

Team Meetings in Specialist Palliative Care: Asking Questions
as a Strategy Within Interprofessional Interaction

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In this article, I explore what happens when specialist palliative care staff meet together to discuss patients under their care. Many studies (e.g., Atkinson) have discussed how health care practitioners in various settings use rhetorical strategies when presenting cases in situations such as ward rounds and team meetings. Strategies for arguing and persuading are central to medical practice in the interprofessional context. The context of specialist palliative care is an interesting place for research, as there is a history of patient-centred holistic approaches to care, within a multidisciplinary context, that is interdisciplinary in its focus, structure, and practice (e.g. Saunders). This article examines the rhetorical accomplishment of teamwork in specialist palliative care settings.

Keywords: discourse analysis; ethnography; institutional; organizations; palliative care

Literature Review

The philosophy of specialist palliative care prioritises person-centred care, and is concerned with total care and teamwork in a non hierarchical setting (Clark, 1999; Hibbert et al., 2003). Therefore, the hospice and palliative care movement proposes a collaborative and team-based model of work (Clark & Seymour, 1999). Team meetings are a way of structuring interprofessional relationships (Hugman, 1991). In the context of specialist palliative care, team work enables a focus on medical concerns such as managing complex symptoms as well as the wider issues of comfort and total care made possible by the interprofessional approach to team meetings, involving practitioners from a variety of disciplines (Gracia, 2002). The patient-centred nature of hospice and specialist palliative care practice is reported in a number of studies, in particular, the attention to physical symptoms as well as psychosocial care (Hibbert et al., 2003). Cicely Saunders, the founder of the modern hospice movement in the UK, proposed that patient's "total pain" could be addressed by having a division of labour represented in the context of team work that addressed the many components of pain, including physical, spiritual, emotional and social aspects (Clark, 1999). Thus, the discipline of specialist palliative care and hospice care has a philosophy of practice that integrates the psychological, physical and spiritual aspects of patient care and is committed to the "total care" approach and the importance of team work (Clark & Seymour, 1999). Therefore the team is an important decision making unit when providing patient centred care that is the founding principle of specialist hospice and palliative care practice.

According to Dingwall, (1980), "team" is a device for concerting action. It is a way of co-ordinating a set of individual activities - in other words, it suggests a division of labour related to work. Dingwall concludes that teamwork is a way of resolving issues related to inclusion and exclusion and can address problems of occupational boundary maintenance. Team members may have quite different organizational or disciplinary agendas but have to align those agendas along shared tracks. Therefore, teamwork has an important place in achieving the alignment of agendas and shared outcomes (Boden, 1994). The alignment of different agendas proceeds through talk-in-action in the team meetings, and this is a complex process involving disciplinary knowledge but it is also a social process. Interaction in team meetings has a strategic objective and according to Arminen, (2005), the strategic intent of interaction can be covert, is difficult to observe and can only be inferred. However White, (2002), using an ethnographic approach to study social relations and case formulations in a child health service, was able to unpack how practitioners used complex rhetorical formulations in multidisciplinary team meetings and concludes that by studying how cases are formulated not only tells us about professional know-how but also about how judgements are made in a social context. A number of authors discuss how little attention has been given to the social organisation of everyday work and to the discourse between health care practitioners (Atkinson 1994; Opie 1997).

Many studies discuss the complexities associated with team work such as "turf battles," "jockeying for position" (Leathard, 1994), managing threats to professional status (Cohen, 2003), building reputation (Arber, 2007), representations of the patient (Crepeau, 2000), and judgements made about credibility (Smith 1978). However, in an interview study with staff caring for older people a common language suggesting collegiality was identified by Sheehan, Robertson, and Ormond (2007) in this data extract:

1. Doctor “We are not getting far with rehabilitation And
2. Physiotherapist (referring to working with an occupational therapist) “We
3. plan the session together; we were going to look at standing together so that
4. the OT could attend to [patient’s] clothing.”

Quoted in Sheehan et al., (2007,p.22)

In this talk the doctor refers to the team action related to a patient’s rehabilitation and evaluates the lack of progress so far using the team device “we” (line 1). In the next turn (line 3) the physiotherapist refers to him/herself and the occupational therapist as “we”. Sheehan et al. (2007) identifies how this team worked together in a collaborative manner through their use of language, particularly the use of “we”. The use of “we” in discourse is a marker of in-group identity according to Brown & Levinson, (1978). Furthermore, Drew & Heritage (1992) say that “we” can be heard as a collective identity and Watson (1987) agrees that it is a team device and identifies oneself as a member of a unit or organisation. According to Opie, (2000), the development of shared linguistic practice is a marker of an interprofessional team. I therefore suggest that the analysis of team talk is a key resource when studying interprofessionality.

