 'I went', 'I spoke', 'I don't think'. Thus use of contrastive rhetoric sets up the 'ongoing drama' that provides a platform for criticism resulting in group solidarity and the formation of a unique identity as a palliative care team (Erikson, 1964). This talk then reaffirms the specific expertise of specialist palliative care professionals. It works to describe the standards of practice essential to specialist palliative care that may be difficult for non-specialist practitioners to develop as they lack the time and 'know how' that such teams have collaboratively developed. Thus, GPs are positioned as 'outsiders' within the context of the palliative care team meetings. Their position as outsiders may be because in all the meetings it is specialist nurses that present the patients. Therefore these nurses have a great deal of authority in how patients and interactions with non-specialist staff are presented. The problem for these nurses is in establishing their authority, credibility and expertise with some GPs. The specialist nurse and GP boundary is a sensitive space. This space contains a threat to the specialist reputation of the palliative care team and that is why these matters are taken very seriously, and verbal strategies utilised to construct specialist and non-specialist expertise in the insider space of team meetings.

7. Discussion

A number of researchers have commented on how nurses in formal and informal gatherings reassure each other by telling stories about what they perceive as the failure of mainstream medicine to deal with the needs of dying people (McNamara, 2001; Seale, 1989; James 1986). In this study specialist palliative care nurses use strategies such as telling atrocity stories, using contrasting devices, contrastive rhetoric and veiled criticisms, which enable them to construct their credibility and reputation as experts in managing difficult symptoms. This talk also constructs a challenge to the specialist nurse and non-specialist doctor boundary. However there is evidence that specialist nurses also protect their relationships with GPs by being reluctant to name the GP (extract d) and by use of humour 'couldn't make head nor tail of that one' (extract e) and keeping neutral in their reports by use of attribution shields (extract c). They use the patients/relatives 'active voice' so they remain factual and neutral in relation to what they report. This may enable them to maintain relationships with GPs and care home staff and manage complex interprofessional relations by avoiding direct criticism and blame. In contrast to the cautious talk of the nurses the palliative care consultant in extract (d) is more explicit in his criticism of a GP and this may indicate the consultants concern with pain management rather than relationships in this instance.

A number of studies over the past twenty years identify pain management as an area for interprofessional boundary disputes leading to feelings of resentment among nurses (Seale and Cartwright, 1994; Lunt and Yardley, 1986; Sims 1984). The tension that exists in the boundary between the community palliative care nurses and GPs is evident throughout my data set. In an analysis of conflict over the division of labour in the home Beck and Beck-Gernsheim (2002) suggest that the reason for conflict occurs at two levels. One concerns the content of mundane activities such as chores in the home and the other dimension concerns the deeper dimension, which is how the division of tasks is bound up with self-image. Therefore, Beck and Beck-Gernsheim argue, that when we talk about the division of labour we are not just talking about work but also about the preservation of identity. This connection can be extrapolated to the palliative care context, where specialist nurses are developing an identity as practitioners with specific expertise in symptom management that some non-specialist medical practitioners do not have. This type of claim is causing the boundary between specialist nurses and GPs to become more fragile (Beck and Beck-Gernsheim 2002). The fragility around the boundary becomes evident in talk about competence and expertise in pain management. Such expertise development is disturbing the professional equilibrium between specialist nurses and GPs. Svensson (1996) says that boundaries are a social construction in nurses' and doctors' talk. Thus talk in the team shapes and produces the expertise of palliative care and positions the specialist nurses as practitioners with differentiated skills that enable them to 'talk up' and sustain reputation in the medical space of team meetings. The concept of reputation enables one to understand how reputation is linked with expertise and skill. It is a co-production in a team setting within a specialist palliative care context that breaks down the boundaries between specialist palliative professionals, as they share their expertise in the team meeting and represent the knowledge base of their discipline rhetorically.