Team meetings are a primary site for the distribution and eliciting of information about patients. Information is checked and verified as well as simply elicited before decisions are made and actions are taken. For example, Mills (2003), explores how individuals negotiate with what they assume are community-of-practice norms in the performance of a particular task. These groups of people engaged in a task have a shared repertoire of negotiable resources accumulated over time (Wenger, 1998). However, communities of practice are in a constant process of change and the interest in this article is in how teams construct their work through talk and how this enables outcomes relevant to interprofessional work. Furthermore, there is now a focus on the “new workplace” as a social institution where resources are produced, professional knowledge constituted, problems solved and decisions made incrementally and achieved interactionally (Boden, 1994; Sarangi & Roberts 1999). In the new workplace, practices such as interprofessional interaction and negotiation are centre stage, and this represents a shift from doing work to talking about it and negotiating it with others (Iedema & Scheeres, 2003). According to Iedema & Scheeres (2003), working within teams encourages reflection and reflexivity. This is because team work enables two things to happen: it enables teams to talk about how work is done as well as how identity is relevant to that work. The politics of the workplace then become centred around challenging boundaries as well as defending them, and constructing what is and should be happening (Iedema & Scheeres, 2003). Power is latent in all conversation, according to Wang (2006), and dialogue and rhetorical strategies enable participants to use their power by bringing in a element of control. Thus, in an analysis of team talk it is possible to have insight into how relations of power are constituted and shaped through communicative practices and how these practices are changing (Wenger, 1998).

How team meetings are organised through verbal and linguistic features is important for a number of reasons. First, in meetings, discourse identities are made relevant by how one organises one’s speech such as asking questions, telling stories, and so forth (Atkinson,1994). Second, the discourse of health care practitioners in team meetings has functional and social significance and

enables an understanding of interprofessional interaction and decision making at one point in time. Third, an approach using discourse analysis enables a detailed grasp of interaction and rhetorical performance and sheds light on how collegiality is constructed, and professional boundaries managed.

I have two aims for this article:

to explore the strategic use of questions when negotiating decisions within the team meetings, and

to discuss the implications for managing tensions through politeness strategies that use questions to manage professional and disciplinary boundaries.

The study

The aim of the research is to understand firstly, how palliative care teams' talk together about patients and secondly the rhetorical features of talk and what this means for interprofessional interaction, collegiality and decision making.

Design

The focus of the research is on the everyday accomplishment of team meetings within the context of specialist palliative care. Therefore this study is located broadly as an ethnography of institutional discourse (Miller, 1994). According to Miller (1994), ethnographies of institutional discourse focus on the ways in which everyday life is organised through language. To be able to focus on the language used in team meetings, naturally occurring data were collected from palliative care team meetings that were regular occurrences at each of the research sites. Although field data were also collected this is discussed elsewhere (Arber, 2006). The approach to collecting naturally occurring data from team meetings enables the researcher to forgo assumptions about what is happening so it is possible to focus on what team members are accomplishing in and through their talk (Gubrium & Holstein, 1997). This approach draws on a micro approach to the rhetorical organization of talk and enables some of the tools of discourse analysis to be applied to the data (Potter, 2004).

The research was reviewed by a research ethics committee, and consent for the study was granted. The issue of consent was reviewed on each visit to the research settings and permission to audio record team meetings was requested at each of the meetings. If any part of the meeting was thought inappropriate for audio recording by staff, the audio recorder was switched off by the researcher. This happened on one occasion only, for a period of about 4 minutes when a delicate family situation was discussed.

Participants

A purposive sample of team meetings in a hospice setting, a hospital palliative care team setting and two different community team settings were chosen. In all 8 meetings were audio recorded; two meetings from each setting. There were a variable number of people present at the team meetings. The hospice team had the most members, which consisted of a consultant, registrar,

hospice nurses, and social worker. The hospital palliative care team meeting consisted of two hospital palliative care nurses (HPCNs), a consultant and a chaplain. The community palliative care team consisted of four community palliative care nurses (CPCNs), and a consultant, and this meeting was attended by the HPCN at one site and inpatient hospice staff at the other community site. At all the meetings, it was the specialist nurses who presented patients within the meeting. Therefore, specialist nurses had a front-stage position within these meetings, and they followed a predefined method. Each patient was presented to the meeting by the specialist nurse who was assigned to the patient's care, and the symptoms of the patient were discussed and any outstanding problems and issues. Generally these meetings lasted between one to one and a half hours. I was present at all of the meetings and used an audio recorder to record the meetings. Staff quickly got used to my presence and seemed comfortable with the audio recording. I transcribed the data verbatim.

Analysis

I have drawn on an ethnographic approach which informed my data collection and analysis and then applied some of the conventions of discourse analysis to break the data down further (Drew & Heritage, 1992; Hutchby & Wooffitt, 1998; Sacks, 1992; ten Have, 1999). Therefore, my study is located in the ethnographic tradition, but by applying some of the tools of discourse analysis I am locating my study as an ethnography of institutional discourse, as according to Miller (1994), ethnographies of institutional discourse focus on the ways in which everyday life is organised through language.

I carried out a line-by-line analysis of the transcribed data, and by using the constant comparative method and deviant-case analysis I was able to test out provisional hypotheses (Silverman, 2001; Strauss & Corbin, 1998). For example, I noticed early on in my analysis that specialist community and HPCNs asked many more questions than any other practitioners in the setting of team meetings. For example, hospice nurses did not use this linguistic strategy, and it was rarely observed being used by chaplains and social workers. Although medical staff asked questions they were far fewer in number than those used by the specialist nurses in the hospital and the community. By applying the tool of discourse analysis, I was able to carry out a microanalysis of talk and gain further insights into the functional significance of talk, in particular the use of the questioning as a strategic device to achieve certain goals or actions. The use of techniques from discourse analysis enabled me to identify how interprofessional work is possible and accomplished rhetorically in the settings studied.

Findings

Strategic use of questions

The overarching theme identified in the data is the strategic use of questions to manage the boundary between one discipline and another. Questions can be used to do a number of things, such as setting the agenda of what is to be talked about, asserting propositions, making requests and imposing conditions that are designed to prefer particular responses (Heritage, 2002; Schiffrin, 1987). In this sense questions can be strategic as they reference a preferred outcome but might also be designed to be diplomatic and polite.

In data extract (a), the HPCN, when speaking to the district nurse (DN) checks the status of the patient's pain:

(a) I just wanted to check with you was she still getting a fair bit of pain? (HPCN1)

The HPCN's question is hedged by use of "just" and "fair bit". Hedging refers to the use of words or phrases whose job it is to make things fuzzier (Lakoff, 1972). According to Atkinson (1995), hedges are used when there is a degree of uncertainty related to propositions or truths. Thus, hedges are used to mark areas of uncertainty as well as areas of potential agreement. The HPCN continues to ask further questions related to putting the patient on analgesic medication, Morphine Sulphate Tablets (MSTs):

(b) Well I just wondered Andrea whether it would be worth trying her on MST 10 milligrams bd? (HPCN1)

In data extract (b), the DN Andrea is addressed in a friendly and polite manner by the HPCN using the DN's first name, and the question is hedged: "I just wondered". Atkinson (1999) says that the use of hedges is part of the rhetoric of case presentation and it encodes the division of labour. The use of the questioning strategy enables attention to politeness and diplomacy, demonstrating a cautious tactic when one is speaking to members of other disciplines and professions about assessing and managing pain.

When speaking to the palliative care consultant in data extract (c) the HPCN asks a question about the patient's pain:

(c) I'm just checking on pain whether or not he is still complaining of? (HPCN 1)

The HPCN hedges her question to the consultant when she says "I'm just checking". She also uses the performative "I" in all her questions (Watson, 1987). The use of "I" is significant because it marks the role that is played in an organisational context (Fasulo & Zucchermaglio, 2002). In relation to the questions used by the HPCN, it establishes her professional identity related to the patient's experience of pain and the pharmacological management of pain. However, this specialist identity is negotiated in a manner that allows the person who is being spoken to, to agree or disagree with her proposals through the use of questions. Thus, this technique enables the questioner to save face should her proposal be unacceptable. By directing the conversation, by use of questions, it enables a degree of control and power for the person in the questioning position and this is discussed next. Questions are therefore linked with power as they potentially enable the questioner to impose his or her will on the person addressed. However, questions can also be face-threatening because they limit the addressee by putting pressure on for a particular outcome (Tsui, 1994).

Another use of questions is in relation to introducing and maintaining an agenda within team talk, which is discussed next in a meeting of the hospital palliative care team:

Controlling the agenda of talk

In the data extract (d) the HPCN uses questions to control the agenda of talk to focus on pain when directing talk to the consultant in palliative medicine (CPM). However the identities of

nurse and doctor are also significant in relation to who has authority to name the type of pain experienced by the patient:

1	HPCN 1	What about pain?	
2	CPM 1	It doesn't seem too bad pain. He has only a little	
3		bit of pain. I suspect he'll get that anyway until he's	
4		stabilised a bit.	
5	HPCN 1	Mm now just going back to the pain a minute. He had	
6		some mm sort of neuropathic symptoms did he, originally?	
7	CPM 1	No, not particularly.	
8	HPCN 2	He said he had these sort of pricking,	
9	HPCN 1	Yeah.	
10	HPCN 2	down his sides.	
11	CPM 1	Yes.	
12	HPCN 2	He was taking dihydrocodeine at night.	
13	HPCN 1	The other thing I wondered was, if he is incontinent of	
		faeces is that	
14		really because he can't control it or is it that he is	
		constipated?	
15	CPM 1	It is possibly a combination of both actually. He is in	
		fact wagglng	
16		his feet around about quite a bit more than he did so that	
		Philip	
17		reckons he is getting quite a bit of recovery.	
18	HPCN 1	Right. Well that is good isn't it?	
19	CPM 1	Yeah. Whether he'll get full spincter control back I don't	
		know.	
20		He's got a catheter in hasn't he?	
21	HPCN 2	Yes	
22	HPCN 1	I'm just wondering if they are looking at his bowels	
		sufficiently,	
23		because I mean if he is constantly being faecally	
		incontinent that is	
24		just awful in a way...Perhaps we ought to check when we are	
		up	
25		whether you know, they are looking at that.	