Specialist nurses position themselves as having more expertise in pharmacological management of pain than some GPs. This can be interpreted as a usurpationary tactic utilised by specialist community nurses in relation to GPs (Witz, 1992). Thus, specialist

nurses can develop their unique identity and expertise in pharmacological therapy for pain by defining their expertise in contrast to those without this expertise the GPs. Thus talk-in-action involving criticism is an usurpationary tactic utilised by specialist nurses in relation to GPs. Parkin (1979) says that usurpationary actions aim to bite into the resources and benefits accruing to dominant groups ranging from marginal redistribution to complete expropriation. Witz (1992) defines a strategy of 'inclusionary usurpation', which she describes is a means by which women challenge a male monopoly over competence. She says it is an inclusionary strategy because the goal is to be included in structural positions rather than excluded. It has been found that hospice nurses use usurpationary strategies to increase their autonomy in relation to the application of complementary therapies (CTs) (Garnett, 2000, p.173). The basis of the usurpationary strategy reported in Garnett's study is the 'specialist knowledge and skills to carry out CTs and to gain autonomy in their use'. Thus specialist palliative care and hospice nurses may be achieving credibility by a range of medical and psychosocial strategies. These strategies share a common goal of increasing nurses' autonomy and influence in decision making (Arber, 2004; Garnett, 2000; Witz, 1992). Thus specialist community palliative care nurses seek more autonomy in the medical space, through expert knowledge of pharmacological approaches to symptom management, while hospice nurses seek to increase autonomy in the psychosocial space through the use of CTs, both strategies are concerned with increasing nurses' autonomy.

Team meetings are a 'hybrid' space, a discursive and decision making space where expertise and competence is socially constructed around complex pain and symptom problems. In a focus group study, which examined professional boundary issues with medical staff from palliative care, cardiology, general medicine as well as primary care the importance of proven expertise and being able to be clinically effective and credible was most important in the discussions of medical staff (Hibbert et al., 2003). The team meeting is one of the settings where one's expertise and credibility is constructed around difficult pain problems. It is a safe space where problems related to non-specialist practice can be talked about and threats to one's reputation can be managed in a supportive team context. It enables the boundaries of palliative care to be explicitly defined around expertise in the management of pain and symptoms as the specialist component of such work and this supports the work of Hibbert et al (2003).

A limitation of my study is that I have studied two settings both located in the South of England. Therefore the size of my sample and the location of the study are a limitation. These factors limit the generalisability of my findings.

8. Conclusion

Team meetings are an interesting space to explore professional boundaries as they are an 'insider' space where stereotypical positions are challenged and new identities framed. A key construct then in the new identity is the concept of reputation. Reputation in the medical space of the team meeting is dependent upon expertise and competency in managing difficult, complex symptoms. The concept of reputation enables a new lens on the interprofessional space of the team meeting. The rhetorical skills involved in negotiating the specialist nurse/non-specialist practitioner boundary include avoidance of direct criticism by using veiled criticism, taking a neutral position, contrastive rhetoric and telling

atrocities stories. The outcome of these strategies is a specialist performance in relation to pain management as well as the management of relationships with GPs and other non-specialist health care staff. The rhetorical performance of specialist nurses is of interest as such talk has implications for how boundaries are negotiated, relationships managed and decisions negotiated. The team setting is a political as well as a rhetorical space and this sets up the action to question professional boundaries between specialist nurses and GPs and contributes to the fragility of professional boundaries between specialist nurses and non-specialist doctors. Attention needs to be given to the narrative performance of specialist nurses and the range of rhetorical strategies used in managing identity in the medical space as this has implications for interprofessional practice. In the future attention needs to be given to the preparation of specialist nurses in particular so that they become aware of how they present their specialist identity and negotiate and inform decisions with medical and other staff. One way forward would be to use transcripts from such meetings as a basis of discussion to heighten awareness of the strategies that facilitate effective decision making in pain management.

Team meetings are a space where professional boundaries are made and unmade and professional identities related to expertise developed in a collegial setting. An analysis of naturally occurring palliative care team talk uncovers the difficulties experienced by specialist palliative care nurses in managing patient's pain in community and care home settings. The area of tension between specialist and non-specialist practitioners requires further research. One way forward is to study naturally occurring conversations between specialist palliative care nurses, GPs and district nurses and to gather more information about the boundary issue with GPs including the GPs' perspectives. It is also important to have information on how these boundaries are negotiated in different primary care contexts. This may provide information to inform educational initiatives in relation to interprofessional work.

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Figure 1