Data extract (d) Hospital Palliative Care Team Meeting

The question-and-answer format evident in this sequence of talk is a recurrent feature of CPCN and HPCN talk in this study. Questions move forward the multiple agendas of the organisation and questioning approaches may serve a number of interactional activities, for example, requests for explanation, clarification and for actions to be taken (Boden, 1994). Question-and-answer sequences are termed “adjacency pairs”, which are coupled activities in which the first part creates an expectation of the second part (Silverman, 1997). The completed answer also enables the questioner to again take the floor (Sacks, Schegloff & Jefferson, 1974). The HPCN asks an open question “What about pain?” The CPM responds by saying, “He has only a little bit of pain” (line 2-3). In this reply, the consultant seems to be ameliorating the pain by making it small through use of “little”. HPCN 1 proposes that the pain may be linked with “sort of neuropathic symptoms” (line 6). This demonstrates that the HPCN has knowledge of the possible causes of this type of pain. However, the consultant does not confirm this link (line 7) although he too hedges his disagreement with “No, not particularly”. The HPCN uses the term “pricking” to describe the

pain (Line 8). The consultant agrees with this description, and he says “yes” at line 11. Perhaps the nurse’s attempt to classify the pain as ‘neuropathic’ comes too close to the doctor’s role in the diagnosis of the cause of pain. In this context, the naming of the pain as ‘neuropathic’ remains the doctor’s area of jurisdiction. Thus, the questioning technique used by the HPCN enables the doctor to keep his footing as a diagnostician who can diagnose neuropathic pain. Therefore, the boundaries between specialist nursing and medicine related to classifying a pain as neuropathic are evident in the talk. However the questioning technique enables the consultant to classify the pain and the HPCN to steer the conversation to the issue of pain. Matters of etiquette and tact are part of collegial interactions where respect for professional knowledge and maintaining a front are considered important to collegial interaction (Goffman, 1959; Specht, 1985). Thus, the specialist nurse is careful not to tread on the consultant’s area of expertise related to classifying pain as neuropathic. The questioning strategy and use of hedges marks her cautiousness when approaching the biomedical boundary related to classifying pain.

According to Specht, (1985), socio political interaction can enter into collegial interactions at any time and these interactions are often about who makes the decision. In the interaction above, it is the consultant who does not confirm the presence of neuropathic pain and it is the HPCN who then steers the conversation and changes the topic of conversation to discuss the patient’s bowels and she identifies the collegial we: “Perhaps we ought to check when we are up” at line 24. The HPCN uses a series of questions to discuss the patient’s pain and then to move on to a second topic related to the symptom of incontinence and constipation. The HPCN is more successful in deciding how they should move forward in relation to the constipation than she is to deciding the cause of the pain. Therefore, the decision is to check whether the staff are considering the patient’s bowel problem, and they are going to check that when they next visit the patient. She manages the agenda of the meeting by introducing topics for discussion. She is successful in making a decision for the team to check on the ward staff in relation to managing the patient’s bowels. Questions enable the HPCN to manage the boundary between herself and the consultant. It enables her to propose suggestions about the cause of pain in a cautious manner. It identifies how bowel care is a nursing rather than a medical concern, and classifying pain is a medical matter. However it also identifies the team concern with these issues through the use of the collegial “we”.

Opinion- and advice-seeking questions

The following sequence of talk takes place in one of the daily meetings of the community palliative care team. The CPCN negotiates with the palliative care consultant to have a patient referred for a specialist ophthalmic opinion:

1	CPCN 1	I mean is it worth me trying to get an	
2		appointment at B hospital? I mean do you think Mr S or	
3		somebody would be able to see anything on ahm	
4	CPM 2	Well they could certainly, one has seen, I’ve seen	
5		bilateral choroidal metastases.	
6	CPCN 1	Can they pick it up with their special	
7		equipment up there. Do you think they will?	
8	CPM 2	They will see. They will see they will look in the eye	
9	CPCN 1	Because that will give us some clout with Dr	

10		J	
11	CPM 2	If there is some choroidal metastases he will see	
12		them straight away.	
13	CPCN 1	Can I ring up B hospital or do I have to wait for Dr	
14		K to do a referral? because that's going to delay things	
15		quite considerably unfortunately.	
16	CPM 2	If Dr K agrees.	
17	CPCN 1	Well I give him a ring but yeah	
18	CPM 2	If he agrees then you go ahead.	
19	CPCN 1	I just ring up and his referral can come when	
20		he's ready to write it. You know what he's a bit. He	
		takes a	
21		little bit of time. I think this lady needs to be ahm	
22	CPM 2	Before her sight goes completely.	
23	CPCN 1	Yeah. It's probably more prudent to do that	
24		then to getting her up here to see yourself cause even if	
		you	
25		think agree and think there's cerebral they're still not	
		going to	
26		do anything at the Royal on that are they? They need to	
27		have some more proof.	
28	CPM 2	They want some science.	

Data Extract (e), Community palliative care meeting

CPCN 1 initiates the chain of questions that positions the consultant as the recipient of the questions (lines 2, 7, 14). This turn-taking procedure of question and answer operates to manage a key task in interprofessional relations, namely, the identities of doctor and nurse. By interrogating the consultant's medical know-how, the HPCN treats him as a medical oracle. This achieves his expertise in relation to medicine and enables her to enter into medical discourse while maintaining the consultant's footing as a medical expert. This system enables them to do interprofessional work in a manner that is mutually constructed. She negotiates with the consultant to get the patient seen by an ophthalmic consultant at B Hospital (lines 1-8).

The CPCN wishes to make an ophthalmic appointment at the specialist hospital for this patient and she introduces this topic in a manner that is cautious and polite. CPCN 1 asks a question, "I mean is it worth me trying to get an appointment at B hospital?" (line 2). Cautiousness is evident in the use of the checking device "I mean." In the consultant's reply, at line 4, he orientates to the second part of CPCN's question related to the specialist medical skill of seeing 'bilateral choroidal metastases'. I suggest that this reply marks the referral procedure introduced by CPCN at line 2 as a delicate issue across the nurse-doctor boundary as the CPM avoids answering the first part of the question. Thus, both nurse and doctor orientate to the issue introduced by being cautious. The doctor avoids and delays answering the first part of the question.

The CPCN asks the consultant about what the specialist, whom she names, as Mr S., would be able to see (line 2-3). She then opens up the choice of doctor by using a hedge, "or somebody" (line 3). This achieves the consultant's authority to make a decision about whom to refer to. The CPCN continues her chain of questions, "Can they pick it up with their special equipment up there. Do you think they will?" (line 6-7). The consultant confirms that "They will see" and he uses these words twice to confirm his belief in the ability of these specialists and their equipment

to “see” (line 8). This according to the CPCN will give “some clout with Dr. J” (the oncologist; lines 9-10). The problem in the patient’s eye can only be seen by the specialist consultant: “choroidal metastases he will see them straight away” (line 11-12). At this point the CPCN seems to have achieved the decision for the referral. Clearly, the CPCN wants to have the patient seen by an ophthalmic consultant, and her questions are a masking tactic to enable the consultant to keep his footing as a medical expert and to enable him to work with her to accomplish the referral, without telling him what to do directly. The CPCN is masking a command related to how the referral will be made.

According to Goody (1978), masking questions work in two ways. In one way they mask the questioner’s ability to control the recipient, and in another they work to make the recipient responsible for the consequences of the reply and thus make them a partner. Therefore, the CPCN is proceeding cautiously by using hedges to mark areas of uncertainty and potential alignments; she is also using questions in a way that is masking a command related to the referral procedure. This masking is a way of avoiding upsetting interprofessional. The CPCN is masking her intention to get the referral, by gaining the consultant’s co-operation by the use of questions. These strategies are designed to manage the tensions inherent in interprofessional relations and role responsibilities. They are a way of managing and blurring professional boundaries. The decision to make the referral to the specialist hospital doctor is achieved by line 12. The division of labour in making the decision is that the CPCN makes the proposal for a referral and the CPM agrees that the specialist consultant will see: “choroidal metastases he will see them straight away” (line 12).

At line 13, the topic that now is the focus of talk is how and who will make the referral to the specialist hospital doctor and the nurse seeks permission to carry out the referral herself, which is discussed next.

Permission seeking: pushing at the boundary

The mechanism by which the referral is going to be carried out is again the topic of conversation introduced by the CPCN at line 13. The CPCN asks what is called a self-referencing question: “Can I ring up” (line 13). A self-referencing question depicts the person’s own intentions and motivation. Questions encompassing “Can I” and “I mean” are the most indirect and deferential of the self-referencing frames (Clayman & Heritage, 2002). The CPCN believes having to wait for the GP to do the referral is going to “delay things” (line 14-15). However, the consultant, in his next turn, changes footing out of the role of answerer. He maintains the GP-CPCN boundary by asserting that the CPCN must ask the GP to do the referral. At this point, the CPCN gives the floor back to the consultant, and in his next turn he reiterates, “If he agrees then you go ahead” (line 18). Perhaps one of the reasons behind the insistence on the GP’s agreement is that deferring to the GP for the referral is part of professional etiquette. It is the usual manner of getting a hospital referral for a patient in the community, presumably. Specht (1985), discusses how professional interaction can be collegial with attention to matters of etiquette, good manners and tact but at any time sociopolitical interactions can also take place and enter into collegial interactions. The sociopolitical interactions are usually around matters related to allocation and control of organisational resources and decisions (Specht, 1985). Thus, I suggest the problem of the referral is a political matter, as it goes beyond the boundary between medicine and specialist nursing in this context. Thus, the CPCN has hit an organisational boundary between the two

professions. The consultant is acting as a 'gatekeeper' and monitoring professional boundaries. Thus, there is a tension between the power exerted by the masking strategy of using questions available to the CPCN and the organisational and professional power available to the CPM.

The problem that the CPCN is concerned with is the delay in getting the referral from a GP who she considers is going "to delay things quite considerably" in her opinion (lines 14-15). Thus, her objective is to get a speedy referral to a specialist hospital doctor. However, she has hit a stumbling block or the boundary that is non-negotiable. In her next turn she says, "I just ring up and his referral can come when he's ready to write it. You know what he's a bit. He takes a little bit of time. I think this lady needs to be ahm" (line 19-21). The CPCN makes a repair and hedge, "you know he's a bit, he takes a bit of time". It has been observed that self-repair is a means of repairing "interactional errors", in other words repairing mistakes in the attempt to address and speak appropriately to people in particular circumstances (Jefferson, 1974). In this statement, the CPCN revises her earlier utterance to one that is more acceptable and she is being cautious by using hedges "he's a bit, he takes a bit of time" in contrast to her earlier statement at line 14 "that's going to delay things quite considerably". The CPCN therefore exhibits a preference for agreement and this enables the smoothing out of the interactional troubles.

Reaching agreement

The CPCN and CPM collaborate to contain and smooth over their disagreement between lines 21-23, when they identify the need for the patient to be seen quickly. In fact, the CPM completes the turn for the CPCN by referring to the concern about "Before her sight goes completely" (line 22). Completion of each other's turns may signify a degree of equality in a relationship (Coates, 1998). Thus, the collegial aspect of this talk is evident at this point. This talk establishes the CPCN's reputation as someone who is prudent and careful and who knows the type of "proof" required to enable a decision about what to do (lines 23-27). The CPCN is eager to pursue the referral quickly and is unconcerned about professional sensitivities and etiquette with the GP. She is more concerned with her own competence and credibility as an effective professional who can get a quick referral. However, her approach does not challenge the palliative care consultant but is polite and cautious. She is constructing collegiality through her attention to strategic politeness. Her rhetorical performance consists of agreement with the consultant "Well I give him a ring" (line 17) and "I just ring up" (line 19). Therefore, she avoids challenging the consultant's authority. I suggest this is because the discipline of palliative care is one that respects teamwork and collegiality within the palliative care discipline. For example, a team performance could be disrupted through an inappropriate performance, and there is a reliance on the conduct and behaviour of others to bring of team work (Goffman, 1959). Even where there are practitioners with different statuses within an organisation there is still the recognition of their mutual dependence and this is a source of cohesion.

Questions and their responses specifically mark the disciplinary boundaries between the CPCN and CPM. Only if the GP agrees can she go ahead with the referral (line 18). The CPCN and CPM reach agreement at line 21 and 22 where they both agree that the patient needs to be seen quickly "Before her sight goes completely" (line 22). The CPCN replies "Yeah" at line 23. The CPCN and CPM reference their shared belief in proof (line 27) and science (line 28). This identifies the biomedical base of their respective professions. This is where they are in absolute agreement. I suggest that the issue of the referral references the tension that exists between

specialist palliative care nurses and non-specialist doctors such as GPs, which is discussed elsewhere (Arber, 2007). At this moment, the referral procedure remains a medical matter from one medical practitioner to another, and in this context the CPM has a gate-keeping role. The gate-keeping role is discussed in more detail next.

Gatekeeping

In data extract (f), the CPCN is negotiating with the consultant to have a patient admitted to the hospice. This patient has problems with non-malignant pain:

1	CPCN 2	So this woman is asking a) not to come to day care or if	
		she comes	
2		to come every other week for only an hour or something	
		like this.	
3		We are just going around in circles. What do you want us	
		to do? Do	
4		you want us to call her in?	
5	CPM 1	Has mm S seen her at home the tissue viability sister?	
6	CPCN 2	Not to my knowledge	
7	CPM 1	No mm we can certainly bring her in.	

Data extract (f), Community Palliative Care Team Meeting

This patient is not named she is referred to as “this woman” (Line 1). She meets the category of a troubled patient; one whose symptoms are difficult to control and who rejects suggestions such as coming to day care (Li & Arber, 2006). The nurse is clearly finding no answers to the patient difficulties: “we are just going around in circles” (Line 3). This patient could be a threat to the reputation of specialist palliative care as her symptoms are difficult to control in the community. The CPCN asks an open question followed by a closed question (line 3). “What do you want us to do? Do you want us to call her in?” The consultant’s authority to make decisions about admitting the patient to the hospice is clearly referenced here. He is therefore the gatekeeper for admissions to the hospice. Eagle & de Vries (2005) in a study of hospice admission meetings found that there was a gate-keeping process that guarded against inappropriate admissions to the hospice. They found that consultant staff guarded the doors to hospice admission and community palliative care nurses argued the case for admission. This is the situation in data extract (f). By using “we” in line 7, the decision is identified as a collegial one by the consultant. The use of “we” constructs the team approach (Watson, 1987), and it enables a shared decision to be made to admit the patient to the hospice. Silverman, (1987) agrees with this, as he says the voices of “we” get things done because they enable decisions to be made. The use of the collegial “we” is part of the process of social alignment that enables doctors, nurses, and others to work together and to achieve optimum management of complex symptoms and access to scarce resources.

The cautious and delicate nature of the interprofessional space in the context of the specialist palliative care team meetings is addressed by HPCNs, CPCNs and CPM using questions, hedges and the team device of “we” to enable the minimisation of interpersonal disagreement while maximising agreement. Also, CPCNs use deferential strategies such as the outright seeking permission for referrals and admission to the hospice e.g. “what do you want us to do?”, “Can I?”

This identifies the boundary between medicine and specialist nursing that is being negotiated by using a cautious and protective device of questions. It also establishes the gate-keeping role of the consultant. Consultants and specialist nurses reference a collegial context by using the team device “we” and by demonstrating equality in their relationships by expressions of agreement over the need for speed in making referrals and getting access to in-patient hospice beds.

Discussion

The strategic use of questions, identified in this article, enables specialist palliative care nurses to influence and manage interprofessional interactions in a manner that is diplomatic and polite. The strategic nature of questions is part of the etiquette of team meetings in this context. Questions operate as a social device to manage the boundary between one professional discipline and another. They enable and facilitate interprofessional interaction, and operate by smoothing interactions by recognition and respect for consultant expertise in their role as gatekeepers and diagnosticians. Therefore, issues of authority and power are relevant in relation to how questions arise and the actions they produce. The questioning strategy positions consultant staff as the boundary maintainer and gatekeeper and the specialist nurses as the boundary tester and manager. Together, specialist nurses and consultant staff are strategically managing the boundaries of their professional disciplines through the use of interactional devices such as questions to manage the tensions inherent in interprofessional work. The linguistic strategies used in interprofessional talk are identified in Table 1.

Specialist nurses use questions in a strategic and polite manner to achieve their professional agenda, to present their professional identity and to manage the tensions involved in interprofessional working. Boundaries, according to Svensson (1996), are a social construction in nurses', doctors' and other members' talk. Therefore, how boundaries are orientated to in the talk give insight into the use and availability of power. The power position in interaction is associated with an ability to initiate the trajectory for action and to set its agenda. The questioning strategy used by the CPCNs enable topics to be raised and agendas to be initiated that contribute to decisions about specialist palliative care practice. According to Griffiths & Hughes (1994), team members when formulating grounds for decisions within the language of one specialism carries the risk of marginalizing the contributions of others. They refer to “natural rhetorics” as part of the ongoing ritual reaffirmation of team identity and legitimacy of team practice. One aspect of the natural rhetoric of palliative care team meetings is the strategic use of questions. The questioning strategy enables the specialist nurses to initiate the action trajectory for the eventual decision and are influential precisely because of the naturalness of the questioning strategy. It is social device; it is used to test out the boundary between medicine and nursing, it aligns others; it is goal directed. Most important, it enables specialist palliative care nurses to both influence and direct decisions on matters of a medical nature. In the context in which they occur they are presented in a polite and face-saving manner. Therefore, the questioning strategy is both palatable and non- dominating in delivery and enable the medical and nursing boundary to be negotiated in a manner that is acceptable to senior medical professionals.

The use of questions has been identified as having a gendered dimension, with women asking more questions to develop rapport during social interaction than men (Fishman, 1978; Tannen, 1989). However, the person asking the questions has a lot of control of the conversation and to

some extent controls what the next speaker is able to say. The key relevant variable in organisational interaction, according to Mills, (2003), is occupational status not gender. Furthermore, managing different perspectives and disparities is a key dimension of interaction. The skilled nature of the negotiations around the professional boundaries involving questions, opinion and advice seeking, permission seeking and collegial agreement are ways through which perspectives, disparities, and tensions are anticipated, managed and mitigated (Boden, 1994). Questions in the context in which they occur are a social device that enables the boundaries of specialist nursing and medicine to be negotiated collegially, respectfully and courteously.

Questions can be hedged and therefore operate as protective devices. Hedges such as “I think”, “little bit”, “just,” protect specialist nurses by being guarded and cautious. Maintaining face is a condition of interaction according to Goffman, (1959), and face-saving practices are sometimes called tact, diplomacy and social skill. To be able to employ face-saving techniques, one needs to exercise perceptiveness, according to Goffman, (1959). Thus, saving one’s own face but also saving the face of others is both defensive and protective. The questioning strategy is designed to be respectful to consultant expertise and to manage the biomedical boundary. The team meeting occurs in a setting that orientates to face by being respectful, polite and extending to senior medical staff their ceremonial due (Strong, 1979). In this study, there is also evidence of the use of deferential rhetorical strategies related to opinion-seeking and permission-seeking strategies; for example, when making requests for referrals to specialist hospitals and when seeking access to in-patient hospice resources. It could be argued that nurses have developed a skilled way of masking their subordination to doctors’ decisions by using questions related to opinion-seeking and permission seeking. However, this hypothesis can be challenged because of the way that specialist nurses use covert or masked questions to test the limits of gatekeeping and to rhetorically push for particular patient outcomes in a strategic manner.

The use of questions in interaction has been noted in legal and broadcasting contexts and in the workplace generally (Clayman, 1992; Greatbach, 1992; Greatbatch & Dingwall, 1999). For example Greatbach (1992), in the context of news interviews, explores the relationship between the turn-taking provisions and the legal requirement that broadcast journalists should maintain impartiality in their coverage of news and current affairs. According to Greatbach turn-taking procedures pre-establish the local roles of broadcast journalists as report elicitors, which maintains their neutralistic stance as soliciting information and opinion. He says that interviewees collaborate by avoiding challenging or commenting on the character of the interviewers’ questions and therefore collaborate to maintain the neutralistic stance taken by the interviewer. Thus, I suggest that the questioning technique adopted by the specialist nurses enables them to avoid giving an opinion directly, and this may avoid the tensions associated with being direct and confrontational to a member of one’s team who is a senior medical practitioner. This technique therefore is a tool to manage interprofessional relations directed by specialist nurses and aligned with by consultant medical staff. However, unlike the interviewees in the context of broadcasting, consultant medical staff have a gatekeeping role in managing access to resources and the boundary between one group and another. I therefore suggest that the alignment through the use of adjacency pairs is only possible up to a point. When decisions about medical referrals and access to hospice beds are discussed the consultant’s role of gatekeeper is evident.

Questions are a social device but they also have a strategic importance as the person who asks the question has the right to talk again afterwards, and as long as one is in the position of doing

questions one is in part in control of the conversation (Sacks, 1992). Cameron, (2000), agrees with this; she says that the person asking the questions in formal settings has a dominant role and gives that person a considerable amount of power to direct interaction. This is interesting, as the role of the questioning strategy suggests that it has emerged as a social device to deal with differences in status and power within interprofessional settings such as team meetings. Therefore, this strategy works to balance power differentials and enables specialist nurses to work with the consultant in a manner that is mutually acceptable.

One of the limitations of my research is the small number of teams that have been researched. For example Perakyla (2004:296) asks whether “everything that is said in case studies on institutional interaction apply exclusively to the particular site that was observed, or do the results have wider relevance?” Studies such as this on a limited number of team meetings may have limited reliability. However, Perakyla suggests that the question of generalisability could be approached from the point of view of possibilities. Therefore in this study there is the possibility that the strategic use of questions is a technique that is used to manage the boundary between one profession and another in other settings. This technique may be used both interprofessionally and intraprofessionally and may be used by staff working collegially and across professional and disciplinary boundaries. The strategic use of questions may be specific to specialist nurses in their role as boundary testers and expanders as they develop their role and place in multidisciplinary teams.

Conclusion

The questioning strategy is a way to save face, do politeness and not to rock the interprofessional boat. This is skilled communication in a sense that enables interprofessional interaction, contributes to decisions and preserves the etiquette and politeness evident in much of medical practice (Strong, 1979). The use of questions enables interprofessional dialogue in the context of this study and enables the CPCNs and the HPCNs to retain a degree of control of the agenda of the meeting. Although Wang, (2006), argues that power is relevant in all interaction whether informal or formal she suggests that power is covert in informal settings and overt in institutional settings. I think this contention needs further research as this can be disputed in this article. There are reasons why a person with less status vis-a-vis others uses questions in a masked way to guide interaction, introduce topics, and negotiate decisions during meetings. The questioning strategy enables the boundary between one profession and another to be negotiated in a mutually acceptable manner through questions that mask and control, elicit advice, seek permission, direct action and get access to specific resources such as hospice beds. What drives this approach is the concern for establishing not only a specialist identity, but effective referrals that maintain the reputation of the speciality of palliative care.

It may be possible for the team to reflect on how they conduct their meetings, and transcripts of team meetings may be a starting point in developing insight into how the team works together to make decisions from a social and interactional perspective. This would complement other approaches to rational decision making and highlight the interactional accomplishment of interprofessional work. This work is important to the development and education of specialist practitioners as their effectiveness in the team setting may be dependent on not only their professional knowledge and competence but how this is negotiated in team meetings. In the

future, further studies of teamwork in a variety of contexts would expand on the interactional perspective developed in this article, with the elucidation of further markers of interaction in the interprofessional context of team meetings. This would develop interactional competencies that are interprofessional and may guide practice and education in relation to team work in the future. Finally it would be useful to develop further research related to the interactional aspects of teamwork and decision making, and how team work is achieved. This could include comparisons across cultures and disciplines, as well as different medical contexts, to test out the emerging linguistic markers of interprofessional work.

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Table 1 A Summary of Categories, Verbal Strategies and Outcomes in Interprofessional Talk

Theme	Categories	Strategy	Outcome
Strategic use of questions	Doing interprofessional talk	Adjacency pairs	Identity management
		Aligning, masking, hedging	Face saving Protective
	Professional Etiquette		
	Permission seeking	Can I, do you, do I	Authority Decision
	Opinion/advice seeking	What about, is it worth, do you think	Information Boundary testing Strategic politeness
	Tension and managing agreement	Isn't he, who is, no, if, but, he's a bit, well, if	Boundary management Gatekeeping Decision
		Doing teamwork	I and we, yeah, us I think, just, you know